

ADDITION OF ACUTE CARE BEDS

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 into 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 set to provide maximum surveillance and support of vital functions 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: 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. Long Term Acute Care Hospital (LTACH): An acute care hospital that provides care for patients who have been in an intensive care or short-term acute care setting and who require an extended length of stay (greater than twenty-five days). LTACHs are often referred to as a "hospital within a hospital".

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

U. Neonatal Intensive Care Unit: A special unit of the hospital set up to provide extraordinary surveillance and support of vital functions and definitive therapy for infants having acute or potentially reversible life threatening impairment of a vital system(s).

V. 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.

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

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

Y. 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.

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

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

BB. Patient Origin Study: A special study of a 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.

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

DD. 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.

EE. Projected Bed Supply: For a given future year, licensed acute care beds, plus any beds set up and staffed with state sanction at Welch Emergency Hospital, over and above the licensed number plus or minus any addition or deletion of beds approved or not required to be approved through the certificate of need process plus or minus the changes in bed supply proposed by an applicant or applicants for a certificate of need in a study area.

FF. Psychiatric: The branch of medicine concerned with mental disorder.

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.

HH. Use Rate: The number of acute care inpatient days utilized in a twelve (12) month period expressed in terms of days per 1,000 population.

II. CURRENT INVENTORY

The Authority will provide each applicant with a current inventory of existing acute care beds, by specialty unit.

III. NEED METHODOLOGY

The Authority will not approve an application for additional acute care beds if the resulting number of licensed acute care beds for the hospital is equal to or exceeds 160% of the average daily census for licensed acute beds for the last twelve (12) month period. The Authority may grant an exception to 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. In determining the average daily census, the hospital may adjust for observation equivalent days and swing bed days. The Authority, in its discretion, may also take into consideration data submitted by the hospital to demonstrate the impact of a distinct part unit on the hospital's average daily census.

IV. QUALITY

A. An applicant which proposes to add acute care beds to an existing facility must demonstrate compliance with applicable licensing and certification requirements. In the case of a new facility or a facility which is being renovated to meet regulatory, licensure or certification standards, the applicant must demonstrate that a substantive and detailed plan exists to show how the facility will come into compliance with applicable regulatory, licensure and certification requirements.

B. The applicant must document the ability to recruit and employ any additional professional personnel required to staff the additional beds.

C. For approval, the proposal must involve the provision of space and related equipment for ancillary and support services shown to be appropriate for the projected patient load of the hospital. A configuration that allows for flexible use by both inpatients and outpatients will generally be considered the desirable alternative when it can be achieved with reasonable increases in construction cost.

D. The applicant must demonstrate that the physical layout for the new beds is conducive to efficient staffing and transportation of patients to appropriate ancillary services.

V. CONTINUUM OF CARE

A. The applicant must demonstrate that the proposal under consideration is a less costly or more appropriate alternative to provide the needed services to the population.

B. The applicant must demonstrate that it has in place effective utilization review, quality assurance, peer review, and discharge planning processes.

VI. COST

A. The applicant must demonstrate financial feasibility. 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 as defined by the Authority.

B. 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 proposal are appropriate and reasonable.

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 project, will be conducive to efficient staffing and transportation of patients.

4. If the physical layout of the hospital, following completion of the project, 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 and JCAHO Accreditation.
6. If the cost per square foot for the project compares to the normal cost of good quality hospital construction as evidenced by recognized trade journals. 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 an existing 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. 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 thirty (30) minute access to another hospital or Critical Access Hospital (CAH).

VIII. ALTERNATIVES

A. Communities or entities considering the addition of new acute care beds to serve a population that is not presently accessible to a hospital within 30 minutes' driving time shall first consider less costly alternatives to the construction of a new

hospital that would secure or improve access to needed services. Except for CAHs, new hospitals shall be considered only when there is a proposed service area population of at least 5,000 not within 30 minutes driving time to other existing hospitals and the applicant presents reliable, probative and substantial evidence that the facility is reasonably expected to attract the projected market share that will support the occupancy rate.

B. An applicant for the construction of new beds must demonstrate that it has explored the consolidation of services (through merger of facilities or sharing of services) to make maximum economic use of all existing beds in the region and that the addition of the acute care beds constitutes the most economic alternative.

C. The applicant must demonstrate that the project is the superior alternative, after considering in significant detail, the cost 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;
6. Closure of the service; or,
7. Other alternatives suggested by the Authority.

IX. SPECIALIZED ACUTE CARE

An applicant which proposes to develop or expand specialized acute care beds will not be considered for approval by the Authority if the resulting number of licensed acute care beds for the hospital is equal to or exceeds 160% of the average daily census of the hospital's licensed acute care beds for the last twelve (12) month period.

Notwithstanding this requirement, 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 not 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 addition of acute care beds, proposals involving specialized acute care units must comply with the following.

A. Tertiary Pediatric Care Units: An application for the addition of beds to expand or create a tertiary pediatric care unit shall be in substantial compliance with the following guidelines.

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 Units: An application for the addition of beds to expand or create a neonatal intensive care unit (NICU) 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 study 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 1,100 deliveries per year.

C. Obstetric Units: An application for the addition of beds to expand or create an obstetric unit shall be in substantial compliance with the following guidelines.

1. Level II and Level III obstetric units shall perform at least 1,100 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 5,000 being more than 30 minutes normal driving time from another obstetric unit.
4. Level I and Level II units shall have policies defining the level of birth risk and newborn complications that they will attempt to serve, as opposed to patients they will refer to higher level facilities.

D. Critical Care Units: Any proposal to expand or create an intensive care unit (ICU) or a coronary care unit (CCU) (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 Units: An application for the addition of beds to expand or create an acute psychiatric inpatient unit 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.

X. LONG-TERM ACUTE CARE HOSPITAL

A. Host hospital: An existing general acute care facility that has excess acute care beds and space for the development of an LTACH. The host hospital would receive rent/lease payments from the LTACH for the existing space.

B. An application to create a Long-Term Acute Care Hospital (LTACH) shall be in substantial compliance with the following guidelines:

1. The host hospital must de-license any acute care beds used in the development of the LTACH. If the LTACH ceases to exist, terminates its services, or does not offer services for a period of twelve months, the beds de-licensed by a host hospital to establish the LTACH revert back to the host hospital.
2.
 - a. The development of a LTACH shall be limited to existing space within an existing general acute care facility. Space within the existing acute care facility shall be specifically designated for the LTACH and shall be designed to accommodate the treatment requirements of the LTACH patients.
 - b. An applicant, as part of a project for renovation or replacement of an existing facility, may demonstrate that the development of the LTACH in newly constructed space is more cost effective than the development of the LTACH in existing space. The space shall be specifically designated for the LTACH and shall be designed to accommodate the treatment requirements of the LTACH patients. If the LTACH ceases to exist, terminates its services, or does not offer its services for a period of twelve months, the beds de-licensed by the host hospital to establish the LTACH revert back to the hospital; however, the host hospital shall not include the cost of new construction for an LTACH in its rate application.
3. The applicant shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients. The applicant may submit documentation on the expected service area based upon national data or statistics, or upon projections generally relied on by professionals engaged in health planning or the development of health services.
4. The applicant shall document expected utilization for the service to be provided. The applicant shall consider the number of discharges from acute care facilities within the proposed service area that have an average length of stay greater than twenty-five (25) days in making its utilization projections.
5. After establishing expected utilization or demand, the applicant shall document the number of existing LTACH providers within the service area and the extent to which the demand is being met by existing LTACH providers.
6. 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.

7. New LTACH beds that would result in an increase in total licensed beds above 160% of the average daily census will not be approved. Excess acute care beds within an existing acute care facility must be converted to fill any unmet need for additional LTACH beds.
8. A LTACH shall not be less than 10 beds.
9. The project must be shown to be consistent with the facility's long-range plan.

XI. DATA SOURCE

The Authority will maintain a hospital data base needed to perform the calculations for specific situations. In addition, the Authority will make available tables containing data on the flow of hospital patients to and from all counties and relevant population data. As new data and estimates become available for use in these calculations, the Authority will provide affected parties notice of intent to revise the data tables so that they may comment on the proposed new data prior to official adoption of data revisions by the Authority. Certificate of Need applicants should inquire of the Authority regarding the data currently being used. Applicants must use data approved by the Authority; however, they may propose the use of alternate data sources by submitting clear and convincing evidence documenting changes in circumstances that would cause the proposed data to be found to be more accurate than the data adopted by the Authority.