Medical Facilities Planning

Acute Care Services Committee Draft Minutes

May 5, 2010
10:00 am – 12 Noon
Council Bldg Room 201

MEMBERS PRESENT: Dr. Sandra Greene; Greg Beier; Dr.Brenda Latham-Sadler; Dr. Leslie Marshall; Dr. Zane Walsh; John Young
MEMBERS ABSENT: Bill Bedsole; Dr. Lawrence Cutchin Medical Facilities Planning Section Staff Present: Victoria McClanahan; Carol Potter; Gene DePorter; Kelli Fisk DHSR Staff Present: Elizabeth Brown; Craig Smith Attorney General's Office: Juanita Twyford

Standing Agenda	Discussion	Motions	Recommendations/ Actions
Welcome & Introductions	Dr. Greene welcomed members, staff and visitors to the meeting. She noted that the meeting is open to the public, but that the meeting did not include a public hearing. Therefore, discussion was limited to members of the Committee and staff, unless questions were directed specifically to someone in the audience.		
Review of Executive Order No. 10: Ethical Standards for the State Health Coordinating Council	Dr. Greene reviewed Executive Order 10 Ethical Standards for the State Health Coordinating Council. Dr. Greene gave an overview of the procedures to observe before taking action at the meeting. Each member of the Committee described his or her professional/institutional interest and no member affirmed that he or she would derive any financial benefit from any matter coming before the Committee for action at this meeting. No member recused himself or herself from voting on any item on today's agenda.		
Approval of minutes from the April 14, 2010 Meeting	A motion was made to approve the April 14, 2010 minutes.	Dr. Walsh Mr. Beier	Minutes approved
Acute Care Hospitals	Dr. Greene provided an update on the Acute Care Services Work Group and reviewed the work group's membership and the charge to the work group. Dr. Greene then presented the work group's recommendations, shown below: 1. Revise the acute care bed need methodology used in Table 5A as follows: • Data Source *Current method* – use all days, including psychiatric, substance abuse, rehabilitation; exclude outliers and non-NC resident days *Proposed method* – use acute care days only; exclude psychiatric, substance abuse and rehabilitation days; include outliers and non-NC resident days • Historical patient day growth rates *Current method* – 4 years of data and 3 years of trend *Proposed method* – 5 years of data (2005-2009 for 2011 SMFP) and 4 years of trend • Number of projection years *Current method* – 6 years *Proposed method* – 4 years • Calculation method for growth rate factors *Current method* – statewide growth rate of days as defined in data source above *Proposed method* – county growth rate of days as defined in data source above		

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- Target occupancy rates

Average Daily Census (ADC)	Target Occupancy Rates: Current Method	Target Occupancy Rates: Proposed Method
ADC 1-99	66.7%	66.7%
ADC 100-200	71.4%	71.4%
ADC>200 and <=400	75.2%	75.2%
ADC>400:	75.2%	78.0%

2. Convene an Acute Care Bed Need Methodology work group in 2012 to evaluate the Acute Care Bed Need Methodology and to determine if adjustments/changes are needed.
3. Do not change the target occupancy rates used in SMFP Policy AC-4: Reconversion to Acute Care, SMFP Policy AC-5: Replacement of Acute Care Bed Capacity and do not change the target occupancy rates the CON Section uses when evaluating acute care bed CON applications.

Discussion points:

- Health care reform's effects on future inpatient acute care utilization unknown at this time.
- Market currently shrinking – suggestion to weight current data more given this fact.
- Not all unnecessary utilization removed from system.
- A significant portion of the 386 projected AC beds may not be needed by the time they are launched – after DRG's were launched there was an immediate 15% decrease in inpatient occupancy rate.
- The 386 projected new beds represent approximately a billion dollars in capital.
- Given the expected changes in the healthcare system, hospitals need to become 10-15% more efficient.
- Suggestion that a moratorium be placed on new acute care beds – require hospitals to petition for projected beds.
- Aging population may result in need for more, not fewer, beds.
- Hospitals may petition to take beds out of Plan.
- If put a moratorium on new beds and petitions for beds submitted, then ACS Committee and SHCC can determine if beds needed.
- If require petitions, then need to be clear about basis for recommending approval of petitions.
- Growth rate most significant factor in increasing need for additional beds.
- Admissions likely to go down once "medical home" concept widely implemented.
- Healthcare reform occurring in stages making it hard to plan.
- If appropriate, ACS Committee could modify AC Bed Need methodology before Plan sent to Governor.
- Summer petitions/comments can provide information about several issues (readmits, operational efficiency, medical home) – will help Committee determine if methodology needs further revision.
- Unnecessary readmits/potential avoidable complications critical because soon the federal government will stop paying for them – hospitals and doctors need to

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<tr><th>Standing Agenda</th><th></th><th>Motions</th><th>Recommendations/ Actions</th></tr>
<tr><td></td><td>determine how to manage care such that unnecessary readmits/potential avoidable complications don't occur.

The following motion was made:
Accept the Acute Care Services Work Group recommendations, including the bed need determinations resulting from application of the revised Acute Care Bed Need methodology, with the following proviso:
The proposed need determinations generated by the Acute Care Bed Need methodology, as revised by the ACS Work Group, will be shown in the 2011 Proposed Plan. However, the ACS is recommending a moratorium on new AC beds in the proposed plan in light of the expected reductions in utilization with healthcare reform. In order for any AC Bed Need determination to be brought forward to the Final 2011 Plan, a Special Need petition must be filed for that AC Bed Need determination. All such petitions and comments from the public hearings will be fully considered by the ACS committee in its fall meeting. Based on this information, the ACS committee will recommend a final bed need, if any, to the SHCC for inclusion in the 2011 SMFP</td><td>Mr. Beier
Dr. Walsh</td><td>Motion unanimously approved.</td></tr>
<tr><td>Operating Rooms</td><td>Ms. McClanahan reviewed the draft Operating Room Data and Need Projections, noting that application of the standard methodology showed the following need determinations:

<table><tr><th>Operating Room Service Area</th><th>Operating Room Need Determination</th></tr><tr><td>Columbus County</td><td>1</td></tr><tr><td>Rowan County</td><td>1</td></tr><tr><td>Wake County</td><td>2</td></tr><tr><td>Statewide Total</td><td>4</td></tr></table>
Ms. McClanahan noted that Fall 2009 population numbers were used in projecting OR need and that those numbers would be updated before the Proposed Plan is published. Updating the population numbers could change the need determinations.
Discussion:
• Single Specialty Ambulatory Surgery Facility ORs are not included in the inventory used in the OR need determinations because the Single Specialty Am Su demonstration project CON applicants are not limited to proposing to locate the ORs in a single county but may choose to apply to locate the ORs in 1 of 3 counties.

Motion to accept the Operating Room Data and Need Projections, with the understanding that staff will make necessary corrections and updates.</td><td>Mr. Beier
Dr. Latham-Sadler</td><td>Motion unanimously approved</td></tr>
<tr><td>Other Acute Care Services</td><td>Ms. McClanahan reviewed the draft Open Heart Surgery and Heart Lung Bypass Machines Data and Need Projections.
Discussion:
• Concern expressed that 15 out of 22 facilities now performing fewer than 500 OH surgery cases/year.</td><td></td><td></td></tr>
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	• Prediction that use of statins and other drugs will result in continued decline in OH surgery. • Focus now on looking at continuum of care for people with coronary artery disease. • Some states developing teams of providers who treat coronary artery disease and work in multiple hospitals. Ms. McClanahan reviewed the draft Burn Intensive Care Services Data and Need Projections. Discussion: • If utilization at 80% or greater next year, methodology will show need for additional burn intensive care services in the 2012 SMFP. Ms. McClanahan reviewed the draft Transplantation Services Data and Need Projections. Motion to accept the Other Acute Care Services Data and Need Projections, with the understanding that staff will make necessary corrections and updates.	Mr. Young Dr. Marshall	Motion unanimously approved
Inpatient Rehabilitation Services	Ms. McClanahan reviewed the draft of Inpatient Rehabilitation, Bed Data and Need Projections. Discussion: As discussed at the last ACS Committee meeting, the methodology with the new last steps shows need for 14 additional IP Rehab beds in HSA IV. Motion to accept the Inpatient Rehabilitation Services need projections, with the understanding that staff will make necessary corrections and updates.	Dr. Marshall Dr. Lathan-Sadler	Motion unanimously approved.
Other Business	A motion was made to allow staff to update and correct the Acute Care Services tables and need projections, as necessary, and to forward to the Council all of today's recommendations for the Proposed 2011 plan. Nancy Bres Martin was asked to clarify an issue regarding revised Policy AC-5. She expressed concern that the policy revision does not address critical access hospitals' operating rooms. She proposed adding a new Critical Access Hospital policy instead of revising Policy AC-5. She said that Cape Fear Valley Health System planned to submit a petition in response to the recommended changes made by the Committee to Policy AC-5.	Mr. Beier Dr. Marshall	Motion unanimously approved.
Adjournment	There being no further business, Dr. Greene adjourned the meeting.		