# Acute Care Services Committee

## Recommendations to the North Carolina State Health Coordinating Council

## May 26, 2010

The Acute Care Services (ACS) Committee met twice after the March Council meeting, first on April 14th and again on May 5th.

The topics reviewed and discussed at the April 14th meeting included:

- Current Acute Care policies and methodologies;
- Recommendations made by the Acute Care Services Work Group related to Acute Care Bed and Operating Room Service Areas;
- An acute care bed petition to revise SMFP "Policy AC-5: Replacement of Acute Care Bed Capacity";
- An operating room petition to revise the definition of underutilized surgical facilities, and;
- A petition, labeled as an operating room petition, to change the composition and authority of the State Health Coordinating Council.

The topics reviewed and discussed at the May 5th meeting included:

- Recommendations made by the Acute Care Services Work Group related to revising the Acute Care Bed Need methodology, and;
- Preliminary drafts of need projections generated by the standard methodologies and by the revised Acute Care Bed Need Methodology

Following is an overview of the Committee's recommendations for the Acute Care Services Chapters, chapters 5-8, of the Proposed 2011 SMFP. The report is organized by Chapter of the SMFP.

**Chapter 5: Acute Care Beds**

*Acute Care Hospital Policies:*

- For the 2011 Proposed Plan, the Committee recommends no changes to the Acute Care Hospital Policies, **except** for revising "Policy AC-5: Replacement of Acute Care Bed Capacity".

Policy AC-5 was the subject of a petition that the Committee considered. Summarized below are the petition and the Committee's recommendation for changing the policy.

**Petitioner:**

Mike Vicario, NCHA Vice President of Regulatory Affairs

**Request:**

"NCHA petitions the State Health Coordinating Council to amend Policy AC-5 to enable Critical Access Hospitals to count acute and swing bed days of care in the formula used to determine needed replacement capacity."

The Committee agrees with counting swing bed days when calculating Policy AC-5 target occupancy rates. The Committee also agrees with including in the revised policy that swing bed days would only be counted for proposals to replace acute care beds in Critical Access Hospitals proposing to remain Critical Access Hospitals.

**Committee Recommendation:**
The Committee recommends revising Policy AC5, as follows:
**Revised Policy AC5:**

> "Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant's hospital in relation to utilization targets found below. For hospitals not designated by the Center for Medicare and Medicaid Services as Critical Access Hospitals, in determining utilization of acute care beds, only acute care bed "days of care" shall be counted. For hospitals designated by the Center for Medicare and Medicaid Services as Critical Access Hospitals, in determining utilization of acute care beds, only acute care bed "days of care" **and** swing bed days (i.e., nursing facility days of care) shall be counted in determining utilization of acute care beds. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application. Additionally, if the hospital is a Critical Access Hospital and swing bed days are proposed to be counted in determining utilization of acute care beds, the hospital shall also propose to remain a Critical Access Hospital and must demonstrate the need for maintaining the swing bed capacity proposed within the application. If the Critical Access Hospital does not propose to remain a Critical Access Hospital, only acute care bed "days of care" shall be counted in determining utilization of acute care beds and the hospital must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application."

| Facility Average Daily Census | Target Occupancy of Licensed Acute Care Beds |
|---|---|
| 1 – 99 | 66.7% |
| 100 – 200 | 71.4% |
| Greater than 200 | 75.2% |

*Acute Care Bed Need Methodology:*

- The Acute Care Services Work Group provided recommendations to the Committee on revising the Acute Care Bed Need Methodology. Following is an overview of the Acute Care Services Work Group history and actions.

  The charge to the Acute Care Services Work Group, which first met in early 2009 and continued meeting until April of this year, was expanded in late 2009 to include Acute Care Bed and Operating Room Service Areas. The expanded work group charge is shown below.

  1. To evaluate the present bed methodology with respect to the impact that uneven growth in days in acute care hospitals throughout the state has on the methodology.

2. To develop recommendations for the bed need methodology which can effectively and fairly address the growth disparities and which will be consistent with the present methodologies in the 2010 SMFP.

3. To develop a methodology to define multi-county service areas (for counties with no hospitals) for acute care bed needs and operating rooms. This methodology is to be developed for application to the 2011 SMFP and should address the frequency of updates thereafter.

The work group met four times between February 2009 and April 2010 and reviewed and discussed Acute Care Bed Service Areas and Operating Room Service Areas and acute care days data variables, including acute care days data source, patient day growth rate, number of years to project acute care days and occupancy rate targets. The work group analyzed a number of Table 5A scenarios using different combinations of the variables. The work group then developed recommendations for revising the Acute Care Bed Need methodology, and those recommendations are summarized below:

**Acute Care Bed Service Areas:**
In reviewing Acute Care Bed Service Areas, the Acute Care Services Work group discussed and recommended statewide application of the concept of a county lacking a licensed acute care hospital being part of more than one Multicounty Acute Care Bed Service Area. (For the 2010 SMFP, this concept was applied only to Hoke County.) In evaluating the threshold to use when determining to which counties this concept should apply, the work group reviewed 2006, 2007 and 2008 combined acute care days patient origin data. The work group agreed that 35% should be the threshold. That is, if two counties each accounted for at least 35% of the acute care days generated by patients from a county lacking an acute care hospital, then that county would become part of two Multicounty Acute Care Bed Service Areas. Also, as part of the Acute Care Bed Service Area definition, the Committee recommends that a county lacking an acute care hospital becomes its own service area upon licensure of an acute care hospital.

The Acute Care Services Work Group recommended that the Acute Care Bed Service Area definition be changed to the definition shown below:

> Counties that have at least one licensed acute care hospital are Single County Acute Care Bed Service Areas unless the county is grouped with a county lacking a licensed acute care hospital. When a county that has at least one licensed acute care hospital is grouped with a county lacking a licensed acute care hospital, a Multicounty Acute Care Bed Service Area is created.
>
> All counties lacking a licensed acute care hospital are grouped with either one or two counties that each have at least one licensed acute care hospital. A Multicounty Acute Care Bed Service Area may consist of multiple counties lacking a licensed acute care hospital that are grouped with either one or two counties that each have at least one licensed acute care hospital.
>
> The three most recent years of available acute care days patient origin data are combined and used to create the Multicounty Acute Care Bed Service Areas. These data are updated and reviewed every three years. The Multicounty Acute Care Bed Service Areas are then

updated, as indicated by the data. The first update will occur in the 2011 Plan. The following decision rules are used to determine multicounty acute care bed service area groupings.

1) Counties lacking a licensed acute care hospital are grouped with the single county where the largest proportion of patients received inpatient acute care services, as measured by acute inpatient days, unless;
   a) Two counties with licensed acute care hospitals each provided inpatient acute care services to at least 35% of the residents who received inpatient acute care services, as measured by acute inpatient days.
2) If 1)a) is true, then the county lacking a licensed acute care hospital is grouped with both the counties which provided inpatient acute care services to at least 35% of the residents who received inpatient acute care services, as measured by acute inpatient days.

A county lacking a licensed acute care hospital becomes a Single County Acute Care Bed Service Area upon licensure of an acute care hospital in that county. If a Certificate of Need is issued for development of an acute care hospital in a county lacking an acute care hospital, the acute care beds for which the certificate of need has been issued will be included in the inventory of beds in that county's multi-county acute care bed service area until those beds are licensed.

An acute care bed's service area is the acute care bed planning area in which the bed is located. The acute care bed planning areas are the single and multicounty groupings shown in Figure 5.1.

**Acute Care Bed Need Projection Methodology:**

The Acute Care Services Work Group recommended that the Acute Care Bed Need Projection Methodology be revised, as described below:

Use the following assumptions in Table 5A:

a. Data source for growth rates: use acute care days only; exclude psychiatric, substance abuse and rehabilitation days; include outliers and non-NC resident days
b. Historical patient day growth rates: use 5 years of data (2005-2009 for 2011 SMFP) and 4 years of trend
c. Number of projection years: use 4 years
d. Calculation method for growth rate factors: county growth rate of days as defined in data source above
e. Use the following Target Occupancy Rates:

| | |
|---|---|
| ADC 1-99 | 66.7% |
| ADC 100-200 | 71.4% |
| ADC>200 and <=400 | 75.2% |
| ADC>400: | 78.0% |

The work group also made the following two recommendations:

1. 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.

2. Do not change the target occupancy rates used in SMFP Policy AC-4: Reconversion to Acute Care and 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.

**Committee Recommendations:**
The Committee concurs with the Acute Care Services Work Group's recommendations for revising the Acute Care Bed Need methodology. The Committee also recommends showing the proposed need determinations generated by the Acute Care Bed Need Methodology, as revised by the ACS Work Group, in the 2011 Proposed Plan. However, the ACS Committee is recommending a moratorium on new AC beds in the proposed 2011 Plan in light of the expected reductions in utilization with Health 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.

Petitioners will be asked to demonstrate what beds, if any, shown in the Proposed 2011 SMFP need determinations, are still needed after removing AC Days due to avoidable readmissions, operating larger hospitals, i.e. hospitals with ADC>400, at an efficient occupancy rate of at least 85%, and including expected utilization declines when the medical home concept has been implemented. Petitioners may also include any other information they believe to be relevant to the need determination for their specific county.

*Draft Table 5A and Draft Table 5B:*

- The Committee recommends publication in the Proposed 2011 Plan of draft Table 5A Revised Methodology. The Committee also recommends publication of draft Table 5B, which shows the need determinations listed below, as generated by the Revised Acute Care Bed Need Methodology.

| Service Area | Acute Care Bed Need Determination |
|---|---|
| Bertie | 3 |
| Buncombe-Madison-Yancey | 69 |
| Cumberland-Hoke | 63 |
| Pitt-Greene | 48 |
| Mecklenburg | 101 |
| Wake | 102 |
| **Statewide Total** | **386** |

However, the Committee recommends including with the Proposed 2011 SMFP Table 5B the proviso outlined above related to a moratorium on new acute care beds.

- Additionally, as in past years, the Committee authorized staff to work with the Sheps Center and the hospitals during the summer to improve discrepant data and to recalculate the need projections based on the improved data.

**Chapter 6: Operating Rooms**

*Operating Room Need Methodology:*

- The Committee recommends two changes to the Operating Room Need Methodology for the Proposed 2011 Plan. First, the Committee recommends changing the Operating Room Service Area definition. Second, the Committee recommends changing the definition of "chronically underutilized facilities".

**Operating Room Service Area Definition**

As noted above, the Acute Care Services Work Group was charged with reviewing and making recommendations to the Committee for changing the Operating Room Service Area definition.

In reviewing Operating Room Service Areas, the Acute Care Services Work group made the same recommendations for Operating Room Service Areas that it made for Acute Care Bed Service Areas.

**Committee Recommendations:**

The Committee concurs with the Acute Care Services Work Group's recommendation for changing the Operating Room Service Area definition and recommends adopting the following definition of Operating Room Service Areas for the Proposed 2011 SMFP:

"Single County Operating Room Service Area: A county with at least one licensed facility with one or more operating rooms.

Multicounty Operating Room Service Area: A group of counties including:

- one or two counties with at least one licensed facility with at least one operating room **and**;
- one or more counties with no licensed facility with at least one operating room.

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All counties are either Single County Operating Room Service Areas or are part of a Multicounty Operating Room Service Area. A Multicounty Operating Room Service Area may consist of multiple counties with no licensed facility with at least one operating room grouped with either one or two counties, each of which have at least one licensed facility that includes at least one operating room.

The three most recent years of available surgical patient origin data are combined and used to create the Multicounty Operating Room Service Areas. These data are updated and reviewed every three years. The Operating Room Service Areas are then updated, as indicated by the data. The first update will occur in the 2011 Plan. The following decision rules are used to determine multicounty operating room service area groupings:

1. Counties with no licensed facility with at least one operating room are grouped with the single county where the largest proportion of patients had surgery, as measured by number of surgical cases, unless;

2. Two counties with licensed facilities with at least one operating room, each provided surgical services to at least 35% of the residents who received surgical services, as measured by number of surgical cases.
3. If 1)a) is true, then the county with no licensed facility with at least one operating room is grouped with both the counties which provided surgical services to at least 35% of the residents who received surgical services, as measured by number of surgical cases."

   A county lacking a licensed facility with at least one operating room becomes a Single County Operating Room Service Area upon licensure of a facility with at least one operating room in that county. If a Certificate of Need is issued for development of a facility with at least one operating room in a county lacking a facility with at least one operating room, the operating room(s) for which the certificate of need has been issued will be included in the inventory of operating rooms in that county's multi-county operating room service area until those operating rooms are licensed."

   In 2006, in response to an adjusted need determination petition, the State Health Coordinating Council added Swain County to the Jackson-Graham Multicounty Operating Room Service Area. This created a Multicounty Operating Room Service Area including two counties that have licensed facilities with at least one operating room and one county lacking a licensed facility with at least one operating room.

   An operating room's service area is the operating room planning area in which the operating room is located."

**Chronically Underutilized Facilities**
The definition of "chronically underutilized facilities" was the subject of a petition that the Committee considered and the petition and the Committee's recommendations for changing the definition are summarized below.

**Petitioner:**
Barb Freedy, Director, CON, Novant Health
**Request:**
The petitioner requested revising the definition and criteria for "Chronically Underutilized ORs in Licensed Facilities" used in Step 4(m), Chapter 6, "Operating Rooms", so that at least 36 full months of actual OR case volume data are considered in determining whether the ORs are "operating in licensed facilities at less than 40% utilization."

The Committee agreed with increasing the period necessary for a facility to be licensed before the facility is considered underutilized.

**Committee Recommendation:**
The Committee recommends changing the definition of chronically underutilized facilities, used in Step 4(m) of the Operating Room Need Projection methodology, to the following:

> **Step 4(m):**
> "…Chronically underutilized licensed facilities are defined as licensed facilities operating at less than 40 percent utilization for the past two fiscal years, which have been licensed long enough to submit at least ~~two~~ **three** License Renewal Applications to the Division of Health Service Regulation."

*Operating Room Petition:*

- The Committee received a petition, labeled as an operating room petition, which is summarized below along with the Committee's recommendations.
  **Petitioner:**
  Affordable Health Care Facilities
  **Request:**
  The petitioner requested revising the composition and authority of the SHCC and establishing parameters for more CONs to be issued where increased price competition would be beneficial to consumers to increase quality, access, and value of health care services.

**Committee Recommendation:**
The Committee recommends denial of the petition because it is outside the purview of the current regulations governing the State Health Coordinating Council.

*Draft Table 6B and Draft Table 6C:*

- The Committee recommends approval of the draft Tables 6B and 6C. Application of the standard methodology indicated need for two additional operating rooms: one operating room in the Columbus County OR service area and one operating room in the Rowan County OR service area.

**Chapter 7: Other Acute Care Services**
*Other Acute care Services Policy/Need Methodologies:*

- No petitions or comments were received related to any of the Other Acute Care Services. The Committee recommends no changes to Policy AC-6 (Heart-Lung Bypass Machines for Emergency Coverage) or to the methodologies.

*Open Heart Surgery Services and Heart-Lung Bypass Machines Need*

- The Committee recommends no need for additional Open Heart Surgery Services and no need for additional Heart-Lung Bypass Machines for review in 2011.

*Burn Intensive Care Services Need*

- The Committee recommends no need for additional burn intensive care services for the Proposed 2011 Plan.

*Bone Marrow Transplantation Services and Solid Organ Transplantation Services Need*

- The Committee recommends no need for additional bone marrow transplantation services and no need for additional solid organ transplantation services for the Proposed 2011 Plan**.**

**Chapter 8: Inpatient Rehabilitation Services**

*Inpatient Rehabilitation Services Need Methodology:*

- No petitions or comments were received related to Inpatient Rehabilitation Services. The Committee recommends carrying forward the current methodology for the Proposed 2011 Plan with one change – the addition of steps that calculate the number of additional beds needed when need for additional beds is projected. The proposed additional steps are shown below.

  If need for additional inpatient rehabilitation beds in an HSA is determined, the number of beds needed is calculated as follows:

  Step 1: Calculate the HSA's three year average annual growth rate for inpatient rehabilitation days of care using the four most recent years of HSA data.

  Step 2: Calculate the projected days of care in the HSA by multiplying the HSA's most recent year's days of care by the three year average annual rate of change calculated in Step 1 then adding this to the HSA's most recent year's days of care.

  Step 3: Determine, as shown below, how many additional beds are needed in the HSA such that the utilization rate for the sum of the HSA's total planning inventory (existing, CON issued and pending development/review/appeal beds), and the additional beds is 80 percent.

  [Projected Days/365/.8]-[Total Planning Inventory]=Additional Beds Needed

*Draft Table 8A:*

- The Committee recommends approval of the draft Table 8A. Application of the standard methodology, with the addition of steps that calculate the number of additional beds needed, indicated need for 14 additional Inpatient Rehabilitation Beds in HSA IV.

Additionally, the Acute Care Services Committee has authorized staff to make changes in Acute Care Services data and narratives as additional information is received.