Healthcare Planning & Certificate of Need

Acute Care Services Committee Minutes

April 4, 2017
10:00 AM – 12:00 PM
Brown Bldg. Room 104

MEMBERS PRESENT: Dr. Sandra Greene; Christina Apperson, Dr. Mark Ellis, Stephen Lawler, Kenneth Lewis, Dr. Christopher Ullrich (*ex officio*)
MEMBERS ABSENT: Representative Donny Lambeth, Dr. Robert McBride
HPCON Staff Present: Dr. Amy Craddock, Paige Bennett, Elizabeth Brown, Patrick Curry, Andrea Emanuel, Tom Dickson, Martha Frisone, Mike McKillip
DHSR Staff Present: Mark Payne
AG's Office: Derek Hunter

Agenda Items	Discussion/Action	Motions	Recommendations/ Actions
Welcome & Introductions	Dr. Greene welcomed members, staff, and the public to the first Acute Care Services Committee meeting of 2017. Dr. Greene asked Committee members and staff in attendance to introduce themselves. Dr. Greene explained that the meeting was open to the public, but discussions, deliberations and recommendations would be limited to members of the Acute Care Services Committee and staff. Dr. Greene stated that the purpose of this meeting was to review the policies and methodologies for the Proposed 2018 State Medical Facilities Plan (SMFP).		
Review of Executive Order No. 46 Reauthorizing the State Health Coordinating Council and Executive Order No. 122 Extending the State Health Coordinating Council	Dr. Greene reviewed Executive Orders 46 and 122, with committee members and explained procedures to observe before taking action at the meeting. Dr. Greene inquired whether any member had a conflict of interest or needed to declare that they would derive a financial benefit from any matter on the agenda. She asked if any member intended to recuse himself or herself from voting on any agenda item. There were no recusals. Dr. Greene requested members to make a declaration of the conflict if a conflict of arose for a member during the meeting.		
Approval of minutes from the September 13, 2016 Meeting	A motion was made and seconded to approve the September 13, 2016 minutes.	Mr. Lawler Ms. Apperson	Minutes approved

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Acute Care Hospital Beds – Chapter 5	**Policies and Need Methodology Review** No petitions or comments were received pertaining to Chapter 5. Dr. Craddock reviewed the GEN policies in Chapter 4 of the SMFP. They apply to all Health Services. Dr. Craddock reviewed Policy AC-1 (Use of Licensed Bed Capacity for Data Planning Purposes), AC-3 (Exemption from Plan Provisions for Certain Academic Medical Center Teaching Hospital Projects), AC-4 (Reconversion to Acute Care) and AC-5 (Replacement of Acute Care Bed Capacity). Dr. Craddock reviewed the methodology for Chapter 5. 1. Determine acute care bed service areas 2. Determine number of beds in inventory (licensed, CONs, prior year need determinations) 3. Enter total inpatient days of care for current reporting, as provided to Truven Health Analytics 4. Calculate the growth rate multiplier by using the average change in days of care over the past four years. 5. Calculate projected census for 2020. 6. Multiply projected census by target occupancy factor. 7. Determine the surplus or deficit of beds for each facility or owner (for facilities under common ownership). 8. Sum the surpluses and deficits for each service area/owner to determine the number of beds needed. **Committee Recommendations** A motion was made and seconded to carry forward the Acute Care Bed policies and need determination methodology without changes.	Mr. Lewis Ms. Apperson	Motion approved
Other Acute Care Services - Chapter 7	**Policies and Need Methodology Review** There were no petitions or comments received regarding the policies and methodology for Chapter 7.		

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	Dr. Craddock reviewed the Acute Care policy pertaining to this chapter. **Policy AC-6 Heart-Lung Bypass Machines for Emergency Coverage** A need is determined for one additional heart lung bypass machine whenever a hospital is operating an open heart surgery program with only 1 heart-lung bypass machine. **Methodology** **Open Heart Surgery Services** This need determination methodology was eliminated beginning with the 2012 SMFP. However, a CON is required to obtain heart-lung bypass equipment. **Burn Intensive Care Services** There will be a need for new burn ICU beds when both of the existing services have an average annual occupancy rate of at least 80% for the immediate two reporting years. If this occurs, then calculations are performed to determine the number of beds needed. To determine need: 1. Calculate 4-year average annual growth rate for burn unit days of care, using the 5 most recent years of data. 2. Determine the number of beds needed such that the total projected utilization (of existing and CON-approved beds) would be 80%. 3. To arrive at the need determination, subtract the total existing beds from number of beds generated by the projected utilization for 2020. **Transplantation Services** **Bone Marrow Transplantation Services** The need determination is based solely on the number of allogeneic bone marrow transplants performed. These are performed only Academic Medical Center Teaching Hospitals. A need is determined when each of the existing services has performed at least 20 allogeneic bone marrow transplants during the fiscal year just prior to the development of the current SMFP.		

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	Solid Organ Transplantation Services Solid organ transplantation services are limited to Academic Medical Center Teaching Hospitals and availability of solid organs. There is no mathematically-based methodology for calculating need. **Committee Recommendation:** A motion was made and seconded to carry forward the current methodology for the Other Acute Care Services.	Ms. Apperson Dr. Ellis	Motion approved
Inpatient Rehabilitation Services – Chapter 8	**Need Methodology Review** Dr. Craddock reviewed the Inpatient Rehabilitation Services methodology steps, and explained that need determination was calculated by Health Service Area (HSA). 1. Calculate 3-year average annual rate of change for inpatient rehabilitation days of care, using the 4 most recent years of data for each HSA. 2. Determine the number of beds needed in 2020 such that the total utilization (of existing and additional beds) would be 80%. 3. To arrive at the need determination, subtract the total existing beds from number of beds generated by the projected utilization for 2020. There were no petitions or comments received regarding the policies and methodology for Chapter 8. **Committee Recommendation:** A motion was made and seconded to carry forward the current methodology for Inpatient Rehabilitation Services.	Mr. Lawler Dr. Ellis	Motion approved
Operating Rooms – Chapter 6	**Need Methodology Review** There are no OR policies in Chapter 4 of the SMFP. Dr. Greene deferred the need methodology review until her presentation of the Operating Room Methodology Workgroup recommendations, later on the agenda.		

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	One petition was received pertaining to Chapter 6. One comment on the petition was received after the March 16, 2017 deadline. The Agency did not consider this comment in preparation of the Agency Report. A motion was made not to accept or consider the late comment. The Committee made a second motion supporting a strict adherence to the deadlines for comments as outlined in the SMFP. Dr. Craddock then presented the Agency Report on the petition. J. Arthur Dosher Memorial Hospital submitted a petition that requested the following: Policy AC-7: Critical Access Hospitals: "To ensure the viability of Critical Access Hospitals (CAH) in North Carolina, addition of one or more operating rooms to a service area in which a CAH operates is only permitted if the certificate of need application includes a signed letter from an authorized representative of the CAH stating that the project will not have an adverse impact" on the CAH. and Methodology Recommendation: "In a service area with a Critical Access Hospital, rounding up should not occur if the Critical Access Hospital itself does not report 90 percent utilization of its operating room capacity." Brunswick County has two facilities that provide surgical services. J. Arthur Dosher Memorial Hospital (Dosher), a CAH, has two shared operating rooms (OR). Novant Brunswick Medical Center (Novant) has four shared ORs and one dedicated C-section OR (which is excluded from the need determination calculations). The 2016 SMFP included a need determination for one OR in Brunswick County. Need determinations are based on utilization of existing ORs and projected population growth. Brunswick County had a deficit of .37	Mr. Lawler Dr. Ellis Mr. Lawler Ms. Apperson	Motion approved Motion approved

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	ORs. The need was rounded up to one OR because the county has between six and ten ORs, per the standard methodology. Two certificate of need (CON) applications are currently under review for this need determination. A decision is expected by April 29, 2017. The Petitioner's requests center around the following four issues. **Proliferation of Unnecessary ORs:** Generally, the Petitioner claims that CAHs can be disadvantaged when the SMFP shows an OR need determination in a county with a CAH. The Petitioner asserts that both a new policy and a methodology change are required to address this potential statewide problem. The Agency's analysis finds no evidence of a current or potential statewide problem (see Table 1). Rather, the conditions likely to trigger an OR need determination exist only in Brunswick County for two reasons. It is the only county with a CAH and another facility providing surgical services that are both included in the methodology. Also, Brunswick County is the fastest growing county with a CAH. Pender County (which is contiguous with Brunswick and has a CAH) has a projected 7.86% growth rate for the same time period. Growth rates for all other counties with a CAH are substantially lower or declining. Even though Pender County has a high population growth rate, its low OR utilization rate (4.8%) renders it extremely unlikely that the county will show a need for additional ORs. **Rounding:** The Petitioner notes that the rounding method can easily create excess capacity in a small county. The rounding method in the current methodology first appeared in the 2009 SMFP; this change emerged from the 2007 OR Workgroup and a petition from a hospital. The rationale for the rounding method is that smaller facilities generally cannot achieve the economies of scale possible in larger facilities. As such, the methodology should not require them to meet the same efficiency standards as large facilities. In other words, the rounding system was specifically designed to benefit service areas with a small number of ORs. **Operating Room Utilization at Critical Access Hospitals:** The Petitioner requests that rounding should not occur in service areas with a CAH unless the CAH reports 90% OR utilization. For a hospital in the group that includes		

	CAHs, the Workgroup recommends 1,500 hours be considered full utilization. Using the recommended methodology, the Petitioner proposes that rounding should not occur until the CAH reaches 120% of full utilization. Implementation of this requirement would put a CAH at a disadvantage in developing a new OR, if utilization ever does reach this need determination threshold. **Procedure Rooms:** The Petitioner claims that rounding can create a situation in which an entity can apply for an OR and also propose to develop new procedure rooms that (according to the Petitioner) can increase capacity well beyond the county's needs. Development of a procedure room is not a "new institutional health service" which requires a CON except under limited circumstances. Therefore, changing the rounding process will not affect the development of procedure rooms. ***Agency Recommendation:*** The Petitioner's arguments reflect the situation in Brunswick County only and do not reflect a statewide situation. The arguments also do not address a situation likely to exist in the future in other service areas with a CAH. The SHCC is sensitive to the needs of rural areas, but the requested policy and methodology changes would not have an impact on rural counties in general. Only Brunswick County has exhibited the conditions that could possibly trigger implementation of the requested changes. Moreover, the SMFP provides a process for entities to address concerns regarding need determinations published in a proposed SMFP. Any entity could have submitted a petition in July of 2015 to request removal of the need in Brunswick County in the Proposed 2017 SMFP. Given available information submitted by the March 16, 2017 deadline, and in consideration of factors discussed above, the agency recommends denial of the Petitioner's request for a new policy and the request for a change to the methodology. **Committee Recommendation:**		
	The committee discussed the petition and Agency Report. A motion was made to deny the petition from J. Arthur Dosher Memorial Hospital.	Mr. Lawler Dr. Ellis	Motion approved (3 in favor, 1 opposed. Dr. Greene and Dr. Ullrich did not vote.)
	A further motion was made to have the staff study and review issues surrounding the provision of surgical services in Brunswick County and report	Mr. Lawler Mr. Lewis	Motion approved

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	their recommendations back to the Acute Care Services Committee for whether, and if so how, to address its unique characteristics in the methodology, with special attention to issues of rural health care and the type of rounding used in the methodology. **Presentation from Triangle Orthopaedics Surgery Center** As requested at the September 13, 2016 Committee meeting, Ms. Christine Washick (administrator of Triangle Orthopaedics Surgery Center) gave a report on the facility's efforts to comply with the requirement that 7% of the facility's total collected revenue be attributed to self-pay and Medicaid. Ms. Washick She also described the efforts to work with referral sources to meet this requirement. She also presented data from the last three quarters (July 2016-March 2017) showing that the facility had achieved 10.6% of revenue from self-pay and Medicaid sources. A motion was made to accept the Report from Triangle Orthopaedics Surgery Center. **Operating Room Methodology Workgroup Recommendations** Dr. Greene presented the recommendations from the Operating Room Methodology Workgroup. Recommendation 1: Categorize facilities into groups based on the total number of surgical hours reported on the most recent License Renewal Application (LRA), with two exceptions – Academic Medical Center (AMC) Teaching Hospitals and Ambulatory Surgical Facilities (AMSUs). AMCs will form a separate group. AMSUs will form two separate groups. One group will consist of AMSUs with at least 50% of total surgical procedures in either the ophthalmology or otolaryngology category or a combination of the two. All other AMSUs will be in the second group. See Table 1 for grouping. Recommendation 2: Assign Availability (hours per day and days per year routinely scheduled for surgery) based on the facility's group membership. See	Mr. Lewis Dr. Ellis	Motion approved

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	Table 1 for grouping. This categorization replaces the current methodology availability assumptions of 9 hours per day and 260 days per year. Recommendation 3: Implement 75% as the assumption of full utilization of an OR for all facilities. This percentage replaces the 80% assumption in the current methodology. Recommendation 4: Apply the facility's reported average inpatient and average ambulatory surgery case times from the current LRA to determine the total surgical hours. For facilities with a greater than 10% increase in case time from the previous LRA, the need determination calculations will use the value corresponding to 10% above the previous year's reported case time. Inpatient and ambulatory case time adjustments will be made separately. In addition, for non-AMC facilities with average case time greater than 1 standard deviation above the mean for their group, their average case time will be reduced to the value equal to 1 standard deviation above the mean for the group. AMCs with an average case time above the standard deviation will **not** have their case time reduced. Recommendation 5: Use the four year population growth rate in each service area to calculate the projected surgical hours. Recommendation 6: Calculate OR deficits/surpluses by facility/owner rather than by service area. Calculate deficits and surpluses separately for each facility in the service area unless under common ownership/controlling entity with others in the service area. Otherwise, total the deficits and surpluses for all facilities under a common owner/controlling entity in the service area. Determine service area OR needs by summing the deficits for all facilities and owners/controlling entities in each service area. Recommendation 7: Revise Policy AC-3 to include in the planning inventory and need determination calculations all ORs approved under this policy, regardless of approval date. Dr. Craddock presented the staff's proposed alteration to Recommendation 4. In addition to the provisions of Recommendation 4, the staff recommends that		

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	for facilities with a greater than 20% decrease in case time from the previous adjusted case time, the need determination calculations will use the value corresponding to 20% below the previous year's adjusted case time. Dr. Greene then presented the final recommendations, which are relevant to the 2019 SMFP and beyond. Recommendation 8: Improve the LRA data to make it more accurate and verifiable by revising terminology, clarifying definitions, and providing instruction and guidance regarding key data elements. Focus specifically on improving the reporting of ownership/controlling entity information, surgical availability, inpatient case time, ambulatory case time, and number of inpatient and ambulatory cases. Recommendation 9: In agreement with the 2007-2008 Operating Room Methodology Workgroup, the current Workgroup recommends the use of accurate and verifiable billing data regarding surgical procedures performed in ORs. This information would come from the data that hospitals and AMSUs submit to Truven Health Analytics. The Acute Care Services Committee should continue to explore the use of Truven data to identify procedures performed in licensed ORs (versus procedure rooms or elsewhere) and to function as the official source of data on surgical procedures. The Committee discussed the Workgroup's recommendations. Based on the number of ORs needed in the preliminary Proposed 2018 SMFP data, they asked the staff to make recommendations to the committee regarding a phased approach to implementation of the new methodology. **Committee Recommendation:** A motion was made and seconded to carry forward the policies and methodology for operating rooms proposed by the Operating Room Methodology Workgroup, as amended by Staff Recommendation 4.	Ms. Apperson Dr. Ellis	Motion approved
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 2018	Mr. Lewis Dr. Ellis	Motion approved

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	SMFP as new and updated data is received. Dr. Craddock reminded members to complete their contact and disclosure forms, if they had not already done so. There was no other business brought before the Committee. The next meeting of the Committee is Tuesday, May 2, 2017 at 10:00 am.		
Adjournment	Dr. Greene adjourned the meeting.	Mr. Lewis Ms. Apperson	Motion approved