Medical Facilities Planning

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

Monday, February 23, 2009

11:00 am – 3:00 pm

Council Building

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; 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; Sue Collier, RN, MSN, Vice President, Planning & Strategy Development, University Health Systems of Eastern Carolina; 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; L. Lee Isley, CEO, Granville Health System; Kristina K. Hubard, MHA, FACHE Director, Business Analysis and Planning, New Hanover Regional Medical Center; Melanie Phelps, North Carolina Medical Society; Lawrence Cutchin, MD, State Health Coordinating Council (SHCC representative substituting for Dana Copeland, MD)
MEMBERS ABSENT: Dana Copeland, MD, State Health Coordinating Council; Brad Weisner, COO, Nash Health Care Systems
STAFF PRESENT: Jeff Horton, Lee Hoffman, Victoria McClanahan, Kelli Fisk

AGENDA	DISCUSSION/RECOMMENDATIONS	ACTIONS/CONCLUSIONS
1. Welcome & Announcements	Dr. Greene welcomed work group members and other attendees.	
2. Member Introductions	Work group members introduced themselves and rated their familiarity with the current Acute Care Bed Need methodology.	
3. Work Group Charge	Dr. Greene reviewed the work group charge: • 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 methodology. • To develop recommendations which can effectively and fairly address the growth disparities and which will be consistent with the present methodologies in the 2009 SMFP. Dr. Greene provided an overview of the history of the current Acute Care Bed Need methodology, and outlined the work group task, noting the following: • Current methodology first used in the 2004 State Medical Facilities Plan. • Prior to the 2004 Plan, no bed needs had been generated in many years. • 2004 Plan bed need: 367 beds. • 2005 Plan bed need: 94 plus an adjusted need determination for 50 for a total of 114. • 2006 Plan bed need: 275 plus an adjusted need determination for 24 for a total of 299. • After the 2006 Plan, bed need began decreasing with the 2009 Plan showing need for	None

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	only 30 beds. • Problem with the current methodology is the statewide growth rate. • Dr. Myers wants the work group to consider incremental changes to the current methodology. He does not want a major revision of the current methodology.	
4. Overview of Current Acute Care Bed Need Methodology	• Ms. McClanahan reviewed the current acute care bed need methodology. • Dr. Greene reviewed target occupancy factors noting that smaller hospitals have lower target occupancies than larger hospitals. • Discussed rationale for using total inpatient days in acute care hospitals for growth rate instead of using only acute care days – using total inpatient days captures non-acute patients who are treated in acute beds.	
5. Option for Revising Current Acute Care Bed Need Methodology HSA Growth Rates	Dr. Greene reviewed the tables showing acute care bed need resulting from using HSA specific inpatient days growth rates, calculated for the three most recent years for which data are available, noting the following: **HAS growth rates generate need for 259 beds for 2009 Plan, as opposed to 30 beds with current methodology.** • HSAs are similar in population size. • HSA 3 the only HSA with positive patient day's growth for each of the last 2 years. • HSA 4 shows the most patient days growth. • Buncombe county the only county in HSA I with positive patient days growth. • Majority of HSA 2 counties show positive patient days growth. • HSA 3 shows much variation in patient day's growth rates among counties. • HSA 4 shows overall positive patient days growth with Wake, Durham and Orange counties showing the most patient days growth. • HSA 5 shows negative growth. • HSA 6 shows overall negative growth.	Group consensus that an HSA growth rate is not appropriate due to significant variation in growth rates by county within HSAs.
6. Discussion of Options for Revising Current Acute Care Bed Need Methodology	• Population change, trends in admit rates and length of stay and market share shifting all affect growth in patient days. • Do not want to reward increasing length of stay that is due to inefficiency and do not want to penalize areas with barriers to access to care those results in lower patient days. • NC population has grown 8-9 percent between 2001 and 2007 whereas statewide days of care have grown about 4 percent. • Population growth and growth in days of care are related but it is not a 1:1 relationship. • Changing practice patterns impact growth in inpatient days - some care delivered today on an inpatient basis will be delivered on an outpatient basis in the future. • Consider using the following factors when determining patient days growth rate: Admit rate	• If new factors are added to the methodology, ensure that it is feasible for the Agency to obtain and use the

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	Average length of stay Population change Case mix severity index • Determining case mix severity index is a complex process, which we do not currently have the resources to do. • Better for now to let individual hospitals, not the State, mange length of stay. • Even when comparing 2 major hospital systems there is much variation in case mix index • A hospital without obstetric services will have longer average length of stay than a similar hospital with obstetric services. • Overall, hospital data is improving due to hospitals' efforts.	factors, given the Agency's resources, and keep the methodology as simple as possible. • Group consensus that current Thomson reports of expected versus actual length of stay needs improvement – not all patients are coded correctly for severity of illness.
7. Option for revising current bed need methodology – County Growth Rates	Dr. Greene reviewed the tables showing acute care bed need resulting from using county specific inpatient days growth rates, calculated for the three most recent years for which data are available, noting the following: **County growth rates generate need for 793 beds in 2009 Plan. as opposed to 30 beds with the current methodology.** • Data show some extreme growth rates (Davie County, Dare County, Avery County), which result in irrational need determinations. • Is 3 years a long enough period of time to use when calculating an average growth rate? • Review of the data led to defining outliers as "counties with fewer than 100 beds and with a growth rate of 5 percent or greater". • Franklin County meets the outlier definition but may not be an outlier. Discussion: • Bertie County's growth is the result of implementing an appropriate model of care at the county's hospital – physicians now admitting patients they previously automatically sent to another hospital. • Greater fluctuations in patient days from year to year with individual hospitals than with large groups of hospitals. • Hospitals identified as outliers and thus determined to need no additional beds will be able to submit an adjusted need determination petition for additional beds. Since outliers are all small hospitals, this means that small hospitals will have to spend time and money to obtain additional beds when growth is real and not due to error. • 3 years may not be the right period. • Use 4-year average growth rate instead of 3-year average growth rate. • One period for the trend may not work for all hospitals. • Change the target occupancy factor? With large hospitals, there are now so many subspecialty beds that at any given time there may be need for additional beds of a particular type when other types of beds are unoccupied. For example, lack of beds	• Group consensus was that using county growth rates has promise as an improved methodology. They would like to see additional development work undertaken. - use 4 years historical data instead of 3 - consider grouping counties with small hospitals and calculate a "small county" rate. • Group consensus to leave target occupancy rates the same.

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	for elderly patients cannot be alleviated by having available pediatric beds. Consequently, the occupancy factor should not be too high. • CON noted that a frequent complaint from large hospitals in CON applications is that they cannot reach their target occupancy because of subspecialty beds. • Suggestion that 80-85 percent occupancy is an appropriate occupancy factor. • Utilization variability is related to other factors besides population growth, e.g., availability of physicians. • Instead of using HSA groups of counties, create new groups of counties with "to be determined" commonalities and assign group specific growth rates – this makes sense for small counties but what about large counties? Suggestion to create 3 groups: small hospitals located in moderate growth counties; small hospitals adjacent to counties with high growth; large hospitals. • Statewide data not appropriate to use for large hospitals (>200 beds). • In addition to patient days, factor geography and population into growth rate. • Base growth rate on acute days. •20% of the counties in North Carolina have generated 80% of the recent population growth.	
8. Next Steps	Update the county specific methodology in late summer using another year of data. This will allow observation of utilization patterns after the beginning of the economic downturn. Also continue refinement of the methodology as cited above. Reconvene the work group in the Fall of 2009 to look at new results and continue discussion of methodology revisions.	• Group consensus that given the economy now is not a good time to be changing the methodology such that need for 700 or 800 beds will be generated – the economy has changed dramatically since the petitions were filed. • Given the current 1M cost per bed, there is not enough money in the capital markets now to build 700-800 new beds. • Some hospitals currently are at high occupancy and may need adjusted need determinations. • Workgroup felt the session had been very informative and productive, and enthusiastically agreed to reconvene in the fall.