Operating Room Petition 3:

- Petitioner: Franklin Regional Medical Center
- Request: a change to the OR need methodology that would apply different thresholds for OR need determination to service areas based on the number of current OR's in that service area.

- Agency Report

- Petition

AGENCY REPORT

OR Petition 3: Franklin Regional Medical Center

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Request
FRMC requests a change to the OR need methodology that would apply different thresholds for OR need determination to service areas based on the number of current ORs in that service area. This tiered approach was proposed by Dr. Dana Copeland, a SHCC Member, at the February 8, 2007 meeting of the OR Work Group Meeting. FRMC proposes the following change drawn from Dr. Copeland's approach:

- In a service area with five or fewer OR's and a "Projected OR Deficit" greater than or equal to 0.20 and less than or equal to 1.0, the "OR Need Determination" is equal to 1.0.
- In a service area with six to ten OR's and a "Projected OR Deficit" greater than or equal to 0.30 and less than or equal to 1.0, the "OR Need Determination" is equal to the "Projected OR Deficit" rounded to 1.0.
- In a service area with ten or more OR's and a "Projected OR Deficit" greater than or equal to 0.50, the "OR Need Determination" is equal to the "Projected OR Deficit" rounded to the next whole number.
- In all service areas with "Projected OR Deficit" greater than 1.0, the "OR Need Determination" is equal to the "Projected OR Deficit" rounded to the next whole number.

Background Information
Chapter 2 of the Plan allows petitioners early each calendar year to recommend changes that may have a statewide effect. According to the Plan, "Changes with the potential for a statewide effect are the addition, deletion, and revision of policies and revision of the projection methodologies." Clearly, the change recommended by this petitioner, if approved, would have a state-wide effect and would be a methodology revision.

Much interest has been shown in the operating room need projection methodology and the consequences of its application since the methodology was adopted and first used in the 2004 State Medical Facilities Plan. The operating room petitions filed annually since 2004 and the recent vigorous discussions of the methodology during Acute Care Services Committee and State Health Coordinating Council meetings are evidence of this interest.

In response to this interest, an Operating Room Methodology Work Group was convened and met four times during 2007. This work group reviewed and recommended a set of revisions to the operating room need methodology, to be phased in over the next several years. One of the Work Group's recommendations, to exclude facilities with chronically under utilized ORs from operating room need projections, was incorporated into the 2008 State Medical Facilities Plan. Given the work group's recommendations, there is clearly an understanding of the value and strength of the current operating room methodology as well as an understanding of the need for the planning process to be dynamic and responsive in a measured way to new ideas.

Analysis/Implications

In support of their petition, Franklin Regional Medical Center presents the data shown in the table below:

A	B	C	D	E
Existing # of OR's	OR Deficit Threshold	OR's Required (A+B)	Projected Surgical Hours (C x 1,872 hours)	Minimum Projected Utilization Rate (D ÷[A x 1,872 hours])
1	0.5	1.5	2,808	150.0%
2	0.5	2.5	4,680	125.0%
3	0.5	3.5	6,552	116.7%
4	0.5	4.5	8,424	112.5%
5	0.5	5.5	10,296	110.0%
6	0.5	6.5	12,168	108.3%
7	0.5	7.5	14,040	107.1%
8	0.5	8.5	15,912	106.3%
9	0.5	9.5	17,784	105.6%
10	0.5	10.5	19,656	105.0%
11	0.5	11.5	21,528	104.5%
12	0.5	12.5	23,400	104.2%
13	0.5	13.5	25,272	103.8%
14	0.5	14.5	27,144	103.6%
15	0.5	15.5	29,016	103.3%
16	0.5	16.5	30,888	103.1%
17	0.5	17.5	32,760	102.9%
18	0.5	18.5	34,632	102.8%
19	0.5	19.5	36,504	102.6%
20	0.5	20.5	38,376	102.5%

The table shows the minimum projected utilization rate per operating room necessary to generate a need determination, assuming from one to 20 operating rooms. Review of the data clearly show inequity in the necessary utilization rate per operating room in a facility with one operating room and a facility with 20 operating rooms. These data support the first two bulleted items shown in the petition request.

In addition to the data shown above, the petitioner provides two supportive examples from the State Medical Facilities Plan of the use of a tiered approach for utilization rates in need methodologies: the Acute Care Bed Need methodology and the MRI Need methodology.

Agency Recommendation

In consideration of the above, the Agency recommends approval of the first two bulleted items in the petition request, shown below:

- In a service area with five or fewer ORs and a "Projected OR Deficit" greater than or equal to 0.20 and less than or equal to 1.0, the "OR Need Determination" is equal to 1.0.
- In a service area with six to ten ORs and a "Projected OR Deficit" greater than or equal to 0.30 and less than or equal to 1.0, the "OR Need Determination" is equal to the "Projected OR Deficit" rounded to 1.0.

Additionally, the Agency recommends that the rounding factors described above for service areas with five or fewer and six to ten operating rooms extend to projected operating room needs that are greater than 1.

- For example:

  In a service area with five or fewer ORs and:
  a "Projected OR Deficit" greater than or equal to 1.20 and less than or equal to 2.0, the "OR Need Determination" is equal to 2.0;
  a "Projected OR Deficit" greater than or equal to 2.20 and less than or equal to 3.0, the "OR Need Determination" is equal to 3.0, etc.

  In a service area with six to ten ORs and:
  a "Projected OR Deficit" greater than or equal to 1.30 and less than or equal to 2.0, the "OR Need Determination" is equal to 2.0;
  a "Projected OR Deficit" greater than or equal to 2.30 and less than or equal to 3.0, the "OR Need Determination" is equal to 3.0, etc.

However, the Agency does not recommend approval of changing the methodology as described in the last two bulleted points, which would change the rounding factor for all service areas, regardless of the number of operating rooms in the service area.

PETITION FOR A CHANGE IN OPERATING ROOM NEED METHODOLOGY

North Carolina State Health Coordinating Council

Submitted to:
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Introduction

Franklin Regional Medical Center (FRMC) is a 70 bed general acute care hospital in Louisburg (Franklin County). FRMC has three shared inpatient/outpatient operating rooms located at the main hospital facility and is the sole provider of surgical services in Franklin County.

Summary

FRMC requests a change in the methodology for projecting operating room (OR) need to address the unequal treatment of service areas in determining OR need. Specifically, the current methodology requires service areas with fewer OR's to more heavily utilize those OR's in order to generate a need determination, compared to service areas with a greater number of OR's, which trigger a need determination with lower average utilization. The proposed change would create a tiered approach to determining OR need that would treat service areas more equitably. Although the full impact of the proposed petition cannot be known until final surgery data from hospitals and ambulatory surgery providers is collected by the Medical Facilities Planning Section, the implementation of the

proposed methodology change would likely have minimal impact for the *Proposed 2009 State Medical Facilities Plan*. Using the data in the *2008 SMFP*, the proposed petition would result in the allocation of a total of three additional OR's across the state.

The primary purpose of this Petition is to address the inequality inherent in the methodology for projecting OR need. According to the current methodology, every service area must achieve a projected OR deficit of 0.50 or greater in order to generate a need determination. A service area with fewer OR's must demonstrate higher projected OR utilization than a service area with more OR's in order to generate the required deficit of 0.50 or greater, when in fact, the opposite should be true. Service areas with fewer OR's should have lower thresholds for OR utilization because they are frequently served by small, rural providers that need additional OR's in order to attract and retain physicians and whose smaller physician base limits their ability to achieve high OR utilization. Any provider or service area without adequate OR capacity cannot provide the most cost-effective, most accessible, and highest quality of care to its patients. This Petition will address the inequality created by the current methodology and present a more equitable tiered approach to determining need. Not only will this proposed tiered approach trigger need at lower levels for counties with fewer OR's, it will also serve to align OR need determination with existing portions of the current *SMFP*, namely acute care bed and MRI need methodologies, which already utilize a tiered approach in determining need.

Requested Change

FRMC requests a change to the OR need methodology that would apply different thresholds for OR need determination to service areas based on the number of current OR's in that service area. This tiered approach was proposed by Dr. Dana Copeland, a SHCC Member, at the February 8, 2007 meeting of the OR Work Group Meeting. FRMC proposes the following change drawn from Dr. Copeland's approach:

- In a service area with five or fewer OR's and a "Projected OR Deficit" greater than or equal to 0.20 and less than or equal to 1.0, the "OR Need Determination" is equal to 1.0.
- In a service area with six to ten OR's and a "Projected OR Deficit" greater than or equal to 0.30 and less than or equal to 1.0, the "OR Need Determination" is equal to the "Projected OR Deficit" rounded to 1.0.
- In a service area with ten or more OR's and a "Projected OR Deficit" greater than or equal to 0.50, the "OR Need Determination" is equal to the "Projected OR Deficit" rounded to the next whole number.

- In all service areas with "Projected OR Deficit" greater than 1.0, the "OR Need Determination" is equal to the "Projected OR Deficit" rounded to the next whole number.

The proposed change would create a more equitable OR need methodology, but would not entirely eliminate the unequal treatment of service areas with few existing OR's. FRMC considered alternatives to the proposed methodology change that would have determined OR need solely on projected OR utilization which would have treated all service areas equally. However, FRMC believes that such a change would have been a radical departure from the current methodology requiring the *SMFP* to define OR need in a drastically different manner. FRMC believes that the proposed change is optimal because it uses the current methodology's definition of OR need and because it is based on a needed change, as recognized by a SHCC member.

Reasons for Proposed Change

FRMC is petitioning for a change to the OR need methodology because the current methodology, as applied, produces inequitable results. As shown in the *2008 SMFP*, OR need is determined for a given service area by estimating the total surgical hours from the previous year, projecting future surgical hours based on projected population growth, and determining need based on the difference between the current inventory of OR's and the number of needed OR's. However, even if a service area shows need for additional OR capacity, it must have a deficit of 0.50 OR's or greater in order to generate a need determination for an additional OR. The current OR need methodology correctly adjusts for differences in population growth, so that service areas with higher projected population growth will generate need for additional OR's at lower current utilization rates than service areas with lower projected population growth. This allows service areas with fast growing populations to provide surgical services to meet the need of the changing population. However, service areas with different numbers of existing OR's are treated differently under the current methodology. Specifically, the current methodology requires service areas with fewer existing OR's to demonstrate higher projected utilization per OR than service areas with more existing OR's. The table below demonstrates the minimum projected utilization rate required to achieve an OR need determination based on the number of existing OR's in a service area. The analysis also assumes 100 percent projected utilization is equal to 1,872 hours, the standard number of hours per OR per year as defined in the *SMFP*.

Minimum Projected Utilization Rates for OR Need Determination

A *Existing # of OR's*	B *OR Deficit Threshold*	C *OR's Required (A+B)*	D *Projected Surgical Hours (C x 1,872 hours)*	E *Minimum Projected Utilization Rate (D ÷[A x 1,872 hours])*
1	0.5	1.5	2,808	150.0%
2	0.5	2.5	4,680	125.0%
3	0.5	3.5	6,552	116.7%
4	0.5	4.5	8,424	112.5%
5	0.5	5.5	10,296	110.0%
6	0.5	6.5	12,168	108.3%
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18	0.5	18.5	34,632	102.8%
19	0.5	19.5	36,504	102.6%
20	0.5	20.5	38,376	102.5%

The table demonstrates that the current need methodology creates an inverse relationship between the number of existing OR's in a service area and the projected OR utilization rate that a service area must achieve in order to generate a need determination. ***In order to generate an OR need determination, service areas with fewer existing OR's must demonstrate higher projected utilization rates than service areas with more existing OR's.*** This inverse relationship exists irrespective of population growth, which varies among service areas and is adjusted for in the methodology. FRMC believes that this methodology is inherently unequal and should be changed.

The following table presents data on those service areas that demonstrated a deficit of OR's in the *2008 SMFP*. The table presents the current utilization rates for each service area, as opposed to the projected utilization rates presented above. In addition, the table demonstrates the minimum current utilization rates those service areas would need to achieve in order to generate the need for an additional OR.

Service Areas with OR Deficits in *2008 SMFP*

Service Area	*Existing # of OR's*	*2006-2010 Pop. Growth*	*2010 OR Deficit*	*Current Utilization Rate*	*Minimum Current Utilization Rate To Generate OR Need*
Franklin	3	8.96%	0.25	99.3%	107.1%
Columbus	5	1.74%	0.34	104.9%	108.1%
Johnston	7	13.23%	0.07	89.1%	94.6%
Union	8	19.27%	0.01	83.9%	89.1%
Cleveland	9	0.55%	0.46	104.6%	105.0%
Moore-Hoke	27	9.79%	0.22	91.8%	92.8%
Pitt-Greene	32	6.54%	0.25	94.6%	95.3%
New Hanover	41	9.34%	0.01	91.5%	92.6%

Note: Only includes counties where the *2008 SMFP* has identified an OR deficit, regardless of adjustments for OR need determinations, as in the case of Pitt-Greene.

As the table demonstrates, the current OR need methodology correctly adjusts for differences in population growth. Service areas with higher projected population growth such as Johnston and Union are not required to achieve as high minimum current utilization rates as service areas with lower projected population growth like Cleveland. However, as the prior analysis shows, the methodology does not adjust for differences in the existing number of OR's. Franklin, Columbus, and Cleveland counties would need to achieve current utilization rates ***above 105 percent*** in order for the current methodology to create an OR need determination. Moreover, Franklin County has 8.96 percent projected population growth from 2006 to 2010 which is well above the statewide average of 7.05 percent. Yet, Franklin is prevented from achieving an OR need determination because of the inequitable treatment of service areas with fewer existing OR's that exists under the current methodology.

Although the current OR need methodology adjusts for population growth variance among service areas, it fails to adjust for the existing number of OR's in a service area, which impacts that service area's ability to accommodate a deficit of 0.50 OR's. Moreover, service areas with fewer existing OR's are inherently

disadvantaged in achieving high OR utilization rates. Providers with limited OR's face challenges when recruiting additional surgeons that would help increase OR utilization. In the case of FRMC, one of the chief concerns expressed by potential surgeons is the lack of sufficient operating room capacity in the county. The allocation of an additional operating room would dramatically improve FRMC's ability to attract surgeons to care for Franklin County patients. However, the current OR need methodology requires FRMC to achieve these goals in reverse: it must achieve greater than 100 percent utilization of its existing OR's before it can acquire the needed additional OR capacity which in turn would allow for the recruitment of additional surgeons in order to achieve higher OR utilization. FRMC's situation is far from unique; hospitals across North Carolina face the same issue, as evidenced by numerous petitions filed over the past several years.

In addition to the difficulties of recruiting surgeons, service areas with fewer existing OR's have disadvantages due to their physician base. In North Carolina, service areas with fewer than ten existing OR's are almost exclusively rural areas.[1] Like many rural counties, Franklin County has a limited number of surgeons and proceduralists. Doctors in the community work in small physician groups where responsibilities cannot be shared as easily as in larger groups, and thus less time can be divided amongst the physicians to more efficiently handle on-call time, office visits, and rounding, and as a result, less time can de devoted to performing surgery. In addition, physicians in Franklin County often have offices in the Raleigh area, an hour's drive away, which can prevent them from performing surgeries throughout the day. In fact, only one surgeon on FRMC's medical staff practices exclusively at FRMC. All the others have offices in other parts of the county or in other counties, and most practice at other hospitals in the area as well. As a result, FRMC has difficulty utilizing its operating rooms for nine hours per day, as assumed in the statewide methodology. This situation limits the medical center's ability to achieve the high utilization rates that are required to generate the need for additional operating room capacity. Again, these physician dynamics are not unique to FRMC; rural providers across North Carolina confront the same problems. It is important to understand that FRMC recognizes that the use of nine hours per day is a statewide average that includes providers with higher and lower hours of operation; this Petition supports the use of the nine hours per week average and does not propose to change it. However, it is important to note that those providers who fall below the average are further disadvantaged by the current inequitable OR need methodology.

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[1] According to the list of urban and rural counties provided by the NC Rural Economic Center Development Center, Inc. (http://www.ncruralcenter.org), the only urban county in North Carolina with ten or fewer OR's is Davidson County; however, parts of Davidson County could certainly be considered rural.

Service areas with limited OR capacity have a harder time achieving higher utilization rates because of the increased burden on each OR to operate as efficiently as possible. In the *2008 SMFP*, each OR in Franklin, Columbus, and Cleveland counties were projected to operate at over 105 percent in 2010, as demonstrated in the table below. Franklin County and the Pitt-Greene service area were each projected to have an OR deficit of 0.25. However, that same deficit means that each of Franklin's three OR's will operate at 108.3 percent of capacity while each of Pitt-Greene's OR's will only need to operate at 100.8 percent, as shown in the following table.

OR Utilization Rates for Service Areas with OR Need

County	*Projected OR Need*	*Existing OR's*	*Projected OR Utilization in 2010*
Franklin	3.25	3.00	108.3%
Columbus	5.34	5.00	106.8%
Cleveland	9.46	9.00	105.1%
Johnston	7.07	7.00	101.0%
Pitt-Greene	32.25	32.00	100.8%
Moore-Hoke	27.22	27.00	100.8%
Union	8.01	8.00	100.1%
New Hanover	41.01	41.00	100.0%

Note: Only includes counties where the *2008 SMFP* has identified an OR deficit, regardless of adjustments for OR need determinations, as in the case of Pitt-Greene.

As another example of the increased burden on service areas with limited OR capacity, FRMC examined the impact in terms of additional hours per OR. In order for Franklin County to reach the 0.5 OR need to trigger an allocation, each of the three OR's in county must be projected to operate at the standard 1,872 hours per year, plus one-third of the additional hours needed to meet the 0.5 need threshold. Therefore, each OR must provide an additional 312 hours per year of service for an average of 1.2 additional hours per day per OR. In contrast, in order for the Pitt-Greene service area to reach the 0.5 OR need to trigger an allocation, each of the 32 existing OR's in the service must operate at the standard 1,872 hours per year, plus 6.75 minutes, which is each OR's share of the time needed to meet the 0.5 need threshold.

Finally, both the acute care bed and MRI need methodology provide important examples of a tiered approach to determining need. With regard to acute care beds, the target occupancy rate of licensed acute care beds is determined according to the average daily census of the provider as shown below.

Acute Care Bed Need Methodology

Average Daily Census	*Target Occupancy of Licensed Acute Care Beds*
1-99	66.7%
100 - 200	71.4%
Greater than 200	75.2%

The reason for the use of different occupancy rates for hospitals with different censuses is based on the recognition that hospitals with higher overall capacity have the ability to achieve higher utilization rates before reaching their effective "full capacity."

With regard to MRI need methodology, the target threshold for MRI need is determined according to number of fixed scanners in the service area as shown below.

MRI Need Methodology

Acute Care Service Area Fixed Scanners	*Inpatient and Contrast Adjusted Thresholds*	*Planning Threshold*
4 and over	4,805	70.0%
3	4,462	65.0%
2	4,118	60.0%
1	3,775	55.0%
0	1,716	25.0%

As with the acute care bed methodology, the MRI methodology recognizes that service areas with greater numbers of MRI scanners can more easily accommodate higher utilization before needing additional capacity.

The same rationale that applies to these two methodologies is also warranted for operating rooms. The MRI and acute care bed need methodologies recognize that service areas and providers with different levels of health care resources need to be considered differently in determining the future need for those resources. FRMC believes that OR need methodology must demonstrate a similar level of discrimination with regard to the amount of existing resources in a service area. The proposed change would create a more uniform *State Medical Facilities Plan*

where the need methodologies for acute care beds, MRI's, and OR's would all incorporate tiered approaches in determining future need.

Impact of Request

The proposed change will create a more equitable OR need methodology and, more importantly, will align future *State Medical Facilities Plans* further with the following basic governing principles:

- Promote Cost-Effective Approaches
- Expand Health Care Services to the Medically Underserved
- Encourage Quality Health Care Services

The impact of the proposed change in relation to these three areas will be discussed in turn.

Promote Cost-Effective Approaches

The proposed change will allow the small, rural service areas that will be affected to provide more cost-effective surgical approaches to the populations they serve. In the past 25 years, hospitals have witnessed dramatic shifts in the provision of health care. One notable trend is the growth in demand for outpatient services, particularly ambulatory surgery. In parallel, advances in technology have led to increases in minimally invasive surgery and robotic surgery. These trends are driven in part by their clinical efficacy and additionally by their cost-effectiveness, as they decrease or eliminate inpatient stays. Providers with limited OR capacity do not have the ability to adapt to these emerging practices in order to deliver the most cost-effective care because these procedures are often time intensive, using more OR time than traditional procedures.

In addition to the broader effects on clinical services described above, the proposed change would have positive impacts on clinical operation. Facilities with limited OR capacity cannot use staff and physicians as efficiently as larger facilities. In smaller facilities, physicians must often wait after each procedure while the room is cleaned and prepared for the next patient. Facilities with greater capacity can more effectively schedule surgeries and share staff and physicians across OR's.

Expand Health Care Services to the Medically Underserved

The proposed change will allow for expanded OR capacity in service areas with fewer than ten OR's. Providers in these areas with high OR utilization rates can be challenged to provide patients with the appropriate level of access to surgical

services. In addition, providers in these service areas are often disadvantaged when recruiting surgeons because of their lack of OR capacity, as discussed above. Surgeons who do practice in these areas often do so on a part-time basis; this is particularly true for FRMC where only one surgeon practices at the hospital full-time. As a result, the patient populations in these areas are provided with limited access to surgical care and are forced to travel elsewhere to receive it. This lack of access can potentially result in cases where patients cannot receive surgical care due to lack of surgery capacity or the unavailability of local clinicians. The proposed change in the OR need methodology would allow service areas with high OR utilization to add OR capacity in order to address these issues and to deliver the needed services to their patients.

Promote Quality Health Care Services

As described above, the provision of health care has undergone rapid changes in the last 25 years resulting in less invasive treatments and better clinical outcomes, particularly in ambulatory surgery. Providers with limited OR capacity do not have the ability to adapt to these emerging practices in order to deliver the most cost-effective care because these procedures often take more OR time as they are more time intensive. In addition, providers can face difficulties providing patients with timely surgical interventions if OR's are forced to operate above capacity. In service areas where OR capacity is limited, patients might be required to travel significant distances to providers with OR capacity in order to receive care. In such situations, patients who leave their homes and families in order to seek care are not receiving the most convenient, patient-friendly care. Patients traveling to another provider might be forced to seek care from another physician thereby threatening the continuity of care established by a home physician. The proposed change in the OR need methodology would allow providers to reduce these adverse effects in the future.

The implementation of the proposed methodology change would result in the allocation of three additional OR's, based on the data in the *2008 SMFP*. Each of these three OR's would be in service areas that already demonstrate a deficit of OR's under the current methodology, as a key component of the proposed change is that it only modifies the OR need deficit threshold for service areas with fewer than ten existing OR's. As the table below demonstrates, under the proposed change, service areas with fewer than ten existing OR's would be required to reach lower utilization thresholds than under the current methodology.

Impact of Proposed Change on Minimum Utilization Rates for OR Need Determination

Existing # of OR's	*OR Deficit Threshold*	*Minimum Projected Utilization Rate under Current Methodology*	*Minimum Projected Utilization Rate under Proposed Methodology*
1	0.2	150.0%	**120.0%**
2	0.2	125.0%	**110.0%**
3	0.2	116.7%	**106.7%**
4	0.2	112.5%	**105.0%**
5	0.2	110.0%	**104.0%**
6	0.3	108.3%	**105.0%**
7	0.3	107.1%	**104.3%**
8	0.3	106.3%	**103.8%**
9	0.3	105.6%	**103.3%**
10	0.3	105.0%	**103.0%**
11	0.5	104.5%	**104.5%**
12	0.5	104.2%	**104.2%**
13	0.5	103.8%	**103.8%**
14	0.5	103.6%	**103.6%**
15	0.5	103.3%	**103.3%**
16	0.5	103.1%	**103.1%**
17	0.5	102.9%	**102.9%**
18	0.5	102.8%	**102.8%**
19	0.5	102.6%	**102.6%**
20	0.5	102.5%	**102.5%**

Please note that the proposed methodology change still requires service areas to achieve utilization levels over 100 percent. Moreover, service areas with fewer existing OR's must still demonstrate higher projected utilization rates than service area with more existing OR's. However, the proposed need methodology is ***more equitable*** than the current methodology.

The application of the proposed change to those services areas with a projected operating room deficit in the *2008 SMFP* results in the following need determinations:

Impact of Proposed Change on OR Need Determinations

Service Area	*Existing # of OR's*	*Current Utilization Rate*	*Proj. OR Deficit*	*Projected Need for New OR's*
Franklin	3	99.3%	0.25	1
Columbus	5	104.9%	0.34	1
Johnston	7	89.1%	0.07	0
Union	8	83.9%	0.01	0
Cleveland	9	104.6%	0.46	1
Moore-Hoke	27	91.8%	0.22	0
New Hanover	41	91.5%	0.01	0

Note: FRMC considered using more recent data as provided by the 2008 Hospital License Renewal Applications, however, data for ambulatory surgery facilities is not yet available.

The OR need determinations that would result from the proposed change would address the OR capacity issues in Franklin, Columbus, and Cleveland counties. Each of these service areas is a rural county with growing surgical cases. The addition of OR capacity will allow providers in these service areas to more successfully recruit surgeons and provide surgical services to patients close to home. Most importantly, the additional OR capacity will allow providers to deliver more cost-effective, more accessible, and higher quality surgical care to patients.

Adverse Effects If Change Is Not Made

We believe that the proposed Petition demonstrates a number of compelling reasons to update the current OR need methodology. The proposed change would address the inequitable treatment of service areas with fewer existing OR's under the current OR need methodology. However, in the event that a change is not made to the current OR need methodology, adverse effects will result, a number of which are potentially devastating to small rural counties. Namely, the current need methodology will adversely effect:

- Physician recruitment
- Cost-effectiveness
- Delivery of clinical services
- Quality of care
- Access

Alternatives to the Proposed Change

Maintain Status Quo

The current OR need methodology requires service areas with fewer existing OR's to achieve higher OR utilization rates in order to generate a need determination than service areas with more existing OR's. Specifically, FRMC has achieved extremely high utilization of its OR's and strived to maintain adequate recruitment and retention of surgeons in order to achieve a *SMFP* generated need determination. Unfortunately, the challenges of the OR need methodology for service areas with few existing OR's have proved too great for FRMC to overcome. Despite FRMC's determined actions, Franklin County has not received an OR need determination since the change in the CON law to include operating rooms in the *SMFP*. More importantly, achieving additional OR capacity through the current methodology would do nothing to address its unequal treatment of service areas with limited OR capacity. If a provider in such a service area achieved an OR need determination and continued to grow to the point that it required another OR, it would still face the same challenges.

File a Special Need Petition

Providers in service areas requiring additional OR capacity may also file special need petitions with the *State Health Coordinating Council*. These special need petitions allow entities to request adjustments to the need determinations identified in the *SMFP* based on the unique and special attributes of a particular geographic region. FRMC did not view this as a viable option given that a special need petition would not address the inherent inequity of the current OR need methodology; further, FRMC did file a Special Need Petition in 2007, which was denied because "the Agency supports the current Operating Room Methodology and anticipates that every hospital could potentially contend that the methodology should be adjusted to better meet their needs," as stated in the September 4, 2007 Agency Report to the Acute Care Services Committee. On that basis, FRMC does not believe that a special need petition would be approved, since it would not be based on the current OR methodology.

It should also be noted that since the change in the CON law in 2001 to include operating rooms, not a single petition for a special need adjustment for operating rooms has been approved, until the final SHCC meeting of September 26, 2007, which approved allocations for two service areas. The following list shows the number of petitions for operating rooms that have been repeatedly denied since 2002.

- 2002 (*2003 SMFP*): six petitions, all denied;
- 2003 (*2004 SMFP*): four petitions, all denied;
- 2004 (*2005 SMFP*): four petitions, all denied;
- 2005 (*2006 SMFP*): three petitions, all denied;
- 2006 (*2007 SMFP*): four petitions, all denied;
- 2007 (*2008 SMFP*): five petitions, one approved.[2]

Moreover, the allocation of additional operating rooms for Wake County occurred despite the projected surplus of operating rooms in that service area. FRMC's 2007 petition for an additional OR was denied in spite of a projected deficit of operating rooms in Franklin County. The Agency report on the five special need petitions in 2007 concluded that Franklin County had the greatest need for additional OR capacity. However, the Agency Report recommended denying all five petitions in part because of its support for the current methodology. Therefore, FRMC believes that a change in the methodology is the only suitable alternative.

Revise OR Need Methodology

The current proposal to change the OR need methodology represents the best alternative for creating a more equitable methodology. Without a fundamental change, service areas with fewer OR's will continue to be required to demonstrate higher OR utilization rates than those with more OR's in order to achieve a need determination. The proposed change to the methodology would create a more equitable system.

Evidence that the Proposed Change Will Not Result in Unnecessary Duplication

The proposed change will not result in the unnecessary duplication of services because it only affects service areas that have demonstrated a need for additional OR's based on the projected growth of their current OR utilization. Given that the affected service areas have demonstrated a need for additional OR's, the *SMFP* has determined that there will be a deficit of OR's and, therefore, additional ORs would not unnecessarily duplicate services.

Summary

In summary, the proposed petition to change the OR need methodology would result in a more equitable OR need methodology and address the challenges faced by services areas with few existing OR's in acquiring additional capacity.

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[2] The SHCC approved one petition for the Pitt-Greene Service Area. Although four operating rooms were also allocated for Wake County, the SHCC denied both petitions that requested a special need adjustment.

The proposed change applies only to service areas with ten or fewer existing OR's that project a deficit of OR's under the current methodology. Using data in the *2008 SMFP*, the proposed changes would result in the allocation of three additional operating rooms: one each in Franklin, Columbus, and Cleveland counties. These three counties have projected OR deficits for 2010 and fewer than ten existing OR's. The proposed change would allow these counties to provide needed surgical services to patients who would otherwise travel for that care or forgo it.

We appreciate your careful consideration of this petition. Please let us know if we can assist the Acute Care Services Committee or the SHCC in your review of this petition.

Thank you.

North Carolina State Health Coordinating Council

Public Hearing

March 5, 2008

Presented on behalf of: Franklin Regional Medical Center

Good afternoon. I am Bonnie Little, Director of Business Development at Franklin Regional Medical Center and I am here today on behalf of our petition requesting a change to the operating room methodology for the *Proposed 2009 State Medical Facilities Plan*. Specifically, we are requesting a change in the methodology to minimize what we believe is a negative impact of the current methodology on counties with 10 or fewer OR's. The written petition details the need for the proposed change; however, I wanted to speak today in this

public setting about why we believe the proposed change is needed.

As you may recall, we came to the SHCC last summer to request a special need adjustment for Franklin County, which would have allocated one additional OR for our county, which currently has only three OR's. Despite the Agency's analysis, which concluded that Franklin County OR's are operating at the highest utilization of any county in the state, our petition was denied. According to the Agency Report, "the Agency supported the standard methodology and recommended that the Petition be denied." On that basis, we are here to petition that the standard methodology be changed to more equitably reflect the need in counties with fewer OR's.

As you may also recall from last year, our proposed change is not without precedent. In fact, the change

we propose is based on changes suggested last year by Dr. Dana Copeland. We again urge you to consider these changes, as they will strengthen what is already a good OR methodology.

Specifically, the current methodology dictates that until there is a deficit of at least 0.5 operating rooms in a given county, no need will be generated. According to the *2008 SMFP*, there will be a deficit of 0.25 operating rooms in Franklin County in 2010. Using the statewide methodology, there will be no additional operating room allocated to Franklin County in the 2009 Plan because the deficit has not yet reached 0.5. As OR volume in the county continues to grow and operating room capacity remains the same, a deficit of OR's has a greater impact than it might in another community with greater current capacity. It is important to

understand what a "deficit" of OR's really is. It means that providers in the county are projected to operate above the volume thresholds established in the *SMFP*. For counties like Franklin, which have fewer operating rooms to begin with, the challenge of operating above capacity is greater than in other counties. Let me try to use an example to explain the impact of the current methodology.

In order for Franklin County to reach the 0.5 need to trigger an allocation, that extra volume must be spread among the three existing OR's in Franklin County; thus, each of them must operate at 100% of the threshold of 1872 hours per year, plus one-third of the additional hours needed to meet the 0.5 need threshold. This equates to each room providing an additional 312 hours per year of service. *That's an average of 1.2 hours per day per operating room* ***above the***

nine hour average calculated in the methodology, *for a total of* ***10.2 hours per day, five days per week, 52 weeks per year, just to trigger a need.*** Then, we must continue to operate at or above those levels in the intervening time it takes to have the need in the *SMFP*, apply for it, be approved, and develop the additional operating room. I suggest that it would be a rare community hospital whose OR's were each operating over 10 hours per day, every day, for several years—it just is not feasible and I believe that's easy to recognize.

In comparison, Cleveland County, which shows nearly twice the OR deficit of Franklin County, has nine existing OR's, or three times Franklin County's OR's to absorb the volume represented by the 0.5 OR threshold. That equates to only 96 additional hours per OR per year, or only 22 extra minutes per OR per

day—compared to the extra 1.2 hours per day required in Franklin County.

There are several other factors and statistical reasons that we'll be providing in our petition, but I didn't want to take your time today reading off a list of numbers and percentages. What we are requesting is that, much like the existing acute care bed and MRI methodologies, a tiering approach be included in the OR methodology, to lower the 0.5 threshold to 0.2 for counties with five or fewer OR's; to 0.3 for counties with six to 10 OR's, and no change in the 0.5 threshold for counties with more than 10 OR's.

We believe there is a clear and present need as I've discussed today and as further outlined in our petition. We appreciate your careful consideration of this petition and hope it will prevent similar counties

from requesting special need adjustments as we did last year. Please let us know if we can assist the SHCC or the Acute Care Services Committee in your review.

Thank you.