Operating Room Methodology Workgroup History

Since 2007, the SHCC has convened three workgroups to address various aspects of the operating room (OR) methodology. The topics and charges for each workgroup are as follows:

2007 - OR Methodology

1) Review the present methodology and assess its appropriateness for determining OR need in all areas of the state.
    a. Review each variable in the need methodology formula (average hours per procedure, standard hours per OR) and consider whether changes are needed.
    b. Address the issue of single specialty ORs and consider whether the need methodology should be modified to reflect such need.
2) If changes in the methodology are needed, prepare recommendations to the Acute Care Committee.
    a. Ensure that all recommendations are consistent with the Basic Principles governing the development of the NC State Medical Facilities Plan (SMFP).
    b. Base any recommendations on a data driven process in which verifiable data can be obtained.
    c. Include in the recommendations how data would be collected and verified.

2009 - Single Specialty Ambulatory Surgery

- Develop a plan to evaluate and test the concept of single specialty ambulatory surgery centers in North Carolina.
- Formulate recommendations regarding the number of sites and potential geographic locations for pilot projects.
- Identify measures that can be used to evaluate the success of the pilot projects, to include measures of value, access to the uninsured, and quality and safety of care
- Recommend how the test sites will be held accountable and responsible in the event they are unsuccessful in meeting target guidelines.

2011 – Pediatric ORs

Investigate and develop recommendations about the need for the OR methodology to include a determination of need for dedicated pediatric ORs. Consider:

1) implications of revising methodology;
2) potential for reducing overall need due to dividing need between two age groups;
3) degree of flexibility recommended for providers to switch between OR types once a CON has been issued; and
4) implications for ambulatory surgery centers (ASCs).

The tables below present recommendations for all workgroups, their current status and impact.

Table 1. 2007 OR Workgroup

Recommendations	Status	Impact
(1) Immediate action for 2008 SMFP: Chronically Underutilized ORs. Amend the current OR methodology to exclude facilities with underutilized (UL) ORs when projecting OR need beginning with the Proposed 2008 SMFP. Facilities with UL ORs are defined as facilities whose OR utilization is less than 40% of capacity, based on current OR Methodology assumptions. Facilities with UL ORs will be excluded only in OR service areas with more than one facility.	This recommendation was implemented in the 2008 SMFP. Through the 2016 SMFP, need determination calculations excluded the UL ORs from the planning inventory but included their procedures. In preparing the 2017 SMFP it was determined that this was not the intent of the recommendation; the intent was to eliminate both the ORs and procedures from the calculations. This clarification was implemented in the 2017 SMFP.	UL ORs are listed in Chapter 6. There are approximately 10-15 such facilities annually, most of which are ASCs. In general, these facilities tend to be one of two types: (1) facilities with few ORs and cases located in urban counties with a large number of providers; or (2) low volume facilities in a county with only one or two other providers. Per the methodology, counties in which all ORs are UL are not treated as such in the calculations.
(*2) Short Term action for 2009 SMFP: Hospital tiers.* Recommend Agency develop capacity to further refine the OR methodology using facility-specific total surgical hours, as reported in the license renewal data, to develop tiers of like institutions. This would allow calculation of median resource hours per day and case times per tier group, to be considered by the Acute Care Services Committee (Committee), for replacing the current use of 9 hours of OR availability, 3 hours for inpatient cases, and 1.5 hours for outpatient cases.	Staff provided data to the Committee showing how tiering may affect need determinations. Using the tiered data assumptions resulted in a much greater surplus of ORs compared to using the standard methodology assumptions. The tiered approach is more complex. The workgroup also concluded that use of actual hours of operation and case times is problematic due to annual fluctuations. The Committee recommended not adopting the tiered methodology for determining need for additional ORs for the 2009 SMFP and continuing to evaluate the tiered approach. This recommendation was not implemented.	

Table 1. 2007 OR Workgroup *(continued)*

Recommendations	Status	Impact
(3) Long Term action for 2010 SMFP and beyond:		
(3A) "Uniform Procedure Count:" Recommend the SHCC adopt utilization of accurate verifiable billing data to count the number of procedures that require the use of an OR, in both inpatient and outpatient surgical facilities.	*(3A):* Not implemented. The NC Hospital Association held a workgroup in 2012 on the use of Truven data to report surgical cases. Data for both ASCs and hospitals showed large differences between the number of cases reported on the LRA compared to the number reported by Truven (using Uniform Billing codes). This information was presented to the Committee, but no action was recommended. One major issue was that Truven data did not distinguish between procedures performed in licensed ORs versus other types of rooms (e.g., procedure rooms).	*(3A):* N/A
(3B) License Renewal Application (LRA). Improve the LRA data to make it more accurate and verifiable by revising terminology, clarifying definitions, and providing instruction and guidance regarding key data elements. Focus specifically on improving the reporting of average resource hours, inpatient case time, outpatient case time, and number of inpatient and outpatient cases. Consider the feasibility of electronic data reporting.	*(3B):* Changes were made to the 2008 hospital LRA to clarify entry of average case times. Additional changes were made to the 2012 LRA to provide a worked example of how to calculate case times. The Agency is working on an electronic data reporting system.	*(3B):* A brief comparison of case times from the 2008 to the 2016 LRA shows: an increase from 120 minutes to 134 minutes for inpatient cases; an increase from 83 to 88 minutes for ambulatory cases; an increase from 236 days per year of operation to 246 days; and negligible change in hours per day of availability, from 8.7 to 8.6. It is unknown whether the changes in the LRA data reflect improved reporting or actual changes in case times and availability.

Table 1. 2007 OR Workgroup *(continued)*

Recommendations	Status	Impact
(*4) Enforce required reporting of "Uniform Billing" data*. Change Medical Care Data Act to give DHSR authority to enforce sanctions for non-compliance with reporting all required information to the Statewide Data Processor.	Not implemented.	
(5) Panel of experts Recommend DHSR convene expert panel to determine which ICD and CPT codes to include when planning for OR capacity. This list would be used with the "Uniform Billing" data to ensure the same procedures are counted in each facility regardless of where the procedures are performed.	Not implemented	
(6) CON accountability. Change the CON rules to allow DHSR to take action against any licensed facility engaged in the practice of surgery that demonstrates a pattern of not serving underserved populations in at least the proportion the facility projected in its CON application. Suggested actions include levying fines and/or issuing time limited CONs and making extension of the CON dependent on the CON holder meeting the access projections made in its CON application.	Not implemented	
Ask SHCC to appoint a Workgroup to consider how to incorporate issues of patient quality, safety, and outcomes in Planning and Certificate of Need (CON) Process.	Quality, Access and Value Workgroup formed in 2008. Reconvened in 2010 to examine quality metrics.	Revised Basic Principles section incorporated into 2009 SMFP (and beyond) to reflect workgroup recommendations.

Table 2. 2009 Single Specialty Ambulatory Surgery Workgroup Recommendations

Recommendations	Status	Impact
The charge to the 2007 workgroup directed the group to address single specialty ORs. In 2009, a workgroup formed to address this issue and recommended a demonstration project with the following criteria. (1) Establish a special need determination for three new separately licensed single specialty ambulatory surgical facilities with two ORs each, one each of the following service areas: • Mecklenburg, Cabarrus, Union counties (Charlotte Area), • Guilford, Forsyth counties (Triad), and • Wake, Durham, Orange counties (Triangle). (2) Give priority to facilities owned wholly or in part by physicians. (3) Provide indigent care such that the percentage of the facility's total revenue that is attributed to self-pay and Medicaid revenue shall be at least seven percent. (4) Report utilization and payment data to statewide data processor. (5) Complete a Surgical Safety Checklist. (6) Report patient outcomes in at least the areas of wound infection rate, post-operative infections, post-procedure complications, readmission, and medication errors. (8) Develop systems which will enhance communication and ease data collection, for example, electronic medical records that	Criteria for selection were included in the 2010 SMFP. Demonstration sites were selected and facilities have been licensed. Piedmont Outpatient Surgical Center, an otolaryngology facility in Winston-Salem, was licensed in February 2012. Triangle Orthopaedics Surgery Center in Raleigh was licensed in May of 2013. Mallard Creek Surgery Center in Charlotte was licensed in May of 2014. The Agency evaluates each facility at the end of the first calendar year the facility is in operation and annually thereafter. The Agency may require corrective action if the Agency determines that a facility is not meeting or is not making good progress towards meeting the demonstration project criteria. The Agency will evaluate each facility after each facility has been in operation for five years. If the Agency determines that the facilities are meeting or exceeding all criteria, the work group encourages the SHCC to consider allowing expansion of single specialty ambulatory surgical facilities beyond the original three demonstration sites. The Agency may require corrective action if the Agency determines that a facility is not	Project is ongoing. Facilities collect data and report to the Healthcare Planning and Certificate of Need Section annually. Healthcare Planning compiles the data and reports to the Acute Care Services Committee. At the most recent meeting of the Committee, members concluded that more frequent reporting should be requested for projects that are experiencing challenges in meeting the 7% requirement.

Table 2. 2009 Single Specialty Ambulatory Surgery Workgroup Recommendations (continued)

Recommendations	Status	Impact
support interoperability with other providers. (9) Encouraged to provide open access to physicians. (10) Affiliated physicians are required to establish or maintain hospital staff privileges with at least one hospital and to begin or continue meeting Emergency Department coverage responsibilities with at least one hospital. (11) Obtain a license no later than two years from CON issuance. (12) The Single Specialty Ambulatory Surgery Work Group values the collective wisdom of the North Carolina Hospital Association and the North Carolina Medical Society and requests that the two organizations work together to assist the demonstration project facilities in developing quality measures and increasing access to the underserved. (13) Facilities will provide annual reports to the Agency showing the facility's compliance with the demonstration project criteria in the SMFP.	meeting or is not making good progress towards meeting the demonstration project criteria. If the Agency determines that a facility is not in compliance with any one of the demonstration project criteria, the Department, in accordance with G.S. 131E-190, "may bring an action in Wake County Superior Court or the superior court of any county in which the CON is to be utilized for injunctive relief, temporary or permanent, requiring the recipient, or its successor, to materially comply with the representations in its application. The Department may also bring an action in Wake County Superior Court or the superior court of any county in which the CON is to be utilized to enforce the provisions of this subsection and G.S. 131E-181(b) and the rules adopted in accordance with this subsection and G.S. 131E-181(b)."	

Table 3. 2011 Pediatric OR Workgroup Recommendations

Recommendations	Status	Impact
Change OR methodology to consider calculating need using a different multiplier (1.125) for pediatric ORs. This means that all pediatric surgeries (except for circumcisions) will be weighted 12.5% more than adult surgeries. Pediatric patients are defined as those less than 18 years of age.	Not implemented. The Committee concluded that designation of ORs for pediatric surgical services might be better handled by hospitals themselves than by a change to the methodology. Facilities with large numbers of pediatric surgical cases should petition the SHCC for an adjusted need determination if they believe that their facilities need additional capacity. The SHCC supported the recommendation of the Committee.	Not applicable