

**RENOVATION-REPLACEMENT OF ACUTE CARE  
FACILITIES AND SERVICES**

I. DEFINITIONS

A. Acute Care: Inpatient hospital care provided to patients requiring immediate and continuous attention of short duration. Acute care includes, but is not limited to, medical, surgical, obstetric, pediatric, psychiatric, ICU and CCU care in a hospital.

B. Acute Care Bed: Any licensed inpatient bed dedicated to the use of patients requiring acute care.

C. Admission Rate: The number of patients entering the hospital for acute care services per 1,000 population.

D. Average Daily Census: The average number of licensed acute care beds in the hospital that are used by inpatients.

E. Average Length of Stay: The average number of days a patient stays in the hospital.

F. Bed: A general measure of hospital size and capacity.

G. Capital Expenditure: Those expenditures as defined in W.Va. Code § 16-2D-2, including a series of expenditures exceeding the expenditure minimum and determined by the Health Care Authority to be a single capital expenditure subject to review.

H. Coronary Care Unit (CCU): A special unit of the hospital equipped to provide maximum surveillance and support of vital function and definitive therapy to patients with acute or potentially reversible life-threatening impairment of the cardiovascular system.

I. Critical Access Hospital (CAH): A hospital designated as such by the West Virginia Office of Rural Health Policy in conformance with the requirements of the Medicare Rural Hospital Flexibility Program.

J. Discharge Planning: A coordinated effort to ensure that each patient to be discharged from a health care facility has a planned program of needed continuing care and follow up that seeks optimum functioning of that patient and the earliest practicable discharge.

K. Discharge Rate: The number of patients who have received acute care services discharged per 1,000 population.

L. Inpatient: A patient who has been admitted to the hospital for an overnight stay or longer.

M. Intensive Care Unit (ICU): Care provided in a specially licensed unit set up for the purpose of providing maximum surveillance and support of vital functions and definitive therapy for patients suspected of having acute, or potentially reversible life-threatening impairment of single or multiple vital systems (pulmonary, cardiovascular, renal or nervous systems). Such a unit requires special equipment and specially trained staff.

N. Level I Obstetrical Unit: A hospital obstetric unit, the function of which is to provide services primarily for uncomplicated maternity and newborn patients.

O. Level II Obstetrical Unit: A hospital obstetric and neonatal unit, the function of which is to provide a full range of maternal and newborn services for uncomplicated births and for the majority of complicated obstetrical problems and certain neonatal illnesses.

P. Level III Obstetrical Unit: A hospital obstetric and neonatal unit, the function of which is to provide care for normal births but especially for all the serious types of maternal-fetal and neonatal illnesses and abnormalities.

Q. Levels of Care: A system of categorizing services according to complexity and sophistication. Normally, acute care is divided into three levels: primary, secondary, and tertiary, with the primary level being comprised of the most basic services and the tertiary level being comprised of the most complex services.

R. Licensed Beds or Hospital Beds: The basic index of hospital capacity, consisting of the beds in each hospital which are licensed for acute care use. In the case of state-operated acute care facilities, it is the number set up and staffed.

S. Neonatal: A term used to refer to an infant less than 29 days old.

T. Neonatal Intensive Care Unit: A specialized medical treatment unit of the hospital set up to provide extraordinary care to critical infants.

U. Observation Services: Services ordered by a patient's physician and provided by a hospital on the hospital's premises. These services include the use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary for a possible admission to the hospital as an inpatient. Observation beds are not licensed acute care beds.

V. Observation Equivalent Days: The total observation hours divided by 24. Observation equivalent days may be added to acute care days to demonstrate peak occupancy.

W. Obstetrics: The branch of medicine that deals with the care of women before, during, and directly after childbirth.

X. Occupancy Rate: The average percentage of licensed beds in a hospital or one of its units that are filled as of midnight each day. To demonstrate peak occupancy, the hospital may also document the occupancy rate at a different time of the day.

Y. Outpatient: A patient who is not admitted to the hospital for an overnight stay.

Z. Patient Flow: A hospital's pattern of patient admissions and discharges.

AA. Patient Origin Study: A special study of hospital's patient flow designed to determine the particular geographic areas from which an institution draws its patients and the institutions to which residents from an area go for hospitalization.

BB. Pediatric: The branch of medicine that deals with the care of children under 14 years of age.

CC. Peer Review: The evaluation of health professionals and their performance by their peers. This term relates to programs such as utilization review and professional review organizations.

DD. Psychiatric: The branch of medicine connected with mental disorder.

EE. Replacement: A project for the erection, construction, creation or other acquisition of a physical plant or facility. All beds in the replacement facility must be located within the same county or within fifteen (15) miles of the original facility.

FF. Renovation: A project for modernization, improvement, alteration or upgrading of an existing physical plant or equipment.

GG. Swing Beds: Beds used in small rural hospitals that may be used interchangeably as either general/medical/surgical beds or skilled nursing beds. Reimbursement is based upon the specific type of care provided. Swing bed days may be added to acute care days to demonstrate peak occupancy.

## II. CURRENT INVENTORY

The Authority shall provide a current inventory of existing acute care beds and hospital beds by specialty to each applicant.

## III. NEED METHODOLOGY

A. The Authority will consider for approval proposals for renovation or replacement of hospital beds or services, if the applicant submits reliable, probative, and substantial evidence that the project is necessary. Such necessity may only be proven by establishing one or more the following:

1. The service(s) provided by the applicant requires space, or the facility requires replacement or renovation to meet minimum requirements documented by written recommendations from appropriate accreditation or licensing agencies or documentation based upon comparisons to the minimum departmental square footage requirements of comparable services.
2. There are significant operating problems that can most effectively be corrected by the proposed replacement or renovation as documented by data regarding specific projected cost savings that would be achieved if the project were completed, and the proposed level of investment is appropriate in relation to such projected cost savings.
3. The replacement or renovation is being proposed to correct deficiencies that place the facility's patients' or employees' health and safety at significant risk. Such deficiencies must be demonstrated by reference to the minimum requirements of licensing, regulatory, and accrediting organizations.

B. Regardless of the provisions of Section III (A) above, the Authority will not approve a renovation or replacement if the proposed project will perpetuate or result in excess capacity of acute care beds. For the renovation or replacement of a patient care area, the following requirements also apply:

1. The Authority will not approve any renovation or replacement to a patient care area of a hospital where the number of licensed acute care beds, after completion of the renovation or replacement project, will equal or exceed 160% of the average daily census of the hospital for the past twelve (12) months. The Authority may consider an adjustment by the hospital to its average daily census for observation equivalent days and swing bed days. The Authority may also consider the impact of a distinct part unit on the hospital's average daily census.
2. An applicant must remove acute care beds from its license to meet the 160% requirement. The applicant must submit an amended license to demonstrate the reduction in acute care beds during substantial compliance review.
3. If the removal of acute care beds from the hospital's license would cause a breach of a covenant in a bond instrument, or other debt instrument to which the applicant is a party, the removal of beds from service may be used to meet the requirements of these standards. In this case, the applicant must meet the requirements of the "Addition of Acute Care Beds Standards" to return said beds to service.
4. The Authority may grant an exception to the reduction of beds to meet the 160% average daily census requirement if the applicant has experienced significant fluctuations in its occupancy levels and (a) the applicant is the sole hospital in a county or (b) the applicant has exceeded an 85% acute care occupancy level for two consecutive months during the past twelve (12) months.

5. An acute care facility which has removed acute care beds from its license pursuant to the requirements of Section III (B)(1) of these Standards, may restore acute care beds to its license if it meets the following requirements:
  - a. The facility has experienced significant fluctuations in its occupancy levels;
  - b. The facility has exceeded an 85% acute care occupancy level for two consecutive months during the past twelve (12) months;
  - c. The facility may add up to 10% of the number of acute care beds on its current license on an annual basis without undergoing certificate of need review, however it may not exceed the number of acute care beds on its license immediately prior to the reduction of beds pursuant to Section III (B)(1) of these Standards; and,
  - d. The facility must notify the Authority a minimum of ten (10) days prior to requesting an amendment increasing acute care beds on its license.
- C. Critical access hospitals are not subject to the requirements of Section III (B).

#### IV. QUALITY

The applicant making the proposal for renovation or replacement for hospital beds must be in compliance with applicable licensing or certification organization requirements or have in place a substantive and detailed plan to come into compliance with applicable licensing or certification requirements.

#### V. CONTINUUM OF CARE

A. The applicant must demonstrate that the replacement or renovation under consideration is the most cost effective or otherwise most appropriate alternative to provide the needed services to the population to be served.

B. The applicant must demonstrate that it has an effective utilization review, peer review, quality assurance and discharge planning process.

#### VI. COST

A. The applicant must demonstrate financial feasibility of the facility following completion of the replacement or renovation. The applicant must also demonstrate that the capital related costs of the project are consistent with the Authority's rate setting methodology in effect as of the date of application. The applicant must further

demonstrate that the charges and costs used in projecting financial feasibility are equitable in comparison to prevailing rates for similar services in similar hospitals are defined by the Authority.

B. The applicant must demonstrate that the project is the superior alternative, after considering in significant detail the costs and effectiveness of the following alternatives:

1. Maintaining extant facilities;
2. The alternative project, if any, which is likely to result in the greatest increases in operating and cost efficiencies;
3. The alternative project, if any, which would use the lowest cost construction methods complying with licensing, accreditation, and building code requirements;
4. A combined analysis of items two and three above considering and analyzing the trade-offs between increases in operational efficiency juxtaposed with lower cost construction alternatives;
5. Merger, consolidation of facilities or sharing of services, and/or delivery of the service in an alternative setting; or
6. Closure of the service and/or such other alternative as may be suggested by the Authority.

C. The applicant shall submit reliable, probative and substantial evidence to demonstrate that the proposed square footage, construction cost per square foot and cost of fixed equipment for all nursing units, ancillary services and support areas directly affected by the replacement and/or renovation are appropriate and reasonable for the types and volumes of patients which are projected to utilize the hospital's services in the fifth year following completion of the project.

In preparing this objective analysis, the applicant must show that it has given prudent consideration to internal and external factors that will impact the operating environment of the hospital upon completion of the project.

The factors to be considered must include:

1. Trends in the demand for specific hospital services and recent demographic and/or medical practice changes that are likely to modify the trends.
2. The forecast of demand for the hospital's services based upon the most probable assumptions. The applicant must submit a comprehensive listing of the assumptions underlying the forecast.

3. If the physical layout of the hospital, following completion of the replacement or renovation, will be conducive to efficient staffing and transportation of patients.
4. If the physical layout of the hospital, following completion of the replacement of renovation, will seek to maximize the amount of net usable square footage available for patient care.
5. A search of the literature and an architect's certification regarding the amount of net usable square feet required for the performance of hospital activities at projected volume levels. The literature search shall include, but not be limited to, the requirements for state licensing or JCAHO Accreditation.
6. How the cost per square foot for replacement projects compares to the normal cost of good quality hospital construction as evidenced by recognized trade journals. For renovations, the applicant must consider how the cost per square foot for renovation of hospital areas compares to – and should not exceed – the normal cost of replacement. Where practicable, the applicant should reference recognized trade journals, such as Means Square Foot Costs, BOECKH, Engineering News Record or Marshall and Swift. In determining normal cost adjustment, consideration should be given for the hospital departments involved, terrain, geographic area and other factors relevant to the source(s) utilized.
7. If the facility design and construction methods employed in the proposal will allow for flexibility to accommodate future changes in the mix of inpatient versus outpatient utilization at the hospital and the mix of services by the hospital.
8. How the hospital will accommodate disruption of normal operations during the period of construction and how savings in operating cost relate to increased capital cost incurred to minimize such disruptions.
9. The steps the hospital is taking to transfer inactive storage and other non-patient activities to less expensive off site areas.
10. Such other factors as may be requested by the Authority.

## VII. SPECIALIZED ACUTE CARE

A hospital may change its bed complement, within its approved licensed beds, among specialized units for services that are currently offered by the hospital and which do constitute the addition of a new institutional health service, or the deletion of an existing health service.

In addition to the criteria set forth elsewhere for the replacement or renovation of acute care facilities, proposals involving specialized acute care units must comply with the following requirements:

A. Tertiary Pediatric Care Unit: An application for the replacement or renovation of a tertiary pediatric care unit shall be in substantial compliance with the following:

Tertiary pediatric care units will be operated in only three West Virginia hospitals: West Virginia University Hospitals, Inc., Charleston Area Medical Center, and Cabell-Huntington Hospital.

B. Neonatal Intensive Care Unit: An application for the replacement or renovation of Neonatal Intensive Care Unit (NICU) beds shall be in substantial compliance with the following guidelines.

1. The number of NICU beds shall not exceed four beds per 1000 live births in the service area.
2. Level III NICU services shall be centralized at West Virginia University Hospitals, Inc., Charleston Area Medical Center and Cabell-Huntington Hospital.
3. Level II NICU services shall be considered for approval only at hospitals performing at least 1100 deliveries per year.

C. Obstetric Unit: An application for the replacement or renovation of obstetric unit beds shall be in substantial compliance with the following guidelines.

1. Level II and Level III obstetric units shall perform at least 1100 deliveries per year.
2. Level I obstetric units shall perform at least 750 deliveries per year.
3. New Level I obstetric units may be considered for approval based upon less than 750 deliveries per year if the absence of the service would result in a population of at least 5000 being more than 30 minutes normal driving time from another obstetric unit.

D. Critical Care Unit: An application for the replacement or renovation of Intensive Care Unit (ICU) beds or Coronary Care Unit (CCU) beds (collectively referred to as critical care units) shall be in substantial compliance with the following guidelines.

1. An ICU or CCU shall be staffed with qualified personnel under the direction of one or more appropriately trained on-site physicians. A hospital offering ICU or CCU services shall have a physician on-site for immediate consultation twenty-four hours a day. A CCU shall have a cardiologist or internist with adequate training in cardiology available for immediate consultation twenty-four hours a day.

2. Hospitals providing ICU or CCU services shall have in place with surrounding hospitals established protocols for the referral of stabilized patients. Hospitals which do not have ICU or CCU should have protocols to see that patients requiring such service be transferred as soon as possible after stabilization.

E. Psychiatric Unit: An application for the replacement or renovation of psychiatric beds shall be in substantial compliance with the following guidelines.

1. A unit within a general acute care facility shall be specifically designated for the treatment of psychiatric patients and shall be designed to accommodate the special privacy, security and treatment requirements of the patients.
2. The applicant must demonstrate that each patient will have a treatment plan which includes a prioritization of major problems, stated in specific terms, with clear, concise and realistic goals and coordinated treatment modalities.
3. The applicant must clearly demonstrate that individuals requiring inpatient treatment will be discharged as soon as they are able to function in a less restrictive setting.

#### VIII. ACCESSIBILITY

The proposal shall not adversely affect the continued viability of an existing hospital or health care services that serves a population of at least 10,000 not having 30-minute access to another hospital or critical access hospitals (CAH).

#### IX. OTHER CONSIDERATIONS

The applicant must demonstrate that the renovation or replacement is in concert with the applicable sections of the applicant's long-range facility and strategic plan.

#### X. DEMONSTRATION PILOT PROJECT

A. The Authority recognizes that occasionally certain acute care facilities which provide psychiatric services have excess capacity in their psychiatric units while other facilities in the same service area may need additional beds. In addition, existing State owned psychiatric beds operated by the Department of Health and Human Resources are insufficient to meet the needs of West Virginia.

As part of the Authority's health planning research activities and responsibility to gather information on access to care, and notwithstanding any contrary provisions in the Renovation-Replacement Standards, the Authority will allow a limited number of acute care facilities with excess capacity to lease psychiatric beds under the conditions and circumstances described below. During this Demonstration Project, the Authority will gather data on the success of these programs and will evaluate whether this arrangement should be allowed on a permanent basis in West Virginia.

B. The Authority will allow no more than two Demonstration Pilot Projects at acute care facilities for the provision of short term psychiatric services.

C. Acute care facilities that wish to apply for the Demonstration Pilot Project must submit their requests on forms prepared by the Authority.

D. Acute care facilities that wish to apply for the Demonstration Pilot Project must submit a signed copy of a collaborative agreement with all parties, including the Department of Health and Human Resources.

E. The application shall be a joint application with the Lessor facility and the Lessee facility. The following criteria must be met by the applicants:

1. The Lessor acute care facility must have a psychiatric unit with excess capacity.
2. The Lessee acute care facility must be a facility which currently provides psychiatric services and is in compliance with all federal and state requirements related to this service.
3. The Lessee must have a need for additional short term psychiatric beds.
4. The Lessee and Lessor must be located in the same acute care service area as defined by the State Health Plan.

F. The Demonstration Pilot Project will be for a two year period. The Lessor facility will report to the Authority, on an as requested basis, any information the Authority may request to determine the feasibility of the continuation of the Demonstration Pilot Project. Should either applicant fail to comply with these standards at any time, the Authority may terminate the Demonstration Pilot Project.

G. The Authority's decision to grant a request to participate in the Demonstration Pilot Project does not constitute a Certificate of Need, or any entitlement to the facilities to provide these services beyond the terms of the pilot. During the pilot, the Authority will closely monitor the success of the program and will evaluate whether it is appropriate to allow this arrangement to continue in West Virginia. The Authority may consult with the Department of Health and Human Resources in evaluating the success of this program.