Acute Care Services Committee
Agency Report
Operating Room Policy AC-7 / Methodology Recommendation
Proposed 2018 State Medical Facilities Plan

Petitioner:
J. Arthur Dosher Memorial Hospital
924 North Howe Street
Southport, NC 28461

Contact:
Tom R. Siemers,
President and CEO

Request:
The petitioner makes the following two requests of the State Health Coordinating Council (SHCC):

Policy AC-7: Critical Access Hospitals: To ensure the viability of Critical Access Hospitals (CAH) in North Carolina, addition of one or more operating rooms to a service area in which a CAH operates is only permitted if the certificate of need application includes a signed letter from an authorized representative of the CAH stating that the project will not have an adverse impact on the *[sic]* its ability to provide comprehensive emergency, inpatient and outpatient medical services to residents of the CAH service area. This shall apply if the CAH has an active license in good standing with NC DHSR.

Methodology Recommendation: In a service area with a Critical Access Hospital, rounding up should not occur if the Critical Access Hospital itself does not report 90 percent utilization of its operating room capacity based on an assumption of 2,000 case hours per operating room per year. The hours assume 250 days a year, 8 hours a day.

Background Information:
Chapter 2 of the State Medical Facilities Plan (SMFP) describes the purpose and process for submitting petitions to amend the SMFP during its development. Healthcare Planning receives petitions twice during the course of plan development. Early in the planning year, petitioners may request changes that have the potential for a statewide impact. The SMFP defines changes with the potential for a statewide impact as "the addition, deletion, and revision of policies or projection methodologies" (p.7, 2017 SMFP).

Brunswick County has two facilities that provide surgical services. J. Arthur Dosher Memorial Hospital (Dosher), a CAH, has two shared operating rooms (OR). Novant Brunswick Medical

Center (Novant) has four shared ORs and one dedicated C-section OR (which is excluded from the need determination calculations).

Analysis/Implications:

The 2016 SMFP included a need determination for one OR in Brunswick County. Need determinations are based on utilization of existing ORs and projected population growth. Brunswick County had a deficit of .37 ORs. The need was rounded up to one OR because the county has between six and ten ORs, per the standard methodology. Two certificate of need (CON) applications are currently under review for this need determination. A decision is expected by April 29, 2017.

The Petitioner's requests assume that the SHCC will approve the methodology changes recommended by the 2016-2017 OR Workgroup. Although the SHCC has not yet acted upon the recommendations, the Agency's analysis also reflects that assumption that they will be approved.

The Petitioner's requests center around the following four issues.

Proliferation of Unnecessary ORs

Generally, the Petitioner claims that CAHs can be disadvantaged when the SMFP shows an OR need determination in a county with a CAH. To mitigate a potential disadvantage, the Petitioner proposes both a new policy and a change to the methodology. To support this position, the Petitioner points to the NC General Assembly's Findings of Fact in G.S. 131E-175 (3), (3a), and (4). The salient sections address the requirement to consider the needs of rural North Carolinians in the CON review process and the recognition that "proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities" (G.S. 131E-175 (3a)).

The Petitioner asserts that both a new policy and a methodology change are required to address this potential statewide problem. The Agency's analysis finds no evidence of a current or potential statewide problem (see Table 1). Rather, the conditions likely to trigger an OR need determination exist only in Brunswick County. That is, Brunswick County is unique among service areas with a CAH in several ways:

- It is the only county with a CAH and another facility providing surgical services that are both included in the methodology. Three other counties have more than one facility in addition to a CAH, but they differ from Brunswick:
    - Dare County has a CAH and an ambulatory surgical facility, but the surgical facility has been underutilized for quite a few years. The standard methodology considers facilities with less than 40% utilization in the two previous consecutive years as underutilized and excludes them from need determination calculations.
    - As such, it is excluded from the methodology.
    - Macon County has two CAHs (which are in the same health system), but only one performs surgery.
    - Halifax County has two hospitals, but all surgical procedures are performed at the non-CAH hospital. The CAH has no licensed ORs.
- Brunswick County is the fastest growing county with a CAH. The 2017 SMFP, using population figures from the N.C. Office of State Budget and Management, projects

10.17% population growth from 2015 to 2019. Pender County (which is contiguous with Brunswick and has a CAH) has a projected 7.86% growth rate for the same time period. Growth rates for all other counties with a CAH are substantially lower or declining decline (see Table 1).

Table 1. County Population Growth and Operating Room Utilization of Critical Access Hospitals, 2015

County	% Utilization		Projected Population Growth %
	Proposed Methodology – Total Utilization (100% utilization=2,000 hours)	Proposed Methodology – Full Utilization (75% utilization=1,500 hours)	2015-2019 (2017 SMFP)
Alleghany	9.46	12.65	2.15
Ashe	40.99	54.65	0.41
Avery	7.83	10.44	0.00
Bertie	16.24	21.65	-5.12
Bladen	25.79	34.38	0.47
Brunswick*	43.52	58.03	10.17
Chatham	22.45	29.94	6.46
Cherokee	61.20	81.61	0.49
Chowan	14.01	18.68	-0.01
Dare*	34.11	11.52	1.49
Halifax*/***	--	--	-2.34
Macon **	46.17	61.56	4.88
Montgomery	4.02	5.37	0.30
Pender	3.60	4.80	7.86
Polk	23.30	31.07	1.91
Stokes	6.30	8.40	0.00
Transylvania	29.25	39.00	3.67

* County has 1 other facility offering surgical services: Brunswick-Novant Brunswick Medical Center (not a Critical Access Hospital); Dare-Sentara Kitty Hawk Ambulatory Surgical Center.

** Macon County has two Critical Access Hospitals. Only Angel Medical Center performs surgery.

*** Critical Access Hospital does not perform surgery. All surgery is performed at Halifax Regional Medical Center (not a Critical Access Hospital).

Note: Swain and Washington Counties do not appear in the table because the Critical Access Hospital is the only facility in the county and does not perform surgery. Yadkin County does not appear in the table because the CAH is currently closed and did not perform surgery in 2015.

The need for additional ORs is based on a combination of OR utilization and service area population growth. Even though Pender County has a high population growth rate, its low OR utilization rate (4.8%) renders it extremely unlikely that the county will show a need for additional ORs. A search of previous SMFPs showed that only once has a need determination existed in a county with a CAH since OR regulation began (in the 2003 SMFP). This need occurred in the 2013 SMFP in Dare County. The Outer Banks Hospital received the CON and completed development in 2016. Before 2003, the SMFP included need determinations for new ambulatory surgical facilities only. During that time, the most recent need determination in a service area that included a CAH was in 1999 (in the area that consisted of Brunswick, Columbus, Duplin, New Hanover, and Pender Counties). Therefore, implementation of a new policy reasonably has the potential to affect only Brunswick County.

Rounding

The Petitioner notes that the rounding method can easily create excess capacity in a small county. The rounding method in the current methodology first appeared in the 2009 SMFP; this change emerged from the 2007 OR Workgroup and a petition from a hospital. The 2016-2017 OR Workgroup recommendations do not propose to change the rounding method. Fractional deficits are rounded up to the next whole number as described in Table 2.

Table 2. Rounding Method for Operating Room Need Determination Calculations

Number of ORs in Service Area	Fractional Values Rounded up to Next Whole Number
5 or fewer	.20
6 to 10	.30
Greater than 10	.50

In almost every case, service areas with five or fewer ORs have only one facility that provides surgical services. Many service areas with six to ten ORs also have only one facility. Similarly, all counties with fewer than six ORs are rural, as are most counties with 10 or fewer. The rationale for the different thresholds is that smaller facilities generally cannot achieve the economies of scale possible in larger facilities. As such, the methodology should not require them to meet the same efficiency standards as large facilities. In other words, the rounding system was specifically designed to benefit service areas with a small number of ORs.

Operating Room Utilization at Critical Access Hospitals

The Petitioner requests that rounding should not occur in service areas with a CAH unless the CAH reports 90% OR utilization, or an average of 1,800 surgical hours per OR per year. This threshold is based on the 2016-2017 OR Workgroup recommendations, in which total utilization is 2,000 hours per OR per year (8 hours per day x 250 days per year = 2,000 hours).

For a hospital in the group that includes CAHs, the Workgroup recommends 1,500 hours be considered full utilization (8 hours per day, 250 days per year, 75% of total utilization). Using the recommended methodology, the Petitioner proposes that rounding should not occur until the CAH reaches 120% of full utilization (1,800 hours / 1,500 hours). The proposed change runs counter to the logic that it is not reasonable to require the facility to reach maximum capacity before generating a need determination, due to the time required to develop an OR. Implementation of this requirement would put a CAH at a disadvantage in developing a new OR, if utilization ever does reach this need determination threshold.

Procedure Rooms

The Petitioner claims that rounding can create a situation in which an entity can apply for an OR and also propose to develop new procedure rooms that (according to the Petitioner) can increase capacity well beyond the county's needs. However, changing the rounding process will not affect the development of procedure rooms. Development of a procedure room is not a "new institutional health service" which requires a CON except under limited circumstances. The term "procedure room" is not used in the Certificate of Need Law; therefore, it is not defined in the Certificate of Need Law. Existing health service facilities may add procedure rooms without first obtaining a CON as long as the capital cost is less than $2 million. When an applicant is required to obtain a CON and the scope of the project also includes the development of one or more procedure rooms, the applicant is expected to explain to the Agency why it is proposing to develop the proposed procedure room(s). However, there are no promulgated standards regarding utilization of procedure rooms whereby the Agency can determine that the rooms are or will be well utilized.

Agency Recommendation:

As indicated above, the SMFP defines changes with the potential for a statewide impact as "the addition, deletion, and revision of policies or projection methodologies" (p.7, 2017 SMFP). If a policy or methodology change is made to alleviate some shortcoming, then the shortcoming should be evident in multiple areas. The Agency's analysis shows that the issues raised in the petition do not meet this standard. The Petitioner's arguments reflect the situation in Brunswick County only and do not reflect a statewide situation. The arguments also do not address a situation likely to exist in the future in other service areas with a CAH. The SHCC is sensitive to the needs of rural areas, but the requested policy and methodology changes would not have an impact on rural counties in general. Only Brunswick County has exhibited the conditions that could possibly trigger implementation of the requested changes. Moreover, the SMFP provides a process for entities to address concerns regarding need determinations published in a proposed SMFP. Any entity could have submitted a petition in July of 2015 to request removal of the need in Brunswick County in the Proposed 2017 SMFP.

The Agency supports the standard acute care policies and the proposed OR need determination methodology. Given available information submitted by the March 16, 2017 deadline, and in consideration of factors discussed above, the agency recommends denial of the Petitioner's request for a new policy and the request for a change to the methodology.