



Technology & Equipment Committee Minutes

April 23, 2014

10:00 am

Brown Bldg Room 104

MEMBERS PRESENT: Dr. Christopher Ullrich, Trey Adams, Dr. Richard Akers, Senator Ralph Hise, Daniel Hoffmann, Kelly Hollis, Dr. Jeffrey Moore Dr. Deborah Teasley
MEMBERS ABSENT: Dr. Prashant Patel
Staff Present: Paige Bennett, Elizabeth Brown, Andrea Emanuel, Tom Dickson, Nadine Pfeiffer, Kelli Fisk
DHSR Staff Present: Drexdal Pratt, Martha Frisone, Lisa Pittman
AG's Office: Bethany Burgon

Agenda Items	Discussion/Action	Motions	Recommendations/ Actions
Welcome & Introductions	<p>Dr. Ullrich welcomed members, staff, and the public to the first Technology and Equipment Committee meeting of 2014. Dr. Ullrich asked that Committee members and staff in attendance to introduce themselves. Dr. Ullrich explained that the meeting was open to the public; however, discussions, deliberations and recommendations would be limited to members of the Technology and Equipment Committee and staff.</p> <p>Dr. Ullrich stated that the purpose of this meeting was to review the policies, methodologies for the Proposed 2015 State Medical Facilities Plan (SMFP), review and vote on five petitions.</p>		
Review of Executive Order No. 46: Ethical Standards for the State Health Coordinating Council	<p>Dr. Ullrich gave an overview of the procedures to observe before taking action at the meeting. Dr. Ullrich inquired if anyone had a conflict or needed to declare that they would derive a benefit from any matter on the agenda or intended to recuse themselves from voting on the matter. Dr. Ullrich asked members to review the agenda and declare any conflicts on today's agenda. There were no recusals.</p> <p>Dr. Ullrich stated that if a conflict of interest, not on the agenda, came up</p>		

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	during the meeting that the member with the conflict of interest would make a declaration of the conflict.		
Approval of September 17, 2013 Minutes	A motion was made and seconded to approve the minutes.	Dr. Teasley Mr. Hoffmann	Minutes approved
Positron Emission Tomography (PET) – Chapter 9	<p>Ms. Bennett noted there are six multi-county groupings called Health Service Area (HSA), and a fixed PET scanner's service area is the HSA in which the scanner is located. Ms. Bennett stated the two mobile PET scanner planning regions are defined as the west region (HSAs I, II, and III) and the east region (HSAs IV, V, and VI).</p> <p>Ms. Bennett stated that after utilizing data from 2014 Hospital License Renewal Applications and Registration and Inventory forms, there was no projected need for any additional fixed PET scanner in the state.</p> <p>Petitions There were three petitions received by the Agency regarding PET scanners.</p> <p><u>The MedQuest Associates, Inc. and Novant Health, Inc.</u> request to (1) “establish a 2015 SMFP health-planning based policy that allows existing hospital providers who own and operate more than one CON_approved fixed PET/CT scanner, for a one year filing period during the 2015 SMFP plan year (1/1/2015-12/31/2015), to seek approval to convert one of their existing fixed PET/CT scanners to a mobile PET/CT scanner through the replacement provision identified at §N.C. Gen. Stat. 131E-176(22a)”; and (2) “replace the mobile East & West PET/CT service areas defined in current SMFPs with a mobile PET service area that includes the entire state of North Carolina for the 2015 SMFP place year and beyond to permit all mobile PET/CT scanners including the existing mobile PET provider</p>		

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	<p>and any subsequent providers to serve all of North Carolina.”</p> <p><u>Randolph Hospital</u> requests “that a methodology for mobile Positron Emission Tomography (PET) be established” and that “if the SHCC determines that providers with fixed PET scanners may convert those to mobile PET... either of the following two standards be applied:</p> <ol style="list-style-type: none"> (1) Providers with fixed PET scanners who wish to convert multiple fixed PET scanners to a mobile scanner may do so; however, the approval of a converted mobile PET scanners shall not be considered to meet the need generated by the utilization of existing mobile PET scanners; or (2) Providers with fixed PET scanners who wish to convert multiple fixed PET scanners to a mobile scanners must include in the CON application at least one mobile PET host site that does not currently provide fixed PET services.” <p><u>Alliance Healthcare</u> requests that the “Positron Emission Tomography basic policies and methodology be changed with the service area definition of a mobile PET scanner to be the entire State of North Carolina and the definition of a mobile PET host site to include existing oncology treatment centers with one or more linear accelerators, existing or proposed Independent Diagnostic Test Facility (IDTF) and existing or proposed licensed acute care hospitals.”</p> <p>Ms. Bennett stated due to several issues discussed in all three petitions are all directly similar in nature, the agency felt it would be most appropriate to provide one report to address all petitions. Ms. Bennett noted in addition, the Agency received 5 comments to these petitions. All of them were in opposition to at least one or more of the various suggested policy changes outlined.</p>		

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	<p>Committee Recommendations</p> <p>A vote was taken to deny the petitions.</p> <p>A vote was taken to accept the following language:</p> <ol style="list-style-type: none"> 1. Revise current the East and West service areas to a statewide service area to allow flexibility in servicing mobile PET sites. 2. Approve a policy to allow the conversion of fixed PET scanners to mobile PET scanners that requires converted PET scanners to (1) continue to serve the facility in which the fixed PET scanner was located; (2) move the converted mobile PET scanner at least weekly to serve at least one facility other than the original site of the converted fixed PET scanner; (3) serve at least one facility in a county that meets the U.S. Census Bureau’s criteria (population less than 50,000) as a rural county using data starting with the certified 2012 population estimates from the North Carolina Office of State Budget and Management; and (4) not serve any mobile host facility located in the county where any existing or approved fixed PET scanner is located unless that facility was the site of the fixed PET scanner that was converted to a mobile PET scanner. <p>A motion was made and seconded to recommend acceptance of the PET assumptions and methodology for the Proposed 2015 SMFP and to advance references to years by one as appropriate.</p>	<p>Senator Hise Dr. Moore</p>	<p>5-0</p> <p>5-0</p> <p>Motion approved</p>
<p>Cardiac Catheterization – Chapter 9</p>	<p>Ms. Bennett stated the cardiac catheterization equipment planning areas are the same as the Acute Care Bed Service Areas defined in Chapter 5, Acute Care Beds, and shown in Figure 5.1. The cardiac catheterization equipment’s service area is a single county unless there is no licensed acute care hospital located within</p>		

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	the county and those counties are grouped with the single county where the		
	<p>largest proportion of patients received inpatient acute care services.</p> <p>There are two standard need determination methodologies for cardiac catheterization equipment. Methodology One is the standard methodology for determining need for additional fixed cardiac catheterization equipment and Methodology Two is for shared fixed cardiac catheterization equipment.</p> <ul style="list-style-type: none"> • Steps: Methodology Part 1 <ul style="list-style-type: none"> ○ For fixed cardiac catheterization equipment, procedures are weighted based upon complexity as described on page 199. ○ The SHCC defines capacity as 1,500 diagnostic-equivalent procedures per year. ○ We determine the number of fixed cardiac catheterization equipment required by dividing the number of weighted or diagnostic-equivalent procedures performed at each facility by 1200 procedures (80% of 1500 capacity). ○ We then compare the calculated number of required units of equipment with the current inventory to determine if there is a need. • Steps: Methodology Part 2 <ul style="list-style-type: none"> ○ If no unit of fixed cardiac catheterization equipment is located in a service area, a need exists for one shared fixed cardiac catheterization equipment when the number of mobile procedures done in this service area exceeds 240 (80% of 300 capacity) per year for each 8 hours per week in operation at that site. <p>Ms. Bennett stated the agency received 2 petitions for Cardiac Catheterization.</p> <p>Petition Johnston Health The petitioner requests “to create language in the 2015 State Medical Facilities Plan that would clarify that fixed cardiac-catheterization</p>		

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	<p>equipment at hospitals should be able to perform both diagnostic and interventional procedures.”</p> <p>Ms. Bennett stated the agency received 3 comments in support of this petition.</p> <p>Committee Recommendation A vote was taken to deny the petition.</p> <p>Ms. Bennett stated the agency received a petition from Rex Healthcare and due to possible errors this petition will be deferred until the May 7th meeting.</p> <p>Committee Recommendation A motion was made and seconded to recommend acceptance of the Cardiac Catheterization assumptions and methodology for the Proposed 2015 SMFP, and to advance references to years by one as appropriate.</p>	<p>Senator Hise Dr. Moore</p>	<p>5-0</p> <p>Motion approved</p>
<p>Magnetic Resonance Imaging (MRI) – Chapter 9</p>	<p>Ms. Bennett reviewed the Acute Care Bed Service Area as defined in Chapter 5 of the 2013 SMFP continues to be the service area for the fixed MRI scanners. Ms. Bennett stated the fixed MRI service area is a single county unless there is no licensed acute care hospital located within the county and those counties are grouped with the single county where the largest proportion of patients received inpatient acute care services.</p> <p>Ms. Bennett stated the methodology for MRI scanners was a bit more intricate as there were tiers of need thresholds based on the number of scanners – which can be found on page 146, weighting of procedures based on complexity – which can be seen on page 146, and a method to deal with MRI service areas that do not have a fixed MRIs but have mobile MRI scanners serving the area. Ms. Bennett reviewed the following steps.</p> <ul style="list-style-type: none"> • Steps: <ul style="list-style-type: none"> ○ We convert the current inventory of clinical fixed and mobile MRI scanners in each MRI service area by site to 		

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	<p>fixed equivalent magnets.</p> <ul style="list-style-type: none"> ○ A value of one fixed equivalent magnet will be assigned for each existing and approved fixed MRI scanner. <p>Temporary mobile services will not be counted separately</p> <p>The number of MRI scans performed at each mobile site are divided by the threshold for the service area to determine the mobile site fixed equivalent</p> <p>Days to be operated are calculated as a fraction of the total days of service to be provided by an approved mobile scanner not yet in service</p> <ul style="list-style-type: none"> ○ The inventory for MRI excluded MRI scanners used for research only, non-clinical MRI scanners, and MRI scanners awarded based on need determinations for a dedicated purpose or demonstration project. ○ We then look at the total numbers of fixed or mobile MRI scans performed at each site delineated by type – such as inpatient, outpatient, with or without contrast or sedation ○ Using the weighting value chart on page146, we multiply the number of MRI scans by type according to their weighting adjustment value in order to determine adjusted total MRI procedures for all sites in each MRI service area and calculate the average of those procedures. ○ Utilization thresholds are listed on page 148 and are used to compare the average procedures per fixed equivalent magnet, with the threshold, to determine if there is a need 		

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	<p>Ms. Bennett stated there were exceptions that there will be no more than one MRI scanner need determination in any one service area per year unless there is an approved adjusted need determination.</p>		
<p>Lithotripsy – Chapter 9</p>	<p>Ms. Bennett noted the lithotripter planning area is the entire state so this is a statewide determination.</p> <p>Ms. Bennett stated using the July 1, 2013 estimated population of the state obtained from the North Carolina Office of State Budget and Management, we determine the estimated incidence of urinary stone disease per 10,000 population.</p> <p>Ms. Bennett reported that based on the assumption that 90% of patients could be treated with lithotripsy. Planning used the estimated incidence to calculate the number of patients in the state who have the potential to be treated by lithotripsy.</p> <p>Ms. Bennett noted the low range of annual treatment capacity is 1000 was used to determine the number of lithotripters needed based upon the projected number of patients.</p> <p>Ms. Bennett stated the need is identified when comparing the number of lithotripters in inventory to the number needed based upon projected incidence of urinary stone disease.</p> <p>Ms. Bennett stated that after utilizing data from 2014 Hospital License Renewal Applications and Registration and Inventory forms, there are 14 lithotripters in the state and there is no projected need for any additional lithotripters.</p>		
<p>Gamma Knife - Chapter 9</p>	<p>Ms. Bennett reviewed the need assumptions and methodology for Gamma Knife. Ms. Bennett stated the gamma knife's service area is the gamma knife planning region in which the gamma knife is located. There are two gamma knife planning regions, the western region (HSAs I, II, and III) and</p>		

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	<p>the eastern region (HSAs IV, V, and VI). The gamma knife located at Wake Forest University Baptist Medical Center in HSA II serves the western portion of the state (HSAs I, II, and III). The gamma knife located in Pitt County at Vidant Medical Center in HSA VI serves the eastern portion of the state (HSAs IV, V and VI). The two gamma knives assure that the western and eastern portions of the state have equal access to gamma knife services. There is adequate capacity and geographical accessibility for gamma knife services in the state.</p> <p>Ms. Bennett stated it is determined that there is no need for an additional gamma knife anywhere in the state and no reviews are scheduled.</p>		
<p>Linear Accelerator – Chapter 9</p>	<p>Ms. Bennett stated the linear accelerator planning areas are the 27 multi-county groupings shown in Table 9I.</p> <p>Ms. Bennett noted the methodology used to determine a need for an additional linear accelerator in a service area must look at 3 criterions: efficiency, geographic accessibility and patient origin.</p> <p><u>For the Accessibility Criterion 1</u> We divide the area population (based on the 2013 population estimate from the North Carolina Office of Budget and Management) by the inventory to determine the population per linear accelerator. If the result is greater than or equal to 120,000 per linear accelerator, Criterion 1 is satisfied.</p> <p><u>For Patient Origin Criteria 2</u> We divide the number of patients served from outside the service area, based on reported patient origin data, by the total number of patients served. If more than 45% of total patients served reside outside the service area, Criterion 2 is satisfied.</p> <p><u>For Efficiency Criterion 3</u> We calculate the average number of Equivalent Simple Treatment Visits (ESTV) per linear accelerator in each service area and divide by 6,750 ESTVs to determine how many are needed. If the</p>		

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	<p>difference between the number needed and the current inventory is greater than or equal to a positive 0.25, Criterion 3 is satisfied.</p> <p>Ms. Bennett noted if any 2 of the 3 criterion are satisfied in a linear accelerator service area, a need is determined for one additional linear accelerator in that service area.</p> <p>Ms. Bennett noted to complete the methodology, Criterion 4 provided an exception for counties who reached a population of 120,000 or more and did not have a linear accelerator in inventory for that county.</p> <p>Ms. Bennett noted after utilizing data from 2013 Hospital License Renewal Applications and Registration and Inventory forms, there is a draft need projection for one additional linear accelerator in Harnett County based upon Criterion 4.</p> <p>Committee Recommendations A motion was made and seconded to recommend acceptance of MRI, Lithotripsy, Gamma Knife and Linear Accelerator assumptions and methodologies for the Proposed 2015 SMFP, and to advance references to years by one as appropriate.</p>	<p>Senator Hise Dr. Moore</p>	<p>Motion approved</p>
Other Business	<p>A motion was made and seconded for staff to make necessary updates and corrections to narratives, tables and need determinations for the Proposed 2015 SMFP as new and updated data is received. There was no other business brought before the Committee.</p>	<p>Dr. Akers Dr. Moore</p>	<p>Motion approved</p>
Adjournment	<p>There being no further business, the meeting was adjourned. The next meeting of the Committee is Wednesday, May 7, 2014 at 10:00 am.</p>		