

Certificate of Need – ASF Rules
Notes for Stakeholder Meeting – June 8, 2016
WAC 246-310-270

Meeting began at 10:00AM with introductions.

Kathy: Purpose of meeting is to design hospital outpatient survey questions. Realize there has been some time that passed between now and last meeting; members busy and may not have had time to respond with draft questions. Use this time to brainstorm.

Jan: Won't need to focus on introductory language; department can draft. Group can focus on drafting questions only.

Jody: Not clear about goal – is this just about the hospitals? Or just HOPDs?

Group clarifies approach for hospitals. Designed to identify information availability and gaps, similar to what we learned about the freestanding ASF.

Jan: One of the things we discussed was the number of ORs – let's look at our current annual ASF survey and see if there is anything we can use. We've identified inpatient, outpatient, (either?). I'm trying to recall what some of the questions were that were appropriate for the freestanding ASF that might not have applied to outpatient hospital surgeries.

Jody: I think what is the scope of the hospital? Is it dedicated outpatient?

Emily: It seems to me that we don't know what the calculation is necessarily going to look like, and what pieces of information we would need...maybe the survey should be broad...right now it seems like the amount of mixed use ORs used for outpatient, is that a component you plug in and we would want to ascertain that information if possible...

Beth: To make sure I captured your question, if the hospitals have a way of saying how much inpatient vs outpatient is done in a mixed use OR....

Frank S: That's pretty easy to do depending on how you code it.

Jody: My understanding from the hospital clients I have is that that data per room is not data they normally collect.

Jan: But if they have, hypothetically, five mixed use ORs, and 70% is used for inpatient and 20% is used for outpatient of those ORs, it's not per room that we're doing right now. It's telling us what percentage and then we can... (00:09:22)

Emily: So I think maybe the question is, how can they tell us that not whether they could tell us that.

Jan: Right.

Nick: It's billing data that is going to tell us this, so billing information will end up being the source for answering that question if we can supply that information, I can go back and find that out from MultiCare's perspective, is do we have the capability, and I would guess that we can at an overall level, but not by room. So as long as we're, you know, ten mixed use ORs and here's what our proportions are, that would not be unreasonable.

Emily: I'm just wondering if in the survey, what part of the information is the percentage used, right? But I also think part of the question is, how can the hospitals quantify it, to help educate us on (unintelligible)(00:10:48)

Jody: And I do think we have to ask about scheduled hours of operation per room because it varies dramatically by room. Some go 12 – 15 hours per days, others do it differently.

Frank S: Is there a way to deal with risk? Based on the patient category, that might be a higher acuity level therefor [the surgery] is done in a hospital...

Jan: But it's still done as an outpatient surgery. What we're looking at is, you know, whether it's mixed use OR or dedicated outpatient or, and from our perspective a freestanding hospital outpatient department that's off the campus that is CN approved. There will be some that were developed prior to 1996 that were developed when there was not that change in Certificate of Need rules but they still would be counted as off campus ASCs for our purposes (00:12:53)

Jody: And I think again, from the hospital perspective, we have to understand the universe of what's in and what's out, so for example, is OB in? And is interventional radiology calculated? I mean, the things that are happening in those rooms – do we need to have apples for apples and are we going to use this for the use rate or are we just using it for capacity, and I think we just want to compare apples to apples.

Jan: So do you want a listing of the ten most common procedures performed in those ORs?

Jody: I don't know if it's that, I just think we need to be clear about what is in and what is out.

Emily: Radiology, for example.

Jody: Interventional radiology?

Emily: I wouldn't include that as inpatient. Maybe a way to approach it is if it can't be done in an ASC setting, it should be included as inpatient minutes or inpatient procedures.

Jody: So here's the issue: some hospitals do C-sections in a dedicated C-section room, and some do them in the OR. Some do interventional radiology in the radiology department, some do interventional radiology in the ORs. So, is it worth it to us to get apple to apples or not?

Jan: Well, I think if they have dedicated rooms, I think that's the other thing that we need to ask, are there dedicated rooms for certain surgeries. And the reason, because, our current methodology excludes rooms dedicated to open heart surgery, those that are dedicated to C-sections I believe is one that's also excluded under the methodology.

Frank S: We just had an outpatient interventional radiology facility open, an ASF (unintelligible)(00:14:35)

Jan: Okay, so as long as they're not doing PCIs they're fine. But those would be something that we would want to identify.

Beth: But if those aren't happening in a dedicated, like, so we would exclude it if it was a dedicated room, but if they are happening, I don't mean open heart, but like C-sections, those are happening and in not dedicated C-section rooms do we count or not count the utilization.

Jan: I think you have to count, I mean, from my perspective if it's a procedure done in a non-dedicated OR it has to be counted because that impacts the availability of those rooms for other procedures.

Beth: So it isn't that C-sections are excluded, it's that C-sections in a dedicated room are excluded. Am I understanding correctly?

Jan: Yes, I mean, right now under our current, you have dedicated rooms for very specific procedures. Part of the reason that C-sections are excluded if it's a dedicated room is that they are unexpected, you generally don't do them, you can, but you don't always schedule C-sections. And so they are rooms reserved for those procedures.

Beth: I only ask for when where we're tracking that data, if we ask for someone to break out their C-sections, what if some of them are in general use ORs and some are in a dedicated room it could be messy.

Jan: But we're probably going to be, I would be surprised, if we're going to get down to the level of how many C-sections did you do in these rooms? We might, but I would be surprised that we would get, that might, down to that level of it, so. (00:16:44)

Kathy: I think if we're going to do a telephone survey – is that what we're envisioning for this?

Jody: I think if you are going to need billing data, you won't be able to do it by telephone.

Kathy: Right, I didn't so, but depending on how these questions come out.

Jan: I think it's going to be more challenging to do it by telephone.

Kathy: Right, for this level of detail.

Zosia (by telephone): What I'm hearing is that this will be an electronic survey as opposed to a telephone survey?

Kathy: Yes

Zosia: My one concern there is that it might be challenging, I'm just worried about the response rate if it's just an email or something.

Jan: We might send it out by email but we would be doing follow up with folks to try and increase that response rate.

Zosia: Oh, okay, that makes sense, thank you. Want to make sure we get good data.

Jan: We rarely send a survey out and don't do follow up.

Jody: I think it's just cleaner to say OB is out or C-sections are out, and then, why do we need them to break that out if we just exclude C-sections because it's not in the use rate, and we don't want it to be in the use rate.

Jan: But I think there is a difference, Jody, in terms of the types of procedures versus, I mean, you're looking at, wanting to look at OR capacity and if they're doing C-sections or let's say that they don't have an open heart surgery suite and they're doing open heart surgeries in whatever suite that they have then that needs to be included because that is taking away from other surgeries that could be performed, I mean, it's a use.

Jody: I'm just trying to balance the equation.

Emily: But I don't think we're necessarily balancing the equation at this point as much as we're getting the information.

Jody: Well, if you don't have it broken out you'll never be able to balance the equation.

Emily: But I think we're trying to ascertain information about the use of the operating rooms.

Jody: But if we don't know the minutes, how are we going to back them out to balance the equation?

Beth: So maybe a good question to ask is what types of rooms do you have dedicated and do you have dedicated services in any other ORs ever? So we would ask, how many ORs do you have that are dedicated to just one thing, and what are they dedicated to, and are any of the services provided in those rooms also provided in non-dedicated rooms?

Jody: But what do we mean by dedicated? Exclusively? (00:20:28)

Beth: Yes, because C-sections seem like an easy one to leap on to – so you have a suite that is exclusively dedicated to C-sections but do you happen to do them anywhere else as well? So that way, we have an idea of how often that happens.

Frank S: I think you are looking at OR capacity, general OR capacity. So, if that OR that we're concerned about is general use is in use, then shouldn't that be counted in the time?

Jan/Beth: Yes.

Jan: And if there are ORs that are dedicated to a specific use, then we need to identify what those uses are.

Kathy: The first question in Part B 1 of the ASF survey was "Can you describe the type or types of surgical services and procedures performed in your facilities" so we could consider changing that to OR rooms, or the pertinent rooms – maybe just revise that question a little. That's what I think we're getting at and what I think I'm hearing.

Jan: Right, and now we're talking about the number of ORs and how you define them and which ones are in.

Jody: So we're not asking them for minutes. That's where I'm coming from – we're just going to get groups (intelligible)

Nick: I thought based on our last meeting we were.

Jody: Which is why I'm saying we need to understand what is happening in these rooms

Jan: To me, you identify the questions that you want about the physical ability, and then you go on to identify the questions that we want about what is happening within those rooms.

Nick: Okay, so your first section is just capacity.

Jan/Kathy: Right. Physical capacity that you have.

Nick: So if we were to summarize the questions we've developed so far, I have them down as identification of the number of OR, whether its dedicated inpatient, dedicated outpatient, or mixed use. The second question being is a hospital, or are the hospitals able to identify how much or what mix of inpatient versus outpatient is occurring in the mixed use [rooms]; and third is, and to Jody's point, hours of operation by room; and then fourth would be the one we just drafted, if ORs are dedicated to a specific use, we need to identify that, so it would be an enhancement to question #1 where we identify the number of dedicated C-section suites versus open heart.

Jan: Right, because your first one, you want the total number of ORs that you've got. And break that down, and of those, how many dedicated one way or the other if any, and then, like that. (00:24:10)

Jody: This question will not get at procedure rooms like endo or pain because hospitals don't think of those are ORs, they think of them as procedure rooms, so do we need to call out specifically the number of ORs, the number of GI, number of pain?

Jan: We can. I think that one of the things we can do, we can provide our definition of what an OR is, which includes those.

Nick: Which if you switched to what you had before, which is your existing or current methodology, to identify that right off the bat, which is the first thing that I saw, that you are including both.

Jan: Yes.

Nick: I think the concern will be billing questions, differentiating that way. Because the way you define what an OR is to be inclusive of the procedure code may be tougher to report on from a billing standpoint because it's not identified that way. And I don't know for sure, I would have to ask.

Frank S: And would that be by code?

Nick: That would be the question.

Frank S: [they would show] ICD 10 if it's not CPT. But if you put a modifier on the ICD10 based on acuity (intelligible)

Nick: It's messy. That's what I'm trying to get at, is that there is no clear distinction from what I know and I could be wrong, but I need to check. So, I think the question is very valid, is do we look at procedure room volumes as opposed to operating room volumes.

Jan: From the department's perspective, those are operating rooms and by definition, those are operating rooms for ASFs. While the common vernacular that we talk about them being procedure rooms, that

surgery, that procedure that's done in that procedure room is billed as a surgery. It is a surgery. It is a surgery under the ASF billing. (00:26:44)

Jody: Only for GI, pain, I mean there is so much more that happens, we don't want to have a generic, I mean, they're suturing, there are casting procedure rooms, there's all kinds of things, cardiac, I mean cath labs are procedure rooms, we don't want all of that in our thing so we don't want to have a wide, most OR, most EDs have procedure rooms in them.

Frank S: But they don't bill s facilities fee for their use like you would an endoscopy room or something like that.

Jody: Yes they do.

Frank S: Not in the same way, not as I understand it. I mean, I might be wrong.

Jody: Yes, they all have procedure rooms, those are the facility and they all get a facility fee. (00:27:23) I think we need to clarify because we're going to be getting suture removals, you're going to be getting a ton of stuff if you aren't clear. I think we need to say what we want in, and what I think you're saying is GI, dental, endoscopy, pain. We don't want to have just a generic procedure room where there are a lot of other things going on that aren't surgeries.

Nick: If we look at the categories or buckets that came out of the last meeting, I think it's realistic to limit ourselves to those. My concern is, and to Jody's point, as to all other/general we need to address what's not included. Or, nothing that is not listed here should be included, because otherwise it is going to become very messy. So from the capacity standpoint, we've highlighted five items: [room?] ORs, designation of those ORs, are hospitals able to identify the (unintelligible) in patient/outpatient mixed use, hours of operation by room, and are there any dedicated specific use ORs. Are there any other capacity related issues?

Jody: So I was thinking under designation of ORs you wanted to know whether it was an HOPD or ASC?

Beth: Yes.

Emily: Separate designation of facility from OR. Make it two questions instead of one.

Frank S /Jody: To clarify what I was talking about – a CMS facility fee versus a clinic fee where it's rolled in for qualification procedures. General facilities fee discussion.

Group reviews existing ASF annual survey. Are we duplicating questions? Is the current data collected in the annual ASF survey not valid? Program response is that this is being done for two different purposes. Currently, the existing annual survey is being used for existing methodology and applying it when the program receives applications.

Jan: The focus of this group is looking forward to a future methodology for the expansion (00:33:03). Whether the methodology remains the same but with different configurations or whether we try to do something very different is why we're looking at trying to identify the types of information that's now available with billing services that are out there, data systems that, you know, when we were first doing the methodology didn't exist, except on paper type of a thing, so that's what we are trying to figure out so that we can have a discussion around what the elements are going to be in a revised methodology. So,

these are the things that we thought were important under our current methodology to get the information to apply the current methodology.

Jody: I'm rethinking what we told Kathy, that this shouldn't be done by phone. I think this is exploratory at this point, and I do think you could reach out to different size and geographically located hospitals and ask, "Is this doable, how do you keep your information" they are not going to be able to answer you, it's going to be the OR manager or billing person, I think there are different people, but I do think you could get that question out there and formulate it enough to get back before you send this out to hospitals.

Zosia: I think that's a really good idea to do almost like a spot-checking exercise to see if it's going to be possible to answer these questions at all.

Kathy: Do we want to send this out to all of the hospitals or do a percentage – representative sample – like we did with the ASFs?

Jody: I think it's important to get a good mix – the rurals, the systems, the tertiaries. I feel like we don't have the expertise around the table – the billing people, the schedulers, who else would we need to help us? Do we want to know the total number of ORs or the ones that are operational?

Moving on to procedures: we asked ASFs if there was a certain way they scheduled different procedures. Do we want to ask the hospitals the same question?

Nick: It's going to be as varied as the responses I'm looking at on the ASF side. I mean, you've got at least 13 different categories for ASF responses as to how they do their scheduling, and I'm not certain we can formulate any sort of valuable intelligence from that, that would be my challenge, my concern. (00:39:08)

Jody: I think the logical question is, average inpatient surgical time and outpatient surgical time, and turnaround times.

Jan: But is asking for average cleanup time going to...

Jody: I think that makes sense because they can tell you that for eye, for GI, for mixed use.

Frank S: I know they keep these for physician time because part of the chart is when the patient enters and when the patient exits.

Do we need anything more than averages? The ASF survey was averages, and that's really what the group focused on. Put GI and endoscopy together. Then take ASF data and pull them into the same buckets. Then we can compare the difference between the two. Biggest concern for Nick will be acuity – when we talk about inpatient minutes we're going to see [a] much higher [number]. Sometimes there are outpatient procedures on high risk patients and they can get lost. Have to know if room is mixed use or dedicated – this is important. Identify inpatient/outpatient/mixed use – average surgery time for each. What about turnaround time? Ask about average turnaround time for each of the five identified buckets. (47:44)

Do we want to know about 23/59? Differentiate between hours of operation and hours that surgeries are scheduled. What are the hours that the ORs are scheduling? If it is an inpatient OR, hours of operation may be 24 hours a day, but on the outpatient side, it may be from 6AM to 6PM from an operational standpoint. But from a surgical standpoint or scheduling standpoint, you may stop scheduling at 3PM. We are looking to measure outpatient capacity for outpatient use. Currently, the methodology combines both

mixed use and dedicated outpatient surgery to determine the number of outpatient surgery minutes. So, we need to know the scheduled hours of operation for outpatient surgeries. And typically, what is the latest that an outpatient surgery is scheduled? Beyond 3:00 or 4:00PM? What was the intent of identifying the same thing for ASF? With respect to ASF operating only a few days a week, was there anything in the ASF survey that covered those topics? If it wasn't asked, should it have been? The answers might be valid for capacity. Are we going to go back and do more fact finding on the ASF side? So the question might really be two questions: scheduled hours of operation by room and surgical minute start and end times (00:56:28). First scheduled or last scheduled?

Frank S: Acuity question: How do we handle this? Someone with high risk, needs surgery – would be counted with every other patient but goes in inpatient. Deliberate decision to do a case outpatient that results in admission.

Discussion of whether this should be captured and how to capture it, whether this will skew the numbers. Is percentage high enough to be concerned about here? We shouldn't assume that 100% of all outpatient surgeries can occur in a freestanding setting. (01:05:30).

Nick: Need to go back and ask ASF about actual days of operation.

Jan: I'm hearing that these are the questions we want to see in the sample.

Jody: For those buckets, we need to ask for average surgical times inpatient/outpatient. We've got to go back and ask for GI, endo, etc.

Nick: It's essentially a matrix, you would build a table with a bunch of columns. I'm looking at whether this can be phone performed.

Jan: Get the sample we want, send it out in advance, call, set up a time and talk to someone to fill it out over the phone. Might be 3-4 people in the room. Schedule an appointment, send out questions in advance for review. If we did this and contacted you [Nick], from the time you received the survey and the time it takes to gather the information, how much time would you need to prepare?

Nick: The first section is relatively straight forward; the second part might involve several others, and might take longer. Depends on data mining and analytic capability. From my perspective, 3 weeks – from the time of receipt of the survey to the time of the meeting. Has to be a way to say, hey, pay attention to this.

Department will do the legwork. Has to be some sort of validation to this process, as well. (01:14:45)

Next steps: Get draft survey out (likely in a couple of weeks). Identify sampling of facilities, won't need another meeting until we have responses back. End of August and early September are next scheduled meetings. Group agrees to cancel August meeting, and tentatively review results of both surveys in September. Then, group will be able to move forward with methodology. On the ASF sampling, we didn't ask for hours or scheduling. Department will go back to surveyed ASF and ask for scheduled hours of surgeries and operation (specifically, how many days of the week an ASF is open along with the number of ORs in ASF). This will provide the same type of information for both hospitals and ASF to allow group to perform meaningful comparison.

Zosia: Meetings during legislative session: if scheduled, might be challenging for some people to attend.