

Hospital Acute Care Bed Need Methodology
Workshop # 1 Issues Outline
October 12, 2009

Policies:

- Do we have the data sources we need to get the information we need?
- Data driven. Supply and demand. Well-defined. Data that is publically available.
- Recognition of the role of regional referral hospitals
- Target occupancies
- Reflects patient choice
- Hospitals have enough beds to operate efficiently
- Statutory parameters
 - Foster access
 - Influence cost containment
- Planning area based
- Exception criteria (needs to follow other methodology principles)
- What type of post decision monitoring is there? What role can we have? What role should there be?
- Protection of the hospital's viability. What role, if any, does the state have in protecting the non-applicant hospital's financial viability
- Need driven as opposed to use driven?
- What weight should the numeric methodology be given? *

A) Methodology (demand):

- **Planning Areas:**
 - Well-defined
 - By zip codes – dynamic
 - Linkage to population data
 - Data sources currently available (DOH In vital stats has current year population by zips). No forecasting
 - How/when up-dated
 - Question connected counties
 - Specialty / regional referral / Tertiary vs one-size fits all
 - Regional referral hospitals
 - Market based
 - Urban vs Rural
 - Challenges re: travel / geography / distance
 - Travel realities
 - Not bounded by political boundaries (state lines)
 - Data sources for other state resident data
 - What role, if any, does WA have to plan for other state resident access to healthcare.

- Is there a minimum population based to support 1 to 2 hospitals per planning area?
- **Population projection sources**
 - OFM
 - Claritas
 - Which data source to use?
- **Planning Horizon:**
 - Additions
 - New Hospital
 - \$ value of project

B) Capacity / Bed Count (supply):

- Physical bed counts
 - Count set up beds
 - Physical spaces that can be put back in place without “significant” construction
 - Staffed bed counts
 - Census bed counts
- Timing of the bed counts
- Physical space for acute care beds
- Licensed bed count vs sufficiency of ancillary and support services
- Flexibility for providers to use their beds for different uses?
- Consistency in bed counting
- Well-defined types of beds:
 - **Tertiary service related bed types:**
 - NICU III
 - Psychiatric
 - Level 1 Rehab
 - Intermediate Care Level II
 - LTC
 - **Service Beds:**
 - ICU
 - Pediatric
 - Gen Med / Surg
 - Ortho

C) Existing facility utilization:

- Operational occupancy (distinct units)
- Market place forces
- Occupancy timelines
- Needs to be tied to our definition of a bed
- Data driven decisions
- Weighted occupancy standard
- Question of difference in service lines, psychiatric, etc. (a bed is not a bed)
- Critical access hospital beds not counted in supply. Or limited service of critical access hospitals. How should these be counted?
- Need vs use of beds

D) Tiebreakers (single vs double, geography, etc)

E) Concurrent review timeline:

F) Surveys (including expectations / consequences regarding participation):

G) HMO contracts

H) Implementation Plan of Rule:

“I”) Others?

- Legal Processes and a review
- A line of cases that state that you can't rely on just the methodology to determine need.
- Are there larger issues being identified that need to be looked in the near future? Is there really a need to adopt a new/revised method.