Comments for the 2017 Operating Room Methodology Workgroup
State Health Coordinating Council
November 10, 2016

Presenters:

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Dr. Kibbe: Thank you for the opportunity to provide comments on the OR Methodology. My name is Melina Kibbe. I recently joined UNC Medical Center as the Chair of the Department of Surgery. Prior to this I served as a Professor of Surgery at Northwestern University Feinberg School of Medicine and Co-Chief of Vascular Surgery at Jesse Brown VA Medical Center. I am board certified in general surgery and vascular surgery.

Facilities that provide Quaternary care are disadvantaged:

First I'd like to speak to an issue experienced by programs providing quaternary care. One of the observations I have made since my arrival is that we do not have enough quaternary ORs. Our main campus ORs are running at 88% utilization. After meeting with several individuals and discussing the need methodology, I learned that quaternary facilities are treated like all other hospitals. This significantly disadvantages facilities like ours when it comes to calculating OR needs.

The term quaternary care can be considered an extension of tertiary care in reference to advanced levels surgical care which are highly specialized, includes uncommon procedures, and not widely provided. This does not equate to being an academic teaching hospital as some large regional facilities also provide such care. Patients are referred to quaternary institutions to receive this unique care, and

at times, it is difficult to be able to accommodate the requests. It is our mission to provide care for these people but the present methodology disadvantages institutions that are required to provide such levels of care. For UNC Hospitals this is reflected in the fact that the main campus' ORs are utilized at 88% of our internal capacity, however the OR Need Methodology reports a surplus of 5.2 ORs for its service area.

For facilities that serve as a regional referral center, having a need determination based on a service area compiled of only 1 (sometimes 2) of the counties it serves, does not reflect the provision of care to all of its patients, which in some instances are cases from all 100 counties. As health care systems continue to evolve, the number of referrals made to these centers will continue to increase. A methodology that only considers its home base county does not take into consideration the increasing volume of patient referrals being received from other counties.

The case times currently assigned to IP and OP cases are inadequate for many of a quaternary facility's cases. If a facility's actual case times cannot be applied, then the case times need to be restructured within the methodology to provide a more accurate portrayal of the utilization of the operating rooms.

A colleague and I just interviewed more than 10 quaternary institutions on how they manage their ORs. Most of them use 80% as the goal, but also told us that they don't want to be much above 80% as it stresses the system far too much and major inefficiencies then develop. If the goal of the methodology is to have ORs performing at 80% utilization, and it takes 2-4 years to develop an OR once the allocation is made, then the performance standard in the methodology should be reduced to allow an allocation to be made earlier, at perhaps 70%. Once a surgical suite hits 80% occupancy its ability to accommodate emergency referrals is compromised. Allowing allocations to be generated prior to hitting this threshold would allow the referral centers to better accommodate the true needs of the patients and other facilities referring to the center.

Ultimately, limited OR capacity severely impacts the amount of quaternary OR care an institution can provide. For a health care system such as the UNC Medical Center, which is a referral center for the entire state of North Carolina, this has significant ramifications. This impacts the core mission of the UNC Medical Center, which is to serve the people of North Carolina. Some of these concerns are perhaps unintended consequences that can be mitigated through the enhancements to the existing Methodology.

Next, I'd like to Introduce Susan Phillips, VP of Surgical Services for UNC Hospitals.

Susan Phillips: Thank you. First I'd like to talk about the impact of recent surgical advances and technology.

Recent surgical advances and technology:

With technology and advancements in healthcare, the lines between inpatient and outpatient blur a bit. In the past 10 years more cases have gone from inpatient to outpatient due to changes at CMS and less procedures being inpatient only. As technology has advanced, more patients can have their cases done on an outpatient extended stay basis. However, outpatient doesn't necessarily equate to a shorter case time. Less invasive techniques allow the patient to go home quicker, but again that doesn't necessarily translate to shorter time in the OR. Additionally, as some cases have moved to procedure rooms, such as cataracts, these shorter cases that were diluting the longer OP case times are removed from the OR case times so the average OR case time goes up.

Operating Room cases verses Procedure Room cases:

An item of note is that although the OR cases on the annual Licensure Renewal Application form may be decreasing, that doesn't mean that the facility's surgical program volume is decreasing, as many facilities

are moving OR cases to procedure rooms in order to "free up" more licensed OR time. A decrease of surgical cases used in the SMFP Tables can be the result of relocating cases from ORs to procedure rooms, but the surgical *program's* volume hasn't declined. This in effect disadvantages those facilities trying to optimize their licensed operating rooms.

Allow existing facilities to add ORs if certain criteria are reached:

Additionally we'd support exploring the addition of a 2nd Step to the OR Need Methodology, which could employ the current "service area need" step and then a new "facility need" step. This would allow an existing facility to submit a CON application to expand and add additional operating rooms once certain criteria are met. High volume facilities would have a means to accommodate their patients and cases and not be penalized.

2010 Hospital Tiers Enhancement to the OR Methodology:

We generally support the implementation of Tiers based on total surgical hours. Including Case Mix Index doesn't appear to be required as it isn't part of the calculation. Also for large facilities with a significant number of medicine beds, the CMI gets diluted and doesn't adequately reflect the case complexity of the surgical program. The current methodology assumes that 9 hours of case times to be available at all facilities, which doesn't reflect that actual operating hours of many entities. Applying a median resource hours per day by Tier would more accurately reflect the programs operations.

Again, thank you for the opportunity to comment on this important methodology.