A meeting regarding the Certificate of Need (CoN) ambulatory surgery rules convened on March 16, 2017. 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  
Matthew Gordon, Swedish  
Nick Shepard, MultiCare Health System  
Jody Carona, HFPD (By telephone)  
Emily Studebaker, WASCA  
Judy Harless, Proliance Surgeons  
Jackie Fowler, WASCA

STAFF PRESENT:  
Nancy Tyson, Executive Director  
Kathy Hoffman, Policy Analyst  
Beth Harlow, Certificate of Need Analyst

9:05AM – Open Meeting

HOPD Survey Follow Up

Modifications consistent with last meeting – questions?

Frank: While a good survey, sample size too small. Only 11 respondents, very significant cell size problems. Renders making inferences or basing methodology off of it problematic.

Kathy: Agree, Dept lacks resources to conduct this type of survey in the way we wanted.

Matt: Clarification: discussion last meeting re what we do with distinction between data from mixed use rooms and how we can look at that data, how informed it is on the
outpatient vs. inpatient question, right? And when we calculate these various numbers, it’s easy enough when you’ve got your outpatient and inpatient ones (numbers) but when we’re calculating these various averages, help me understand what you’re doing with the mixed use rooms?

Kathy: I don’t think I understand your question, Matt….

Matt: I think that’s because it is incapable of being understood.

Kathy: I would agree with you. The way the survey was structured and the questions were drafted, if we want to make that distinction we need to go back to the respondents and ask more questions.

Matt: Yes, so looking at page 6, these figures are just from average overall outpatient rooms. We can’t do anything further in (whittling or parsing that out to inpatient and outpatient rooms).

Kathy: I don’t think we can. I think we found out when we were reviewing this survey at the last meeting that there were a lot of questions that could have been structured differently to flesh out those kinds of things.

Matt: Yes, just trying to clarify what I’m reading.

Kathy: Going back to the questions laid out of pages two and three, and looking at the questions that were related to minutes within the mixed use rooms, or the buckets, we didn’t get to that point.

Matt: On the last page, removing dental and pain, the outliers, is your conclusion that the numbers were pretty similar?

Kathy: Yes, pretty similar.

Nick: And this is removing all of the zero entries so the average is no longer affected by those.

Kathy: Yes.

Matt: One other question: Is the average just taking each bucket by one third?

Kathy: Total number of minutes…

Nick: They are weighted at a third. There may be adjustment based on the number of responses.

Matt: You could make an argument for weighting one bucket if there were a lot more observations than the others.

Nick: And we may or may not use that overall weight if we’re building rates individually based on these buckets.
Planning Area: Zip Code Presentation: Beth

Beth: Zip code defined in draft rule. Took secondary planning areas that are specifically identified in rule, and for those that are in the state health plan, made adjustments on added or subtracted zip codes, and then for the others, used best guess based on geography. This is not a final doc, but a jumping off point for discussion. Will take group through the method used for those planning areas that are in the state health plan.

First, took defined zip codes – central, east, north, south, and southwest, and plugged all of these zip codes into the USPS database to see where these actually are, and found that a number of them are PO boxes. Some were specific to a business so those clearly should not be included because they clearly do not have a population. Then, looked at whether any zip codes were added. To accomplish that, used Claritas data – main data source for populations for ASF reviews – and filtered by King County and cross referenced with the State Health Plan and if zip was already there, put “N/A” and if not in state health plan, took whatever city it was assigned to and based on what is in state health plan, assigned it so it was consistent.

So, if 98002, which is in the state health plan in SE King, then 98001 which is not in the state health plan but is also in Auburn, should be in SE King as well. What we end up with is a complete list of zip codes. I only defined those planning areas that are partial counties. Anything that speaks to single counties isn’t defined because we would just use whole county data from OFM.

Nick: From a population standpoint, residential zip codes have a corresponding population. How did the department handle PO Box and business entity zip codes within the definitions previously? The reason I bring this up is that we have patients who will provide PO Box address information that tends to be excluded even though you can identify what that parent zip code is for that PO Box and properly assign those patients to that parent zip code.

Beth: So another thing that I did, and I didn’t mention this, is for every one of these that is a PO Box, I checked the Claritas data to make sure that there wasn’t somehow population associated with it. And, we don’t use patient specific data in the ASF methodology, it’s just facility specific, so even if a patient has a PO box zip code, that won’t affect the methodology.

Frank: Although, with this methodology, you want to make sure that you have a data set that is consistent with what organizations are using when they are looking at acute care bed need because these two planning area definitions are one and the same. That’s why Nick’s point is very important. I see that in CHARS, where people do assign a PO Box.

Beth: So far as ASF is concerned, the way that we have interpreted it historically is that we have that list of planning areas but none of them are explicitly defined except for a couple in the state health plan which is why we’ve had, sort of, that license to make
adjustments as needed. Especially like East King. Great example. As you can see there are number of zip codes that have been added just over the last 30 years, so we can make those appropriate adjustments. I can’t speak to what we would do if we make any changes here, how that would affect the acute care bed methodology.

Frank: I just think you’d want one definition to cut across both. I think you would be raising a lot of unnecessary confusion by having two definitions for secondary planning areas.

Jody: I agree with that. Let’s update definitions.

Beth: What we have now in the draft rules is just a proposed clean up, it’s not really proposing anything significantly different, but offered as a starting point.

Frank: Good approach, but I would take it one step further and if you are going to do anything, I’d say undertake a revision that’s comprehensive, complete and accurate, and can be used for acute care when you get to that point. I would also suggest overlaying your definitions with the working definitions the department uses now just to see the similarities and differences.

Beth/Frank: This is consistent with what the department is using now. There are quite a few sub-county or multiple county definitions that may not be captured here. That’s okay, but we need to identify where those issues are and agree that we ought to revise them. For instance, Thurston County isn’t just Thurston County, it is Thurston County and a couple of other counties.

Beth: Maybe what we can do is distribute this example to the group along with the list of the secondary service planning areas, that would include the whole counties that may or may not be whole counties, and also the multi-county ones, and if anyone has suggestions or edits, I’ve heard of splitting planning areas, collapsing planning areas, whatever your suggestions are, we’d love to hear them. So I will get a spreadsheet out that has all of those in it. And then we can get your input.

Group: That would be very helpful.

Beth: Great, I can get that put together very quickly.

Frank: And a map would be very helpful, too.

Beth: I don’t have a map, but used Google maps and found zip codes. Nothing official yet.

Frank: I have proprietary software that I can’t share, but it shows the weirdness. Don’t know that I can share because it’s a license I had to sign, but it would be very helpful if the department could get zip code maps and then after we clean up this list, see if we could map them and see what that array looks like.

Beth: What is the software?
Frank: I did use MapPoint (Microsoft) but it’s no longer being supported and I forget the name of the new software.

Nick: We use one called Maptitude. (Shares Maptitude screen on personal tablet device).

Kathy: Here’s what I had our GPS mapping folks put together for me when we started this rulemaking (shares three maps on overhead screen). Glad to share with group if interested.

Emily: Solicit comments on Beth’s work.

Department will share maps, Beth’s zip code workbook and Frank’s zip code worksheets with group. Group will provide feedback and suggestions.

**Draft Rule Review**

Kathy frames discussion: Dept not wedded to this draft, offered as a starting point. Want to concentrate on methodology at this meeting if possible. Before recording of meeting started, there was informal discussion thinking back to our first few meetings and whether we should consider separate methodologies for the buckets we’ve identified – maybe that isn’t the path to take based on what we’ve learned so far.

Frank: I brought it up. It’s obvious from the survey data, if we want to use it, that if we want to modify the methodology based on survey data, that data isn’t robust enough to do that. There are too few sample size observations from the different discreet buckets. We had five buckets identified but when you look at the data, and there are only one or two observations, it would be very risky to build a methodology off of that. Sounds good in theory, but may not be workable when we actually use it.

Emily: I think the idea of separate methodologies was derived from the idea that the current methodology may not be suitable for certain types of specialty surgery centers. So some centers may not be appropriate for the methodology. Build in a mechanism to accommodate those centers. We do that for endoscopy centers now.

Beth: So you are suggesting that we have one methodology, but have mechanisms in place to accommodate certain specialties?

Emily: Right. Whether exempting them, or whatever is appropriate.

Frank: What we see now when we’re using just one bucket of ambulatory surgeries is that when you get the survey data, eye centers for example, or pain centers, they do have very different data but maybe we can think about those unique cases where we know that they are very different but the survey data that we have now does not support that. The survey data suggests that they are all pretty much the same if you believe the very small sample size that we have right now. I think there’s no question that five discreet buckets is too many and maybe we want to subset that down to maybe two or three. Eyes are clearly different, so is GI/endoscopy…maybe we just have three
buckets and in the overall methodology build different methodologies. For example, for eye centers, we survey only eye centers and use only eye center data to build the forecast. But having five discreet buckets won’t work, not without more data.

Nick: Speaking of data, there was some discussion about trying to use or investigate the annual survey data, and what percentage of completion there was as a possible alternative or additional source to supplement the surveys we completed.

Beth: I can elaborate on that. The most recent survey that we sent to all of the hospitals and ASFs in the state – we got between a 50 and 60% response rate. Granted, we didn’t have the resources to chase down providers last year, and I can confidently say that if we were to follow up we could have gotten closer to 80%. It is a completely voluntary survey and there is nothing we can do to compel folks to respond. So far as alternative data sources go, we do defer to ILRS for OR count and procedure count, but there aren’t any minutes and on top of that, the data from ILRS isn’t reliable and we can’t use for it hospital-based ASCs or ASCs that are under a hospitals license.

Beth provides license update examples from ILRS on overhead screen. Discussion follows re data fields, limitations of data, and differences between ASC and hospital licensing screens/data fields.

Nick: If we have 50 – 60% response rate, are we more or less confident that those would be averaged out with a much larger cell size, or sample size than we’ve asked for already?

Beth: Depends on the county. Across the counties as a whole, but not within the sub-counties.

Frank: The only way that would work is if you have state level data, and then use that data for the discreet buckets.

Beth: Sometimes there are only one or two kinds of ASCs in a county, and if only one of them responds to the survey then we rely on default data and that isn’t very reliable.

Beth describes the ASF license packet on the screen, describes how doc is filled out from the licensing perspective as opposed to the CoN perspective. Procedure room vs operating room – these are all the same from the CoN perspective. Also provides and describes hospital survey. Suggests we partner for future surveys – received an 85% response rate on hospital survey when WSHA assisted with messaging.

Discussion of survey data and use rates. Do we want planning area specific use rates or do we want use rates based off state averages? Use rates could be tremendously variable, from 50 per 1000 to 150 per 1000 depending on what is there now. If you had a statewide database, you could look at those types of questions. Such a database could create a baseline for us. We’ve asked a lot of questions, but we need something to base our methodology on. Now that we know what we’ve learned from the surveys, it sounds like a statewide database would help, but we’d need to modify the surveys to
get the information needed. CoN does not have such a data base – surveys are scanned into a file and tracked on a spreadsheet, and surveys do not differentiate across the buckets.

Kathy: Seems like we are at a crossroads. Nick, are you thinking we might want to do more surveying?

Nick: What I’m wondering is the timeline of what this group was hoping to hit, and establishing a baseline that we recognize is not 100% but something that we can build on so we can adjust the surveys going forward to reflect more accurately what we’re trying to capture.

Frank: Agree. Where we started and where we are now are two different places, and we have to decide if we want to make substantive revisions to the rules without data and that’s risky, or do we want to leave what we have alone, and go out there and get more data. The surveys have been great but they don’t come close to getting us the data we need for rulemaking.

Kathy: And that’s what I thought I was hearing. Let’s not throw out this concept of exempting certain specialties, but at the same time do we really have enough to go forward with this at this time to create a meaningful methodology that really does what we want it to do. And it sounds like, it might be worth our while to revise the current CoN survey going out, try to collect the data that we want, and then come back to rulemaking. Is that kind of what we want?

Group: Not sure how we could revise the methodology without data. We don’t know if the current standards for minutes in rule are accurate. Those are pivotal pieces of the methodology. Create supplemental survey for ASF? We’re not ready to go forward because we don’t have enough data. Need to address centers that are open only a few days a week. And, need to make sure we have a definition section on the survey.

**Decision Point: Put rulemaking on hold right now because we don’t have enough data to move forward.**

Move quickly on drafting supplemental survey questions, make sure to describe intent of collecting data requested by survey. Department will partner with WASCA and WSHA to work on messaging designed to encourage responses. Since group is gathered now, brainstorm questions for supplemental survey.

Quick discussion of what exemption means in this context, how we might approach in the future.

*Hospital questions (partial):*

- Surgery minutes in total
- Surgery minutes performed in total
- Surgery minutes performed for outpatient cases only
Total ORs and ORs for outpatient only

Can we get data that would allow us to split out outpatient activities from everything else? If you have overall surgery minutes, and you have outpatient only, that could allow you to carve out, on a percentage basis, the capacity for outpatient only, because what we’re trying to do is build an outpatient only methodology. What if we said, if a room is exclusively dedicated to this service, it is excluded – can you name and identify these rooms?

Frank: The way you get mixed use is look at total OR vs. outpatient only ORs, and then multiply that number by the percentage of outpatient minutes over total minutes. Program already asks for mixed use minutes in survey because we don’t have a new methodology yet, and it’s already on the survey.

What does mixed use minutes really mean? Total minutes. Hospital respondents usually report just mixed use minutes in a table on the survey.

Jody: We’ve come full circle with this. We’ve looked at other states, and wondering what we’re going to get by getting more data. Seems like an exercise in futility. What are we going to get by getting more data? Just trying to avoid months and months of work that won’t add to our knowledge. Hospitals have different definitions of surgery minutes, and you’re not going to get a standard definition. I think we know in our guts that this methodology is the best it’s going to be without mandatory reporting and if that’s the case then maybe we need to go back and look at the (national?) methodology.

Emily: The conclusion that the methodology we have right now is the best we’re going to get is not reflective of my view or WASCA’s.

Jody: Do you have a methodology we can use? Because where we’re going is not going to get us what we need.

Kathy: Sounds like there are people in the room that would really like to examine more data more closely, and the results of our surveys didn’t really get us to where we wanted to be with that, so we’re hoping that maybe another stab at it will give us what we need. Is that summarizing where we’re at? I understand what you are saying Jody, and hear your frustration…

Jody: Not frustrated, just think we’re going to get five months down the road and not get anything new to add.

Beth: This is a good opportunity to ask for more data. If we potentially change the inputs and the structure remains the same, do you think that would be an acceptable methodology? Should we do an overhaul while we’re getting the data?

Matt: Maybe Jody’s comments reflect that there’s some lack of agreement on what core data we’re trying to capture? Do we have agreement or the same understanding of what data we really need for the methodology?
Frank: Yes, outpatient data, however that term is defined. We want to get information on the utilization and supply of outpatient activities. The difficulty is that it’s easy on the ASC side but hard on the hospital side because those two activities, inpatient and outpatient, are comingled in most cases.

Jody: What do we do if we find that we have, for example, 3 rooms for outpatient volume, but they also have 3 other rooms that are sitting idle? What are we doing with that?

Frank: Use the hospital survey data to count those ORs as supply.

Jody: I don’t think that’s what we want to do – we want to freeze that. So are we even asking about that in the survey?

Frank: If we ask about that then we have to ask about that across the freestanding organizations as well, which we don’t right now. There’s idle capacity where ever you look, depending on who is responding. I think that’s a real slippery slope.

Kathy: In what way?

Frank: I don’t think hospitals would be very anxious to say we’ve got 3 ORs that we’re actually using and we’ve got 3 ORs that we could use but we’re not currently using them, and to freeze out those other ORs that does not seem reasonable, and it isn’t something hospitals would agree to because supply is supply. But what we want to do if we’re looking at outpatient only is count the supply used for outpatient activities, and that’s going to somehow cause us to partition the overall outpatient ORs the hospitals used because based on your surveys, hospitals comingle inpatient and outpatient in the ORs.

Beth: So to sum up are you suggesting, it’s 6 ORs and out of those half of their minutes are outpatient so we would count 3 of those as mixed use outpatient.

Franks: It’s the only way to get the information. What we haven’t decided is that of the overall ORs, are there ORs that should be excluded from supply. In the rules now there are, like open heart or C-section rooms. I don’t think you see that many of those unique OR set ups any more. Now you just see ORs used for multiple purposes.

Additional questions:

Do you have any ORs that are used for single use and give an example (open heart, C-section, L&D, etc.)

All ORs dedicated to single service?

Do we want to look at the buckets we’ve identified? Should we ask them based on minutes? Identify by CPT codes? Maybe use descriptors like “eye cases” or “GI/endoscopy cases.” Adding that level of complexity (CPT codes) is going to drive our response rate down. Sometimes smaller facilities have a hard time with total minutes. So instead total cases, could we ask for average total cases for this bucket? Getting
more complicated, but Beth believes she can craft this in table version. Do we really need the buckets? What about a checklist? Is it helpful information?

*Group moves to questions for ASF:*

- Idle capacity.
- Same as hospital questions noted above.
- Total single specialty ORs
- What specialties?
- Days of the week – full day, half day, limited number of days per week, etc.

Nick: What if we were to take these question and applied some “mocked” data, does that data help us to change the methodology that we’re attempting to address or modify, before we go out and try to survey?

Frank: Just looking at it, yes. That would allow you to run the methodology.

Beth: What about the default values?

Frank/Nick: Wouldn’t ask that in the survey; maybe contact certain organizations.

Jody: What about asking about scheduled hours of operation per room?

Frank: They won’t provide that on a survey.

Jody: Why not?

Beth: So if we were to ask that question, would do it in a broader way.

Jody’s clients would answer question; Frank’s wouldn’t. Nick’s organization wanted to know same thing, had to contact six people to gather data. Don’t think it will be easy to get idle capacity information from hospitals when each room is utilized slightly differently. Defaults are important to test the data. Need a representative sample. (01:32:56)

What about the buckets? How do we turn the results into something useful? The results of the revised survey, assuming we get a significant response rate, would be the basis for validating the methodology as a whole, not specifically a reference to a certain number of minutes. If we go out with these survey questions, they won’t inform us as to buckets at all, and maybe what we do is see what this tells us, and then revisit the issue of exemptions or different methodologies for certain of the buckets, and agree that it’s not five buckets, but a few, and then we might consider special surveys for ophthalmic and GI/endoscopy, but that would be after we did this to see how robust it is. What if we have another question for ASF that said for multi-specialty practices only, out of all the specialties identified, do any of them have more or less minutes, and that’s where we can ask for the average minutes per case by specialty. General thought: would cause
confusion. Have to be black and white with questions. The specialties are very different. Eye centers are in methodology but that seems curious.

Should we ask for cases and minutes for pain and endoscopy? If we’re going to identify entities that may be exempt because they are so different, would that be useful? Depends on how specialty is defined.

Continued bucket discussion. Take off bucket question, and follow up later.

Any additional questions we would ask ASF that are licensed under the hospital license?

What would be a good response rate? This will go out with the program's annual survey. This year we won’t have two surveys going out at the same time – that created a great deal of confusion for hospitals and ASF. Hopefully with just one survey that will boost the response rate. 50% response rate for the state as a whole is good, but if buried within that is only a 10% response rate for Thurston County, that isn’t very good. We need to see how far down in the data we can disaggregate. Could be that this would be state level data. If we can get 80% that would be great, especially if we collaborate with the organizations.

Timeline discussion. Response time no less than six weeks, phone calls to follow up with organizations after that. Will develop test questions, distribute to a test group to assure questions are not too cumbersome, just need a few identified. Draft questions will be distributed to group in a week along with planning area workbook. Group discusses additional timelines and deadlines.

Kathy will create a work plan and distribute. April meeting cancelled. Group will reconvene in late July once survey is completed.