Hospital Acute Care Bed Need Methodology
Workshop # 5 Outline
April 22, 2010

Capacity / Supply / Bed Count:

Models Discussed:

- **Model 1: Setup Beds**
  - Count physical spaces that can be put back in place within 24 hours and without "reviewable – CRS" construction.
  - CRS approved to begin construction (A2BC) beds counted
  - Count CoN approved beds not yet licensed
  - Count cannot exceed number of licensed beds
  - Attestation by CEO or authorized executive that count is accurate
    - The following services require CoN approval separately from the general acute care beds. These services are distinctly defined, require a separate methodology and are not interchangeable. Informally referred to as "Hard Fences."
      - Psychiatric
      - LTC/TCU/SNF/NF
      - LTAC
      - NICU (II & III)
      - Rehab level 1
      - Chemical Dependency *
    - The following services are included in the general acute care bed methodology. Informally referred to as "Soft Fences."
      - Med / Surg beds
      - Pediatric (hospital defined)
      - ICU
      - Adult Intermediate care / PCU
      - OB – mother bed
      - All others (using a default occupancy)
  - Different types of beds having different occupancy standards
  - Hospital specific weighted occupancy standards
  - Flexibility for designated bed types – not all types are interchangeable

- In earlier workshops, the group discussed how to set a target occupancy. What was thought to be a reasonable approach was to group beds (example: ICU, CCU, Med/Surg, etc.) and establish target occupancies for those sub-sets of beds based on nationally recognized planning standards (example: a planning standard for an ICU will be much lower than an OB unit). Based on those planning standards, and the count of beds, we would use that data to establish a weighted occupancy factor for a hospital and then for the larger planning area. We hadn't addressed the data problems of (1) knowing how to count those beds and (2) there really aren't any national planning standards to look to for a set %. There is broad agreement about what those numbers are, we just don't have a precise number – thus a level of uncertainty. This approach allows you to differentiate the standard based on the severity of the patients utilizing those different beds by hospital by planning area. This would be a better standard if we could cross that data gap. Unfortunately, we cannot.
- CONSENSUS: The group continued this discussion and came full-circle, recommending that the current bed need approach used by CoN (the 5 occupancy standards adjusted by 5% points) should be continued.

- Pros:
  - Doable
  - Repeatable
  - Doesn't imply taking away licensed capacity
  - Realistic
  - Less DOH staff required

- Cons:
  - Spaces are physically but without staff or support services directly related to the patient room
  - Smaller critical access hospitals – how do we reconcile their actual capacity?
  - Self reporting is too subjective without third party validation
  - No base point to start from

- **Model 2: Average Daily Census (little support for using this as a primary model – possibly a secondary test)**
  - Capacity calculated annually as a multiple of average acute inpatient census.
  - Count all CoN approved beds?
  - What is the multiplier? Research needed?
  - Data source – CHARS
  - Take the past three year average, compare to last year and use the larger of the two.
  - If the multiplied ADC for each hospital exceeds the license at that hospital, then you would use the licensed hospital count.
  - This model could be used as a back up test against individual hospitals?
    - The following services require CoN approval separately from the general acute care beds. These services are distinctly defined, require a separate methodology and are not interchangeable. Informally referred to as "Hard Fences."
      - Psychiatric

    - LTC/TCU/SNF/NF
    - LTAC
    - NICU (II & III)
    - Rehab level 1
    - Chemical Dependency *
  - The following services are included in the general acute care bed methodology. Informally referred to as “Soft Fences.”
    - Med / Surg beds
    - Pediatric (hospital defined)
    - ICU
    - Adult Intermediate care / PCU
    - OB – mother bed
    - All others (using a default occupancy)

- Pros:
  - Simple approach
  - Repeatable
  - Verifiable
  - Only counting space where care is being provided
  - Using the same data source as demand
  - Doesn’t imply taking away licensed capacity

- Cons:
  - CHARS data has 8-9 month lag time
  - Not a good primary test – relatively crude
  - Does not measure capacity rather it measures utilization
  - No obvious multiplier
  - Results could penalize efficiency over the 71% standard
  - Capacity that could come on-line at anytime
  - Doesn’t address appropriateness of use
  - Only counting space where care is being provided

- **Model 3: Licensed Beds (currently no support for this model)**
  - Count licensed beds

  - Pros:
    - Simple
    - Repeatable
    - Verifiable
    - Transparent
  - Cons:
    - Doesn’t reflect the reality about available beds in Washington State
    - Unfair to take such a simplistic approach

Additional considerations for all methods:

Well-defined types of beds:

- **Discrete service related bed types:**
    - Psychiatric
    - LTC/TCU/SNF/NF
    - LTAC
    - NICU II & III
    - Rehab Level 1
    - Chemical Dependency *
- **General service related bed types**:
    - Med / Surg beds
    - Pediatric (hospital defined)
    - ICU
    - Adult intermediate care / PCU
    - OB – mother bed
    - Ortho???
    - All others (using default occupancy standard)

Timing of the capacity counts:

- Midnight census – CHARS data available only for midnight
- Late morning
- Mid day

Data collection:

- 2 year capacity survey
    - Lending stability for long term planning
    - CN adjustments
    - Adjust for facility closures
    - Adjust for CRS completed / approved projects
    - Electronic survey tool needs to be well defined – reduce grey areas as much as possible
    - Critical review / quality control check
    - Identifying rooms that can be turned back into patient room within 24 hours
- Collected electronically
- Physical count of capacity?
- Attestation by CEO or authorized executive?
- Reliable source of data-Today

Planning Horizons (PH):

- One size does not fit all – there should be different planning horizons for different projects:
  - Different criteria for expansion projects versus new hospital?
  - Consideration should be given to the capital side of the project.
  - Different screening criteria should be used for a 1 million versus and 200 million dollar project.
  - A 7 year PH for a 200 million dollar project would not make sense.
  - A longer PH more consistent with the financial criteria of a larger project is more sensible.

- Take into consideration project phasing:
  - Bed need should start to materialize in short term from the baseline (CHARS) year without the project (within a few years)
  - The last phase can't be brought online more than "X" years after the first phase.
  - What surplus would be allowable in the final / target year?

- Concept: Every approved project over beds a community for a certain amount of time. What's the tolerance for having a community over bedded?
- Concept: Planning horizon is tied to the reliability of the forecast.
- Concept: Reliability of the forecast – longer forecasts are less reliable.
- DOH currently looks at a 7 year PH for projects that add beds and approximately 20 years for a new hospital.

- 7 year PH for routine / minor expansion? 10 year PH for major expansion? 15 year PH for new hospital? From the base-year.
  - 7 year PH could be linked to a capital expenditure amount - projects less than 75 million?
  - 10 year PH could be linked to a capital expenditure amount – projects more than 75 million?
  - 15 year PH for new hospitals – assuming project costs over 75 million?

- Concept: Only a project that is including beds would we assess what importance is the capital to the planning horizon. Example: A $100 million remodel that does not add beds would not be subject to CoN.
- Concerns about capital expenditure being tied to thresholds for planning horizons – it may incentivize choosing a project size on the basis of what planning horizon is linked to it?
- Capital project size may not be appropriate to set planning horizons
  - The risk we run is fragmenting the projects to a place where we lose efficiencies.
- The logic of tying planning horizons to capital expenditure is that it renders the department's decision more consistent with financial decisions.
- Concerns about tabling "Use Rates" from the planning horizon discussion.
  - Use rates become a more important issue when talking about planning horizons over say 7 years.
- 7 years projection is a minimum - based on the last full years of CHARS at the time of filing?
- What about a standard 10 year PH?
- Is a 15 year PH for new hospitals the right number? Should it be lower?
  Sub-committee work needed on data analysis of past decisions and use rate forecasts.

<u>Consensus Areas for Planning Horizons:</u>

- Projects of different natures makes a difference:

- New Hospitals:
  - Newly licensed facility on a new campus
  - New beds - not transfers
  - A standard 15 year planning horizon for new hospitals.
  - If new hospital application received, then existing provider allowed a 15 year planning horizon to compete concurrently (leveling the playing field).
  - Demonstration of Need Options:
    - Option # 1 – Year 5 shows some need -- 50% materialize by year 10 – 100% by year 15.
    - Option # 2 – 50% materialize by year 10 – 100% by year 15.
    - Option # 3 -- 100% by year 15
    - Ask Mark (CoN) to do some modeling to show what the above scenarios would look like.
- Expansions:
  - May or may not have more than one planning horizon.
  - A standard 10 year planning horizon regardless of size of expansion project based on the last full years of CHARS at the time of filing.
    - Capital expenditures would no longer be an issue.
    - Applicant's request cannot exceed the number of beds projected in year 10.
    - 10 years and under.
    - Additional qualifier to approve an application - there should be some demonstration of net need in the planning area forecast by the 5th year of the forecast
  - Rule should say that applicants need to use the currently published data relating to supply to build and submit their applications and that data is used by the department to review said application – this approach should remove uncertainty about supply.
  - Concern: Moving from a 7 to 10 year planning horizon has created some level of predictability problems.
  - Concept: To try to relieve concerns over predictability, demonstrate that there is some need by year 5, and focus on increased need being demonstrated between years 5 to 10. If need can be demonstrated in years 5 thru 10, it would lend more confidence to the 10 year forecast.
  - Concern: If we agree that 10 years is where need ought to be shown for a project, why do we care what it is in prior years? Why do we want and try to create some artificiality to a decision rule?
  - Demonstration of Need Options:
    - Option # 1 – Year 5 shows "some" need -- 100% by year 10
    - Option # 2 – 50% materialize by year 5 -- 100% by year 10
    - Option # 3 -- 100% by year 10
  - Provide an exception to the rule:
    - Exceptions should be a high hurdle.
    - Exceptions would be granted based on clearly demonstrated unique community need(s).
    - What should the exception criteria look like?

Population Projections:

- Data sources:
  - County level - OFM
  - Sub-county level – commercially available population data sources
- There is no standard definition of planning area
- Certain counties have zip codes that bleed over into adjacent counties. This can be problematic because it is unclear how OFM treated these zip codes. Need to know how OFM treated those zip codes.
- Should we rely on OFM data for county and sub-county?
- Should we always use OFM intermediate series data? Or, are there times when the low or high series data should be used? If so, what is the test that we would apply to make that decision? Applicant's burden to show why low or high series should be used.
- Applicant uses the series that is most accurate for them?
- OFM intermediate series data is going to be the most accurate the majority of the time.
- Do we run the risk of projection wars? Hospitals choosing data sources that best supports their case / goals.
- Use data approved by the department
  - DOH develops a process for approving the source of the data
- Use OFM data as a test beyond the projections in the approved commercial source.
- Best fit population series from OFM
  - What does this analysis look like? Consult with subject matter experts to understand the process and then be able to write in rule the steps involved?
- OFM offers zip code level data but it is not projection or age cohort specific.

Consensus Areas for Population Projections:

- Use whatever OFM population forecast that is the most accurate – not simply the easiest to apply.
- Use whatever OFM population forecast that most accurately represents past growth.
  - An applicant must demonstrate why they are using a population series other than OFM medium.
  - DOH has the discretion to use the most accurate series – including OFM low.
  - In order to determine which series is the most accurate, OFM forecast should be compared retrospectively.
  - Sub-county level – use commercially available data

Consensus Areas for Planning Areas:

- Planning areas should be market-based and defined by zip code areas, since that is how patient days and population statistics are compiled and used in the methodology.
  - First, the Department should prepare a complete list and definition, including population statistics, for each of the current 54 planning areas. These planning areas should be plotted on maps and include hospital locations.
  - Second, the Department should provide this most current set of definitions to hospital executives and ask them if there are any suggested changes. If there are, the hospital(s) requesting such change should also provide the logic behind their proposal(s). This should also include the effects on surrounding hospitals and planning areas.

- Third, the Department should route any suggested revisions to the planning area definitions through the acute care bed methodology workgroup so it can be discussed/evaluated.

Consensus Areas for Market Share Assumption:

- Currently, the methodology assumes that migration—into and out of the planning area remains constant at the most recent actual figures.
- Participants agreed if there was sound, statistical evidence that migration in or out of a planning area had been changing over the prior 5 or 10 year period, this should be considered by the Department.
- Burden would not be on the applicant -- criteria would be in rule -- similar to Dialysis rules

Consensus Areas for Concurrent vs. Comparative Review:

- There was agreement the Department needed to better explain its apparent position to use concurrent review cycles.
- There was also agreement the approach should be market-driven, not driven by a calendar.
- Review Alaska rules that are market driven (not calendar)
- When an application comes in:
    - Process on hold for 30 days
    - Other providers are notified and allowed to apply as well within a specific time frame
    - Need to have a prescribed timeline once triggered.
    - If a second letter of intent is submitted, this will trigger a separate timeline for comparative review (letters of intent good for 30 days)
    - Application must follow letters of intent within 30 days
    - Have a more compressed second screening

Surge Capacity:

- When an unforeseen event occurs, hospitals utilize their emergency plan.
- Unforeseen events – What role should this have in setting the routine bed capacity in hospitals? Perhaps no role?
- Beds and staffing available to take care of the patients
- Setting the target occupancy to address surge capacity.
- Policy that hospitals overbuild to be able to address a certain percentage of needed surge capacity.
- Keep considerations about unforeseen events separate from the usual considerations about occupancy standards.

Tiebreakers:

- History of community involvement.
- Community preventative education
- Charity care
    - Count number of charity patients compared to total patients?
    - Tax burden?
- For profit / non-profit?
- Level of Medicaid service within a planning area

- Dollars expended for physician recruitment (not verifiable)
- Number of primary physicians employed or recruited and practicing within the primary service area
- 24/7 hospitalist
- Fully deployed electronic health record
- Better care integration (integrated delivery systems)
- Cost effectiveness? Measured how?
- If both applications are equal, split the beds?
- Use criteria that is already reported.
- Non-solicited quality awards?
- Discretionary services – low margin services for unmet need
    - Trauma
    - Stroke
- Superior alternatives?
- New hospital over expansion of existing facility?
- Improving access? Travel distances?
- (No consensus has been reached on use of specific tie breakers)

HMO Contracts:

- (No discussion has occurred on HMOs)

Other:

- Licensed bed count vs. sufficiency of ancillary and support services
- Flexibility for providers to use their beds for different uses?
- Are we looking at a strict numeric methodology for determining a decision? Should we also be looking at the general overall worthiness of an application and the community need to approve beds?