MEMORANDUM

To: Chair Greenlick and Members of the House Health Care Committee
From: Cheryl Nester Wolfe, RN, CEO Salem Health
Date: March 23, 2017
RE: HB 2664 Opposition

Salem Health's strong belief is that HB 2664 should go to a 2018 workgroup. We absolutely understand and agree with the ongoing evolution of health care service delivery so that many types of care can be shifted away from the acute setting. We concur that care should happen in the most efficient way possible—without jeopardizing the quality of care and the safety of patients. We believe that HB 2664 as proposed, and with proposed amendments, fails to forward this effort.

Our rationale, and concern, is that extended stay centers, given the surgeries that could be performed with an "extended stay" under 48 hours, essentially create freestanding surgical hospitals - but without the patient safety standards (reporting of adverse events, infections, clear guidelines on audit/investigations, etc.) that our communities expect to be in place for hospital care.

With a workgroup in 2018, we believe that a broad group of stakeholders, including representatives from hospitals from a variety of communities in Oregon, as well as representatives of freestanding and joint venture ambulatory surgery centers, including the patient's voice, could craft a reasonable structure to move forward with charting pathways to safe and cost-effective care in the extended stay ambulatory setting. This group in our vision would carry out the appropriate research for Oregon, using the evidence to design what would serve our community members best incorporating access to care, cost-effectiveness, and quality of care, and most importantly patient safety.

We strongly oppose the -4 amendment that characterizes this as an emergency. We believe that this is something our state should embark upon in a data-driven and thoughtful way.

We also oppose the -5 amendments. The -5 amendment, for example, specifies that only an ambulatory surgery center that has operated for at least 24 consecutive months may apply for a license. This is an unnecessary restriction that would prevent qualified new ASCs or hospitals from providing this care. It also references "preference" for ASCs performing "highly complex procedures". This is undefined and raises questions about what incentives might be created for an ASC to offer more complex procedures.

We further oppose the concept in both amendments of allocating licenses based on the ownership of extended stay centers. We would rather see no cap on the licenses; thereby allowing each application to stand on its own merit – with a process in place that ensures facilities will operate in a manner that best protects patient safety.

We firmly oppose the -5 amendment that allows for the OHA to "solicit and accept gifts, grants, and donations" to carry out the duties brought forward by this bill. We find an ethical conflict in a regulatory agency potentially accepting funds from those that could benefit by the work of the agency.

We find the rest of the bill's and proposed amendments too vague on how the extended stay centers' ongoing practice and licensure will be regulated. This concerns us, based on the increasing

complexity of procedures that could be performed at these centers, and lead back to our conclusion that a work group is the best way to approach this for our state to ensure that patient safety is as rigorously reviewed and emphasized as in today's hospital-based setting for these procedures.

We strongly believe that when Oregon embarks upon a process to extend the allowable stays for ambulatory surgical care in order to improve access and ensure cost-effective care, it's important for these extended stay centers to accept patients covered by Medicaid as well as those who are un-or-under-insured. This is a fair requirement that protects equivalent access to care for Oregonians on Medicaid and ideally would provide savings to the state on surgical costs. We would absolutely support language that requires the extended stay centers to have a patient population that mirrors the community they serve; providing charity care and serving patients covered by Medicaid in the same proportion as a local hospital providing similar procedures.

Further, to prevent surgical complications from becoming negative outcomes, it's imperative to require that the extended stay facility have a transfer agreement with a hospital that is both geographically close and clinically prepared to handle the expected complications from the procedures provided at any sponsoring ASC. We prefer a distance of no further than 5 miles. The current proposed statement also allows the extended stay facility to just have "emergency procedures in place." This could be interpreted as lightly as "We'll call 911 and send the patient via ambulance," and as written does not ensure the readiness and willingness of the receiving hospital to handle known complications.

A proposal that we could support would address both the time and distance to the accepting hospital and ensure that the hospital has the necessary equipment, staff members, and specialists to address the patient's urgent need. For instance, consider the example of a joint replacement surgery, which is a procedure starting to be done on an outpatient basis nationally and locally. In this major surgery, it is possible for a vascular injury - an unintended puncture of a large artery or vein - to take place. Depending on the severity of this injury, interventions including providing blood products or a transfusion, or even assistance from a vascular surgeon may be necessary. During the recovery from a joint replacement, it's possible for patients to experience blood clots, including a life-threatening pulmonary embolism. In these known complications, the speed to appropriate treatment is key to providing the best possible outcome for the patient. For these reasons, we strongly believe that any facility undertaking these procedures must have a hospital close by - we recommend no further than 5 miles - that has specifically agreed to accept potential transfers from the facility. We also believe that hospital should have the choice whether to sign a transfer agreement with any other facility; it is unfair to both our community's hospitals and the patient to simply assume or mandate a hospital to accept all transfers. This would mirror today's CMS guidelines which do not mandate to individual hospitals that they must sign requested agreements. We also would support language that helps protect the hospital accepting a transfer of an ASC patient—whose care is already not going as expected—from undue liability.

In conclusion, we at Salem Health believe that Oregon will be best served by exploring extended stays in the ambulatory surgery setting collaboratively. We believe that with thorough analysis including broad input from stakeholders, we as a healthcare community can design together a system that addresses our state's need to seek evidence-based, high-quality, and cost-effective care in the right setting at the right time. We think there are major flaws in the proposed bill and amendments that fail to adequately protect patient safety. For these reasons, we oppose HB 2664, but support moving this topic forward via a 2018 work group.