Medical Facilities Planning

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

Friday, February 19, 2010

10:00 am – 1:00 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; L. Lee Isley, CEO, Granville Health System; Brad Weisner, COO, Nash Health Care Systems; 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
MEMBERS ABSENT: Sue Collier, RN, MSN, Vice President, Planning & Strategy Development, University Health Systems of Eastern Carolina; Lawrence Cutchin, MD, State Health Coordinating Council; Melanie Phelps, North Carolina Medical Society
STAFF PRESENT: Martha Frisone, Victoria McClanahan, Craig Smith, Gene Deporter, Patrick Baker

AGENDA ITEM	DISCUSSION/RECOMMENDATIONS	ACTIONS/CONCLUSIONS
Welcome & Announcements	Dr. Greene welcomed work group members and other attendees and reviewed the agenda for the meeting.	
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.
11.19.09 Meeting Minutes Review	Minutes from 11.19.09 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	None

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	uneven growth in days in acute care hospitals throughout the state has on the 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 New Acute Care Bed Need Projection Data	Dr. Greene reviewed the summary of the seven acute care bed need projection simulations, which were posted on the internet, noting the following:
	• The data source for the growth rate was the acute care days used in the 2007-2010 SMFPs – psychiatric, substance abuse and rehab days were excluded and non North Carolina residents and outliers were included.
	• The 2004 data, used in the 2006 SMFP, were excluded since there were problems with that data.
	• In response to the concern expressed at the last meeting about grouping small counties, small counties were not grouped for several scenarios.
	• Items varied in the scenarios:
	  • Number of years into the future need is projected
	  • Target occupancy rates
	  • Growth rate
	
	Discussion:
	• Scenario 7 (projecting need for 425 beds) is close to Memorial Mission's modeling results, which look at admit rates.
	• The 425 beds generated in Scenario 7 seem like a reasonable number of beds to be generated – generation of a much larger number of beds would be too costly.
	• 425 beds seems like the right result but need to look at each variable used in the scenario which resulted in 425 beds.
	• 2009 data will not be available until May, which makes it difficult to evaluate the scenarios, since they are based on old data.
	• Recommendation to use 2005-2009 data for growth rate.
	• Adding a year to the growth rate data helps smooth out the data and buffer outlier data.
	• Incorrect growth rates can result from including data from years when beds are added.
		The workgroup decided to focus on the 5 variables that make up the bed need methodology. There was agreement on the first 4 variables:
		
		1. Data source
		- match data used in Table 5A (acute care days with psychiatric, substance abuse and rehab days excluded; non North Carolina residents and outliers included)
		
		2. Historical patient day growth rate
		- 5 years of data (2005-2009)
		- 4 years of trend
		
		3. Number of years need is projected
		- 4 years
		
		4. Calculation method for growth rate factors
		- County specific growth rate for each county (NO grouping of counties with small hospitals)
		
		The group was unable to come to consensus on the fifth variable – **target hospital occupancy rates**. Consequently they directed staff to prepare 3 scenarios, all using the 4 variables as agreed upon above.
		
		1. Current occupancy rates (66.7%, 71.4%, 75.2%)
		2. Current occupancy rates and 78% >400 ADC
		3. Current occupancy rate <100 ADC; 74% 100-200 ADC; 77%>200 ADC and <400 ADC; and 80% >400 ADC
		
		In addition to the 3 new scenarios above, also create a fourth scenario

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	• Suggestion that more weight be given to the most recent year's data. • In some cases, data issues may be best resolved through the petition process. • For Mecklenburg and other counties, average growth rate likely to be reduced by about 20% if add 2009 data since growth is abating. • Suggestion to consider using weighted averages. • Adding 09 data likely to decrease growth rate. • Since 09 data more recent, is more relevant – better to add 09 data than to add 04 data. • Most counties generating bed need are in MSAs – use MSA growth rate instead of county growth rate? • Point made that if counties with positive growth aggregated the average for this group of counties would be 2%-2.5%. • If other than county growth rate used then low growth counties may be penalized. • Only 6 of 78 hospitals with 1-99 beds are above target occupancy rates. • 80% of hospitals with >200 beds are above their target occupancy rate. • Recommendation to use county specific growth rates but consider MSA growth rates if issues arise with county specific rates. • 80% occupancy rate seems too high, especially for hospitals with specialty beds. • Larger hospitals can operate at higher occupancy rate than smaller hospitals. • Could change the CON occupancy rate projections, if necessary. • Average 80% occupancy rate means there are periods when rate could be as high or higher than 87%. • Season, time of day, day of week all affect occupancy rates. • Should length of stay (LOS) be considered when looking at occupancy rate targets? LOS has been considered before but decision was that it is too complicated for our current system to handle. Whereas Thomson Reuters database has data enabling adjusting LOS for acuity, this is something that could be referred to the QAV Committee for their review.	using the current methodology (statewide 3 year average growth rate using total inpatient days for 2007, 2008 and 2009). Have conference call to review the 4 scenarios. Present recommendations to the Acute Care Committee in May for their consideration.

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New Service Area Data	Dr. Greene reviewed the new service area data prepared for today's meeting, noting that acute care patient origin data rather than total inpatient patient origin data were used for determining the Multicounty Acute Care Bed Service Area s. Surgical patient origin data did not change.	None
Discussion of New Service Area Methodology	First Issue: Should 30% or 35% of patients be the threshold for assigning a county with no hospital/licensed facility with at least 1 OR to more than 1 county? • Data showed that using 30% as the threshold resulted in too many combinations of multicounty groupings, which would create difficulties for CON. • Using 35% as a threshold resulted in a reasonable number of shared multicounty service areas. Second Issue: When does a county with no hospital/licensed facility with at least 1 OR become a single county service area? • According to Policy Gen-2, a county with no hospital/licensed facility with at least 1 OR would become a single county service area upon issuance of a Certificate of Need for acute care beds/ORs. • Using Hoke County as an example, two CONs have been conditionally approved but due to litigation, have not been issued. Following Gen-2, Hoke County would become a single county service area when one of the CONs is issued. • If Gen-2 followed, concern expressed about CON issued inventory existing in a county with no accompanying utilization. Suggestion to modify Gen-2 such that a county with no hospital/licensed facility with at least 1 OR becomes a single county service area upon licensure. • Point made that delaying designation of a county as a single county service area until licensure would speed development of the project. • Point made that in most cases, facilities are developed soon after CONs issued. • Difference between transferred beds and new beds – designating county as single county service area upon issuance of CON makes sense for new beds • In Hoke county example, only 8 beds transferred from Moore Regional are to be developed. Showing Moore Regional with 8 fewer beds while the Hoke facility is developed would not have much impact on the ratio of inventory to utilization at Moore Regional. • From the county residents' perspective, their county would be shown as a single county service area with no facility. • Question asked, "How likely is it that there will be a situation similar to Hoke County in the future?"	• Use 35% as the threshold for determining if a county with no hospital/licensed facility with at least 1 OR would be assigned to 2 counties, i.e., use the following decision rules: Acute Care Beds: 1. Counties lacking a licensed acute care hospital are grouped with the single county where the largest proportion of patients received inpatient acute care services, as measured by acute inpatient days, unless; a. Two counties with licensed acute care hospitals each provided inpatient acute care services to at least 35% of the residents who received inpatient acute care services, as measured by acute inpatient days. 2. If 1.a is true, then the county lacking a licensed acute care hospital is grouped with both the counties which provided inpatient acute care services to at least 35% of the residents who received inpatient acute care services, as measured by acute inpatient days. Operating Rooms: 1. Counties with no licensed facility with at least one operating room are grouped with the single county where the largest proportion of patients had surgery, as measured by number of surgical cases, unless; a. Two counties with licensed facilities with at least one operating room, each provided surgical services to at least 35% of the residents who received surgical services, as measured by number of surgical cases. 2. If 1.a is true, then the county with no licensed facility with at least one operating room is grouped with both the counties which provided surgical services to at least 35% of the residents who received surgical services, as measured by number of surgical cases. • With respect to when a county with no hospital/licensed facility with at least 1 OR becomes its own single county service area, the

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	• Recommendation that the Acute Care Services Committee determine when a multicounty service area county becomes a single county service area. • Should the technology service areas be the same as the acute care bed or the OR service areas? • Recommendation that equipment service areas continue to match the Acute Care Bed Service Areas.	workgroup recognizes that according to Policy Gen-2, the trigger is upon issuance of a CON for acute care beds/ORs. However, the workgroup expressed concerns about the unintended consequences with respect to the generation of continued need (in the paired county) prior to opening of new services, and recommends that the Acute Care Services Committee consider modifying Policy Gen-2 to establish licensure, rather than CON issuance, as the trigger point. • Refer Acute Care bed and Operating Room Service Area recommendations to the Acute Care Services Committee for their review and approval. • Refer recommendation that Equipment service areas should continue to match the Acute Care Bed Service Areas to the Technology and Equipment Committee for their review and approval.
Adjournment	Meeting was adjourned by Dr. Greene.	