Recommendations
2016-2017 Operating Room Methodology Workgroup

The Operating Room (OR) Methodology Workgroup met five times: October 11, November 10, and December 13 of 2016, and January 11 and February 15 of 2017. The Workgroup reviewed the current operating room methodology, heard extensive comments from interested and affected parties and recommends substantial changes to several areas of the OR assumptions and methodology. These recommendations are made to the Acute Care Services (ACS) Committee of the SHCC for consideration in the planning cycle for the 2018 State Medical Facilities Plan (SMFP). At the June 7, 2017 meeting, the State Health Coordinating Council (SHCC) will receive the final report from the ACS Committee for consideration in the Proposed 2018 SMFP.

Immediate Action for 2018 SMFP

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 Units (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.

Table 1. Facility Grouping

Group	Hours per Day	Days per Year
1. Academic Medical Center Teaching Hospitals	10	260
2. Hospitals reporting more than 40,000 surgical hours	10	260
3. Hospitals reporting 15,000 to 40,000 surgical hours	9	260
4. Hospitals reporting less than 15,000 surgical hours	8	250
5. AMSUs performing at least 50% of their procedures in either ophthalmology or otolaryngology or a combination of the two.	7	250
6. All AMSUs not in category 5.	7	250

Recommendation 2: Assign Availability (hours per day and days per year routinely scheduled for surgery) based on the facility's group membership. See 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.

Action for 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.