ASCENDIENT
Chapel Hill, NC • Washington, DC

MEMORANDUM

TO: AMY CRADDOCK, PHD
FROM: DANIEL CARTER
SUBJECT: OPERATING ROOM PLANNING METHODOLOGIES IN OTHER STATES
DATE: DECEMBER 7, 2016

Amy,

In response to Christina Apperson's question during the last OR methodology workgroup meeting, I have summarized the approach used by various other CON states in planning for operating room need. As I mentioned during the meeting, the regulatory schemes in other states vary widely, and although operating rooms are widely regulated to some degree, I do not believe that any other states have as robust a planning methodology as North Carolina. Specifically, as explained in detail below, no states that I am aware of calculate need for all operating rooms in every setting for every county (or multi-county area) as North Carolina does. Thus, while other states can be a helpful template for generating ideas for our planning approach, their methodologies as a whole are driven by a different set of regulations. Below I have provided a high-level summary of the methodologies used by other states in which I have experience. Please note that I have purposefully limited the details in order to make the key points easier to understand.

State	***Regulated Services***	***Need determination for a particular geography?***	***Standard capacity definition***	***Geographic or other Tiering?***	***Other notes of interest***
Georgia	Ambulatory surgical services	Yes, by planning area (multi-county area)	1,000 cases/yr.	No, but methodology based on planning area likely captures geographic and demographic differences	Capacity based on assumption of 250 days/year, 5 patients per room each day at 80% utilization

State	*Regulated Services*	*Need determination for a particular geography?*	*Standard capacity definition*	*Geographic or other Tiering?*	*Other notes of interest*
Michigan	Surgical services provided in a hospital or outpatient facility (freestanding or hospital-based)	No; applicants file CON applications if they can demonstrate conformity with utilization/ capacity standards	New or replacement: 1,500 hours (inpatient) 1,042 cases or 1,125 hours (outpatient) Note: higher standards apply for expansion of existing surgical services	Yes, urban versus rural Rural capacity is 839 cases or 1,200 hours (hospitals), or 80% of standard capacity	Also exclude burn and trauma ORs, as well as "hybrid" ORs (ORs with units of angiography or cardiac cath equipment), but only 0.5 ORs are excluded for each type.
Virginia	General purpose surgical operating rooms (IP and OP)	Yes, by Health Planning Districts (multi-county areas)	1,600 hours, based on 40 hours per week, 50 weeks per year, at 80% utilization	No, but methodology based on Health Planning District likely captures geographic and demographic differences	Need based on use rate x projected population x average hours per case, divided by the capacity of 1600 hours. Statistics based on 5-year running average

State	*Regulated Services*	*Need determination for a particular geography?*	*Standard capacity definition*	*Geographic or other Tiering?*	*Other notes of interest*
Tennessee	New or expanded ASF only	No	"Full capacity" = 1,263 cases/yr; "Optimum capacity" = 884 cases/yr.	No	Capacity assumes 8 hours/day, 250 days/year, 95 minutes/case, at 70% utilization (optimum)
Maryland	New operating rooms (hospital or ASF)	No	Inpatient and shared: 2,375 hours/year, but optimal capacity of 1,900 hours; Outpatient: 2,040 hours/year, with optimal capacity of 1,632	N/A	Optimal capacity is based on 80% of full capacity

It is important to understand that even those states listed here with a "methodology" do not normally implement it as North Carolina does. Instead, providers are free to apply for a CON based on the methodology, but most states do not publish a list of needs by geography. From my perspective, the most helpful information from these other methodologies is the fact that our current capacity assumption is higher than each of the other methodologies, and unlike some of the others, is applied equally to all operating room types, which may reflect some of the issues we've heard from providers with capacity constraints.

Please let me know if I can answer additional questions.