Meeting Notes

The Acute Care/Ambulatory Surgery Subcommittee of the

State-Wide Health Care Facilities and Services Plan Advisory Body

July 14, 2011 at 10:30 a.m.

Agenda Item	Discussion	Action/Results
I. Opening Remarks II. Introduction of Members III. Outline of Plan's sections IV. Discussion of Subcommittee Purpose and Expectation	Kim Martone opened the meeting, introduced Karen Goyette as the subcommittee facilitator and reiterated the subcommittee's role (reviewing and/or recommending service standards, guidelines and methodologies for acute care bed need, ambulatory surgery and operating rooms as relates to Certificate of Need; identifying data limitations and suggesting potential data sources; reviewing and/or identifying possible unmet need; and recommending subject matter experts to assist in subcommittee tasks). A draft of the Proposed Table of Contents for the Facility and Services Plan was distributed along with an outline of the acute care and ambulatory surgery services chapters of the plan. Kaila Riggott discussed areas of those chapters needing the subcommittee's input and assistance. She also encouraged recommendations on additional services that should be covered in the plan and planning areas to be adopted for these chapters (e.g., statewide, service specific or health planning areas).	No specific actions taken.
V. Presentation on Acute Care Bed Need Methodology	Brian Carney presented Connecticut applications of bed need models from three states: North Carolina, Alabama and South Carolina to start the conversation on acute care bed need and what considerations to make in developing a Connecticut-specific model. For planning area demonstration purposes, Department of Emergency Management and Homeland Security (DEMHS) regions and counties were both used. Licensed beds were used for the analyses since CON decision making on capacity is restricted to licensed beds. Common elements several state models incorporate are: planning areas, historical trends in bed days, population changes, target occupancy rates and patient age groups. Concerns/comments raised by the subcommittee: ▪ Licensed beds are not true counts of beds in some hospitals because while observation beds on medical floors are considered part of licensed, staffed and available beds, they are not counted as part of licensed capacity if they are in ED units. Licensed beds also include bassinets, and it was suggested they be excluded from the analysis.	Brian will contact modeled states for more details on how they arrived at target occupancy rates. He will also replicate the Illinois model that incorporates in/out migration and determine if the overall results vary from the three states presented. If possible, members with access to releasable discharge data from neighboring states will provide the data to OHCA to help gauge the impact of in/out migration on border town hospitals and net migration among planning regions.

VI. Review and Discussion	▪ None of the models presented consider in- and out-migration, which tends to be significant for border town hospitals and may skew current results. (For budgetary reasons, OHCA is not able purchase current discharge data from bordering states to capture the extent of out-migration from CT to hospitals outside the state and net migration.) ▪ It was suggested that OHCA possibly consider regions other than those which have been established for other purposes. Because of the complexity it was suggested that this issue be discussed in depth at a future meeting. ▪ While at the macro level the planning area concept seems appropriate, it may ignore the characteristics of individual hospitals and rolls up bed usage to the regional level which may make the results less relevant to most individual hospitals. ▪ Occupancy rates utilized in the models are a point in time estimate and based on historic data which are not necessarily reflective of the current picture in most hospitals. Ideally, the model that is developed would need to be dynamic to allow for significant and/or fluid changes such as resulting from the change in rules governing acute versus sub-acute bed days. This may be most realistically and appropriately addressed with exceptions. It was noted that IL has a mechanism for significant changes, called the ten-bed rule. If there is a spike in census, hospitals are allowed to increase bed capacity by ten without CON, allowing for the industry to self-correct. It is important to ensure that language that comes out in the plan does not encourage a precipitous elimination of beds or politicize the issue of excess capacity. It appears that licensed beds should be used as the unit of measure since the considerations for staffed and available beds are too broad. Once all available information is incorporated into the plan that will be released in 2012, then objective changes may be made in the five-year updates. ▪ Surge capacity, its size and if it should be at the regional level are additional considerations.	As there is a need for additional research on occupancy rates, members with access to national studies will make them available to OHCA. OHCA will research American Hospital Association (AHA) database on target occupancy rates by hospital size and by service and additional utilization information from the federal Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization (HCUP) database. Patrick Charmel will provide articles on surge capacity to OHCA.
VII. Other Business: Amb Surg Survey update	Members received the list of facilities and who had or not responded to the survey. To date, 24 of 30 (or 80%) general hospitals and 52 of 62 (or 84%) facilities registered as outpatient surgical facilities (OSF) have responded. Six hospitals and 10 OSF are yet to respond. Kaila Riggott asked that members of the subcommittee who have contacts at the non-responding facilities assist with the follow-ups. OHCA's website is now a page on the Department of Public Health website at www.ct.gov/dph/ohca. To access the Survey Monkey version of the survey, scroll down the page and click on **2010 Outpatient Surgery Questionnaire**.	Lisa Winkler will follow-up with Wilton Surgery Center, LLC and Judith L. Ward with New Milford Hospital and The Hand Center of Western CT, Danbury after being provided with contact information of who received the survey notices.

VII: Next Steps	Data elements for feedback: 1. Regions 2. Obtain information from SC, AL and NC on how they determined target occupancy rates by hospital size and how they handle border hospitalizations. 3. Data or Information on in/out migration to and from CT hospitals. 4. OHCA to make the CT estimates of and the three models under study available to the group. Logistics: The group has to set a robust meeting schedule to ensure a timely completion of its charge. The group will meet every other week for the next three months. Discussions and presentations on Ambulatory Surgery facilities will be at the third meeting.	Members will email all feedback and information to Kaila Riggott and OHCA will pull together for the next meeting. Brian will provide models and results to members to have them review more extensively for comments. Kaila will send her email address to members to ensure delivery of materials members send. She will also email meeting notes and calendar.

Attendees: Karen Goyette, Louise Dechesser, Lisa A. Winkler, Jean Ahn, Lisa Brady, Judith L. Ward, Betty Buzzuto, Beth Chaty, Dennis McConville, Patrick Charmel
Attendees from OHCA: Kimberly Martone (for introduction of meeting), Kaila Riggott, Brian Carney, Laurie Greci, Olga Armah