

**Boston Outpatient Surgical Suites, LLC**  
**DoN # BOSS-22051213-AS**

**APPLICANT QUESTIONS #4**

*Responses should be sent to DoN staff at [DPH.DON@State.MA.US](mailto:DPH.DON@State.MA.US)*

While you may submit each answer as available, please

- List question number and question for each answer you provide
- Submit responses as a separate word document, using the above application title and number as a running header and page numbers in the footer
- When providing the answer to the final question, submit all questions and answers in one final document
- Submit responses in WORD or EXCEL; only use PDF's if absolutely necessary. If "cutting and pasting" charts, provide them in a PDF so they can be clearly seen
- **Whenever possible, include a table with the response**
- **For HIPAA compliance Do not include numbers <11.**

**Factor 1a: Patient Panel Need**

1. In the responses to DoN Questions #2, the Applicant states that it continues to experience higher last-minute cancellation rates due to COVID infection or other illness, than prior to the pandemic (pg. 3).
  - a. Please provide data demonstrating higher last-minute cancellation rates than prior to the COVID-19 pandemic.
- **Applicant Response:** As noted in the Applicant's response to DoN Questions #2 question 1, the Applicant continues to experience higher last-minute cancellations at its current site than before the pandemic; however, the cancellations continue to decline as demonstrated in the table below. Increased cancellation rates were identified as just one of several reasons for a decrease in cases and procedures at the current site over the last several years (and, as the Applicant noted in its response in DoN Questions #2, these cancellations have had less impact on case volume than the other reasons provided —e.g., limited number of ORs (3), high OR utilization, and higher acuity cases requiring longer OR time). Still, as the cancellation rates continue to decline, there will be more pressure on the Applicant's OR utilization, which, even with the higher cancellation rates, is back to a pre-pandemic average rate of 90%, i.e., higher than the 70-80% optimal utilization rate targeted by experts<sup>1</sup>.

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<sup>1</sup> Many experts have targeted 70-80% as an optimal utilization rate, with single specialty ASCs in the higher end of that range. Rachel Fields, "Defining 'Full Utilization' of an Ambulatory Surgery Center: Q&A With Jim Scarsella of Anesthesia Staffing Consultants" Becker's ASC Review, February 25, 2011, accessed at <https://www.beckersasc.com/asc-news/defining-full-utilization-of-an-ambulatory-surgery-center-qaa-with-jimscarsella-of-anesthesia-staffingconsultants> .

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<b>Year</b>	<b># Cancellations</b>	<b>Covid Related</b>	<b>Other Illness (unspecified)</b>	<b>Cancelled by Anesthesia</b>
2018	28	0	26	2
2019	25	0	22	3
2020	244	193	38	13
2021	119	56	43	20
2022	90	14	56	20
2023	52	5	31	16
2024 YTD	17	0	15	2

2. The responses to DoN Questions #2, the Applicant states that as surgical cases have become longer and more complex, the number of surgeries that can be performed in a facility with a limited number of ORs (and OR time) necessarily decreases (pg.2).

a. What other factors have the potential to increase operating room time, and how do they impact OR time at the existing ASC?

- **Applicant Response:** Following is a list factors have the potential to increase operating room time at the existing ASC and how they impact OR time at the existing ASC.
  - i. **Case complexity:** As Medicare has approved more complex cases to be performed at ASCs (e.g. total knee arthroplasty approved in 2020, total hip arthroplasty approved in 2021, and total shoulder arthroplasty approved in 2024), the average surgical time for surgeries performed at the Applicant's ASC has increased. As the OR time increases, surgeons are not able to book as many cases in their respective block times, which are assigned in 4 hour or 8 hour blocks by surgeon.
  - ii. **Number of procedures in a case:** Some complex cases require multiple procedures. For example, an orthopedic surgeon may perform a shoulder arthroscopy on one patient—e.g., a patient with impingement syndrome that requires one procedure to repair the injury, for total OR time of approximately 60 minutes, while another case—e.g., for a patient with impingement syndrome, synovitis, adhesive capsulitis, and a rotator cuff tear, might require five procedures to repair the injury and approximately 120 minutes of OR time.
  - iii. **Patient age, weight and/or co-morbidities:** As noted in Applicant's Application commentary and previous responses, Applicant expects that its patient panel will increase in age and that it will be serving patients who are increasingly obese and/or who have more co-morbidities. Cases involving older patients, obese patients, and/or patients with co-morbidities often take longer, due to potential associated characteristics (i.e., adhesions in diabetic patients, potentially degraded tissue in patients of advanced age, and considerations with positioning, anesthetizing and/or navigating additional tissue of patients who are obese).
  - iv. **Equipment needs:** More complex cases often require additional or unique equipment which, in turn, may increase the time needed for setup, take-down, and sterilizing/processing that equipment. For example, spine procedures utilize a specific type of bed for positioning a patient in the prone position, a microscope and additional instrumentation that requires calibration for each surgery, as well as additional trays of surgical equipment. Some surgeries also require the use of imaging during the case,

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which also requires the use of a large C-arm x-ray device that must be calibrated and positioned uniquely to each patient multiple times during a surgical procedure. These are only a few examples.

- v. **Sterilization/Clean-up:** Cases that require additional or unique equipment also require additional time for sterilization and clean-up, which means more time needed to complete one case and begin the next.

**3. In responses to DoN Questions #3, the Applicant provided data to show significant increases in the numbers of three complex cases at Applicant's current site (pg. 2).**

- a. **What does the Applicant mean by Spine, in the table included in the response?  
What types of procedures fall within this category?**

Year	2019	2023	Increase	% Increase
Total Joint Arthroplasty	44	108	64	245%
Hip Arthroscopy	16	43	27	269%
Spine	4	7	3	175%
<b>Total</b>	<b>64</b>	<b>158</b>	<b>94</b>	<b>147%</b>

- **Applicant Response:** Spine surgeons on the Applicant's medical staff have been performing microdiscectomies, laminectomies, hemi-laminectomies and anterior cervical discectomy and fusions (ACDF's) at the existing ASC. Moving forward, the Applicant expects that in addition to these spine procedures, more complex spine procedures such as multiple level ACDF's, single-level lumbar fusions, and two-level lumbar fusions, among others, may be performed at the new ASC when there is more OR capacity to allow for spine surgeons to have additional designated block time.

**4. In response to a DoN Question on wait times, the Applicant reported on wait times from one of the practices that provides services at BOSS.**

- a. **What are reasonable average wait times (including source) for the procedures listed?**

- **Applicant Response:** The Applicant has not been able to identify specific sources that identify ideal wait times for the procedures performed at the Applicant's ASC. The Applicant has attached an article that, although published in the UK and relating to a public health system that is very different from our system, does reflect the concerns of, and impact of wait times on, providers and patients for orthopedic surgeries, including, for the latter, the significant impacts on daily living/activities, ability to perform work, etc. **Attached pdf file: Predicted waiting times for orthopaedic surgery Bone Joint Res 2022;11(12)-890-892.**

- b. **Is it possible to provide wait times for the other practices providing services at BOSS?**

- **Applicant Response:** The Applicant does not maintain wait times in its medical record. The wait times provided below are a snap-shot in time based on input from the office manager at

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another large surgical practice (with 12 surgeons) that provides services at BOSS. The wait times below reflect next best available OR data for all the sites at which these surgeons perform surgeries (expressed in both number of days, and months, until next availability).

<b>Surgeon by specialty</b>	<b># of days until next surgical availability</b>	<b># of months until next surgical availability</b>
Sports Medicine Surgeon 1	68	2.3
Sports Medicine Surgeon 2	56	1.9
Sports Medicine Surgeon 3	41	1.4
Sports Medicine Surgeon 4	30	1.0
Arthroplasty Surgeon 1	270	9.0
Arthroplasty Surgeon 2	239	8.0
Spine Surgeon 1	131	4.4
Spine Surgeon 2	58	1.9
Spine Surgeon 3	49	1.6
Foot & Ankle Surgeon 1	43	1.4
Hand Surgeon 1	42	1.4
Hand Surgeon 2	39	1.3

5. In the responses to DoN Questions #1 the Applicant states that given the limited number of ORs currently and the advanced booking of these ORs, surgeons are rarely able to book last minute cases for urgent/emergent cases at the ASC (pg. 6-7)
  - a. Explain why the ASC setting is the appropriate setting for urgent/emergent cases requiring access to an available OR within 24 hours, as opposed to the hospital setting.
- **Applicant Response:** The Applicant did not intend to suggest that the ASC is the appropriate setting or alternative for urgent/emergent cases. Rather, the Applicant was seeking to emphasize the lack of flexibility the Applicant has, currently, to accommodate last minute surgical cases at the ASC without additional ORs. Although most emergent cases are most appropriately addressed in an ED, some “urgent” orthopedics cases (e.g., fractures, ligament/tendon ruptures) could potentially be accommodated in the proposed, expanded ASC and, if they can, may help to relieve current burdens on EDs and hospital ORs in the Commonwealth. Those burdens at Commonwealth hospitals are evidenced in part by commentary relating to recent DON approvals for hospital expansions, reflecting the pressure on hospitals to accommodate current patient demand and, as appropriate, decant patients to alternate settings. Concerns about possible facility closures in the Commonwealth also underscore the need for alternate care settings and capacity, including outpatient surgical capacity.

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6. The year-over-year changes in forecasted new case volume decreases steadily from Year 1 to Year 5, except for General Surgery. Explain the year-over-year changes in General Surgery case volume.

	Year 1-Year 2	Year 2-Year 3	Year 3-Year 4	Year 4-Year 5
Existing Cases	4.0%	4.0%	4.0%	4.0%
<b>New Cases</b>				
Joint Arthroplasty	7.0%	7.0%	7.0%	7.0%
Spine	4.1%	3.9%	2.0%	2.0%
Orthopedics & Podiatry	4.0%	4.0%	2.0%	2.0%
General Surgery	3.8%	4.2%	1.8%	2.2%
Pain Management	4.0%	4.0%	2.0%	2.0%
Total New Cases	4.6%	4.6%	3.0%	3.1%
Total Forecasted Cases	4.3%	4.3%	3.5%	3.5%

- **Applicant Response:** Due to the smaller number of General Surgery cases at the Applicant's facility compared to the number of cases in the other listed sub-specialties, the changes forecasted for General Surgery in the chart above is somewhat misleading. By rounding up (and down) the numbers for the 4 years identified in the chart, General Surgery is forecasted with a similar progression to the other sub-specialties, at 4%, 4%, 2%, 2%.
7. During the review for completeness, the Applicant stated that it has not historically and does not currently collect race/ethnicity information for its patients.
- a. Explain why the Applicant does not collect race/ethnicity data for its patients.
    - i. Does the ASC have any requirements around the collection and reporting of race and ethnicity data?
  - b. If the Proposed Project is approved, will the Applicant be able to collect race/ethnicity data for its patients at the new site?
- **Applicant Response:** Until recently, the Applicant has utilized a paper booking sheet to collect patient information for procedures, as well as a pre-operative questionnaire. Neither the booking sheet, nor questionnaire explicitly solicited information regarding patient race or ethnicity, and the ASC is not required to collect or report such data, including for accreditation purposes or by payers. The Applicant has recently converted to an electronic medical record (EMR) system and is also re-evaluating its pre-operative questionnaire. The Applicant will seek to have its EMR, and pre-operative questionnaire configured to collect race/ethnicity data for its patients at the new site.