Comments for 2017 Operating Room Methodology Workgroup

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The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System (CHS) is submitting these comments related to proposed changes in the operating room methodology contained in the State Medical Facilities Plan (SMFP). CHS supports the robust health planning process and certificate of need law in North Carolina. We appreciate the acknowledgement of the State Health Coordinating Council (SHCC) for the need to examine the current methodology to determine future need for operating rooms.

We have spent significant time and resources examining the operating room methodology over the last ten years. We offer the following comments and suggestions with the goal of improving the reliability and accuracy of the methodology.

1. Service area – We support the continuation of the current service area definitions at the county level when a county has a provider and multi-county where no provider is present in the county.

2. Source of utilization data – We recommend a transition to Truven data as the source for surgical case volumes. Providers should still be asked to report case volumes on license renewal forms and the two sources could be compared for verification similar to the current method used in the acute care bed need methodology.

3. Case time assumption – We propose a shift from a fixed case time to the reported average case times reported on licensure forms. The current methodology assigns 3 hours per case for inpatients and 1.5 hours for outpatients which overstates the utilization of operating rooms. The most recent licensure form data indicate only 14 percent of hospitals have case times of 3 hours or more. In addition, only 15 percent of ambulatory surgery centers report case times of 1.5 hours or more.

4. Capacity – The current capacity factor of 1,872 hours may be too high as a universal standard. The current methodology assumes a 9-hour day of scheduled surgical procedures operating at 80 percent utilization for 260 days per year. The most recently reported data from licensure forms indicates only 25 of 151 providers (16.7%) report a scheduled day of 9 hours or longer. The other capacity factors of annual days of operation and percent utilization should also be evaluated to determine appropriateness.

5. Tiered levels of providers – There is a very wide range in utilization and capacity between and among hospitals and ambulatory surgery centers. There are some easily discernible groups when comparing total case volumes and case times. Factors such as total case volume, case times and number of ORs can be used to define tiers of similar providers. A tiered approach could be useful for improving the appropriateness of both case times and capacity.

6. Growth rate – The current methodology uses the population growth rate of the county to forecast growth in surgical volumes four years into the future. We recommend evaluating a change to the historical county growth rate in surgical procedures similar to how the acute care bed methodology is structured.

I will be happy to address the workgroup at its November 10, 2016 meeting to explain these items in more detail. We appreciate the opportunity to provide these comments.