A meeting regarding the Certificate of Need (CoN) ambulatory surgery rules convened on December 08, 2016. The meeting was held at the Department of Health, 111 Israel Road SE, in Town Center 2, Conference Room 158, Tumwater, WA 98504.

PRESENT: Frank Fox, Providence Health & Services
         Susie Tracy, WASCA
         Dave Fitzgerald, Proliance Surgeons
         Matthew Gordon, Swedish
         Christine Kiefer, Harborview/UW Medicine (By telephone)
         Nick Shepard, MultiCare Health System (By telephone)
         Lori Aoyama HFPD (By telephone)
         Emily Studebaker, WASCA (By telephone)
         Zosia Stanley, WSHA (By telephone)
         Joel Flugstad, Skagit Regional Health (By telephone)

STAFF PRESENT: Nancy Tyson, Executive Director
                Janis Sigman, Program Manager
                Kathy Hoffman, Policy Analyst

9:05AM – Open Meeting

- Welcome, introductions. Review handouts, including issue/topic table, where the group has been, and current group direction.

Presentation and Discussion: Hospital Outpatient Survey Results

- Kathy presented and discussed HOPD survey results, by each question and response.
- Of the nineteen facilities identified, fifteen responded.
- Responses were influenced by the way organizations answered the questions.
- There is not a DOH database that tracks operating rooms; survey instruments for freestanding facilities and HOPD were very different.
• Discussion regarding survey question, Part C Time Tracking, Question 1.1, 1.2, 1.3. Follow up: need to consider a follow up question and re-work data. Trying to distinguish the difference in time for the average inpatient surgery and the average outpatient surgery, even if it’s done in mixed use ORs because that impacts the number of ORs necessary to perform the number of surgeries, whatever type it is. It's capacity.
• Issue might be with the way question C was crafted. Kathy will re-work numbers and group will reassess whether we need to do another follow up questions.
• Outliers – really small sample – some observations are obviously outliers. If we try and do anything with data, consider leaving outliers out. Anomalous.
• Group discussed the times for average surgical procedures, variances, etc. Also, these are averages across a small number of facilities.
• Discussed questions and associated limitations, variances.,
• Question C3: Should be a linkage between hours of operation, or the hours a hospital is typically operating. Would be total number of hours that the ORs might be available, and then the average hours that are actually schedule. Might be open 12 hours a day, but surgery is actually scheduled for 8. Seems to be a disconnect.
• Question seems to suggest staffed OR hours, and the number surgeries are actually scheduled.
• Is there a way to get at the information by asking a slightly different question? What we’re trying to figure out is, you have the physical capacity, but in reality, how are the rooms really being used? Perhaps maybe it isn’t really the open OR time, but how are they being used? What is the average daily OR usage?
• We’re trying to find a way to test the current rules where we’re talking about capacity for ORs in minutes because there is an assumption that each OR has a capacity for xx-number of surgeries per or based on the type. So, we’re trying to figure that out with the survey. When is first surgery scheduled to begin and when is last surgery scheduled to begin. Are they closed during the lunch hour?
• Question C3 tests the current assumption in rule – 40 hours a week, M-F. But surgical procedures have changed significantly since the rules were written.
• Maybe a follow up question is: how much time is actually being used in the OR?
• Discussion: variance between hospital based and freestanding (last page of report). May want to compare exactly the same general buckets for both facility types. Kathy will re-average numbers, even though it seems like there is not that much of a variance between freestanding and HOPD times across identified buckets.
• For follow up, need to be clear and careful. Some indicated that from what the survey suggests, methodology might be fine as is. But, might want to clarify questions as opposed to posing new questions. Looks like some questions may have been interpreted and answered differently, and for those, we should follow up. Go back to methodology and confirm what we wanted to test.
• Maybe analyze survey questions that weren’t answered? If we go back to providers, go back in one effort, and but determine weaknesses first.
• What is the status of the CoN annual hospital survey? Can we use some of the reported minutes as a reasonableness test to the survey results? Beth is not
able to attend today, but looks like 80-90% survey response rate. Might be useful to compare years.

- We’re talking about a methodology that is very specific as opposed to the current methodology where we’re talking about aggregate minutes for ORs. The current surveys will help with looking at aggregate, but the historic surveys won’t give us the level of detail.

**WAC 246-310-270- Methodology Review and Discussion**

- Planning area discussion: Are we going to have a better definition of those planning areas? For example, Central Adams, Southwest Adams are related to counties. Do we want to define them better or have multiple people define by zip codes?
- Don’t have to do it now, but work with Kathy and based on historical information we have or CoN that we’ve used, what have historically been identified as those planning areas?
- Frank has a data base that he can work with Kathy on. Zip code table similar to that used in kidney dialysis rules might be preferable. Is it the 59 planning areas? It’s the secondary planning areas. Some were identified by zip code, others weren’t. Jan has historical data and docs; SHP broke counties into smaller service areas.
- Lori’s group has a listing of the zip codes, as well, for purposes of comparison.
- WAC at subsection (6): consider something that after the effective date of these rules, ASC constructed must have a minimum of 2 OR or something. Trying to distinguish those that have been operated with a single OR under an exemption and are now seeking to be an approved ASC. They would be permitted to have a single OR. Should we make the distinction in rule between a single-room OR that is newly being built and the conversion of an existing single room OR to a CoN approved facility. More of a question than a proposal at this point, allows flexibility.
- Propose to strike section (6); obsolete – not a consensus at this point, and considering this.
- Subsection (7) is statutorily required (charity care); leave as is.
- Subsection (8) is superfluous and redundant.
- Subsection (9) assumption is we don’t know about the hours yet. Sections (9)(a)(i) and (ii) are the identification of the annual capacity of types of OR, dedicated outpatient and mixed use.
- In Subsection (9)(a)(iv), we talk about excluding special purpose rooms, but the survey suggests the special purpose rooms are a now a more narrow subsection. We’re looking at 5 buckets now: would we look at the elements contained in (a) for each of the five buckets? Annual capacity would vary between the types of buckets we’re considering using. Exclusions would be based on the bucket type. Might be harder to do in the general category. How much to you count mixed use OR to count outpatient capacity?
• GI labs are considered operating rooms, and will be included when the purpose of the ASC being applied for is GI. Those are special purpose ORs; we are now recognizing that these are one of the buckets.
• Example: 20 mixed use OR used 50% of the time would be counted as 10. Once we get below a certain number, it becomes a data problem. Can’t verify data. The issue is the mixed use OR – how do we count them? Central issue.
• For future need, department typically does 3 year projection from base year. How do we define base year? It’s the year in which you are applying for the CoN. Easy to define here because these would be concurrent review. Should we extend to five year projection horizon? Reasoning: it takes nine months to do a review, so already one year into 3 year period. Once awarded CoN, applicant has 2 years to commence the project that may or may not be opening. If converting from an exempt ASC to a non-exempt ASC, should not take 2 years. Might take longer for Medicare certification, but not 2 years. Assume allowance for construction time, may take another year and a half before it becomes operational. Do we want to add an additional year to address need at time of opening?
• Financial feasibility considers third full year of operation after the facility has been operating.
• Five years make sense on the need methodology; seems reasonable. Similar to acute care methodology. Maybe here we do 3 years for expansion and 5 years for new ASC from the base year when the base year is defined as the year of application. Given the lag in CoN approval process for a new ASC, looking at probably 3 years down the road from the base year. So maybe 3 for expansion; 5 for ground up. Seems like a reasonable approach. Approach seems understandable.
• Fundamental calculations: numbers we put into calculation. If you are looking at sub (9)(c)(i), looking at average minute time. We’re trying to figure out the minutes that would go into that calculation. Discussion of occupancy calculation. We discussed adjusting for OR that aren’t used five days per week. Currently no adjustment downward, and we talked about this earlier meetings. Methodology picks it up, but it’s buried. Calculations still work, but we need to work on the assumptions to determine how the calculations are made.
• Capacity piece contains two elements: what ORs do you count; and for those that are counted, how often are they used? What is the real capacity of those ORs?
• Preference to outpatient currently written in rule might not be necessary any longer.

Conclusion/Next Steps:
• Service area, planning areas – Kathy and Frank
• More work/follow up on survey data – Kathy
• Question of looking at current annual surveys to do a cross check
• Doing a cross check with ILRS with licensed ASF and number of ORs identified as capacity – would this tell us anything of value?
• Use rate – should we consider? Tremendous variability based on who is there currently. Should we consider a regional use rate? Does it matter if the use rate varies between Western/Eastern WA? And, should we trend it over time?
• Question for Beth: 4 regions and King County; run King County and others alone, and see what that tells us. Maybe do a three year historical?
• Group agrees to meet more frequently; six week intervals, acknowledging that everyone will be busy during the legislative session, and will adjust when necessary.