Comments for 2017 Operating Room Methodology Workgroup

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PDA appreciates the opportunity to submit these comments on the operating room methodology for the State Medical Facilities Plan. We understand the difficulty associated with developing a simple methodology that accommodates fair, reasonable growth and competition, and protects critical safety net providers. Some of these comments and suggestions are concrete. Others are discussion points.

1. **Operating rooms and procedure rooms** – Counting interventional radiology procedures and rooms dedicated to this purpose in the surgical methodology would add confusion. Such rooms are easily identified by their equipment; and most providers can maintain use records for these rooms with minimal difficulty. Surgical cases done in these rooms should not be included in the operating room methodology.

   Procedure rooms that function in the surgical department are different, however, Because North Carolina Licensure rules permit development of procedure rooms at operating room construction standards, the methodology should recognize and count both procedure rooms and operating rooms that are in surgical departments, especially the ones that are meet to operating room construction specifications. It should recognize case counts for these rooms, as well. Initially, the counts might produce a calculated surplus of operating rooms in the Plan. However, the counts from one facility to the other will be more uniform. Then, other policies can address growth and competition. The policy of excluding C-section and trauma rooms from the methodology should continue. Table 8e) on LRA page 12 should have better instructions that include a definition of "non-surgical case."

2. **Time per case** – Attributing 3.0 hours to an inpatient case and 1.5 hours to an outpatient case is somewhat arbitrary. But, rather than make time variable for every facility, moving the outpatient case time up to 2.0 hours would accommodate the increasing length of time for outpatient procedures and provide time for infection control requirements to thoroughly clean rooms between cases.

3. **Data source** – Truven has valuable data, but, under present arrangements, those data are not publically available to all providers without significant cost. This creates inequities that favor the larger or non-profit providers. Moreover, the data available to the state are not current. Unless the state can make the Truven data as available as NC Licensure Renewal data, licensure renewal applications should be the standard. DHSR could add an attestation page

that applies to the full license renewal data supplement for purposes of improving data accuracy.

4. **Operating room hours per day** – Most surgery programs run cost effectively on an 8-hour operating room day, particularly smaller facilities. The efficiency applies to both ambulatory surgery centers and hospitals with small surgical programs. Large facilities can balance volume with longer days and staggered shifts. A tiered planning methodology could address this issue. For example: up to six operating rooms: 8-hour day; more than six operating rooms: 9-hour day. The methodology should not assume a uniform 9-hour day.

5. **Service area/ tiered system** – The current methodology has tiering in the rounding factors. It uses historical surgical procedures done in the county, and the approach has the advantage of recognizing growth needs of counties with high concentrations of specialists. However, it has a little bias against counties that are growing large enough to support new specialists. . It may be that small adjustment to the rounding factor would address the issue.

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