Medical Facilities Planning

North Carolina State Health Coordinating Council
Acute Care Bed Need Methodology Work Group Meeting Minutes

Thursday, November 19, 2009

11:00 am – 3:00 pm

Cecil B. Sheps Center

MEMBERS PRESENT: Sandra Greene, Chair, Senior Research Fellow Cecil G. Sheps Center for Health Services Research, Research Associate Professor Health Policy and Administration, School of Public Health; Dana Copeland, MD, State Health Coordinating Council; Brian Moore, Director of Planning & Government, Mission Hospitals; Barbara Freedy, Financial Planning and Analysis--Certificate of Need Director, Novant Health; Del Murphy, Vice President CHS Management Company, Carolinas HealthCare System; Duncan Yaggy, Chief Planning Officer, DUHS; Sandy T. Godwin, Executive Director of Corporate Planning, Cape Fear Valley Health System; Lisa Hamby, Director of Planning, Catawba Valley Medical Center; Michael L. Freeman, Vice President, Medical Center Planning, Wake Forest University Baptist Medical Center; Kevin Deter, Vice President, Business & Network Development, Iredell Memorial Hospital; Kristina K. Hubard, MHA, FACHE Director, Business Analysis and Planning, New Hanover Regional Medical Center; Melanie Phelps, North Carolina Medical Society
MEMBERS ABSENT: Sue Collier, RN, MSN, Vice President, Planning & Strategy Development, University Health Systems of Eastern Carolina; L. Lee Isley, CEO, Granville Health System; Brad Weisner, COO, Nash Health Care Systems; Lawrence Cutchin, MD, State Health Coordinating Council
STAFF PRESENT: Floyd Cogley, Kelli Fisk, Martha Frisone, Victoria McClanahan, Carol Potter, Craig Smith

AGENDA	DISCUSSION/RECOMMENDATIONS	ACTIONS/CONCLUSIONS
Welcome & Announcements	Dr. Greene welcomed work group members and other attendees.	
Review of Executive Order No. 10, Ethical Standards for the State Health Coordinating Council Member Introductions	Dr. Greene gave an overview of Executive Order No. 10 procedures to observe before taking action at the meeting. She asked if there was anyone who wanted to make a public disclosure before the proceedings began and if there were any items on the agenda from which members wished to recuse themselves at this time. No work group member made a disclosure or recused themselves. Work group members introduced themselves, identified their workplace and/or their position on the Council and addressed if they or any member of their family would derive a financial benefit from any item on today's agenda. No member affirmed that he or she or any member of their family would derive a financial benefit from any item on today's agenda and no member recused himself or herself from any item on today's agenda. Dr. Greene asked members to declare during the meeting any conflicts that come up as agenda items are discussed.	No member recused himself or herself from any agenda item.
2.23.09 Meeting Minutes Review	Minutes from 2.23.09 approved.	None
Work Group Charge	Dr. Greene reviewed the revised work group charge, which follows: 1. To evaluate the present bed methodology with respect to the impact that uneven growth in days in acute care hospitals throughout the state has on the	None

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	methodology. 2. To develop recommendations for the bed need methodology which can effectively and fairly address the growth disparities and which will be consistent with the present methodologies in the 2010 SMFP. 3. To develop a methodology to define multi-county service areas (for counties with no hospitals) for acute care bed needs and operating rooms. This methodology is to be developed for application to the 2011 SMFP and should address the frequency of updates thereafter.	
Review of 2.23.09 Work Group Discussion/ Recommendations	Dr. Greene reviewed the 2.23.09 work group meeting and noted the following: • Work group concluded that HSA level growth rates were unacceptable due to wide variance in growth rates within HSA's. • County level growth rate had promise but needed to be enhanced. • Recommendation to use 4 years' data instead of 3 years' data for growth rate. • Different approach needed for counties with small hospitals. • Applying county level growth rate resulted in need for approximately 800 additional beds, which the work group was not comfortable with due to the economic conditions – not a good time for hospitals to be making large capital expenditures. • Work group discussed adding factors such as admit rates, average length of stay, case mix index and population.	
Review/Discussion of New Acute Care Bed Need Projection Data	• Work group reviewed map showing growth in inpatient days by county. Highest Inpatient days growth is occurring in counties near large metropolitan areas. • Discussed using total inpatient days for determining growth rate. Rationale for using total IP days – small hospitals cannot separate psych, rehab and substance abuse days from their acute days. • Why exclude non NC residents from the growth rate? Removing outliers from the growth rate affects the growth rate in areas that border high population urban areas and areas affected by changes in tourism. • Recommendation to include non NC residents if use county growth rate. • Discussed excluding outliers from growth rate data - noted that including outliers changes growth rate data. • HSA growth rates same if use total IP days or acute days. • A small hospital with a higher growth rate than the aggregated growth rate could petition for their growth rate to be used to determine need. • Occupancy rates: additional beds needed but 1000 too many beds at one time. • WakeMed running at 95% occupancy. • Increase or decrease occupancy rates at small hospitals? Small hospitals have more general beds than larger hospitals so don't have problem that larger hospitals have of	

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	specialty units reaching capacity (once ICU unit full, can't place a patient needing ICU in another type of bed).
	• Rationale for not increasing larger hospitals' occupancy rate:
	  ◆ Observation patients occupy AC beds but are not counted
	  ◆ Seasonality – peak census issues
	  ◆ Midnight census off as much as 20% compared to noon census
	• Suggestion to compound the growth rate 5 years instead of 6 years. Opinion expressed that it now takes more time to build beds – this was countered by the opinion that it now takes less time to build beds.
	• Point made that WakeMed uses observation beds built as observation beds. WakeMed able to manage 80% occupancy rate.
	• Hospital better able to manage higher census if there are other "buffer" hospitals nearby.
	• Duke Hospital has been running at 85% for the last few years (based on staffed, not licensed beds) – 80-82% occupancy acceptable to Duke.
	• Temper growth rate by adjusting based on most recent year's growth? Use weighted moving average for growth rate?
	• 82% seems too high. Some other states have lower occupancy rates (GA rural 65%, urban 75%; MD >300 beds 83%, 100-300 beds 80%, 50-100 beds 75%m 1-50 beds 70%). Concern expressed about using 80% occupancy rate for large hospitals.
	• Adding small number of beds more cost effective than adding new floor or new unit.
	• Look at changing occupancy rates after results from using Table 5A acute days data are known..	

Potential Actions/Recommendations Related to the Acute Care Bed Need Methodology	Consensus: • For growth rate, use Table 5A data (acute days data) and include non NC residents. Outliers are included in 5A data. • For hospitals with fewer than 100 beds, create need determination scenarios using aggregated growth rate data and county level data. • Create scenarios using data from 2005-2009 and from 2006-2009	New scenarios will be created based on work group consensus.
Overview of Current Service Areas: Acute Care Bed Operating Rooms MRI and Cardiac Cath	Ms. McClanahan and Dr. Potter reviewed the current Acute Care Bed, Operating Room, MRI and Cardiac Cath service areas. Ms. McClanahan noted that the Acute Care Bed and Operating Room Service Areas used in the 2004-2009 SMFPs were developed in 2002 and have not been updated since then. Dr. Potter noted that the MRI and Cardiac Cath Service Areas are the same as the Acute Care Bed Service Areas.	
New Service Area Data	Dr. Greene reviewed the acute care bed and surgical patient origin data prepared for this meeting, noting that most multicounty groupings have not changed since their inception. Dr. Copeland noted that the data show that Hoke is evenly split between Cumberland and Moore counties, thus Hoke should be shared by those counties. Dr. Greene posed the following questions:	Agreement that realigned multicounty groupings should be included in the Proposed Plan.

AGENDA	DISCUSSION/RECOMMENDATIONS	ACTIONS/CONCLUSIONS
	1. How often should multicounty groupings be evaluated for realignment? 2. What data should be used to determine multicounty groupings? 3. Which years data should be used when evaluating multicounty groupings?	
Discussion of New Service Area Data	• When there is a need determination in a multicounty service area, sites in the county or counties without services should be eligible locations for the proposed health services. • Cost of building space for new services is greater than the cost of adding to space for existing services. • When choosing a county for allocating additional acute care beds, counties with no hospital less likely to be chosen than counties with a hospital.. • CON holders may apply for a CON to move existing healthcare resources from one location within a service area to another location within the same service area. • MRIs located in smaller counties lower the threshold that small counties must meet in order to obtain an initial MRI machine.	
Potential Actions/ Recommendations Related to Service Areas	Recommendations: • Rerun patient origin data report using **acute care** days patient origin data instead of **total inpatient** days patient origin data. • Show multicounty groupings based on where 30% and 35% of patients living in counties with no hospital/OR receive services. • The point at which a county without a hospital/licensed facility with at least one OR is **issued a CON** is when the county becomes a single county service area.	Prepare reports, based on recommendations, for next meeting.