

Ambulatory Surgery Facilities

MINUTES

The meeting was facilitated by Bart Eggen and started with a review of the agenda followed by introductions around the room – about thirty-two stakeholders attended. Bart gave a recap of the previous 11/22 stakeholder meeting and began today's discussions by introduced Linda Foss who presented the department's survey experience.

Linda's data represented 69 surveys from 2009 through early December 2011. The average survey length was 113 hours, the mean 101 hours. The 69 included initial and re-credential surveys, and Medicare and accredited facilities. The facilities that had never been surveyed before were not included in the 69. Linda noted that 60% of the 69 required follow-up surveys.

Linda reviewed the significant common problems encountered during surveys. The top two are quality assurance and infection control. Next are medical staff, nursing services, governing board, and structural-fire wall.

Bart mentioned the current staffing/survey model based on assumptions for 300 facilities and 210 facilities. The cost to industry between the 300 and 210 models would differ little because more facilities would bring in additional revenue that would cover increased program costs.

Discussions and comments:

WASCA asked for time to comment to make three points: 1. WASCA is opposed to any increase. 2. DOH should have approached industry for input from the start. 3. WASCA disagrees with the department's numbers and model.

Why aren't the difficult non-compliers charged more for additional visits and work? The better performers are penalized by covering the costs of the poorer performers. We need a user fee based on compliance. However, the law currently doesn't allow charging for noncompliance.

What are the current proposed models, 300 and 210 facilities, based on? The department's experience still supports the original 80 hours, \$13,940 fee model. The new model assumes best case scenarios. The new 3-tier fees assume 32 hours for small facilities, 42 hours for medium, and 52 hours for large facilities - they include on-site hours and overhead. There are no follow-up surveys included in the model. This is an extremely optimistic model. Is the state going to ask for more in the future? This model potentially may not fully fund the program in two to three years. Not because of a mistake – it's a thin model. Our experience supports our original model.

The industry will continue to work with DOH on compliance issues. DOH will help educate industry so the surveys are better. Future – whatever number we come up with, the survey hours are going to come down. We can tweak the statute:

- Charge for revisits,
- Length of survey frequency, and
- Where do we want to build in flexibility.

DOH indirect costs are too much. - Bart explained that the indirects are established, have not changed with rising costs, and are dictated and scrutinized by the Feds.

We need to gather data about patient safety to show any difference in outcomes with or without oversight. Because this is a newly regulated field as of 2009, there is no data gathering yet.

DOH should get help from industry such as volunteer surveyors. DOH will look into this possibility although the group expressed doubt due to DOH being regulatory and well trained.

What about our request for credit for one survey rather than pay for two? DOH will write up the legal analysis. Currently the statute doesn't allow for split or additional fees necessary to make this work. And in fact all facilities share equally the savings of fewer surveys.

Some issues that kept coming up were based on the ASF statute. So we reviewed the parameters that constrain the department's ability to be flexible with the fees, including:

- ASF facilities are required to be licensed every three years, for a three-year period,
- ASF facilities are required to be inspected every 18 months/ twice in three years, and
- The expense to regulate ASFs is required to be funded by the ASF industry.

If industry is charged additional \$\$, some may have to drop accreditation. Dropping accreditation may lessen protection of patient safety and quality.

DOH does public health protection very well. DOH survey staff are very experienced and well educated. We hope that once a facility has experienced a survey with Linda's team, had a plan of correction developed, taken to heart by the provider, and they implement those things that are designed to provide good quality patient outcomes, that this results in good patient care.

There was recognition and credit given to DOH for having listened to the group at the Nov. 22 meeting, and that DOH went back, relooked at things, and came up with different numbers.

There is a difference between accreditation and licensing. Accrediting organizations can drop a facility for noncompliance and walk away. The state has a regulatory role and, while it can close a facility for noncompliance, it cannot walk away. That's not what DOH is about – DOH works to make facilities compliant and successful.

DOH fee timeline? Plan to have the fee rule effective May 2012; public hearing March; continue collaborative work on a model now; and hold another stakeholder meeting January 12, 2012.

Meeting Results:

The group decided to hold an industry workgroup to develop survey efficiencies and model. DOH will reexamine its experience, look for additional efficiencies, and share results with the workgroup. The workgroup will bring its results to the next ASF stakeholder meeting Jan 12.

DOH will work with Emily Studebaker on the legal question – surveys shared with Medicare.

DOH will distribute the audio files of this and the 11/22 stakeholder meetings, Linda's PowerPoint presentation, and the survey compliance checklist.

Next stakeholder meeting will be January 12, 2012, different time – 12:30 – 3:00 p.m., same location – DOH, 310 Israel Rd, Tumwater, PPE building, room 152/153.