North Carolina Hospital Association
Serving North Carolina's Hospitals & Health Systems

February 8, 2017

MEMORANDUM

TO: OR Workgroup/NC State Health Coordinating Council

FROM: Mike Vicario, Vice President of Regulatory Affairs
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SUBJECT: Operating Room Methodology Workgroup: Comments

The North Carolina Hospital Association would like to thank the State Health Coordinating Council's (SHCC) Operating Room Methodology Workgroup for the opportunity to comment on the operating room (OR) need methodology and its accuracy in determining operating room need in all areas of the state.

In a recent meeting the group was presented with a modeling tool to enable the manipulation of several of the following variables to assess their impact on the proposed need for operating rooms. The resulting need determinations vary significantly depending on the inputs. NCHA has the following comments regarding the data, models and policy considerations.

Data Sources
Self-reported data are currently derived from the Annual Hospital and Ambulatory Surgery Licensure Renewal Forms (LRA). The use of claims based data from the (Truven) Patient Data System (PDS) has been investigated, but differences in the way data are identified and grouped have shown inconsistent (especially outpatient) results when compared with the LRA data. The OR workgroup should not recommend implementation of the PDS until there is a higher level of consistency between the two counts. The Workgroup should consider what would be a tolerable level of difference, and recommend that the Acute Care Committee establish a process to incorporate needed modifications and monitor annual comparative reports to assess progress.

Tiered Groups
Because additional data are now available from the LRA forms on case times and hours of operation, tiers for organizing similar facilities can be developed to improve the accuracy of the need methodology.

- Currently there are two case time assumptions, (90 minutes for OP and 180 minutes for IP procedures). Modification and/or expansion of the tiers, and use of median values to create separate groups should be considered. Ambulatory Surgery Centers and tertiary/ quaternary medical centers have case time values that are different enough to warrant individual groupings.
- Reaching the standard utilization threshold of 80% can present difficulty, especially for a large provider with multiple ORs. Consider adjusting utilization requirements downward.
- Availability and hours of operation also vary, with large medical centers operating more days per year and more hours per day. Consider incorporating "hours of operation" differences into the tier structure.

Growth Rate
Currently the need methodology applies a population growth rate factor from the service area to forecast changes in need. Applying surgical growth rates instead of population growth rates has been suggested as a potentially more accurate method to project this need. While the modeling tool produces need for large numbers of operating rooms in several service areas, some of this may be caused to reporting differences or other unrelated changes. Models using a "no growth" factor project a moderated, but still clear increase in need in many areas, especially when the "fully utilization" variable is moved downward from 80%. But a growth factor may be needed for a sustainable need methodology. We suggest that the workgroup consider whether these alternative models would be more accurate.

Facility Specific Need
Need is currently estimated by combining all ORs in the service area and determining a net need factor, which can penalize the busiest providers when others' utilization is low. The current methodology assumes that patients will migrate to lower utilized sites when preferred OR sites are full, but there is no evidence showing that this occurs. The methodology would be improved if need was identified when a single system reaches an identified need threshold, as it would enable affected providers (and others) to apply for a CON when need is identified in that facility. However there are potential issues with such a change:

- If combined with a methodology that uses self-reported case times, a facility with very short duration procedures could generate an incorrect need determination. (For this reason we support the use of groupings instead of individually reported case times.)
- If a facility moves procedures from procedure rooms to operating rooms, it could quickly generate a need determination.
- Other unintended consequences could arise as individual providers would have more control over the need methodology than under the current process, which uses averages from all providers in the service area.
- Consider establishing limitations on the number of operating rooms needed per service area in a given year. Need should be manageable for the Division's review process but not so small that development costs are unnecessarily increased.

Policy AC-3
Because Academic Medical Centers do not isolate specific operating room surgical counts from ORs awarded under Policy AC-3, there is not a practical way to count only the surgical procedures from those specific ORs. Unless the AC-3 operating rooms are limited to only certain surgical procedure(s) with substantially different surgical volumes, we suggest they and their surgical volumes be included in the regular inventory of operating rooms.

Quality, Access and Value
The *Single Specialty Ambulatory Surgery Facility Demonstration Project* applies the SMFP principles of quality, access and value in the development of three ambulatory surgery centers. In developing the project the SHCC established population and payer mix requirements for those facilities. The OR workgroup and the Acute Care Committee should consider if these requirements could improve the need methodology, and whether any of the criteria from that project should be incorporated into the operating room methodology.