

WAKE FOREST BAPTIST HEALTH

PRESENTATION ON PROPOSAL FOR AN ADDITIONAL OPERATING ROOM NEED METHODOLOGY

JANUARY 11, 2017

Good morning. My name is Todd Hemphill, and I am an attorney with Poyner Spruill here in Raleigh. I am speaking today on behalf of my client, Wake Forest Baptist Health, which submitted comments to the Workgroup earlier this week regarding the models considered thus far to modify the operating room need methodology.

With me today is Marisa Barone, the Senior Planning Manager in WFBH's Strategic Planning Department.

WFBH generally supports the proposals submitted by Carolinas HealthCare System and UNC Hospitals to develop a methodology which identifies need based on a system of tiers. As others have noted, the nature, complexity and length of surgical cases in different hospitals and ASCs varies widely, depending on the type of facility providing the service. For that reason, we support the Workgroup's and Planning Staff's development of models which take these factors into account.

However, WFBH believes that the models proposed so far do not sufficiently take into account the unique capabilities and needs of Academic Medical Centers. The operating rooms in Academic Medical Centers generally treat a much sicker population than ASCs, smaller community hospitals, and even some larger tertiary care medical centers. As a result, case times are significantly longer. As discussed in our written comments:

- More than half of the surgical patients at North Carolina Baptist Hospital have an ASA status of 3 or greater, based on the American Society of Anesthesiologists ASA Physical Class Classification System.¹ This means that those patients have substantive functional limitations, with one or more moderate to severe diseases.
- Conversely, the average ASA physical status of patients at ASCs and general acute care hospitals is 2, meaning that they have mild diseases only without substantive functional limitations.
- As shown in Attachment A to our written comments, the average outpatient case length in AMCs is 139 minutes, as opposed to an average of 104.5 minutes in other Tier 1 facilities, and 55.4 minutes in ASCs.

In short, the patients being served in the AMC operating rooms are the sickest and have the longest and most complicated surgeries.

WFBH has recommended that Tier 1 be split into two tiers, based on total case hours. WFBH recommends that four of the Academic Medical Centers, all of which have over twice as many case hours as the minimum threshold for Tier 1, be placed in a new Tier 1.

¹ A copy of the ASA Physical Class Classification System is attached to these comments.

WFBH has not recommended that Vidant Medical Center be included in the new Tier 1, because its total case hours are significantly lower than the other four Academic Medical Centers. However, WFBH notes that the outpatient case times at Vidant are more in line with the other Academic Medical Center hospitals, indicating that it does serve more complex patients than community hospitals. For this reason, WFBH does not oppose the inclusion of Vidant in the new Tier 1.

WFBH further proposes that for this new Tier 1, only the facility generating the need for operating rooms would be able to apply for the rooms. In this instance, it is the highly acute, complex, and long cases that create the need for additional ORs.

There is precedent in the SMFP for such a “facility need” methodology. Currently, an existing dialysis facility may apply for additional dialysis stations even where there is no need for a new dialysis facility in that county, if the applicant can show significant growth and high utilization.

More to the point here is the recent addition of Policy TE-3 in the 2017 SMFP, allowing existing hospitals without an MRI to apply for one, regardless of whether the standard county-wide MRI need methodology identifies a need. This policy is a recognition by the SHCC that hospitals provide unique services to both inpatients and outpatients, and the availability of an MRI at another site within a service area is inadequate. The SHCC ultimately determined that this need determination should be facility-based, even where there are multiple hospitals within a county that do not have an MRI.

Similarly, the needs of the surgical patients served by Academic Medical Centers are unique. If any applicant can apply for ORs generated by the cases performed in an Academic Medical Center, those patients would not be adequately served, as other applicants would not be able perform the complex and lengthy surgeries that created the need. For that reason, WFBH believes that the need determinations generated in the new Tier 1 should be facility-based, and limited to the facilities which generated that need.

Attachment D to WFBH’s previously-filed comments contains need determinations for that new Tier 1. Ms. Barone and I will be happy to address any questions the Workgroup has about that methodology or anything else.

ASA PHYSICAL STATUS CLASSIFICATION SYSTEM

Last approved by the ASA House of Delegates on October 15, 2014

Table 1: Current definitions (NO CHANGE) and Examples (NEW)

ASA PS Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
<p>*The addition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)</p>		

1 **Appendix 1**

2
3 References related to use of the ASA PS Classification System

- 4 1. Guidelines for the use of Sedasys by non-anesthesia trained proceduralist and nurse.
5 <http://www.sedasy.com/>
6 2. American College of Surgeons' proposed guidelines for care of pediatric surgical patients.
7 Journal of the American College of Surgeons, 2014;218:479-48
8 3. Guidelines for local anesthesia cases in a major academic center. "Monitoring patients
9 receiving local anesthesia", MGH, Perioperative Nursing, OR L. 16
10 4. Office Based Procedure guidelines
11 [https://phpmm.org/Portals/79/WebFiles/Provider%20Manual%20Updates/Clinical%20Guidel](https://phpmm.org/Portals/79/WebFiles/Provider%20Manual%20Updates/Clinical%20Guidelines/MOIC%202009%20Office-Based%20Surgery%20Guideline.pdf)
12 [ines/MOIC%202009%20Office-Based%20Surgery%20Guideline.pdf](https://phpmm.org/Portals/79/WebFiles/Provider%20Manual%20Updates/Clinical%20Guidelines/MOIC%202009%20Office-Based%20Surgery%20Guideline.pdf)
13 5. Preoperative testing guidelines. [http://www.choosingwisely.org/doctor-patient-lists/american-](http://www.choosingwisely.org/doctor-patient-lists/american-society-of-anesthesiologists/)
14 [society-of-anesthesiologists/](http://www.choosingwisely.org/doctor-patient-lists/american-society-of-anesthesiologists/)
15

16 **Appendix 2**

17
18 Selected References Addressing Inter-Rater Reliability of the ASA PS Classification System

- 19 1. Owens WD, Felts JA, et al. ASA physical status classifications: A study of consistency of
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21 Physical Status – A Recapitulation. Anesthesiology 1978;49:233-6)
22 2. Haynes SR, Lawler PG. An assessment of the consistency of ASA physical status
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30 6. Burgoyne LL, Smeltzer MP. How well do pediatric anesthesiologists agree when assigning
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32 7. Bernard PA, Makin CE et al. Variability of ASA physical status class assignment among
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34 8. Cuvillon P, Nouvellon E et al. American Society of Anesthesiologists' physical status system:
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36 Anaesthesiol 2011;28:742-7
37 9. McMillan M, Brearley J. Assessment of the variation in American Society of
38 Anesthesiologists Physical Status Classification assignment in small animal anaesthesia. Vet
39 Anaesth Analg. 2013 May;40(3):229-36
40 10. Sankar A, Johnson SR et al. Reliability of the American Society of Anesthesiologists physical
41 status scale in clinical practice. Br J Anaesth 2014 Apr 11 (epub ahead of print)