Meeting Notes

The Acute Care/Ambulatory Surgery Subcommittee of the

State-Wide Health Care Facilities and Services Plan Advisory Body

August 11, 2011 at 10:30 a.m.

Agenda Item	Discussion	Action/Results
I. Opening Remarks	None of the absent members asked to call in for the meeting.	OHCA working on providing conference call-in in the current meeting room
II. Further Comments/ Feedback on Bed Need Methodology	To date, Jean Ahn and Karen Goyette have provided feedback on the methodologies presented. The Connecticut Hospital Association (CHA) will also be providing its response. All of the remaining representatives were encouraged to provide comments via email. A new iteration of the IL methodology estimate was updated with all needed information and is now available on the OHCA webpage for review and comment. **Overview of Jean's emailed comments:** • The use of a static data element, such as occupancy rate, may not capture true bed need. Factors such as patients' need for single rooms, patient gender differences, and the need to isolate patients for medical reasons can impede the ability to achieve full bed capacity. These situations may also lead to longer ED wait times. Consequently, bed need methodologies should focus on licensed beds. • There is not much information on benchmarking; in 2004, the industry advisory body recommended an occupancy rate of 80%. **Concerns/comments raised by the subcommittee:** • OHCA acknowledges that observation or 23-hour stays are a valid concern for some hospitals. Unfortunately, the data is not readily available to OHCA at present and the associated bed days cannot currently be factored in. Secondly, annual hospital data reported to OHCA is for the fiscal year, while the plan will utilize calendar year. Finally, members have indicated that there must be federal payment policies to support 23-hour stays to enable objective measurements. The use of	CHA to provide feedback/comments. Members to provide feedback/comments via email. Members to visit www.ct.gov/dph/ohca and use the CT State-Wide Health Care Facilities and Services Plan Advisory Body link to access the information CHA is updating its data reporting tool to allow hospitals to report information on observation stays. The system will go live in the fall.

	inpatient beds for outpatient purposes is an issue that will need to be addressed. • In- and out-migration from and to bordering states -- NY, MA, RI and NH -- may need to be considered for CT's bed need computations due to the fact that hospitals residing close to state borders may receive substantial out-of-state patient volume. CT statutes require decisions to be made with respect to CT residents; however, if a significant number of patients that reside out-of-state are occupying CT hospital beds, it may be necessary to include certain non-resident populations in our planning efforts. • In certain circumstances, exceptions may be necessary to supersede the bed need methodology. For example, an individual hospital may be experiencing overcrowding and require additional beds even though the planning area has been determined to have adequate capacity. It is possible, that the use of an exception may allow this individual hospital to expand license capacity in this situation. Given these complex issues, members will need to give careful consideration when suggesting exceptions.	
III. Presentation on Planning Regions – Laurie Greci	Planning areas differ from an applicant's service area in that the latter may overlap more than one planning area. A review of a number of state plans show that the most common basis for statewide planning areas are counties or zip codes. This can be complicated for towns that share zip codes and census tracts. There are a variety of planning regions utilized by various CT state agencies: 14 regions by the Office of Policy and Management (OPM), five regions by the Department of Mental Health and Addiction Services (DMHAS) and five regions by the Department of Emergency Management & Homeland Security (DEMHS). Most of these regions/areas do not overlap.	Group recommendations on Planning Areas/Regions, Planning Areas/Regions by Service etc.

V. Review and Discussion of Planning Region Presentation	**Concerns/comments raised by the subcommittee:**	
	• Were the states used in the example chosen based on information readily available or on how relevant they are to CT? It was suggested that OHCA look at surrounding states, NY, MA, NH, RI and ME to review their methodologies.	If available, OHCA to post information on planning areas for neighboring states on web and determine their planning areas.
	• While not advocating for the more complex MD model, it includes an important component which allows one to truly look at need because it delineates the cross border movements. On the other hand, the definition is too flexible and might allow facilities to pick and choose which zip codes to include. This problem may be minimized with the proposed definition of PSA from the plan's CT Imaging group; which is, "…geographic area (by town) consisting of the lowest number of contiguous zip codes from which the applicant draws at least 75% of its patients for this service." CHA recommended that the top 75% should be used regardless of state-of-origin.	
	• Currently the facilities/providers submitting CON applications are defining their service area on a project case by case basis.	
	• It was suggested that OHCA determine preliminary planning areas/regions based on geographic areas like natural boundaries, taking into account hospital services areas and then develop and describe the socio economic profile of each region. Hospitals can indicate, when it applies, that they draw from multiple regions and specify what services they provide. A large number of planning areas may increase the risk of unneeded duplication of services and/or excess capacity from a public health perspective.	
	• NY & NJ have planning areas by service, showing the need for the specific service and making the case for exceptions. There is potential in this approach. Also, some services are such that the provider's skill and outcomes improve with experience and volume e.g., cardiac procedures. Other services which utilize a new technology, e.g., a hyperbaric chamber, may be expensive; permitting too many, too soon and may oversaturate the market and drive up cost. Such situations support limiting the number of providers through planning area by service.	OHCA will post a list of plans for different categories of services from various states at www.ct.gov/dph/ohca for members to review and comment on.
	• What is the vision and end use in defining planning areas? Providing CON applicants with the blueprint or guidelines for OHCA standards for determining need.	
	• How is the planning area definition expected to impact hospital services provided by non-hospital providers? OHCA needs members' input on this issue.	

VII. Other Business: VII: Next Steps	Jean Ahn provided OHCA with 2009 Focused Updates: ACC/AHA Guidelines for the Management of Patients with ST-Elevation Myocardial Infraction (Updating the 2004 Guidelines and 2007 Focused Update and ACC/AHA/SCAI Guidelines on Percutaneous Coronary Intervention (Updating the 2005 Guidelines and 2007 Focused Update) [**see Attachment 1**] and provided an updated map of the Statewide Cardiac Catheterization/Interventional Programs [**see Attachment 2**]. Issues for discussion at next meeting: 1. Exceptions to the bed need methodology 2. Continue planning region/area discussion 3. Feasibility of planning regions/areas by service 4. Ambulatory surgical facilities presentation and discussion Logistics: The group requested that OHCA provide presentations or materials for discussion as far in advance as possible before meetings to enable members to be better prepared for discussions. The group will be meeting at 10:30 a.m. on August 25, September 8 and September 22 at the same venue. The new location for the OHCA website is www.ct.gov/dph/ohca. To access all information about the Plan, meeting presentations, materials, agenda and schedule, click on the CT State-Wide Health Care Facilities and Services Plan Advisory Body link.	Jean Ahn to provide information to OHCA. The presentation for Ambulatory Care for the next meeting is already posted on the web.

Attendees: Karen Goyette, Jean Ahn, Sally Herlihy, Carl Scheissl, Beth Chaty, Patrick Charmel
Attendees from OHCA: Kaila Riggott, Steve Lazarus, Brian Carney, Laurie Greci, Olga Armah
Absentees: Louise Dechesser, Betty Buzzuto, Dennis McConville, Lisa A. Winkler