Healthcare Planning and
Certificate of Need

Technology & Equipment Committee Minutes - Draft

April 22, 2015
10:00 am
Brown Bldg Room 104

MEMBERS PRESENT: Dr. Christopher Ullrich, Trey Adams, Dr. Richard Akers, Dr. Jeffrey Moore, Dr. T.J. Pulliam
MEMBERS ABSENT: Dr. Prashant Patel; Senator Ralph Hise, Kelly Hollis,
Staff Present: Paige Bennett, Elizabeth Brown, Amy Craddock Tom Dickson
DHSR Staff Present: Shelley Carraway, Greg Yakaboski, Martha Frisone, Lisa Pittman, Gloria Hales
AG's Office: Jill Bryan

Agenda Items	Discussion/Action	Motions	Recommendations/ Actions
Welcome & Introductions	Dr. Ullrich welcomed members, staff, and the public to the first Technology and Equipment Committee meeting of 2015. Dr. Ullrich asked that Committee members and staff in attendance to introduce themselves. Dr. Ullrich explained that the meeting was open to the public; however, discussions, deliberations and recommendations would be limited to members of the Technology and Equipment Committee and staff. Dr. Ullrich stated that the purpose of this meeting was to review the policies, methodologies for the Proposed 2016 State Medical Facilities Plan (SMFP), review and vote on five petitions.		
Review of Executive Order No. 46: 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.		

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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. Dr. Ullrich recused from voting on the petition from Carolinas Healthcare System.		
Approval of September 9, 2014 Minutes	A motion was made and seconded to approve the minutes.	Dr. Pulliam Mr. Adams	Minutes approved
Magnetic Resonance Imaging (MRI) – Chapter 9	Ms. Bennett provided a review of the General Need Methodology. Ms. Bennett noted the 2016 State Medical Facilities Plan (SMFP), data is compiled from the 2015 Registration and Inventory forms and 2015 Hospital License Renewal Applications with data reporting period of October 1, 2013-September 30, 2014. Ms. Bennett stated there was one policy for T& E. Policy TE1: Conversion of Fixed PET Scanners to Mobile. This policy allows an applicant to convert a fixed PET to a mobile PET if 1. the PET scanner continues to operate in the area where the fixed scanner was approved 2. shall be moved weekly 3. will not serve any mobile site in a county there an existing or approved fixed PET scanner is located except as required by the first subpart. <u>Magnetic Resonance Imaging (MRI) Scanners Section of Chapter 9</u> Ms. Bennett stated two petitions or comments were received regarding the Magnetic Resonance Imaging (MRI) Scanner Section of Chapter 9 of the SMFP. Ms. Bennett reviewed the MRI Need Methodology (pg 145 in 2015 SMFP)		

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	The Acute Care Bed Service Area as defined in Chapter 5 of the 2015 SMFP continues to be the service area for the fixed MRI scanners. The fixed MRI 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. • The methodology for MRI scanners is a bit more intricate as there are tiers of need thresholds based on the number of scanners – which can be found on page 147, weighting of procedures based on complexity – which can be seen on page 147, and a method to deal with MRI service areas that do not have a fixed MRIs but have mobile MRI scanners serving the area. • Steps: o We convert the current inventory of clinical fixed and mobile MRI scanners in each MRI service area by site to fixed equivalent magnets. ▪ A value of one fixed equivalent magnet will be assigned for each existing and approved fixed MRI scanner. ▪ Temporary mobile services will not be counted separately ▪ The number of MRI scans performed at each mobile site are divided by the threshold for the service area to determine the mobile site fixed equivalent ▪ Days to be operated are calculated as a fraction of the total days of service to be provided by an approved mobile scanner not yet in service o The inventory for MRI excluded MRI scanners used for research only, non-clinical MRI scanners, and MRI scanners awarded based on need determinations for a dedicated purpose or demonstration project.		

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	o We then look at the total numbers of fixed or mobile MRI scans performed at each site delineated by type – such as inpatient, outpatient, with or without contrast or sedation o Using the weighting value chart on page146, we multiply the number of MRI scans by type according to their weighting adjustment value in order to determine adjusted total MRI procedures for all sites in each MRI service area and calculate the average of those procedures. o Utilization thresholds are listed on page 148 and are used to compare the average procedures per fixed equivalent magnet, with the threshold, to determine if there is a need • There is an exception that there will be no more than one MRI scanner need determination in any one service area per year unless there is an approved adjusted need determination **Committee Recommendation** A motion was made and seconded to accept the MRI scanner assumptions and methodologies, data, draft need projections and advance references to years by one as appropriate. Ms. Bennett noted two petitions were received: <u>Petitioner: J Arthur Dosher Memorial Hospital</u>: Petitioner requested the following Policy Adjustment and Change to Methodology in the 2016 State Medical Facilities Plan (SMFP) regarding Magnetic Resonance Imaging equipment (MRI). This includes adding a new policy, Policy TE-2 As an alternative to addition of proposed Policy TE-2 change the "MRI Need Determination Methodology" by adding steps 13 and 14 to the methodology.		

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	Committee Recommendation A motion was made and vote taken to defer the petition until the May 13, 2015 Technology & Equipment Meeting. Mr. Adams agreed to develop an alternative policy for consideration by the Committee. <u>Petitioner: Carolinas Healthcare System</u> Request: The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System (CHS) respectfully petitions the State Health Coordinating Council (SHCC) to create a special allocation for one intraoperative magnetic resonance imaging (iMRI) unit in the western portion of the state (Health Service Areas I, II, and III) in the 2016 State Medical Facilities Plan.	Mr. Adams Dr. Akers	3-0
	Committee Recommendation A motion was made and vote taken to deny the petition, but proposed the creation of a policy (TE-2) as follows: **POLICY TE-2:** Intraoperative Magnetic Resonance Scanners Qualified applicants may apply for an intraoperative Magnetic Resonance Scanner (iMRI) to be used in an operating room suite. To qualify, the health service facility proposing to acquire the iMRI scanner shall demonstrate in its certificate of need application that it is a licensed acute care hospital which: 1. Performed at least 500 inpatient neurosurgical cases during the 12 months immediately preceding the submission of the application; and 2. Has at least two neurosurgeons that perform intracranial surgeries currently on its Active Medical Staff; and 3. Is located in a metropolitan statistical area as defined by the US Census Bureau with at least 350,000 residents. The iMRI scanner shall not be used for outpatients and may not be replaced with a conventional MRI scanner. Intraoperative procedures and inpatient procedures performed on the iMRI shall be reported separately on the hospital license renewal application. These scanners shall not be counted in	Dr. Akers Mr. Adams (Recusal by Dr.Ullrich)	3-0

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	the inventory of fixed MRI scanners; the procedures performed on the iMRI will not be used in calculating the need methodology and will be reported in a separate table in Chapter 9. **Supporting language for Policy TE-2 to add to Chapter 9:** MRI: Intraoperative Magnetic Resonance Scanners (iMRI) approved through Policy TE-2 shall not be counted in the inventory of fixed MRI scanners and the procedures performed on the iMRI will not be used in calculating the need methodology. Intraoperative procedures and inpatient procedures performed on the iMRI shall be reported separately on the hospital license renewal application and will be reported in a separate table in Chapter 9Q (7). The iMRI scanner shall not be used for outpatients and may not be replaced with a conventional MRI scanner. **Committee Recommendation** A motion was made and vote taken to accept the proposed creation of policy (TE-2) <u>Data Presentation</u>**:** For MRI there is one table with updated data for the 2016 plan, Table 9P MRI Fixed and Mobile procedures by MRI Service area with Tiered Thresholds and Fixed Equivalents (page 151 2015 SMFP). The data indicates there is a draft need projection for two additional MRI machines. One in Lincoln and one in Mecklenburg County. There are caveats to the data. There are missing mobile and freestanding fixed MRI facilities data and some of the data still needs vetting. We have begun the follow up process and anticipate having more complete data by the SHCC June 3rd. **Committee Recommendation** A motion was made and vote taken to accept the data and need projections with the understanding that staff will make necessary corrections and changes**.**	Dr. Akers Mr. Adams Mr. Adams Dr. Akers	3-0 3-0

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Cardiac Catheterization – Chapter 9	Ms. Bennett stated 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. There are 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 o For fixed cardiac catheterization equipment, procedures are weighted based upon complexity as described on page 199. o The SHCC defines capacity as 1,500 diagnostic-equivalent procedures per year. o 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). o We then compare the calculated number of required units of equipment with the current inventory to determine if there is a need. • Steps: Methodology Part 2 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. o in operation at that site.		

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	Committee Recommendation A motion was made and vote taken to approve policies and methodologies and forward them to the SHCC. Ms. Bennett stated the agency received 1 petitions for Cardiac Catheterization. <u>Petitioner: WakeMED</u> Request Petition 1: Request that the methodology for determining need for cardiac catheterization equipment in North Carolina be revised for the 2016 State Medical Facilities Plan. **Committee Recommendation** A motion was made and vote taken to deny the petition Ms. Bennett provided an overview of the data presentation: <u>Data Presentation:</u> There are five tables with updated data in cardiac cath. They are starting on Table 9s (page 175 in the plan). Adult Diagnostic Fixed cardiac cath procedures by facility and aggregate cardiac cath totals. 9T (pg. 177) Pediatric diagnostic cath procedures 9U (178) Mobile Cardiac Cath Procedures 9V Percutaneous coronary Interventional procedures 9W (pg. 180). Fixed Cardiac Catheterization, capacity and volume (This is the table where needs are calculated and displayed). The data indicates there is a draft need projection for one additional cardiac catheterization equipment in Cumberland County, in the proposed state medical facilities plan **Committee Recommendation**	Dr. Akers Mr. Adams Dr. Akers Mr. Adams	3-0 3-0

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	A motion was made and seconded to recommend acceptance of the Cardiac Catheterization assumptions and methodology for the Proposed 2016 SMFP, and to advance references to years by one as appropriate.	Dr. Akers Dr. Moore	Motion approved
Lithotripsy – Chapter 9	Ms. Bennett noted the lithotripter planning area is the entire state so this is a statewide determination. Ms. Bennett 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. Bennett 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. Bennett 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. Ms. Bennett 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. **Data Presentation:** There are three tables with updated data for Lithotripsy 9A Mobile Lithotripsy Providers and Locations Served 9B Fixed Lithotripsy Providers and Locations served 9C Mobile and Fixed Lithotripsy (pg 120) There is a draft need projection for one additional lithotripter statewide. **Committee Recommendation** A motion was made and voted to accept the data and need projections with		

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	the understanding staff will make necessary corrections and changes. **Committee Recommendation** A motion was made and seconded to recommend acceptance of the Lithotripsy assumptions and methodology for the Proposed 2016 SMFP, and to advance references to years by one as appropriate.	Dr. Akers Dr. Moore	Motion approved
Positron Emission Tomography (PET) – Chapter 9	Ms. Bennett provided the review for Chapter 9 – PET: • The Service areas for PET scanners are defined in the SMFP as follows: o *There are six multi-county groupings called Health Service Area (HSA). A fixed PET scanner's service area is the HSA in which the scanner is located.* o *The two mobile PET scanner planning regions has been defined as a statewide service area.* • Steps: Methodology Part 1 o For PET scanners, we determine current inventory and multiply the number of fixed PET scanners at each facility by 3,000 procedures to determine capacity at each facility. o A need is determined for an additional fixed PET scanner if the utilization percentage is 80 percent or greater at a facility. • Steps: Methodology Part 2 o This part of the methodology provides a condition to determine a need for one additional fixed PET scanner if a hospital based major cancer treatment facility program or provider does not own or operate a fixed dedicated PET scanner. • The exception to this is that for both parts of the methodology combined, the maximum need determination for a single HSA in any one year will be no more than two		

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	additional fixed PET scanners regardless of the numbers generated individually by each part of the methodology. • No distinct methodology has been developed specifically for mobile PET scanners. Mobile capacity has been described in the SMFP as 2,600 procedures. Ms. Bennett reviewed the three tables in PET: Data Presentation: There are three tables in PET. They are on page 141-142 of SMFP. 9L PET scanner Utilization of existing fixed dedicated scanners. 9M1: PET scanner Provider of Mobile Dedicated Scanners 9M2: PET scanner Sites Utilization of Existing Mobile Dedicated Scanners. PET- No Need in either fixed or mobile **Committee Recommendation** A motion was made and a vote taken to accept PET Scanner assumptions and methodologies, data, draft need projections and advance references to years by one as appropriate.	Dr. Akers Dr. Moore	3-0
Linear Accelerator – Chapter 9	Ms. Bennett stated the linear accelerator planning areas are the 28 multi-county groupings shown in Table 9I. Ms. Bennett 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. <u>For the Accessibility Criterion 1</u> 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		

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	or equal to 120,000 per linear accelerator, Criterion 1 is satisfied. <u>For Patient Origin Criteria 2</u> 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. <u>For Efficiency Criterion 3</u> 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. Bennett 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. Bennett 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. **Committee Recommendation** A motion was made and vote taken to adopt the table and need projections including the following recommendation: *Motion for an adjusted need filed in the event there was an applicant, suspending that in the following Plan, unless the applicant failed.* **Committee Recommendation** A motion was made and seconded to recommend acceptance of, Linear Accelerator assumptions and methodologies for the Proposed 2016 SMFP, and to advance references to years by one as appropriate. Dr. Ullrich mention at the May 13, 2015 meeting a discussion would take	Mr. Adams Dr. Akers Mr. Adams Dr. Akers	3-0 Motion approved

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	place regarding the discussion he had with staff regarding collecting CPT code data in parallel with the ESTV data starting in the next reporting period for the next 2 years to allow a model of how to migrate off the ESTV onto a standardized billing record of CTP coding going forward.		
Gamma Knife - Chapter 9	Ms. Bennett reviewed the need assumptions and methodology for Gamma Knife. Ms. Bennett 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. Bennett stated it is determined that there is no need for an additional gamma knife anywhere in the state and no reviews are scheduled. **Committee Recommendation** A motion was made and vote taken to adopt the Gamma Knife assumptions and methodologies.	Mr. Adams Dr. Akers	3-0
Other Business	A motion was made and seconded for staff to make necessary updates and corrections to narratives, tables and need determinations for the Proposed 2016 SMFP as new and updated data is received. There was no other business brought before the Committee.	Mr. Adams Dr. Akers	Motion approved
Adjournment	There being no further business, the meeting was adjourned. The next meeting of the Committee is Wednesday, May 13, 2015 at 10:00 am.		