PUBLIC COMMENTS ON BEHALF OF DUKE UNIVERSITY HEALTH SYSTEM REGARDING ACUTE CARE BED METHODOLOGY PETITION

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I am here today with Dr. Michael Cotten, Duke's Chief of the Division of Pediatric Neonatology, to speak about a petition that we are submitting to adjust the acute care bed need methodology to better meet the needs of the state's neonatal patients.

As background, newborns needing regular Level I care are accommodated in bassinets that by regulation are not considered licensed acute care beds. Licensed beds are required for higher levels of care, defined in state regulations to include Level II for neonates and infants who are stable without complications but require special care and frequent feedings; infants of any weight who no longer require Level III or Level IV neonatal services, but still require more nursing hours than normal infants; and infants who require close observation in a licensed acute care bed; up through Level IV neonatal intensive care services for high-risk medically unstable or critically ill neonates or infants requiring constant nursing care or supervision, including intensive supportive interventions.

Specifically, we are proposing that dedicated neonatal beds providing Level II through Level IV care, and the days of care provided in them, be excluded from the need methodology, and that providers be permitted to file certificate of need applications for neonatal beds without a need determination. Under our proposal, a CON would still be required to increase neonatal bed capacity; a CON would still be required to develop Level IV neonatal intensive care services; and existing licensure standards would continue to delineate the quality and safety requirements to offer these services.

This proposal would treat neonatal beds similar to C-Section rooms in Chapter 6. Currently, dedicated C-Section rooms are excluded from the OR inventory, and providers can apply to develop C-Section rooms separate from any OR need determination. This is also analogous to the decision the SHCC made to remove eliminate binding need determinations for inpatient psychiatric beds to increase the flexibility to improve access to care.

Under this change, providers would simply have the option to apply to increase neonatal bed capacity without awaiting or competing for a general acute care bed need determination. This could allow smaller hospitals that currently offer labor and delivery services but not inpatient neonatal care to develop Level II services, which would provide access for newborns who need inpatient admission but not intensive care services closer to home. It would also allow existing providers of higher acuity neonatal services to expand their capacity to meet patient needs more quickly.

Neonatal beds are very different from the beds in all other areas of the hospital, including adult and pediatric units. Not only are the beds themselves different, the physical requirements of the units themselves are distinct under the applicable construction guidelines. These differences mean that hospitals cannot flex beds or units between neonatal and other uses. Because the beds are all lumped together in the inventory and need methodology, however, providers can only increase neonatal bed capacity by giving up capacity in other parts of the hospital, or waiting until a bed need determination arises. Even then, a provider may be competing with other hospitals proposing non-neonatal services and may not be able to expand capacity as needed.

Our petition provides details about some of the facility requirements that drive these issues, and also provide information about the capacity constraints experienced not only at Duke but at providers across the state.

Dr. Michael Cotten, the Division Chief for Pediatric Neonatology at Duke University Hospital, is intimately familiar with the challenge of ensuring access to care for this population. Dr. Cotten has responsibility for Duke University Hospital's 67-bed neonatal service, which routinely sees utilization levels of 90% or higher. Dr. Cotten has some additional comments and is available to answer your questions.

Michael Cotten, MD
Duke University School of Medicine
Professor of Pediatrics
Chief, Division of Pediatric Neonatology

Hospitals across the state are facing capacity constraints in accommodating all of the neonatal patients who need care. We are submitting data about Duke University Hospital's experience, but I am also familiar with the situation at our peer institutions. Starting late summer 2021, during the COVID19 Delta surge, every weekday, representatives from the NICU's and Labor and Delivery hospitals from across the state submit a bed capacity report, indicating who might have capacity to accept transfers of patients.

We work together across the state to address the needs of this vulnerable population but are often limited in what we can do. The state determines need for bed capacity expansion for acute care, inclusive of adult bed spaces, pediatric bed spaces and neonatal bed spaces as acute care bed spaces.

While adults can feasibly be cared for in designated pediatric bed spaces and vice versa, the physical beds and units in which neonates are treated are so different from adult and even other pediatric beds, that NICU bed spaces are not interchangeable with adult or other pediatric bed spaces. Neither adult nor pediatric patients can be provided care in our NICUs, even when we have NICU space available. Similarly, accommodating neonatal patients in other spaces may not be feasible if they do not meet the infrastructure standards for neonatal areas.

Allowing providers to expand NICU capacity without waiting for a need determination would help us to meet the needs of this vulnerable subgroup of North Carolina's growing population. I am happy to answer any questions about this need.