Medical Facilities Planning

Technology & Equipment Committee Minutes

April 24, 2013
10:00 am
Brown Bldg Room 104

MEMBERS PRESENT: Dr. Christopher Ullrich, Dr. Richard Bruch, Dr. Dennis Clements, Laurence Hinsdale; Daniel Hoffmann Dr. Eric Janis, Tim Ludwig; Dr. Deborah Teasley
MEMBERS ABSENT: Harold Hart, Dr. John Holt Jr.
Staff Present: Shelley Carraway, Nadine Pfeiffer, Erin Glendening, Kelli Fisk
DHSR Staff Present: Martha Frisone, Lisa Pittman
AG's Office: Joel Johnson

Agenda Items	Discussion/Action	Motions	Recommendations/ Actions
Welcome & Introductions	Dr. Ullrich welcomed members, staff and guests to the first Technology and Equipment Committee of 2013. He stated that the purpose of this meeting was to review methodologies and data review for the Proposed 2014 State Medical Facilities Plan (SMFP), review and vote on one petition. Dr. Ullrich stated the meeting was open to the public, but deliberations and recommendations were limited to the members of the Technology and Equipment Committee and staff, in order to respect the process of the State Health Coordinating Council (SHCC).		
Review of Executive Order No. 10 and 67: Ethical Standards for the State Health Coordinating Council	Dr. Ullrich gave an overview of the procedures to observe before taking action at the meeting. Dr. Ullrich inquired if anyone had a conflict or needed to declare that they would derive a benefit from any matter on the agenda or intended to recuse themselves from voting on the matter. Dr. Ullrich asked members to review the agenda and declare any conflicts on today's agenda. There were no recusals.		

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	Dr. Ullrich stated that if a conflict of interest, not on the agenda, came up during the meeting that the member with the conflict of interest would make a declaration of the conflict.		
Approval of September 19, 2012 Minutes	A motion was made and seconded to approve the minutes.	Mr. Hinsdale Dr. Clements	Minutes approved
Positron Emission Tomography (PET) – Chapter 9	<u>Need Methodology and Data Review</u> Ms. Carraway noted there are six multi-county groupings called Health Service Area (HSA), and a fixed PET scanner's service area is the HSA in which the scanner is located. Ms. Carraway stated the two mobile PET scanner planning regions are defined as the west region (HSAs I, II, and III) and the east region (HSAs IV, V, and VI). Ms. Carraway stated that after utilizing data from 2013 Hospital License Renewal Applications and Registration and Inventory forms, there was no projected need for any additional fixed PET scanner in the state. <u>Petition: MedQuest Associates, Inc and Novant Health, Inc</u> Ms. Carraway explained that MedQuest Associates, Inc. and Novant Health, Inc. request the establishment of a methodology for mobile PET scanners that generates a need determination for a new mobile PET scanner when an existing mobile PET/CT scanner in the defined service area exceeds the 2,600 annual procedure capacity. The Committee reviewed the petition and agency report, which recommended denial of the petition request. Discussion included a broad look at mobile and fixed PET service capacity and utilization indicating current access and availability of PET scanning services. The Committee recommends the petition request be denied. The Committee also committed to review the entire PET methodology – fixed and mobile – in order to develop a matrix of problems and solutions in order to achieve optimal service to meet the need. The Committee will explore options and alternatives for PET scanning service coverage across the state. If the	Dr. Janis Mr. Ludwig Dr. Clements Mr. Ludwig	Motion approved Motion approved

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	Committee is able to resolve this, it will be brought forward as a proposal for March 2014 for inclusion in the 2015 SMFP. Committee Recommendations A motion was made and seconded to deny the petition. A motion was made and seconded to recommend acceptance of the PET assumptions and methodology for the Proposed 2014 SMFP and to advance references to years by one as appropriate.		
Magnetic Resonance Imaging (MRI) – Chapter 9	Need Methodology and Data Review Ms. Carraway stated the Acute Care Bed Service Area as defined in Chapter 5 of the 2013 SMFP continues to be the service area for the fixed MRI scanners. Ms. Carraway noted the fixed MRI service area is a single county unless there was no licensed acute care hospital located within the county and those counties are grouped with the single county where the largest proportion of patients received inpatient acute care services. Ms. Carraway stated these multi-county service areas were reviewed this year and updated with a few changes that will be outlined in Chapter 5 and are reflected in the draft Table 9P. Ms. Carraway noted that the methodology for MRI scanners is more complex. There are tiers of need thresholds based on the number of scanners (found on page 165), weighting of procedures based on complexity (found on page 166), and a method to deal with MRI service areas that do not have a fixed MRIs but have mobile MRI scanners serving the area. Ms. Carraway noted Table 9P shows all of the data including equivalent values for mobile scanners in MRI service areas. Ms. Carraway stated that after utilizing data from 2013 Hospital License Renewal Applications and Registration and Inventory forms, there was a projected need for one additional fixed MRI scanner in Mecklenburg County as shown in the draft Table 9P. There was no need for any additional mobile MRI scanners		

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	anywhere in the state. Committee Recommendations A motion was made and seconded to recommend acceptance of the MRI scanner assumptions and methodology for the Proposed 2014 SMFP, and to advance references to years by one as appropriate. Issues Related to MRI Scanner Data Collection Dr. Ullrich noted that a letter was received related to the collection of CPT codes for MRI procedures. In 2004, a workgroup of this Committee requested the collection utilization of this data in the need methodology. Issues were discovered and will be reviewed for solutions or discontinuation of data collection. There will be an update in the September meeting of this Committee.	Dr. Clements Dr. Bruch	Motion approved
Lithotripsy – Chapter 9	Need Methodology and Data Review Ms. Carraway noted the lithotripter planning area is the entire state so this is a statewide determination. Ms. Carraway stated using the July 1, 2013 estimated population of the state obtained from the North Carolina Office of State Budget and Management, we determine the estimated incidence of urinary stone disease per 10,000 population. Ms. Carraway reported that based on the assumption that 90% of patients could be treated with lithotripsy. Planning used the estimated incidence to calculate the number of patients in the state who have the potential to be treated by lithotripsy. Ms. Carraway noted the low range of annual treatment capacity is 1000 was used to determine the number of lithotripters needed based upon the projected number of patients.		

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	Ms. Carraway stated the need is identified when comparing the number of lithotripters in inventory to the number needed based upon projected incidence of urinary stone disease. Ms. Carraway stated that after utilizing data from 2013 Hospital License Renewal Applications and Registration and Inventory forms, there are 14 lithotripters in the state and there is no projected need for any additional lithotripters. <u>Committee Recommendations</u> A motion was made and seconded to recommend acceptance of the lithotripsy assumptions and methodologies for the Proposed 2013 SMFP, and to advance references to years by one as appropriate.	Dr. Teasley Mr. Hinsdale	Motion approved
Gamma Knife - Chapter 9	<u>Need Methodology and Data Review</u> Ms. Carraway reviewed the need assumptions and methodology for Gamma Knife. Ms. Carraway stated the gamma knife's service area is the gamma knife planning region in which the gamma knife is located. There are two gamma knife planning regions, the western region (HSAs I, II, and III) and the eastern region (HSAs IV, V, and VI). The gamma knife located at Wake Forest University Baptist Medical Center in HSA II serves the western portion of the state (HSAs I, II, and III). The gamma knife located in Pitt County at Vidant Medical Center in HSA VI serves the eastern portion of the state (HSAs IV, V and VI). The two gamma knives assure that the western and eastern portions of the state have equal access to gamma knife services. There is adequate capacity and geographical accessibility for gamma knife services in the state. Ms. Carraway stated it is determined that there is no need for an additional gamma knife anywhere in the state and no reviews are scheduled. <u>Committee Recommendations</u> A motion was made and seconded to recommend acceptance of gamma knife assumptions and methodology for the Proposed 2014 SMFP, and to advance references to years by one as appropriate.	Mr. Ludwig Dr. Janis	Motion approved

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Linear Accelerator – Chapter 9	Need Methodology and Data Review Ms. Carraway stated the linear accelerator planning areas are the 27 multi-county groupings shown in Table 9I. Ms. Carraway noted the methodology used to determine a need for an additional linear accelerator in a service area must look at 3 criterions: efficiency, geographic accessibility and patient origin. For the Accessibility Criterion 1 We divide the area population (based on the 2013 population estimate from the North Carolina Office of Budget and Management) by the inventory to determine the population per linear accelerator. If the result is greater than or equal to 120,000 per linear accelerator, Criterion 1 is satisfied. For Patient Origin Criteria 2 We divide the number of patients served from outside the service area, based on reported patient origin data, by the total number of patients served. If more than 45% of total patients served reside outside the service area, Criterion 2 is satisfied. For Efficiency Criterion 3 We calculate the average number of Equivalent Simple Treatment Visits (ESTV) per linear accelerator in each service area and divide by 6,750 ESTVs to determine how many are needed. If the difference between the number needed and the current inventory is greater than or equal to a positive 0.25, Criterion 3 is satisfied. Ms. Carraway noted if any 2 of the 3 criterion are satisfied in a linear accelerator service area, a need is determined for one additional linear accelerator in that service area. Ms. Carraway noted to complete the methodology, Criterion 4 provided an exception for counties who reached a population of 120,000 or more and did not have a linear accelerator in inventory for that county.		

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	Ms. Carraway noted after utilizing data from 2013 Hospital License Renewal Applications and Registration and Inventory forms, there is a draft need projection for one additional linear accelerator in Harnett County based upon Criterion 4. Committee Recommendations A motion was made and seconded to recommend acceptance of linear accelerator assumptions and methodology for the Proposed 2014 SMFP, and to advance references to years by one as appropriate.	Dr. Clements Dr. Teasley	Motion approved
Cardiac Catheterization Equipment - Chapter 9	Need Methodology and Data Review Ms. Carraway noted the cardiac catheterization equipment planning areas are the same as the Acute Care Bed Service Areas defined in Chapter 5, Acute Care Beds, and shown in Figure 5.1. The cardiac catheterization equipment's service area is a single county unless there is no licensed acute care hospital located within the county and those counties are grouped with the single county where the largest proportion of patients received inpatient acute care services. Ms. Carraway these multi-county service areas were reviewed this year and updated with a few changes that will be outlined in Chapter 5 and are reflected in the draft Table 9W. Ms. Carraway noted there were two standard need determination methodologies for cardiac catheterization equipment. Methodology One is the standard methodology for determining need for additional fixed cardiac catheterization equipment and Methodology Two is for shared fixed cardiac catheterization equipment. Steps: Methodology Part 1 For fixed cardiac catheterization equipment, procedures are weighted based upon complexity as described on page 199. The SHCC defines capacity as 1,500 diagnostic-equivalent procedures per year.		

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	We determine the number of fixed cardiac catheterization equipment required by dividing the number of weighted or diagnostic-equivalent procedures performed at each facility by 1200 procedures (80% 0f 1500 capacity). We then compare the calculated number of required units of equipment with the current inventory to determine if there is a need. <u>Steps: Methodology Part 2</u> If no unit of fixed cardiac catheterization equipment is located in a service area, a need exists for one shared fixed cardiac catheterization equipment when the number of mobile procedures done in this service area exceeds 240 (80% of 300 capacity) per year for each 8 hours per week in operation at that site. Ms. Carraway stated, after utilizing data from 2013 Hospital License Renewal Applications and Registration and Inventory forms, there was a draft need projection for one additional cardiac catheterization unit in New Hanover County. Ms. Carraway noted a final note on this section of Chapter 9: It was brought to our attention that the heading on Table 9V found on page 205 of the 2013 SMFP is outdated. The term Percutaneous Transluminal Coronary Angioplasty (PTCA) Interventional procedure is no longer used. Instead, the term Percutaneous Coronary Intervention (PCI) procedure is the current reference term to this procedure. With no objections from the committee, we will make the change to reflect the current terminology. <u>Committee Recommendations</u> A motion was made and seconded to recommend acceptance of the cardiac catheterization assumptions and methodologies for the Proposed 2014 SMFP, and to advance references to years by one as appropriate. Dr. Janis gave a follow up briefing on the rule making process for cardiac	Dr. Clements Dr. Janis	Motion approved

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	catheterization as discussed in the September 19, 2012 Technology and Equipment meeting. The Hospital Association is actively working on this effort and is slowly making progress. A meeting is to be held on May 2, 2013.		
Other Business	Discussion took place regarding the next meeting date, scheduled for Friday, September 20, 2013. With general concurrence, the meeting date was changed to Tuesday, September 17th, time and location to be determined and communicated to Committee members. A motion was made and seconded for staff to make necessary updates and corrections to narratives, tables and need determinations for the Proposed 2014 SMFP as new and updated data is received. There was no other business brought before the Committee.	Dr. Janis Mr. Hinsdale	Motion approved
Adjournment	There being no further business, the meeting was adjourned.		