Healthcare Planning & Certificate of Need Section

State Health Coordinating Council Meeting – DRAFT

Minutes

March 1, 2017

Brown Building, Raleigh, North Carolina

Members Present: Dr. Christopher Ullrich, Chairman; Trey Adams, Peter Brunnick, James Burgin, Stephen DeBiasi, Dr. Sandra Greene, Kurt Jakusz, Dr. Lyndon Jordan, Stephen Lawler, Kenneth Lewis, Brian Lucas, Dr. Robert McBride, Denise Michaud, Dr. Jaylan Parikh, Dr. Prashant Patel, Dr. T. J. Pulliam
Members Absent: Christina Apperson, Dr. Mark Ellis, Senator Ralph Hise, Valarie Jarvis, Representative Donny Lambeth, James Martin
Healthcare Planning Staff Present: Paige Bennett, Elizabeth Brown, Amy Craddock, Patrick Curry, Tom Dickson, Andrea Emanuel **DHSR Staff Present:** Mark Payne, Martha Frisone, Lisa Pittman, Fatimah Wilson, Julie Halatek, Gloria Hale, Celia Inman, Mike McKillip, Jane Rhoe-Jones, Bernetta Thorne-Williams, Greg Yakaboski **Attorney General's Office:** June Ferrell, Derek Hunter, Jill Bryan

Agenda Items	Discussion/Action	Motions	Recommendations/ Actions
Welcome & Announcements	Dr. Ullrich welcomed Council members, staff and visitors to the first meeting of the planning cycle for the N.C. 2018 State Medical Facilities Plan (SMFP). He explained the meeting had two parts; The first is a business meeting that was open to the public, but not a public hearing. The second part will allow for a public hearing for anyone asking to address the State Health Coordinating Council (SHCC) and make comments on issues they wish to bring before the Council. He noted that this was the first of seven public hearing held this year with the other six to be held this summer, following the adoption of the Proposed 2018 SMFP Next, Dr. Ullrich asked the Council members to introduce themselves by stating their name, affiliation, and SHCC appointment type. Mr. Mark Payne, Director of the Division of Health Service Regulation, asked that staff and the Attorney General's staff introduce themselves.		

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Review of Executive Order No. 46 Reauthorizing the State Health Coordinating Council and Executive Order No. 122 Extending the State Health Coordinating Council	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 declare conflicts as agenda items came up. Although, he stated the agenda was very light and contained no new items requiring a vote from Council members.		
Approval of Minutes from October 7, 2016	A motion was made and seconded to accept the minutes of October 5, 2016.	Dr. Parikh Mr. Lewis	Motion approved
SHCC Committee Assignments for 2017	Dr. Ullrich ran through the structure of the three standing Committees. Acute Care Services Committee membership includes Dr. Sandra Greene (Chair); Christina Apperson; Dr. Mark Ellis; Representative Donny Lambeth; Stephen Lawler (Vice-Chair); Kenneth Lewis; Dr. Robert McBride. Amy Craddock will staff the Committee. Denise Michaud will now chair the Long-Term and Behavioral Health Committee. Keith Branch, our new member, will also be on the committee. In addition to Peter Brunnick; James Burgin; Kurt Jakusz; James Martin, Jr.; Dr. Jaylan Parikh (Vice-Chair). TJ Pulliam will continue to serve on the committee. Elizabeth Brown, Amy Craddock and Andrea Emanuel will staff the Committee. Technology and Equipment Committee membership consists of Dr. Chris Ullrich (Chair); Trey Adams; Stephen DeBiasi; Senator Ralph Hise; Valerie Jarvis; Dr. Lyndon Jordan, III (Vice-Chair); Brian Lucas; Dr. Prashant Patel. Patrick Curry will staff the Committee. Dr. Ullrich thanked everybody for agreeing to serve.		
Hospital and Patient Trends Impacting the SMFP	Dr. Ullrich gave a presentation to the SHCC that included data on patient trends for acute care and surgical procedures. One of the trends discussed was the shifting of care from more regional/community hospitals to tertiary and quaternary facilities. Data also showed facility utilization was dependent on the size and location of the facility, with community hospitals having lower utilization than those in urban areas. The information included maps on hospital affiliation. The overall message was that patient patterns of care are changing		

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	in NC and these changes will have an impact on the methodologies and needs in the SMFP.		
Operating Room Methodology Workgroup Recommendations	The OR Methodology Workgroup report was provided by Dr. Sandra Greene. The Workgroup met five times: October 11, November 10, and December 13 of 2016, and January 11 and February 15 of 2017. The Workgroup reviewed the current operating room methodology, heard extensive comments from interested and affected parties and recommends substantial changes to several areas of the OR assumptions and methodology. These recommendations are made to the Acute Care Services (ACS) Committee of the State Health Coordinating Council (SHCC) for consideration in the 2018 State Medical Facilities Plan (SMFP). At the June 7, 2017 meeting, the SHCC will receive the final report for consideration in the Proposed 2018 SMFP. **Recommendations for immediate action for the 2018 SMFP:** Recommendation 1: Categorize facilities into groups based on the total number of surgical hours reported on the most recent License Renewal Application (LRA), with two exceptions – Academic Medical Center (AMC) Teaching Hospitals and Ambulatory Surgical Units (AMSUs). AMCs will form a separate group. AMSUs will form two separate groups. One group will consist of AMSUs with at least 50% of total surgical procedures in either the ophthalmology or otolaryngology category or a combination of the two. All other AMSUs will be in the second group. See Table 1 for grouping. Table 1. Facility Grouping		

Group	Hrs. per Day	Days per Year
1. Academic Medical Center Teaching Hospitals	10	260
2. Hospitals reporting more than 40,000 surgical hours	10	260
3. Hospitals reporting 15,000 to 40,000 surgical hours	9	260
4. Hospitals reporting less than 15,000 surgical hours	8	250
5. AMSUs performing at least 50% of their procedures in either ophthalmology or otolaryngology or a combination of the two.	7	250
6. All AMSUs not in category 5.	7	250

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	<u>Recommendation 2</u>: Assign Availability (hours per day and days per year routinely scheduled for surgery) based on the facility's group membership. See Table 1 for grouping. This categorization replaces the current methodology availability assumptions of 9 hours per day and 260 days per year. <u>Recommendation 3</u>: Implement 75% as the assumption of full utilization of an OR for all facilities. This percentage replaces the 80% assumption in the current methodology. <u>Recommendation 4</u>: Apply the facility's reported average inpatient and average ambulatory surgery case times from the current LRA to determine the total surgical hours. For facilities with a greater than 10% increase in case time from the previous LRA, the need determination calculations will use the value corresponding to 10% above the previous year's reported case time. Inpatient and ambulatory case time adjustments will be made separately. In addition, for non-AMC facilities with average case time greater than 1 standard deviation above the mean for their group, their average case time will be reduced to the value equal to 1 standard deviation above the mean for the group. AMCs with an average case time above the standard deviation will not have their case time reduced. <u>Recommendation 5</u>: Use the four-year population growth rate in each service area to calculate the projected surgical hours. <u>Recommendation 6</u>: Calculate OR deficits/surpluses by facility/owner rather than by service area. Calculate deficits and surpluses separately for each facility in the service area unless under common ownership/controlling entity with others in the service area. Otherwise, total the deficits and surpluses for all facilities under a common owner/controlling entity in the service area. Determine service area OR needs by summing the deficits for all facilities and owners/controlling entities in each service area. <u>Recommendation 7</u>: Revise Policy AC-3 to include in the planning inventory and need determination calculations all ORs approved under this policy, regardless of approval date.		

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	Recommendations for action for the 2019 SMFP and beyond: Recommendation 8: 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 ownership/controlling entity information, surgical availability, inpatient case time, ambulatory case time, and number of inpatient and ambulatory cases. Recommendation 9: In agreement with the 2007-2008 Operating Room Methodology Workgroup, the current Workgroup recommends the use of accurate and verifiable billing data regarding surgical procedures performed in their ORs. This information would come from the data that hospitals and AMSUs submit to Truven Health Analytics. The Acute Care Services Committee should continue to explore the use of Truven data to identify procedures performed in licensed ORs (versus procedure rooms or elsewhere) and to function as the official source of data on surgical procedures.		
Dental Operating Room Demonstration Project Update	Martha Frisone provided an update on the dental projects from the 2016 SMFP, which included a need determination for 4 SS ASFs with up to 2 ORs; 1 in each of 4 Regions: Region 1- HSA IV; Region 2- HSA III; Region 3- HSAs V and VI; Region 4- HSAs I and II The Agency received 2 proposals for each Region. The approved applicants were: Region 1: Valleygate Dental Surgery Center of Raleigh, LLC (Garner) (Wake) Region 2: Carolinas Center for Ambulatory Dentistry (Charlotte) (Mecklenburg) Region 3: Valleygate Dental Surgery Center of Fayetteville, LLC and VFD Real Estate Partners, LLC (Fayetteville) (Cumberland) Region 4: Valleygate Dental Surgery Center of the West, LLC (Greensboro) (Guilford) All 4 denied applicants appealed the denial of their application and the approval of the competing application. The parties negotiated a settlement and the settlement agreement has been signed by all parties and the Director of the Division. The certificates will be		

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	issued as soon as the petitioners file notice of withdrawal with prejudice at the Office of Administrative Hearings. As a result of the settlement, the denied applicant in the Region 1 review, Surgical Center for Dental Professionals of Raleigh, LLC, will receive a certificate of need and the project will be developed in Raleigh rather than in Garner. The certificate holders have one year from the date the certificate is issued to obtain licensure.		
Conclusion of the Business Meeting			
Convening of the Public Hearing Regarding the NC Proposed 2018 State Medical Facilities Plan	Dr. Ullrich called the public hearing to order. One speaker signed up to speak. **Mr. Tom Siemers– J. Arthur Dosher Memorial Hospital** Mr. Siemers will be submitting a petition requesting a new policy and a change to the methodology as developed by the Operating Room (OR) Workgroup. The proposed policy, *Policy AC-7 Critical Access Hospitals* reads, 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 op erates is only permitted if the certificate of need application includes a signed letter from an authorized representative of the CAH stating that the project wil l not have an adverse impact on the its ability to provide comprehensive emer gency, inpatient and outpatient medical services to residents of the CAH servi ce area. This shall apply if the CAH has an active license in good standing wit h NC DHSR. The petition will request the SHCC consider adding the following to the proposed OR Workgroup methodology: In a service area with a Critical Ac- cess Hospital, rounding up should not occur if the Critical Access Hospitalits elf does not report 90 percent utilization of its operating room capacity based		

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	on an assumption of 2,000 case hours per operating room per year.The hours a ssume 250 days a year, 8 hours a day. The Council had questions about costs and outcomes if procedures were shifted from the hospital to an outpatient setting. They also discussed the importance of health care delivery in both rural and urban areas and how the SMFP can best address the needs.		
(Reconvening of the Business Meeting) **Old Business**			
Adjournment	There being no further business, Dr. Ullrich adjourned the meeting.	Mr. Lawler Dr. Parikh	Motion approved