

# VIRGINIA DEPARTMENT OF HEALTH

## Office of Licensure and Certification

### Division of Certificate of Public Need

#### Staff Analysis

April 21, 2023

**RE: COPN Request No. VA-8687**

HCA Services of Virginia, Inc. d/b/a Henrico Doctors' Hospital

Ashland, Virginia

Establish a 60-Bed, 4-OR, 1 Catheterization Lab, 1 CT, & 1 MRI Hospital

#### Applicant

HCA Services of Virginia, Inc. d/b/a Henrico Doctors' Hospital ("HDH") will be the sole owner of the proposed medical care facility, Ashland Hospital. HCA Services of Virginia, Inc.'s ultimate corporate parent is HCA Healthcare, Inc. Ashland Hospital is proposed to be located at 10054 Sliding Hill Road, Ashland, Virginia 23005, in Planning District ("PD") 15, within Health Planning Region ("HPR") IV. Ashland Hospital is to operate as a campus of HDH.

#### Background

##### **Planning District 15 Background**

PD 15 is nested within HPR IV in central Virginia. PD 15 has historically had more population growth than the HPR and Virginia as a whole; PD 15 grew at a rate of 10.11% between 2010-2020 while the HPR and Virginia grew at rates of 1.53% and 8.07%, respectively, for the same time period (**Table 1**).

The projected growth for PD 15 is also expected to outpace that of the HPR and Virginia for 2020-2030. The PD 15 projected growth rate is 6.84%, while HPR IV and Virginia are -0.82% and 5.58%, respectively, for 2020-2030 (**Table 1**). While HPR IV is anticipating a decline in population for the 2020-2030 period, PD 15 is anticipating an increase. Hanover County, the locality in which the project is proposed to be constructed, has rates comparable to those of PD 15 for the population as a whole.

Alternatively, the projected rate of change for the 65+ aged cohort for 2020-2030 is projected to be much slower for PD 15 than that of HPR IV and Virginia (**Table 1**). The 65+ cohort for PD 15 is projected to see an increase of 13.35%, while HPR IV is projected to see an increase of 21.93%, and Virginia is projected to see growth of 27.43% between 2020-2030 (**Table 1**). The rate of growth for the 65+ cohort in Hanover County is much lower than the PD, HPR, and statewide projections, expecting an increase in 5.38% for 2020-2030.

**Table 1. PD 15 Population Data**

| Geographic Name      | 2010 Census   | 2020 Census    | % Change 2010-2020 | 2030 Census    | % Change 2020-2030 | 2020 65 + Census | 2030 65+ Census | % Change 65+ |
|----------------------|---------------|----------------|--------------------|----------------|--------------------|------------------|-----------------|--------------|
| <b>Counties</b>      |               |                |                    |                |                    |                  |                 |              |
| Charles City         | 7,256         | 6,758          | (6.86)             | 6,200          | (8.26)             | 3,026            | 3,941           | 30.22        |
| Chesterfield         | 316,236       | 365,627        | 15.62              | 406,942        | 11.30              | 3,215            | 3,300           | 2.65         |
| Goochland            | 21,717        | 24,809         | 14.24              | 27,339         | 10.20              | 3,962            | 4,190           | 5.75         |
| <i>Hanover</i>       | <b>99,863</b> | <b>110,164</b> | <b>10.32</b>       | <b>118,374</b> | <b>7.45</b>        | <b>2,541</b>     | <b>2,677</b>    | <b>5.38</b>  |
| Henrico              | 306,935       | 334,756        | 9.06               | 356,656        | 6.54               | 3,459            | 3,928           | 13.58        |
| New Kent             | 18,429        | 23,069         | 25.18              | 27,067         | 17.33              | 3,669            | 4,842           | 32.00        |
| Powhatan             | 28,046        | 30,355         | 8.23               | 32,152         | 5.92               | 1,204            | 1,164           | (3.30)       |
| <b>Cities</b>        |               |                |                    |                |                    |                  |                 |              |
| Colonial Heights     | 17,411        | 18,150         | 4.24               | 18,658         | 2.80               | 2,587            | 2,872           | 11.03        |
| Richmond             | 204,214       | 226,613        | 10.97              | 245,437        | 8.31               | 3,754            | 4,611           | 22.82        |
| <b>HPR IV Totals</b> | 1,367,170     | 1,483,301      | <b>1.53</b>        | 1,572,716      | <b>(0.82)</b>      | 193,367          | 259,416         | <b>21.93</b> |
| <b>Virginia</b>      | 8,001,024     | 8,646,905      | <b>8.07</b>        | 9,129,002      | <b>5.58</b>        | 1,352,448        | 1,723,382       | <b>27.43</b> |
| <b>PD 15 Totals</b>  | 1,020,107     | 1,140,301      | <b>10.11</b>       | 1,238,825      | <b>6.84</b>        | 27,415           | 31,525          | <b>13.35</b> |

Source: Weldon-Cooper Census Data

The PD 15 poverty rate, 10.1%, is similar to that of the statewide poverty rate of 10.7% (Table 2). Notably, there is a significant variety in poverty rates in PD 15 by locality. For example, Richmond City is experiencing a poverty rate of 25.5% while Hanover and New Kent Counties experience a fraction of the poverty rate at 5.2% (Table 2). However, Richmond was the third most populated locality within PD 15 in 2020, superseded by Henrico (second most populated) and Chesterfield Counties (most populated) (Table 3). The proposed project is to be in Hanover County.

**Table 2. PD 15 Poverty Rates**

| Geographic Name       | Poverty Rate |
|-----------------------|--------------|
| Charles City County   | 12.3%        |
| Chesterfield County   | 7.6%         |
| Colonial Heights City | 13.5%        |
| Goochland County      | 6.7%         |
| <i>Hanover County</i> | <b>5.2%</b>  |
| Henrico County        | 9.0%         |
| New Kent County       | 5.2%         |
| Powhatan County       | 6.9%         |
| Richmond City         | 24.5%        |
| <b>Virginia</b>       | <b>10.7%</b> |
| <b>PD 15 Totals</b>   | <b>10.1%</b> |

Source: Weldon-Cooper Census Data

**Table 3. Population by Municipality in PD 15 in 2020**

| Locality           | 2020             | Percent of Total PD 15 Population |
|--------------------|------------------|-----------------------------------|
| Charles City       | 6,982            | 0.6%                              |
| Chesterfield       | 353,841          | 31.8%                             |
| Goochland          | 23,547           | 2.1%                              |
| Hanover            | 109,244          | 9.8%                              |
| Henrico            | 332,103          | 29.9%                             |
| New Kent           | 23,474           | 2.1%                              |
| Powhatan           | 29,909           | 2.7%                              |
| Richmond City      | 232,533          | 20.9%                             |
| <b>Total PD 15</b> | <b>1,111,633</b> | <b>100.0%</b>                     |

Source: U.S. Census, Weldon Cooper Center Projections, and DCOPN (interpolations)

### Computed Tomography (CT) Background

A CT scan is a diagnostic imaging tool that utilizes x-ray technology to produce imaging of the inside of the body and can show bones, muscles, organs, and blood vessels. CT scans are more detailed than x-rays; rather than the standard straight-line x-ray beam, CT imaging uses an x-ray beam that moves in a circle around the body to show structures in much greater detail.<sup>1</sup> The scans can be used to help diagnose tumors, investigate internal bleeding, or investigate other possible injuries or damage; additionally, early CT detection is key in stroke treatment to determine if thrombolytics can be administered safely. The scans can be done with or without contrast; contrast is a substance taken either orally or injected within the body, causing a particular organ or tissue to be seen more clearly.<sup>2</sup>

**Table 4. PD 15 CT Scanners' Utilization, VHI 2021**

| Facility Name  | Total Stationary Units | Total CT Procedures | Procs. per Scanner | % of Utilization Threshold |
|--|------------------------|---------------------|--------------------|----------------------------|
| <b>Acute Hospital</b>                                      |                        |                     |                    |                            |
| Bon Secours Memorial Regional Medical Center               | 3                      | 36,693              | 12,231             | 165%                       |
| Bon Secours Richmond Community Hospital                    | 1                      | 5,566               | 5,566              | 75%                        |
| Bon Secours St. Francis Medical Center                     | 2                      | 26,099              | 13,050             | 176%                       |
| Bon Secours St. Mary's Hospital                            | 4                      | 43,597              | 10,899             | 147%                       |
| Chippenham Hospital  | 4                      | 43,744              | 10,936             | 148%                       |
| Henrico Doctors' Hospital - Forest                         | 4                      | 33,354              | 8,339              | 113%                       |
| Henrico Doctor's Hospital - Parham                         | 1                      | 12,836              | 12,836             | 173%                       |
| Henrico Doctor's Hospital - Retreat                        | 1                      | 4,093               | 4,093              | 55%                        |
| Johnston-Willis Hospital                                   | 3                      | 30,834              | 10,278             | 139%                       |
| VCU Medical Center   | 7                      | 73,359              | 10,480             | 142%                       |
| Vibra Hospital of Richmond LLC (LTAC)                      | 1                      | 288                 | 288                | 4%                         |
| <b>Acute Hospital Total</b>                                | <b>31</b>              | <b>310,463</b>      | <b>10,015</b>      | <b>135%</b>                |
| <b>Freestanding</b>  |                        |                     |                    |                            |
| Bon Secours Imaging Center Innsbrook                       | 1                      | 1,213               | 1,213              | 16%                        |
| Bon Secours Westchester Imaging Center                     | 1                      | 6,687               | 6,687              | 90%                        |
| Chesterfield Imaging                                       | 1                      | 5,281               | 5,281              | 71%                        |
| Independence Park Imaging                                  | 1                      | 3,265               | 3,265              | 44%                        |
| MEDARVA Imaging  | 1                      | 192                 | 192                | 3%                         |
| NOW Neuroscience, Orthopaedic and Wellness Center          | 1                      | 3,761               | 3,761              | 51%                        |
| Richmond Ear Nose and Throat                               | 1                      | 0                   | 0                  | 0%                         |
| VCU Medical Center at Stony Point Radiology                | 1                      | 7,518               | 7,518              | 102%                       |
| Virginia Cancer Institute - Discovery Drive                | 1                      | 6,509               | 6,509              | 88%                        |
| Virginia Cancer Institute - Harbourside                    | 1                      | 3,912               | 3,912              | 53%                        |
| Virginia Cardiovascular Specialists / Forest Medical Plaza | 1                      | 4,214               | 4,214              | 57%                        |
| Virginia Ear Nose & Throat - Chesterfield                  | 1                      | 528                 | 528                | 7%                         |
| Virginia Ear Nose & Throat - Henrico                       | 1                      | 514                 | 514                | 7%                         |
| Virginia Urology   | 2                      | 8,554               | 4,277              | 58%                        |
| <b>Freestanding Total</b>                                  | <b>11</b>              | <b>35,702</b>       | <b>3,246</b>       | <b>44%</b>                 |
| <b>PD 15 Totals and Percent of Threshold</b>               | <b>42</b>              | <b>346,165</b>      | <b>8,242</b>       | <b>111%</b>                |

Source: DCOPN Records and VHI 2021 Data

<sup>1</sup> <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/computed-tomography-ct-scan#:~:text=Computed%20tomography%20is%20commonly%20referred,fat%2C%20organs%20and%20blood%20vessels.>

<sup>2</sup> Ibid.

Table 4 lists specifically those scanners that were operational and reporting data to VHI in 2021.  
Table 5 illustrates the entirety of the DCOPN inventory.

**Table 5. Inventory of Currently Authorized CT Scanners in PD 15**

| Facility  | Total Authorized Scanners | Total Diagnostic Scanners | Total Simulator Scanners | Total Intraoperative Scanners |
|---|---------------------------|---------------------------|--------------------------|-------------------------------|
| Bon Secours Chester Emergency and Imaging Center <sup>1</sup>   | 1                         | 1                         | 0                        | 0                             |
| Bon Secours Imaging Center at Reynolds Crossing <sup>2</sup>    | 1                         | 1                         | 0                        | 0                             |
| Bon Secours Memorial Regional Medical Center                    | 3                         | 3                         | 0                        | 0                             |
| Bon Secours Richmond Community Hospital                         | 1                         | 1                         | 0                        | 0                             |
| Bon Secours Short Pump Emergency/Imaging Center                 | 1                         | 1                         | 0                        | 0                             |
| Bon Secours St. Francis Medical Center                          | 2                         | 2                         | 0                        | 0                             |
| Bon Secours St. Mary's Hospital <sup>3</sup>                    | 4                         | 3                         | 0                        | 1                             |
| Bon Secours Westchester Imaging Center                          | 1                         | 1                         | 0                        | 0                             |
| Buford Road Imaging <sup>4</sup>                                | 1                         | 1                         | 0                        | 0                             |
| Chester Imaging Center <sup>5</sup>                             | 1                         | 1                         | 0                        | 0                             |
| Chesterfield Imaging  | 1                         | 1                         | 0                        | 0                             |
| Chippenham Hospital   | 3                         | 3                         | 0                        | 0                             |
| Hanover Emergency Center <sup>6</sup>                           | 1                         | 1                         | 0                        | 0                             |
| Henrico Doctor's Hospital - Parham Doctors' Hospital            | 1                         | 1                         | 0                        | 0                             |
| Henrico Doctor's Hospital - Retreat                             | 1                         | 1                         | 0                        | 0                             |
| Henrico Doctors' Hospital - Forest                              | 3                         | 2                         | 1                        | 0                             |
| Independence Park Imaging                                       | 1                         | 1                         | 0                        | 0                             |
| Virginia Cardiovascular Specialists                             | 1                         | 1                         | 0                        | 0                             |
| Johnston-Willis Hospital <sup>7</sup>                           | 4                         | 3                         | 1                        | 0                             |
| Richmond Ear, Nose & Throat                                     | 1                         | 1                         | 0                        | 0                             |
| Richmond Eye & Ear Healthcare Alliance d/b/a Medarva Healthcare | 1                         | 1                         | 0                        | 0                             |
| Richmond Radiation Oncology Center                              | 1                         | 0                         | 1                        | 0                             |
| Scott's Addition ER <sup>8</sup>                                | 0                         | 0                         | 0                        | 0                             |
| Short Pump, LLC <sup>9</sup>                                    | 0                         | 0                         | 0                        | 0                             |
| Swift Creek ER  | 1                         | 1                         | 0                        | 0                             |
| VCU Health Neuroscience, Orthopedic and Wellness Center         | 1                         | 1                         | 0                        | 0                             |
| VCU Massey Cancer Center at Hanover Medical Park                | 1                         | 0                         | 1                        | 0                             |
| VCU Health System <sup>10</sup>                                 | 10                        | 8                         | 1                        | 1                             |
| VCU Medical Center Adult Outpatient Pavilion <sup>11</sup>      | 1                         | 1                         | 0                        | 0                             |
| VCU Medical Center at Stony Point Radiology                     | 1                         | 1                         | 0                        | 0                             |
| VCU Health Emergency Center at New Kent                         | 1                         | 1                         | 0                        | 0                             |
| Vibra Hospital of Richmond LLC                                  | 1                         | 1                         | 0                        | 0                             |
| Virginia Cancer Institute - Harbourside                         | 1                         | 1                         | 0                        | 0                             |
| Virginia Cancer Institute - Discovery Drive                     | 1                         | 1                         | 0                        | 0                             |
| Virginia Ear Nose & Throat - Chesterfield                       | 1                         | 1                         | 0                        | 0                             |
| Virginia Ear Nose & Throat - Henrico                            | 1                         | 1                         | 0                        | 0                             |
| Virginia Urology  | 2                         | 2                         | 0                        | 0                             |
| West Creek Medical Center <sup>12</sup>                         | 1                         | 1                         | 0                        | 0                             |
| <b>Total PD 15 CT Scanners</b>                                  | <b>59</b>                 | <b>52</b>                 | <b>5</b>                 | <b>2</b>                      |

Source: DCOPN Records

<sup>1</sup> COPN No. VA-04656, operational 5/12/2022.

<sup>2</sup> COPN No. VA-04743, operational 5/3/2021; relocated CT from Bon Secours Imaging Center Innsbrook.

<sup>3</sup> COPN No. VA-04683; added intraoperative CT Scanner 3/9/2021.

<sup>4</sup> Did not report data to VHI in 2021.

<sup>5</sup> COPN No. VA-04655; not yet operational.

<sup>6</sup> Did not report data to VHI in 2021.

<sup>7</sup> COPN No. VA-04657; 3rd CT Scanner added at Brain and Spine Center on JWH campus, operational 5/1/2021.

<sup>8</sup> COPN No. VA-04811; to relocate CT Scanner from West Creek Medical Center; not yet operational.

<sup>9</sup> COPN No. VA-04823; to relocate CT Scanner from Independence Park Imaging; not yet operational.

<sup>10</sup> COPN No. VA-04760; additional CT Scanner dedicated to pediatric care; not yet operational.

<sup>11</sup> COPN No. VA-04717; not yet operational. & <sup>12</sup> COPN No. VA-04179; operational and relocating to Scott's Addition ER.

### Magnetic Resonance Imaging (MRI) Background

An MRI is a noninvasive medical imaging test that produced detailed images of almost every internal structure in the human body, including organs, bones, muscles and blood vessels; the images are created using a large magnet and radio waves, and no radiation is produced.<sup>3</sup> An MRI may be used instead of a CT scan when organs or soft tissue are being studied as MRI is better at distinguishing between types of soft tissues and normal and abnormal soft tissues.<sup>4</sup>

**Table 6. VHI 2021 MRI Utilization, PD 15**

| Facility Name  | Total Fixed Units | Total Mobile Units | Total MRI Procedures | MRI Procedures/Scanner | Utilization  |
|--|-------------------|--------------------|----------------------|------------------------|--------------|
| <b>Acute Hospitals</b>                               |                   |                    |                      |                        |              |
| Bon Secours Memorial Regional Medical Center         | 2                 | 0                  | 9,917                | 4959                   | 99.2%        |
| Bon Secours Richmond Community Hospital              | 1                 | 0                  | 961                  | 961                    | 19.2%        |
| Bon Secours St. Francis Medical Center               | 1                 | 1                  | 6,357                | 6357                   | 127.1%       |
| Bon Secours St. Mary's Hospital                      | 3                 | 0                  | 13,856               | 4619                   | 92.4%        |
| Chippenham Hospital                                  | 1                 | 0                  | 6,467                | 6467                   | 129.3%       |
| Henrico Doctors' Hospital - Forest                   | 2                 | 0                  | 5,189                | 2595                   | 51.9%        |
| Henrico Doctor's Hospital - Parham Doctors' Hospital | 1                 | 0                  | 2,419                | 2419                   | 48.4%        |
| Henrico Doctor's Hospital - Retreat                  | 1                 | 0                  | 1,095                | 1095                   | 21.9%        |
| Johnston-Willis Hospital                             | 3                 | 0                  | 13,679               | 4560                   | 91.2%        |
| VCU Medical Center <sup>1</sup>                      | 6                 | 0                  | 19,820               | 3303                   | 66.1%        |
| <b>PD 15 Acute Hospital Total and Average</b>        | <b>21</b>         | <b>1</b>           | <b>79,760</b>        | <b>3798</b>            | <b>76.0%</b> |
| <b>Freestanding</b>                                  |                   |                    |                      |                        |              |
| Bon Secours Imaging Center at Reynolds Crossing      | 2                 | 0                  | 4,029                | 2015                   | 40.3%        |
| Bon Secours Imaging Center Innsbrook                 | 1                 | 0                  | 1,251                | 1251                   | 25.0%        |
| Bon Secours Midlothian Imaging Center                | 1                 | 0                  | 1,362                | 1362                   | 27.2%        |
| Bon Secours Westchester Imaging Center               | 1                 | 0                  | 2,917                | 2917                   | 58.3%        |
| Chesterfield Imaging                                 | 1                 | 0                  | 3,390                | 3390                   | 67.8%        |
| Ellen Shaw De Paredes Institute for Women's Imaging  | 1                 | 0                  | 1,225                | 1225                   | 24.5%        |
| Independence Park Imaging                            | 1                 | 0                  | 3,484                | 3484                   | 69.7%        |
| MEDARVA Imaging                                      | 1                 | 0                  | 371                  | 371                    | 7.4%         |
| NOW Neuroscience, Orthopaedic and Wellness Center    | 1                 | 0                  | 4,709                | 4709                   | 94.2%        |
| OrthoVirginia - Johnston-Willis                      | 0                 | 1                  | 4,616                | 4616                   | 92.3%        |
| OrthoVirginia MRI - Parham                           | 1                 | 0                  | 5,015                | 5015                   | 100.3%       |
| Tuckahoe Orthopaedics MRI                            | 1                 | 0                  | 3,950                | 3950                   | 79.0%        |
| VCU Medical Center at Stony Point Radiology          | 1                 | 0                  | 4,540                | 4540                   | 90.8%        |
| Virginia Urology                                     | 0                 | 1                  | 2,678                | 2678                   | 53.6%        |
| <b>PD 15 Freestanding Total and Average</b>          | <b>13</b>         | <b>2</b>           | <b>43,537</b>        | <b>3349</b>            | <b>67.0%</b> |
| <b>Total and Average PD 15</b>                       | <b>34</b>         | <b>3</b>           | <b>123,297</b>       | <b>3626</b>            | <b>72.5%</b> |

Source: VHI 2021

<sup>1</sup>VCU has one pediatric and one MRI-equipped Linear Accelerator not counted here as they available to exclusive populations.

<sup>3</sup> <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/magnetic-resonance-imaging-mri>

<sup>4</sup> Ibid.

### Catheterization Laboratory (Cath Lab) Background

Cath Labs are imperative in treating heart conditions in a minimally invasive manner; tiny flexible tubes, known as catheters, are inserted in the circulatory system to access the heart as an alternative to surgery.<sup>5</sup> Some common Cath Lab procedures are:

- Cardiac coronary angiogram (procedure to evaluate the blood vessels supplying the heart using catheters and x-ray dye)
- Coronary stent placement (a procedure where small metal scaffolds are placed within a blocked artery to keep the artery open)
- Right heart catheterization (a procedure where physicians examine blood flow and pressure filling in the right side of your heart)
- Peripheral angiogram (procedure that evaluates the flow of blood through arteries in the upper extremities, similar to a coronary angiogram)
- Valve replacement (a minimally invasive procedure that implants an artificial valve in your heart to replace a narrowed heart valve)<sup>6</sup>

PD 15 has 26 Cath Labs, and there are 32 within the HPR. The average utilization is 50.73% per lab, or 609 diagnostic equivalent procedures (DEPs) per lab in 2021 (Table 7). The utilization in Table 6 was calculated using the SMFP threshold of 1,200 DEPs.

**Table 7. Cardiac Catheterization Labs 2023 in PD 15 and 2021 VHI Utilization**

| Facility                                     | Cardiac Cath Labs | Diagnostic Equivalent Procedures (DEPs) |              |                  |               |        |        |           | Utilization   |
|--|-------------------|---|--------------|------------------|---------------|--------|--------|-----------|---------------|
|  |                   | Adult Dx                                | Adult Rx     | Adult Same Visit | Adult Total   | Ped Dx | Ped Rx | Ped Total |               |
| Bon Secours Memorial Regional Medical Center | 4                 | 1,202                                   | 77           | 794              | 2,073         |        |        |           | 43.19%        |
| Bon Secours St. Francis Medical Center       | 2                 | 683                                     | 19           | 310              | 1,012         |        |        |           | 42.17%        |
| Bon Secours St. Mary's Hospital              | 4                 | 1,305                                   | 38           | 593              | 1,936         |        |        |           | 40.33%        |
| Chippenham Hospital                          | 6                 | 2,353                                   | 943          | 858              | 4,154         |        |        |           | 57.69%        |
| Henrico Doctors' Hospital--Retreat           | 1                 | -                                       | -            | -                | -             |        |        |           | 0.00%         |
| Henrico Doctors' Hospital--Forest            | 5                 | 1,711                                   | 563          | 521              | 2,795         |        |        |           | 46.58%        |
| VCU Health System                            | 4                 | 3,103                                   | 756          | -                | 3,859         | 8      | 21     | 29        | 80.83%        |
| <b>Total</b>                                 | <b>26</b>         | <b>10,357</b>                           | <b>2,396</b> | <b>3,076</b>     | <b>15,829</b> |        |        | <b>29</b> | <b>50.73%</b> |

Source: 2021 VHI and DCOPN records

<sup>5</sup> Saira Samani, MD. "What Is a Cath Lab?: Ochsner Health." Ochsner Health System. Ochsner Health System, August 5, 2022. <https://blog.ochsner.org/articles/cath-lab-101-behind-the-laboratory-door>.

<sup>6</sup> Ibid.

### Operating Room (OR) Background

Over the past decade, most academic medical centers have experienced increasing demands for surgical services, with the lack of capacity resulting in a bottleneck of patients needing surgery.<sup>7</sup> Covid-19 pandemic restrictions further exacerbated the backlog of patients needing surgery as the triaging and priority levels shifted with the aim of reducing Covid-19 transmission.<sup>8</sup> While these trends have been studied across larger communities (such as national-level sampling), the impacts of the backlog of surgical services ultimately affect the communities at smaller, local levels.

In PD 15, there are 198 general purpose ORs, 150 of which are at acute care hospital settings. Using 2021 VHI reported information, the average acute care hospital OR utilization is 130.1%, but using the 2021 data and the 2023 authorized units (150), the utilization rate would be 121.4%, or 1,942.9 hours of use per OR (**Table 8**). Italicized in **Table 8** are the HDH hospitals in PD 15 and the utilization as of 2021; the utilization of the HDH facilities will be further examined in Required Consideration 3.

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<sup>7</sup> Wick EC, Pierce L, Conte MC, Sosa JA. Operationalizing the Operating Room: Ensuring Appropriate Surgical Care in the Era of COVID-19. *Ann Surg.* 2020 Aug;272(2):e165-e167. doi: 10.1097/SLA.0000000000004003. PMID: 32675528; PMCID: PMC7268856.

<sup>8</sup> Ibid.

**Table 8. PD 15 Operating Room Utilization Rates**

| <b>Acute Care Hospital</b>                            | <b>ORs</b>             | <b>Total Hours</b> | <b>Hours / OR</b> | <b>Utilization Rate</b> |
|---|------------------------|--------------------|-------------------|-------------------------|
| Bon Secours Memorial Regional Medical Center          | 8 <sup>1</sup>         | 26,229             | 2,017.6           | 126.1%                  |
| Bon Secours Richmond Community Hospital               | 3                      | 967                | 322.3             | 20.1%                   |
| Bon Secours St. Francis Medical Center                | 13 <sup>2</sup>        | 21,262             | 1,932.9           | 120.8%                  |
| Bon Secours St. Mary's Hospital                       | 23 <sup>3</sup>        | 46,198             | 2,199.9           | 137.5%                  |
| Chippenham Hospital                                   | 14 <sup>4</sup>        | 19,593             | 1,959.3           | 122.5%                  |
| <i>Henrico Doctor's Hospital - Parham</i>             | <i>11</i>              | <i>10,132</i>      | <i>921.1</i>      | <i>57.6%</i>            |
| <i>Henrico Doctor's Hospital - Retreat</i>            | <i>5</i>               | <i>5,439</i>       | <i>1,087.8</i>    | <i>68.0%</i>            |
| <i>Henrico Doctors' Hospital - Forest</i>             | <i>21</i>              | <i>20,713</i>      | <i>986.3</i>      | <i>61.6%</i>            |
| Johnston-Willis Hospital                              | 16                     | 24,641             | 1,540.1           | 96.3%                   |
| VCU Health System                                     | 36 <sup>5</sup>        | 116,275            | 3,523.5           | 220.2%                  |
| <b>Total GPORs in Acute Care Hospitals</b>            | <b>150<sup>6</sup></b> | 291,449            | 2,081.8           | 130.1%                  |
| <b>Outpatient Surgical Hospital</b>                   |                        |                    |                   |                         |
| American Access Care of Richmond                      | 2                      | 2,194              | 1,097.0           | 68.6%                   |
| Bon Secours Memorial Ambulatory Surgical Center       | 5                      | --                 |                   | 0.0%                    |
| Boulders Ambulatory Surgery Center                    | 3                      | 6,089              | 2,029.7           | 126.9%                  |
| Cataract and Refractive Surgery Center                | 1                      | 2,700              | 2,700.0           | 168.8%                  |
| Colon & Rectal Endoscopy Specialists & Surgery Center | 1                      | --                 |                   | 0.0%                    |
| Skin Surgery Center of Virginia                       | 2                      | 1,289              | 644.5             | 40.3%                   |
| St. Mary's Ambulatory Surgery Center                  | 4                      | 7,307              | 1,826.7           | 114.2%                  |
| MEDARVA Stony Point Surgery Center                    | 6                      | 9,601              | 1,600.2           | 100.0%                  |
| MEDARVA Surgery Center at West Creek                  | 2                      | 3,500              | 1,750.0           | 109.4%                  |
| Urosurgical Center of Richmond                        | 3                      | 6,997              | 2,332.3           | 145.8%                  |
| VSA Vascular Center                                   | 2                      | --                 |                   | 0.0%                    |
| VCU Health Courthouse Landing Pavilion                | 4                      | --                 |                   | 0.0%                    |
| VCU NOW Center  | 6                      | --                 |                   | 0.0%                    |
| VCU Medical Center-Pediatric Outpatient Surgery       | 2                      | --                 |                   | 0.0%                    |
| Virginia Eye Institute                                | 5                      | 12,533             | 2,505.6           | 156.6%                  |
| <b>Total GPORs in Outpatient Surgical Hospitals</b>   | <b>48<sup>7</sup></b>  | 52,210             | 1,864.6           | 116.5%                  |
| <b>GPORs in PD 15</b>                                 | <b>198<sup>8</sup></b> | 343,659            | 2,045.6           | 127.8%                  |

**Source:** DCOPN Records and VHI Data

<sup>1</sup> 2021 VHI Data includes Bon Secours Memorial Ambulatory Surgical Center operating hours. The 2023 total for Bon Secours Memorial is 8 for the acute care hospital and 5 for the ambulatory surgical center.

<sup>2</sup> 2021 VHI data accounts for 11 ORs. Utilization for this hospital has been calculated with 11 ORs.

<sup>3</sup> 2021 VHI data accounts for 21 ORs. Utilization for this hospital has been calculated with 21 ORs.

<sup>4</sup> 2021 VHI data accounts for 10 ORs. Utilization has been calculated with 10 ORs.

<sup>5</sup> 2021 VHI data accounts for 33 ORs. Utilization for this hospital has been calculated with 33 ORs.

<sup>6</sup> 2021 VHI data accounts for 140 acute care ORs.

<sup>7</sup> The calculations were performed using the 28 VHI 2021 ORs.

<sup>8</sup> The calculations were performed using the 2021 VHI 168 ORs.

For all general purpose ORs in PD 15, the average utilization rate is 127.8% using 2021 VHI reported volume, but using 2023 authorized ORs (199), the average utilization rate would be 107.9%, or 1,726.9 hours of use per OR. For further clarification, the standard of 1,600 hours outlined in the SMFP is established from calculating an OR being in use for 80% of a 40-hour work week, for 50 weeks of the year.



### Hospital-Specific Background

Hospitals are a tool within a larger health system concentrating scarce resources to respond efficiently to population health needs, provides continuous availability of services for acute and chronic conditions, and provide a key role in supporting other healthcare providers and for community outreach and home-based services.<sup>9</sup>

The average occupancy rate in HPR IV per licensed bed is 56.75% for 2021, which is slightly less than the statewide average occupancy rate per licensed bed of 59.88% (Table 9). HDH, the sole owner of the proposed Ashland Hospital, has an average occupancy rate of 39.66%, ranging from occupancy rates of 58.39% at HDH-Forest and 14.09% at HDH-Retreat.

**Table 9. 2021 Occupancy Rates per Licensed Bed in HPR IV**

| Facility Name   | Licensed Beds (LB) | Staffed Beds   | LB Available Days | Patient Days     | Occupancy Rate per LB |
|---|--------------------|----------------|-------------------|------------------|-----------------------|
| Bon Secours Memorial Regional Medical Center                | 225                | 225            | 91,866            | 69,749           | 75.92%                |
| Bon Secours Richmond Community Hospital                     | 104                | 99             | 37,960            | 13,297           | 35.03%                |
| Bon Secours Southern Virginia Medical Center                | 80                 | 73             | 29,200            | 4,565            | 15.63%                |
| Bon Secours Southside Medical Center                        | 300                | 300            | 113,766           | 63,080           | 55.45%                |
| Bon Secours St. Francis Medical Center                      | 130                | 130            | 56,029            | 40,995           | 73.17%                |
| Bon Secours St. Mary’s Hospital                             | 391                | 391            | 162,060           | 106,024          | 65.42%                |
| Centra Southside Community Hospital                         | 116                | 98             | 46,720            | 14,076           | 30.13%                |
| Chippenham Hospital   | 464                | 450            | 187,610           | 126,140          | 67.24%                |
| Cumberland Hospital for Children and Adolescents            | 78                 | 78             | 28,470            | 17,221           | 60.49%                |
| Encompass Health Rehab Hosp of Petersburg                   | 64                 | 64             | 23,360            | 12,443           | 53.27%                |
| Encompass Health Rehab Hosp of Virginia                     | 40                 | 40             | 14,600            | 11,859           | 81.23%                |
| <b>Henrico Doctors’ Hospital – Forest</b>                   | <b>340</b>         | <b>333</b>     | <b>155,490</b>    | <b>90,796</b>    | <b>58.39%</b>         |
| <b>Henrico Doctor’s Hospital – Parham Doctors’ Hospital</b> | <b>200</b>         | <b>141</b>     | <b>73,000</b>     | <b>33,954</b>    | <b>46.51%</b>         |
| <b>Henrico Doctor’s Hospital – Retreat</b>                  | <b>227</b>         | <b>78</b>      | <b>82,855</b>     | <b>11,676</b>    | <b>14.09%</b>         |
| John Randolph Medical Center                                | 147                | 124            | 53,802            | 32,524           | 60.45%                |
| Johnston-Willis Hospital                                    | 294                | 286            | 122,275           | 81,014           | 66.26%                |
| Poplar Springs Hospital                                     | 208                | 173            | 75,920            | 41,759           | 55.00%                |
| Sentara Halifax Regional Hospital                           | 192                | 61             | 71,540            | 12,801           | 17.89%                |
| Sheltering Arms Institute                                   | 114                | 97             | 41,610            | 33,794           | 81.22%                |
| VCU Community Memorial Hospital                             | 70                 | 70             | 29,200            | 15,966           | 54.68%                |
| VCU Medical Center  | 837                | 782            | 305,870           | 247,823          | 81.02%                |
| Vibra Hospital of Richmond LLC                              | 60                 | 46             | 15,756            | 15,756           | 100.00%               |
| <b>HPR IV Total</b>   | <b>213-avg</b>     | <b>188-avg</b> | <b>82,680</b>     | <b>49,878</b>    | <b>56.75%</b>         |
| <b>Virginia Total</b>                                       | <b>19,537</b>      | <b>17,891</b>  | <b>7,577,779</b>  | <b>4,537,513</b> | <b>59.88%</b>         |

Source: VHI 2021 Data and DCOPN Records

### Proposed Project

HDH proposes to establish an acute care hospital in Ashland with 60 inpatient beds, 4 general purpose operating rooms (“OR”), 1 computed tomography (“CT”) scanner, 1 magnetic resonance imaging (“MRI”) scanner, and 1 cardiac catheterization lab (“Cath Lab”). Of the 60 inpatient beds, 54 will be medical/surgical beds and 6 will be intensive care unit (“ICU”) beds. The inpatient beds

<sup>9</sup> [https://www.who.int/health-topics/hospitals#tab=tab\\_1](https://www.who.int/health-topics/hospitals#tab=tab_1)

and Cath Lab will be relocated from Retreat Doctors' Hospital ("Retreat") in PD 15. HDH plans to relocate the 4 ORs from one or more HCA facilities in PD 15, but the decision regarding the specific location from which they will originate will not be made until closer to the date Ashland Hospital opens, based on utilization during that time period. The CT and MRI units will be new inventory to the PD.

The proposed property is a 39.17-acres parcel of land in Ashland, Virginia, that is currently zoned as a combination of B-3 (General Business District) and A-1 (Agricultural District). The applicant will propose to rezone the property to either a B-3 General Business District or a B-2 Community Business District. This proposal for rezoning is consistent with Hanover County's future land use plan, designating the property for business or industrial land use.

HDH anticipates the proposed project will be constructed with energy and logistical efficiency, taking advantage of current technologies to increase patient comfort and satisfaction while being environmentally conscious. Furthermore, the applicant asserts the project will meet or exceed requirements for all applicable building codes.

Ashland Hospital will operate as a fourth campus of HDH. The target opening is projected to be 49 months after COPN issuance. The total capital and financing costs are estimated to be \$233,633,000, with \$219,133,000 of the total cost being dedicated to the new construction costs. The project will be funded entirely through internal resources of HCA Healthcare, Inc.

### **Project Definition**

Section 32.1-102.1:3 of the Code of Virginia defines a project, in part, as the "[e]stablishment of a medical care facility described in subsection A..., [which consists of] [a]ny facility; licensed as a hospital, as defined in § 32.1-123...[requiring the] [r]elocation of beds from an existing medical care facility described in subsection A to another... specialized center ... developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, [or] magnetic resonance imaging (MRI)."

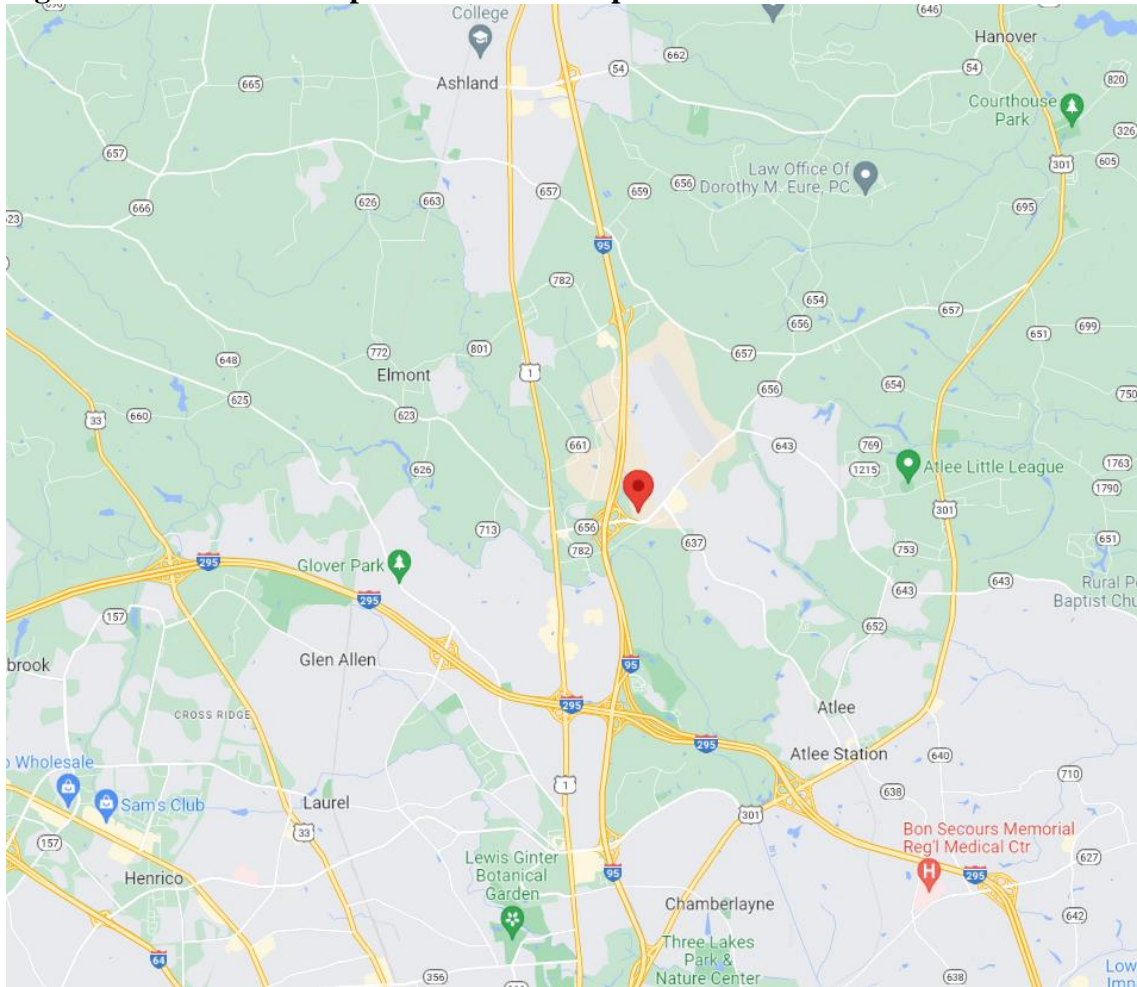
### **Required Considerations -- § 32.1-102.3, of the Code of Virginia**

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable.

- 1. The extent to which the proposed service or facility will provide or increase access to needed services for residents of the area to be served, and the effects that the proposed service or facility will have on access to needed services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.**

Ashland Hospital will be located less than 1 mile off of Interstate 95 and approximately 3 miles from Interstate 295, making it easily accessible for travelers and residents in the area, including emergency vehicles (**Figure 1**).

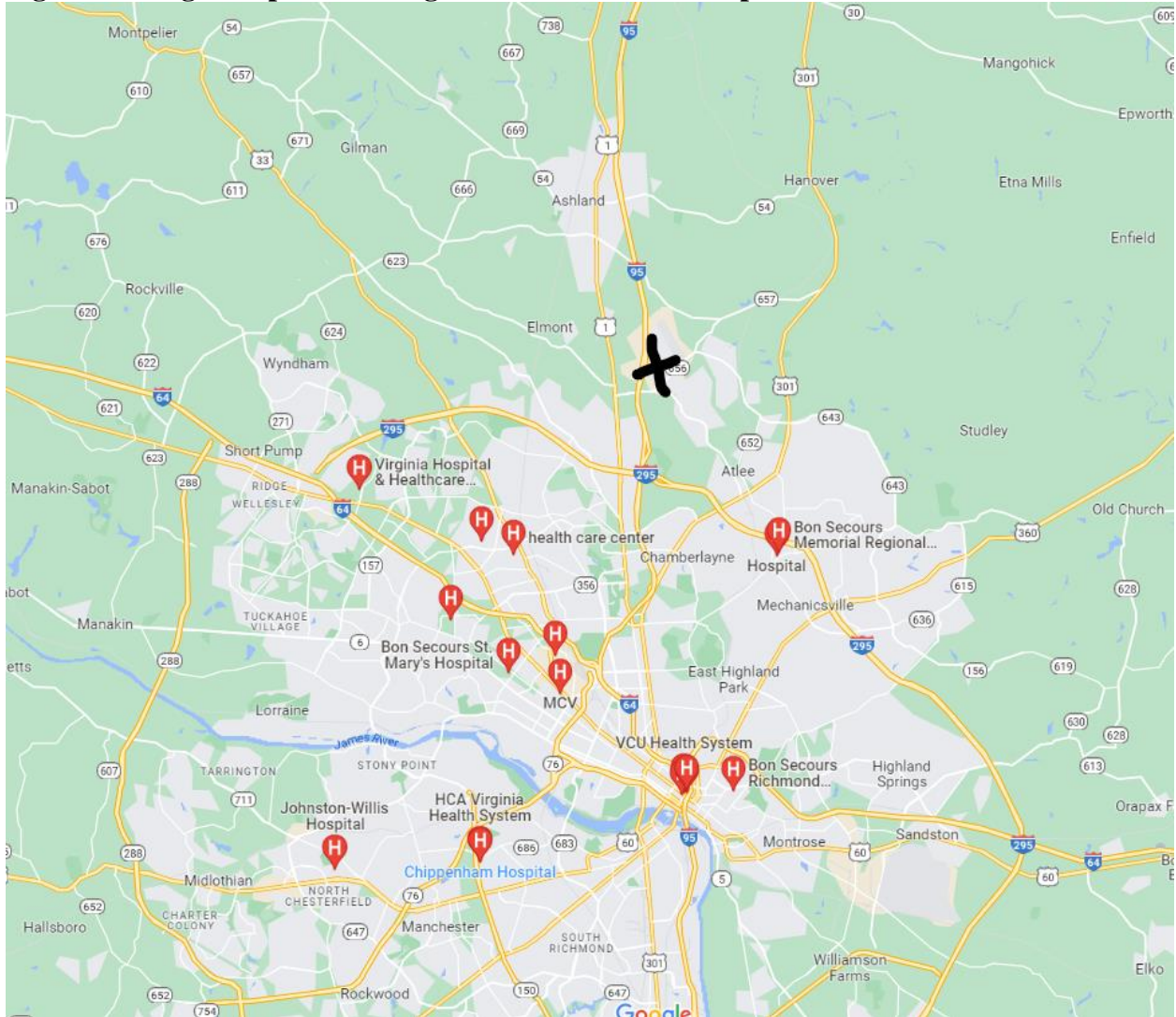
**Figure 1. Location of Proposed Ashland Hospital Site**



Source: COPN Req. VA-8687 provided address and Google Maps

**Figure 2**, below, illustrates hospitals in the greater Richmond area via Google Maps, with a black “X” indicating the approximate site of the proposed Ashland Hospital. As depicted below, Ashland Hospital would be the most northern hospital available in the greater Richmond area.

**Figure 2. Google Maps Rendering of Richmond Area Hospitals**

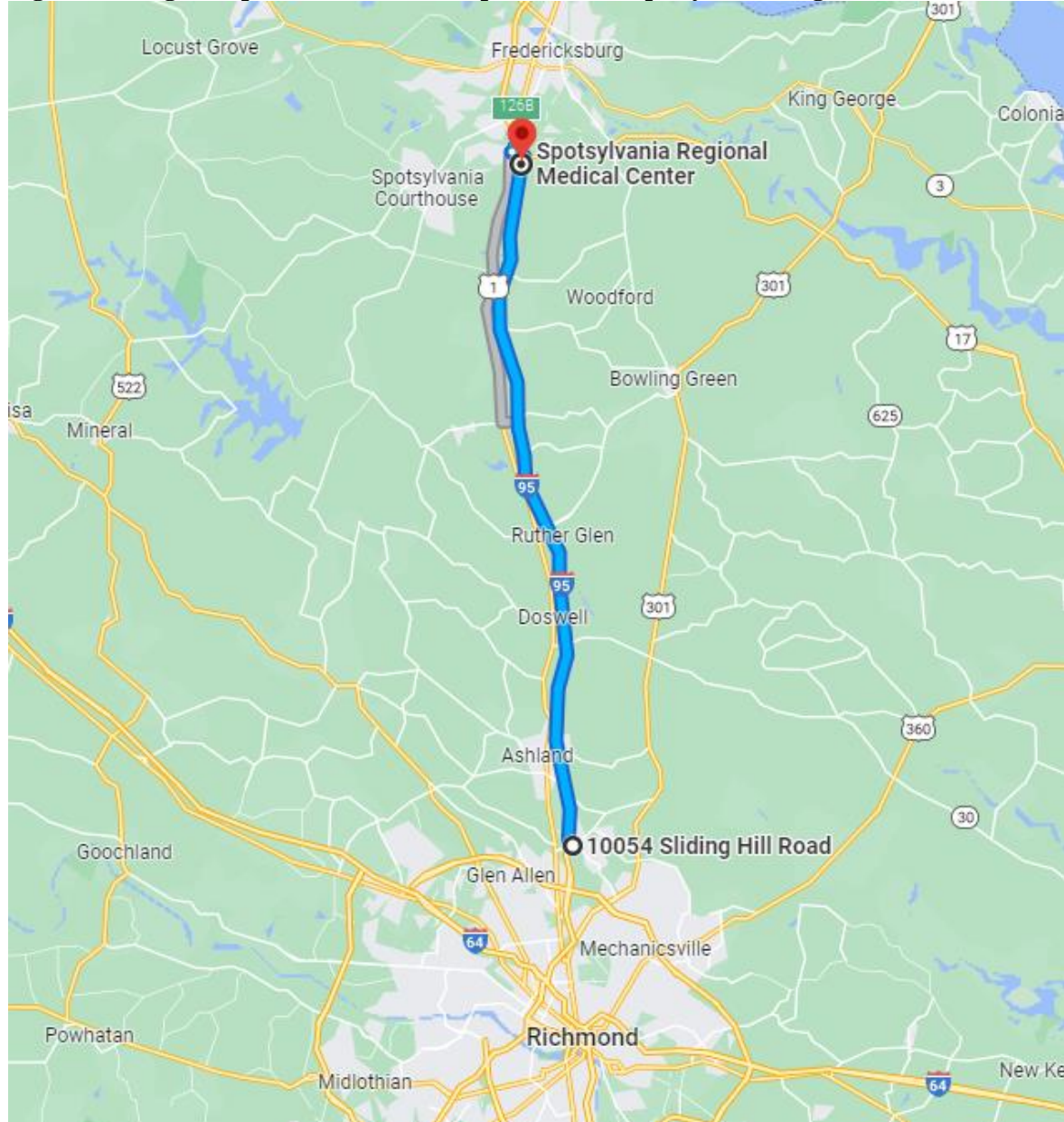


Source: Google Maps

*\*Note: although Google Maps indicates Virginia Hospital & Healthcare Association is a Hospital, it is not.*

**Figure 3** shows the travel path from the next closest hospital north of the proposed site, Spotsylvania Regional Medical Center. The drive time is approximately 40 minutes, or 42 miles from the proposed site to Spotsylvania Regional Medical Center.

**Figure 3. Google Maps Distance from Proposed Site to Spotsylvania Regional Medical Center**



Source: Google Maps

GRTC Transit System, the Richmond area public transportation system, does not provide transport to the proposed location. However, Hanover Dash is a service in Hanover County for individuals 65+ or disabled who can pay a flat \$6.00 rate for a one-way ride for medical appointments, shopping needs, employment, recreation, and Hanover government buildings. Hanover Dash covers the entire County and a 7-mile extension beyond the County's boundaries; the ride must begin or end within Hanover County's boundaries.<sup>10</sup>

<sup>10</sup> <https://www.hanovercounty.gov/1000/HanoverDASH>

Hanover County’s poverty rate is 5.2%, compared to the PD 15-wide average of 10.1% and the statewide average of 10.7% (Table 2). South of the proposed site, Richmond City’s poverty rate is 24.5% (Table 2). According to Google Maps, Richmond City’s center is approximately 12.6 miles from the proposed site, with Richmond City’s borders being closer.

Seniors, identified as those aged 65 and older, are more likely to use emergency services than younger individuals.<sup>11</sup> Between 2020 and 2030, Hanover County is projected to see the 65+ cohort population grow by 5.38%, and neighboring Henrico County and Richmond City’s 65+ cohort to grow by 13.58% and 22.82%, respectively.

The projected primary service area (PSA) of Ashland Hospital is comprised of 43.7% Henrico County, 20.6% Hanover County, 7.5% Richmond City, 3.9% Caroline County, and 24.3% Other residents (the “Other” category is not further defined by the applicant).

**2. The extent to which the project will meet the needs of the residents of the area to be served, as demonstrated by each of the following:**

**(i) The level of community support for the project demonstrated by citizens, businesses, and governmental leaders representing the area to be served.**

Section 32.1-102.6 B of the Code of Virginia directs DCOPN to hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city in the case of competing applications, or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public. COPN Request No. VA-8687 is not competing with another project in this batch cycle and DCOPN did not receive a request to conduct a public hearing for the proposed project. Thus, no public hearing was held.

DCOPN received many letters of support for the proposed project from a variety of sources. These letters articulate several benefits attributed to the project, including:

| Entity  | Main Arguments for Support  |
|---|---|
| Radiology Associates of Richmond, INC.        | Radiology Associates of Richmond (RAR) staffs MRI and CT services at HDH facilities and will continue providing physician coverage and medical direction at the Ashland Hospital. The project will allow RAR to improve access to high quality CT and MRI services as the Ashland Hospital will be convenient to Hanover County and surrounding communities’ patients.  |
| Henrico Cardiology Associates (HCA affiliate) | Dr. Robert Levitt, M.D. will serve as the medical director of cardiac Cath lab services at Ashland Hospital. This project will benefit his patients by offering acute care facility with emergency services, surgical services, advanced diagnostic imaging, and cardiac Cath lab services closer to where they work and live. Cardiovascular disease is the leading cause of death in the United States, with many patients not being aware they have heart disease until they are in the ER for pain or other symptoms. Ashland Hospital will improve access to care for existing HDH patients and continue HDH’s long-standing tradition for exceptional care. |
| Hanover County Board of Supervisors           | Hanover County is in support of Ashland Hospital and the COPN and land use/zoning process will happen concurrently. Hanover County will consider evaluation on traffic impacts, access  |

<sup>11</sup> Park JM, Sohn A. Predictors Affecting the Elderly's Use of Emergency Medical Services. *Osong Public Health Res Perspect.* 2020 Aug;11(4):209-215. doi: 10.24171/j.phrp.2020.11.4.10. PMID: 32864312; PMCID: PMC7442443.

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|  | <p>reviews and mitigation strategies as identified, any known environmental impacts, and any additional raised concerns. The location for Ashland Hospital is off of Exit 86 on Interstate 95, making it accessible for both residents and travelers.</p> <p>The distance of travel during an emergency between Ashland Hospital and other HDH or other hospitals could determine whether or not a patient survives and sees their family again. Ambulances from Hanover County must travel via Interstate 95 and State Routes 1 and 301 to reach Richmond area hospitals, often during high traffic congestion. In addition to increasing timelier access emergency services, Ashland Hospital will afford existing patients of HDH medical care in a location that is much closer to where those patients live and work every day.</p> <p>Hanover County finds it imperative that the County’s healthcare infrastructure grow to continue meeting community demand for high-quality healthcare services.</p>  |
| <p>Hanover County Fire-Emergency Medical Services (EMS)</p>                      | <p>Hanover County operates 16 fire-EMS stations 24 hours a day. The establishment of Ashland Hospital will reduce transport times and enable their EMS units to return to service more quickly, improving care and service for Hanover County residents and those traveling through the County. Each time an ambulance is called into service, it remains dedicated to the call and is unavailable to respond to additional requests. The proposed location will mean EMS crews will be able to get back on the road as soon as possible.</p> <p>One of the most important aspects of providing emergency services is access to emergency medical care and advanced diagnostic imaging, including CT services. For example, with stroke patients, tissue plasminogen activator, tPA, is an effective treatment for ischemic stroke when administered within an hour of the onset of a stroke. However, tPA cannot be administered to patients with a hemorrhagic (bleeding) stroke as tPA would make the bleeding worse. Having timely access to emergency services with a CT scanner allows for the type of stroke to be determined quickly, and tPA to be administered if appropriate, reducing long term functional deficits caused by stroke.</p> |
| <p>Caroline County Fire-Rescue and Emergency Management (FREM)</p>               | <p>Caroline County FREM is a combination volunteer and career fire and rescue service, operating 8 stations in Caroline County. Ashland Hospital will help them provide emergency medical services in a timely, cost-effective manner by reducing transport times and allowing squads to return and be available for the next patient in need of assistance. CT imaging, one of the services Ashland Hospital will have with which to provide comprehensive care, is an indispensable tool in the diagnosis and treatment of many emergency medical conditions, such as stroke.</p>   |
| <p>Del. Hyland F. Fowler, Jr.,<br/>Member of the Virginia House of Delegates</p> | <p>Ashland is a rapidly growing community in need of more infrastructure for healthcare services. The proposed Ashland Hospital will improve residents’ access to health care while also creating new jobs. Transportation for EMS in the area are often delayed by high traffic congestion; Ashland Hospital will help mitigate this concern.</p>  |
| <p>Anthem, and its affiliate Healthkeepers, Inc.</p>                             | <p>Approval of the Ashland Hospital project is essential to the well-being of the people of Hanover County. Ashland and the surround area is a rapidly growing community and needs greater healthcare infrastructure. Ashland Hospital will improve access to convenient and timely care for residents in the area as well as travelers. Ashland Hospital will help ensure immediate availability of emergency, surgical, ICU, cardiac Cath lab, and diagnostic imaging services that is critical for patients who would otherwise travel much farther for the same services, which may have an impact on patient outcomes. Anthem supports the Ashland Hospital project for its ability to increase access to care, promote cost effectiveness, improve health outcomes, and provide greater choice for the community.</p>   |
| <p>OrthoVirginia’s President, David Nedeff, M.D.</p>                             | <p>With more than 100 orthopedic specialists in over 30 locations across the Commonwealth, OrthoVirginia is the Commonwealth’s largest provider of orthopedic medicine and therapy. HDH is an invaluable partner in achieving their goals of striving to set the standard of excellence for patient-centered, high-quality care. Timely-rendered care for orthopedic emergencies is critical for optimal patient outcomes. MRI and CT imaging are critical to orthopedic surgery, depicting bones, joints, and surrounding soft tissue for the surgeon to evaluate for infection, defects, or structural damage. In addition to imaging services, Ashland Hospital’s general purpose operating</p>  |

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|  | rooms will bolster their ability to provide timely care to many patients who live in the Ashland area who rely on OrthoVirginia for life-changing orthopedic surgery.   |
| Virginia Urology’s President, C. Ryan Barnes, M.D.                           | Virginia Urology supports Ashland Hospital’s establishment as it will be an appropriately sized inpatient hospital providing locally available operating rooms and MRI and CT imaging, which are all needed for providing care for their patients.  |
| Virginia Physicians, Inc.’s President, Patrick M. Woodward, M.D.             | Virginia Physicians, Inc. supports this project as the establishment of Ashland Hospital will bring tremendous benefit to our many patients in the area who choose HDH for their care. HDH is a steadfast partner in achieving Virginia Physician Inc.’s goal to provide prompt, efficient, and cost-conscious care for their patients.   |
| Tucker Cardiology Associates, P.C., Stanley C. Tucker, M.D., FACC, FACP      | Dr. Tucker supports this project as it will significantly benefit many of his patients by offering an acute care facility closer to their homes in an area where traffic congestion impeded timely access to critical healthcare services in other areas.<br><br>Cardiovascular disease us a leading cause of death in the United States, and close, convenient access to emergency services is essential to help these patients and give them the best chance for a full and successful recovery. PA [photoacoustic] imaging, MRI imaging, and cardiac Cath lab services are critical tools to diagnose and treat a variety of emergency heart conditions.                                     |
| Nephrology Specialists, P.C., Walid G. Abou Assi, M.D.                       | Dr. Abou Assi supports the project as it will bring tremendous benefit to their patients. CT imaging, for example, is invaluable to the nephrologist as it allows them to examine the kidneys for conditions such as tumors or lesions, obstructive conditions like kidney stones, congenital anomalies or structural defects, polycystic kidney disease, and a host of other conditions. Ashland Hospital’s general purpose operating rooms and inpatient beds will provide their patients with an option much closer to home than HDH in the event they must undergo a nephrectomy or other surgical procedure or must be hospitalized for acute kidney failure or other emergent conditions. |
| CrossOver Healthcare Ministry’s CEO, Julie Bilodeau                          | CrossOver Healthcare Ministry supports the project as Ashland Hospital will ensure immediate availability of a general acute care facility offering emergency, surgical, intensive care, cardiac Cath, and diagnostic imaging services. CrossOver Healthcare Ministry’s mission is to provide high-quality compassionate and comprehensive healthcare services to the uninsured and patients enrolled in Medicaid, of which HDH has been a steadfast partner in caring for their patients.  |
| HDH Executive Committee of the Medical Staff                                 | The HDH Executive Committee of the Medical Staff voted unanimously in favor in support of establishing Ashland Hospital. Ashland Hospital will help ensure immediate availability of a general acute care facility offering emergency, surgical, intensive care, cardiac Cath, and diagnostic imaging services. Additionally, having emergency services and access to imaging needed for life-saving measures closer to the proposed location’s surrounding population will be beneficial in reducing the time for care that is often impacted by traffic conditions in the area.   |
| King William Fire and Emergency Services Department                          | Ashland Hospital will offer a new access point for King William County residents who live closer to the Ashland Hospital site but would otherwise drive or be transported to another HDH campus. King William Fire and EMS operates 3 fire and EMS stations 24 hours a day. Adding a new access point for emergency services saves lives. For many medical conditions, such as stroke, receiving emergency medical care and advanced diagnostic imaging makes the difference in life or death or a successful recover versus a lifetime of disability.  |
| Del. Scott A. Wyatt, Virginia House of Delegates – 97 <sup>th</sup> District | Delegate Wyatt supports the project due to the rapid commercial and residential growth in the area creating a need for more infrastructure and health care services. The proposed location will be easily accessible for existing HDH patients and for EMS providers and travelers passing through the area. Currently, EMS crews struggle with traffic congestion and patient transports.  |
| Steven P. Trivett, Mayor of the Town of Ashland                              | The Town of Ashland supports the Ashland Hospital project due to the rapid commercial and residential growth in the area creating a need for more infrastructure and health care services. The proposed location will be easily accessible for existing HDH patients and for EMS providers and travelers passing through the area. Currently, EMS crews struggle with traffic congestion and patient transports.  |
| Richmond Heart and Vascular Associates (RHV)                                 | RHV supports the Ashland Hospital project. Cardiovascular disease is the leading cause of death in the Unites States; timely access to CT scans are vital to determining whether there is a cardiothoracic emergency. For many cardiothoracic conditions, minutes matter and any delay in   |



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|   | diagnosis and treatment could lead to a catastrophic outcome. Improving access to an emergency department will save lives.  |
| King William County Board of Supervisors                      | King William County strives to ensure each individual receives the emergency medical services they need and deserve, regardless of where they are when a critical situation arises. Ashland Hospital will help us achieve this goal by reducing transport times and allowing our squads to get back on the road faster, ready to address the next medical emergency. Adding a new access point for emergency medical services saves lives.  |
| Mechanicsville Medical Center Family Practice (MMCFP)         | The establishment of Ashland Hospital will improve access to convenient and timely care for MMCFP patients living in Hanover County and the surrounding communities who must currently travel to HDH for treatment. Ashland Hospital will provide an option for comprehensive care that is closer to home, allowing for the close contact with family and friends that is so vital to recovery. Improving access to comprehensive healthcare resources at Ashland Hospital will encourage patients to receive care sooner. Many patients, especially the elderly population, will delay or forego care altogether when the distance and time involved in seeking care are too great. The delay causes disease progression, poorer patient outcomes, more extensive treatment for the patient, longer recovery times, and higher costs to the patient and health system.   |
| Legacy Care   | Legacy Care supports this project as the establishment of Ashland Hospital will bring tremendous benefit to our many patients in the area who choose HDH for their care. Access to comprehensive healthcare is a critical component of caring for the elderly, as this patient population is more likely to require hospitalization and is more susceptible to conditions that require hospital resources to adequately address, even when treating such conditions is planned.   |
| HDH Emergency Medicine Medical Director, Deborah Vinton, M.D. | <p>From Dr. Vinton’s experience as a physician, leader, and educator, the construction of Ashland Hospital will significantly benefit patients in our local community by offering an acute care facility at a location closer to where many HDH patients live and work.</p> <p>For many emergency medical conditions, minutes matter. Distance and travel time are key determinatives for the outcomes of emergency medical conditions such as heart attacks, strokes, and infections. For example:</p> <ul style="list-style-type: none"> <li>• Cardiothoracic conditions: CT scans of the chest can differentiate between a pulmonary embolism and another condition, such as pneumonia. CT images are critical in cardiothoracic emergencies. Pulmonary embolism, if missed, can cause a patient’s condition to deteriorate rapidly. Additionally, Covid-19 increases the risk of pulmonary embolism.</li> <li>• CT imaging is also used to diagnose mesenteric ischemia in patients who present with vague abdominal pain that can progress to severe pain rapidly. Mesenteric ischemia is a condition where the patient experiences decreased blood flow to one or both of their intestines, resulting in insufficient oxygenation; without quick intervention, permanent damage or risk of death are possible.</li> <li>• Stroke is the fifth leading cause of death in America. Patients experiencing an acute ischemic stroke (blood clot in the brain, restricting blood flow and depriving areas of the brain of oxygen) require a fast and coordinated response to ensure patients are able to receive tPA. Before administration of tPA, providers must determine whether the stroke is caused by a bleed (cerebral hemorrhage) as giving a patient tPA when they are experiencing a cerebral hemorrhage would make the bleeding worse (increasing pressure in the skull, exacerbating the stroke). CT scanning is instrumental in differentiating between the stroke types and positively impacting patient survival and recovery.</li> <li>• Sepsis is another condition requiring timely intervention and coordinated efforts by clinicians in a short timeframe. Every hour sepsis goes by undetected, the patient’s risk of death increases. Sepsis patients may visit an emergency department with vague symptoms like general weakness, vomiting, shortness of breath, cough, chills, fever, or even just not feeling well. Ashland Hospital would have the resources to perform a comprehensive assessment including routine lab work, urinalysis, blood cultures and lactate levels, and order imaging such as a chest X-ray to quickly diagnose the patient’s condition while aggressively resuscitating the patient with IV fluids and antibiotics.</li> </ul> |

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|  | <p>HCA uses artificial intelligence and algorithms based on patient vital signs, labs, nursing reports, and other data to identify sepsis earlier as the mortality rate associated with sepsis is significant.</p> <ul style="list-style-type: none"> <li>• Many patients, especially older individuals and those who rely on others for transportation, will delay or forego care altogether when a facility is too far away. When patients finally seek care, their condition has progressed, resulting in more extensive treatment, a longer recovery, and higher costs. Ashland Hospital is ideally located to significantly improve patient outcomes by reducing the time it takes patients with emergency medical conditions to access a full-service hospital.</li> </ul>   |
| <p>Hanover County Fire-EMS Chief, Jethro H. Pilland, III, MPA, NRP, FP-C</p> | <p>This letter of support was provided following a DCOPN request for quantified data regarding the transport times.</p> <p>Hanover County has 16 stations that operate 24 hours a day. In 2022, their average transport time from emergency incident scene was approximately 17 minutes. The average time spent at the hospital in 2022 was 45 minutes to include patient transfer and equipment decontamination and restocking. “Ashland Hospital will reduce transport times and enable EMS units to return to service more quickly, improving care and service for Hanover County residents and those traveling through the County.”</p>  |
| <p>King William Fire-EMS, Fire Chief, Stacy G. Reaves</p>                    | <p>This letter of support was provided following a DCOPN request for quantified data regarding the transport times.</p> <p>“...[W]e view Ashland Hospital as being ideally located to reduce EMS transport times and shorten EMS turnaround.” Hanover Fire-EMS also ascertains that Ashland Hospital would be of much greater benefit to patients than a freestanding emergency room. It is “difficult... to quantify precisely” how much Ashland Hospital would reduce average times an EMS unit is out for a call. “[I]t is absolutely our experience that Ashland is a challenging location for EMS service due in no small measure to the chronic traffic congestion in the area and the absence of a nearby hospital.” In medical emergencies, outcomes are highly dependent on how rapidly the patient receives care. “While freestanding emergency rooms can and do play an important role in the healthcare system, there are many medical conditions that require resources that are only available at a hospital.”</p> |

The letters of support sent at the start of the review offer frequent appeal to emotion but offer little information to quantify their statements. DCOPN received two additional letters of support following the department’s request for more quantitative data regarding the difficulties in patients accessing emergency medical services. The Hanover County Fire-EMS letter gave the 2022 average call times, with 45 minutes being the average time at the hospital and 17 minutes for transporting the patient. 17 minutes is slightly more than half the SMFP 30-minutes driving time radius for hospital services.

King William Fire-EMS’ letter regards quantifying the impact Ashland Hospital would have on transport times as “difficult for us to quantify precisely.” However, the average transport time for 2022 could have been provided, which would have allowed for DCOPN to compare in contrast to the time from a relatively highly populated part of the County to the proposed location. Also, important to note, King William is not explicitly listed in the PSA given by the applicant; DCOPN assumes the King William areas may be included in the 24.3% “Other” category provided by the applicant. King William Fire-EMS cites a lack of a “nearby hospital” being a concern but does not address if Bon Secours Memorial Regional Medical Center is unavailable for them to utilize in EMS calls.

Furthermore, using two towns within King William County, Manquin and Beulahville, DCOPN calculated via Google Maps the approximate distances from those two towns to both the proposed location of Ashland Hospital and Bon Secours Memorial Regional Medical Center. The following was found:

|             | Ashland Hospital                     | Memorial Regional Medical Center     |
|-------------|--------------------------------------|--------------------------------------|
| Manquin     | 28 minutes' driving time, 22.4 miles | 20 minutes' driving time, 15.1 miles |
| Beulahville | 33 minutes' driving time, 25.7 miles | 33 minutes' driving time, 27.5 miles |

Memorial Regional Medical Center is closer to Manquin than Ashland Hospital will be and is the same driving time from Beulahville as it would be to Ashland Hospital. This information is contradictory to the support letter.

DCOPN received two letters of opposition for the proposed project from a resident of the local community which articulates areas of concern regarding the project, including:

| Entity  | Main Arguments of Opposition  |                     |              |                   |  |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
|---|---|---------------------|--------------|-------------------|--|-------------------|--|---------------|--------------|--------------|-------------------------|-----|-----|----|--------|-------|------------------------------|-----|-----|---|--------|-------|----------------|-----|-----|----|--------|-------|----------------|-----|----|----|--------|-------|-----------------|------------------------|----|-----|-------|-------------|
| <b>Robin Dean, Hanover County Resident-Totopotomoy of Sliding Hill</b>  | <p>The COPN program was created to control healthcare cost as well as increase access to care. Approving a 60-bed hospital in Hanover County off Sliding Hill with expensive imaging and within 6 miles of another full-service hospital does not seem prudent. A possible better choice of location would be in Western Hanover County.</p> <p>Convenience is certainly not a reason to support a \$233 million project when controlling health care costs continues to be a challenge. Most critical traumas are medivac to appropriate trauma centers. HCA currently has an emergency center on Rt. 301 3 miles from the proposed site.</p> <p>The Sliding Hill location will certainly be an overload for the road. The Fed Ex and soon to be Wegmans' trucks as well as traffic from the Hanover Air Park creates enough issues for residents. The Hanover Community input process never stopped the Wegmans' project, which to this day could have been approved for a better location North of Ashland.</p>  |                     |              |                   |  |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
| <b>VCU Health System Authority (VCUHS), Interim Senior Vice President, VCU Health Sciences, Interim CEO, VCU Health System, Marlon F. Levy, M.D., MBA</b> | <p>Much of the argument HCA makes for Ashland Hospital surround the improved access to inpatient acute care services for existing HDH patients. HDH operates three hospitals within 20 minutes of the proposed site (HDH-Retreat, Parham, and Forest). HCA's application is bereft of support on its claims of improved access, failing to address the proximity of Ashland Hospital to existing HDH hospitals (or existing capacity at those hospitals), as well as to other hospitals in PD 15. HCA has provided no salient information supporting its assertion that existing HDH hospitals are "too far away" for its patients, or that HDH patients are delaying or foregoing care due to any existing barriers to access. Based upon publicly available data regarding inpatient utilization for HCA's inpatient hospitals, the three HDH hospitals in the area are significantly underutilized and appear to have significant capacity available [Table below provided by VCUHS].</p> <p><b>HCA Inpatient Acute Care Hospitals in PD 15</b></p> <table border="1"> <thead> <tr> <th rowspan="2">Acute Care Hospital</th> <th colspan="3">Beds</th> <th rowspan="2">2021 Patient days</th> <th rowspan="2">2021 Occupancy – Operational beds<sup>5</sup></th> </tr> <tr> <th>Licensed beds</th> <th>Staffed beds</th> <th>"Paper beds"</th> </tr> </thead> <tbody> <tr> <td>HCA Chippenham Hospital</td> <td>324</td> <td>310</td> <td>14</td> <td>89,986</td> <td>75.4%</td> </tr> <tr> <td>HCA Johnston-Willis Hospital</td> <td>250</td> <td>242</td> <td>8</td> <td>60,732</td> <td>67.4%</td> </tr> <tr> <td>HCA HDH Forest</td> <td>340</td> <td>247</td> <td>93</td> <td>73,847</td> <td>59.5%</td> </tr> <tr> <td>HCA HDH Parham</td> <td>140</td> <td>81</td> <td>59</td> <td>17,102</td> <td>33.5%</td> </tr> <tr> <td>HCA HDH Retreat</td> <td>207 (-40)<sup>6</sup></td> <td>58</td> <td>149</td> <td>5,997</td> <td>7.9% (9.8%)</td> </tr> </tbody> </table> | Acute Care Hospital | Beds         |                   |  | 2021 Patient days | 2021 Occupancy – Operational beds <sup>5</sup> | Licensed beds | Staffed beds | "Paper beds" | HCA Chippenham Hospital | 324 | 310 | 14 | 89,986 | 75.4% | HCA Johnston-Willis Hospital | 250 | 242 | 8 | 60,732 | 67.4% | HCA HDH Forest | 340 | 247 | 93 | 73,847 | 59.5% | HCA HDH Parham | 140 | 81 | 59 | 17,102 | 33.5% | HCA HDH Retreat | 207 (-40) <sup>6</sup> | 58 | 149 | 5,997 | 7.9% (9.8%) |
| Acute Care Hospital   | Beds  |                     |              | 2021 Patient days | 2021 Occupancy – Operational beds <sup>5</sup> |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
|   | Licensed beds   | Staffed beds        | "Paper beds" |                   |  |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
| HCA Chippenham Hospital   | 324   | 310                 | 14           | 89,986            | 75.4%  |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
| HCA Johnston-Willis Hospital  | 250   | 242                 | 8            | 60,732            | 67.4%  |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
| HCA HDH Forest  | 340   | 247                 | 93           | 73,847            | 59.5%  |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
| HCA HDH Parham  | 140   | 81                  | 59           | 17,102            | 33.5%  |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |
| HCA HDH Retreat   | 207 (-40) <sup>6</sup>  | 58                  | 149          | 5,997             | 7.9% (9.8%)                                    |                   |  |               |              |              |                         |     |     |    |        |       |                              |     |     |   |        |       |                |     |     |    |        |       |                |     |    |    |        |       |                 |                        |    |     |       |             |

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|  | <p>Specifically, HDH Retreat was only at 7.9% in 2021 and has historically hovered below 10%, with only 58 beds of 207 available beds being staffed. Moving 60 beds from Retreat to Ashland Hospital – with existing staff from other HCA facilities- would effectively more than double the number of Retreat’s staffed (operational) beds. Although the beds proposed for Ashland Hospital technically are existing licensed beds, HCA’s application practically seeks the addition of newly staffed and operationalized beds at a brand-new facility proximate to multiple existing HDH facilities with capacity. The Commissioner, recognizing that staffing is the foundation of access and availability, previously expressed concerns- then based on 2017 VHI data- that “of the 355 unstaffed medical/surgical beds licensed to PD 15 acute care hospitals, 352 (99.2%) sit on the license of an HCA hospital.”</p> <p>HCA relied heavily on traffic congestion and travel times in the proposed service area to support a need for its project. HCA cites extensively to certain findings within the Virginia Department of Transportation I-95 Corridor Improvement Plan regarding Hanover County ambulances and residents having to travel this area with traffic congestion and delays. While drive times are relevant to a public need analysis, traffic congestion is not dispositive of need, particularly when accessibility is well within the SMFP’s drive time standard and HCA has not demonstrated any other indicia of need for its proposal. I-295 and I-64 are ignored by the applicant and also provide access for patients. HCA projects to serve at Ashland Hospital vastly more patients from Henrico County and the City of Richmond than from Hanover County. The applicant projects approximately 20.5% of its projected discharges to be residents of Hanover County. Furthermore, it does not appear Ashland Hospital will be on a public transportation route like HDH-Retreat is.</p> <p>HCA has also failed to demonstrate an institutional need for its proposal. HCA asserts the new facility will “better serve patients already seeking care from HDH” but provides no relevant historical data relating to those patients or their use of HDH facilities. The application is devoid of any historical utilization data for HDH overall. Based on the utilization [pictured in the table above], there do not seem to be constraints at HDH hospitals that would justify the establishment of an entirely new hospital to be outfitted with long-unused beds from Retreat. With the information presented on patient data, it is challenging, if not impossible, to quantify the purported improvement in access to patient care for HDH’s patients that could result from approval of the project or how the project will potentially impact existing providers.</p> <p>The lack of historical patient origin data also impedes any evaluation of HCA’s utilization projections for Ashland Hospital. HCA projects a total of 4,134 medical-surgical and ICU discharges for Ashland Hospital in the first year of operation; this volume reflects (i) more than three times the number of medical-surgical and ICU discharged reported at Retreat in 2021, (ii) more than the 2021 volume of medical-surgical and ICU discharges at Parham (4,094), and (iii) 40% of Forest’s 2021 medical-surgical and ICU discharges (10,521). The applicant also neglects to provide data relating to the volumes anticipated to remain at the other HDH locations following operationalization.</p> <p>Given the apparent diminution of services at Retreat, it is difficult to understand how this project could positively impact that facility. Given Retreat’s location and long-time service to the City of Richmond, the impact of the project on Retreat and other providers, including VCUHS, should be carefully considered. HCA projects Ashland Hospital to be by far the busiest of the HDH hospitals, with 69.1% occupancy in year one and 70.5% in year two. For VCUHS, the adverse impact of HCA’s proposal, further reducing Retreat’s already minimally staffed inpatient services in the City of Richmond, where VCUHS remains one of the few inpatient options, could be significant.</p> |
| <p><b><u>Applicant’s Response to VCUHS</u></b></p> | <p>The assertion that the project is “bereft of support” and “lack[s] substantive support” is incorrect as there is extensive support from local governments, members of the General Assembly, EMS providers, area physicians, CrossOver Healthcare Ministry, and Anthem. The application clearly outlines how the population projects were made utilizing only HDH patients, confirming that Ashland Hospital can meet its projections. The assertion that HDH does not have the patient volume to support Ashland Hospital is unfounded.</p> <p>Retreat Hospital’s occupancy rates are irrelevant due to the March 21, 2023, decision issuing COPN VA-04832 to Inova Healthcare Services, the SMFP’s occupancy and needs standards are not applicable to hospital bed relocation projects that do not add to the inventory of hospital beds in the planning district.</p> <p>The beds to be relocated from Retreat to Ashland are in antiquated space that does not meet current design guidelines and is inefficient for the delivery of optimal patient care. The remaining 167 beds will be sufficient to meet the needs</p>   |

of the patients seeking care at Retreat. Rather than diminishing healthcare resources in Richmond, HCA Health Services of Virginia, Inc. is growing them.

**Bon Secours  
 Mercy  
 Health; Mike  
 Lutes,  
 President,  
 Richmond  
 Market**

There is no need for an additional hospital in PD 15 at this time and HCA’s COPN Request No. VA-8687 should be denied. HCA predicates its argument for the need of Ashland Hospital on the alleged improved access to Henrico Doctors’ Hospital patients. However, the applicant fails to provide evidence supporting the difficulties patients are having, aside from the cited I-95 corridor congestion. The applicant does not address the multiple other routes for patients to travel to HDH hospitals (which are also well within a 30-minute drive from the proposed site).

Moreover, each of the HDH hospitals have substantially underutilized capacity; each HDH hospital is staffing fewer beds than are licensed to it. [Bon Secours Mercy Health includes the following tables in their letter of opposition]:

| HDH Acute Care Bed Staffing 2021 <sup>1</sup> |               |              |                        |                  |
|---|---------------|--------------|------------------------|------------------|
|   | Licensed Beds | Staffed Beds | Unstaffed “Paper” Beds | % Unstaffed Beds |
| HDH-Forest                                    | 340           | 247          | 93                     | 27.4%            |
| HDH-Parham                                    | 140           | 81           | 59                     | 42.1%            |
| HDH-Retreat                                   | 207           | 58           | 149                    | 72.0%            |
| HDH Total                                     | 687           | 386          | 301                    | 43.8%            |

| HDH Acute Care Bed Utilization 2021 <sup>2</sup> |               |              |                 |
|--|---------------|--------------|-----------------|
|  | Licensed Beds | Patient Days | Bed Utilization |
| HDH-Forest                                       | 340           | 73,874       | 59.5%           |
| HDH-Parham                                       | 140           | 17,102       | 33.5%           |
| HDH-Retreat                                      | 207           | 5,997        | 7.9%            |
| HDH Total  | 687           | 96,973       | 38.7%           |

None of the VHI 2021 data support HCA’s assertion that the HDH population has difficulty accessing HDH’s inpatient services across its three licensed acute care hospitals or that any need for a fourth hospital exists. With the intention of Ashland Hospital being to redirect patients from other HDH campuses, the utilization of those existing hospitals will decline.

HDH-Retreat, which is slated to convert 40 acute care beds to inpatient psychiatric beds, and which would contribute an additional 60 beds to the proposed Ashland Hospital, would experience annual occupancy of just 15.4% for its remaining 107 acute care beds based on 2021 reported patient days. If patients are redirected from HDH-Retreat to the HCA Ashland Hospital, as appears HCA’s goal, utilization of the remaining 107 acute care beds undoubtedly will be even lower.

HCA should not be permitted to leverage their bed capacity, much of which has long sat unstaffed and unused and exists merely by virtue of the bed count authorized on the face of each HDH hospital’s license, to manufacture a public need for a fourth HCA hospital. Furthermore, the redirection of HDH patient volumes away from what are already three substantially underutilized inpatient hospital campuses will exacerbate the lack of utilization in the other HDH hospitals.

The Ashland Hospital will likely have a substantial negative impact on other existing providers in PD 15, including Bon Secours Memorial Regional Medical Center, in particular. The substantial underutilization of the three existing HDH hospitals, coupled with the lack of evidence to support HCA’s claim that HSH patients have insufficient access to the three existing HDH hospitals, reveal HCA’s project to be a thinly veiled attempt to increase its market share in the greater Richmond area at the direct expense of other providers of inpatient services.

The utilization of inpatient services in the projected PSA for Ashland Hospital is declining, with the projected PSA experiencing a 7.2% decline in inpatient discharges between 2018-2022. The PSA is currently most served by Bon

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|  | <p>Secours Mercy Health hospitals, including Bon Secours Memorial Regional Medical Center, Bon Secours St. Mary's Hospital, and Bon Secours Richmond Community Hospital- more than any other /health system provider of inpatient services in PD 15.</p>   |
| <p><b>Applicant's Response to Bon Secours Letter of Opposition</b></p> | <p>Bon Secours' opposition "mischaracterizes Ashland Hospital's project and wholly ignores the extensive support explaining the many ways in which Ashland Hospital will save lives and improve outcomes." All of the supporters have "submitted detailed letters outlining the many ways why Ashland Hospital is needed."</p> <p>Bon Secours cannot and has not disputed the traffic congestion in the area being a barrier regarding access to care. Of course, there are other roads to travel to HDH hospitals on, but these roads can also experience heavy traffic, particularly when I-95 is experiencing delays.</p> <p>Bon Secours has not disputed that Ashland Hospital will increase access for HDH patients. Bon Secours provides maps indicating Ashland Hospital being center to Bon Secours' primary service area; however, hospital systems overlap, and the location of Ashland Hospital does not mean it will impact Bon Secours. "Many factors, including patient preference, physician recommendation, and insurance contracts, influence decisions about which hospital serves a particular patient for particular services... The 60-bed Ashland Hospital is no threat to the 269-bed Memorial Regional." The assertion that Ashland Hospital's goal to redirect patients from Retreat is mistakenly claimed by Bon Secours. The goal of Ashland Hospital is to better serve patients who have already selected HDH as their preferred provider. "Bon Secours also complains that Retreat Hospital has a low occupancy and the beds to be relocated to Ashland Hospital have not been in use. As confirmed less than a month ago in the March 21, 2023, decision issuing COPN No. VA-04832 to Inova Health Care Services, the SMFP's occupancy and need standards are not applicable to hospital bed relocation projects that do not add to the inventory of hospital beds in the planning district."</p> |

Regarding the letters of opposition and the responses, there is still a clear void regarding quantitative data for the emergency services argument need. The extensive support letters are referenced as answers to the concerns brought forth by the opposition, but the support letters do not provide adequate quantitative reasoning for the public need of the hospital.

Additionally, two main themes for reasons Ashland Hospital have emerged: (1) HDH patients in the Ashland Hospital PSA are not seeking care because the drive to their preferred provider is too long, and (2) local EMS departments find difficulty in transporting patients timely due to the traffic congestion in the area.

The COPN program fundamentally depends on analysis regarding whether there is a public need for COPN regulated services; there are other locations within the PSA also within a 30 minutes' drive (Memorial Regional Medical Center), in addition to the Henrico County HDH hospitals, that HDH patients can go to for non-emergent care if they choose to do so. The support letters in response to DCOPN's request for quantifiable data regarding the traffic affecting patients' transport times do not corroborate the stated difficulties. Moreover, the EMS letters provided to address the data were from Hanover County, anticipated to be 20.6% of the PSA for Ashland Hospital, and King William County, whose portion of the Ashland Hospital PSA is not able to be determined as they are not directly listed in the PSA breakdown provided by the applicant.

**(ii) The availability of reasonable alternatives to the proposed service or facility that would meet the needs of the population in a less costly, more efficient, or more effective manner.**

Maintaining the status quo is a reasonable alternative; HDH hospitals are within a reasonable distance from the proposed site for those who choose HCA providers. Memorial Regional can be argued as “overutilized” in a variety of COPN regulated areas; however, Richmond Community (approximately 9 miles, or a 15 minutes’ drive south) is also available and is comparatively significantly underutilized. VCU-MCV is approximately 7.5 miles, or a 17 minutes’ drive south of Memorial Regional, too. There are more options for emergency services than HDH hospitals in the area for Ashland residents to be transported to if needed.

Additionally, DCOPN requested data regarding the difficulty in transporting patients timely on multiple occasions, both verbally and in writing. DCOPN was consistently given the I-95 corridor traffic being the difficulty, but was not given any substantive, quantitative evidence that their patients are not receiving timely care or the lengths of time experienced by EMS providers that creates concern.

DCOPN also asked, verbally, on a call with the applicant’s legal representation regarding information on EMS providers being turned away or if Memorial Region was on diversion from regarding stroke, cardiac, and motor vehicle-related traumas; DCOPN was not provided with any information to clarify this. DCOPN was not provided any quantitative evidence that maintaining the status quo was causing harm to patients in PD 15.

An additional reasonable alternative would be to close the unutilized beds at Retreat Hospital as they have not been in use for some time, indicating an overabundance of bed in the hospital.

**(iii) Any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6.**

Currently there is no organization in HPR IV designated by the Virginia Department of Health to serve as the Health Planning Agency for PD 15. Therefore, this consideration is not applicable to the review of the proposed project.

**(iv) Any costs and benefits of the project.**

The financial costs of the project are to be paid using HCA reserves funds and are estimated to total \$233,633,000; additionally, there is a need to hire an estimated additional 293.25 full time equivalent (FTE) staff members. The applicant provides assurances the staff will likely be transferring from other HCA locations; however, this transferring would come at a cost to the other HCA facilities during a time of national difficulty in retaining healthcare employees. Of the 293.25 FTE staff needing to be hired, 111.85 FTE are RNs, 21 are Radiologic Technicians, and 86 are defined as “Other”.

It is reasonable to assume some emergency services traffic may be rerouted from the Bon Secours Memorial Regional Medical Center’s Emergency Room (ER) to the proposed location once finished, creating a cost to an existing local provider. Furthermore, the project proposes to relocate the only Cath Lab available at Retreat, in addition to the 60 medical

beds, from Retreat for use in the new location. While this may result in an increased utilization of the resources (as Retreat is relatively underutilized in a variety of COPN regulated services), the applicant does not address the financial costs of renovating the Retreat campus. The applicant does state, albeit ambiguously, that it would be costly to renovate Retreat, however, there is not a clear presentation on whether the renovations would cost less than nearly one-quarter of a billion dollars.

The applicant reports the increased benefit (with support from community emergency services departments and other governmental supporters) of reduced travel times for many HDH patients in the general Ashland area. However, there is no data provided within the body of the application to showcase the amount of time EMS typically are spent on calls that go to HDH hospitals from Ashland area currently verses the expectation with the proposed project's completion. The benefit is reasonable, but the extent to which the benefit outweighs the costs is unclear. Furthermore, opposition from a community member close to the proposed site argues that the Sliding Hill Road area will become even more congested for residents if the hospital is approved and constructed, placing costs onto residents in the area.

**(v) The financial accessibility of the project to the residents of the area to be served, including indigent residents.**

Hospitals often serve as the “insurers of last resort,” caring for uninsured patients.<sup>12</sup> To this end, the charitable contributions provided by medical care facilities are vital to the health of the communities in which they serve.

The applicant has provided assurances that inpatient, medical/surgical bed, Cath Lab, CT & MRI services, will be accessible to all patients, regardless of financial considerations. In 2020, the most recent data available, HDH reported providing charity care at a rate of 1.06% of their gross revenues, which is slightly less than the average of HPR IV of 1.3% (**Table 10**). Contrarily, the Pro Forma Income Statement provided by the applicant anticipates a charity care contribution equal to 1.6% of gross revenues derived from COPN regulated services at Ashland Hospital for Years 1 and 2, an amount greater than the average HPR IV contribution (**Table 10**). Recent changes to §32.16-102.4B of the Code of Virginia now require DCOPN to place a charity care condition on all applicants seeking a COPN. For this reason, DCOPN recommends that the proposed project, if approved, be subject to a 1.3% charity care condition, to be derived from total Ashland Hospital COPN project services' revenues, consistent with the HPR IV average. DCOPN again notes that its recommendation includes a provision allowing for the reassessment of the charity care rate at such time as more reliable data becomes available regarding the full impact of Medicaid expansion in the Commonwealth.

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<sup>12</sup> <https://www.fels.upenn.edu/recap/posts/1071>



**Table 10. 2020 Charity Care Contributions for HPR IV**

| 2020 Charity Care Contributions at or below 200% of Federal Poverty Level |                         |                                    |                                  |
|---|-------------------------|------------------------------------|----------------------------------|
| Hospital  | Gross Patient Revenues  | Adjusted Charity Care Contribution | Percent of Gross Patient Revenue |
| Bon Secours St. Francis Medical Center                                    | \$909,600,664           | \$28,930,399                       | 3.18%                            |
| Bon Secours Richmond Community Hospital                                   | \$916,350,189           | \$28,612,659                       | 3.12%                            |
| Bon Secours St. Mary's Hospital   | \$2,028,786,995         | \$51,459,409                       | 2.54%                            |
| Bon Secours Memorial Regional Medical Center                              | \$1,425,167,696         | \$28,386,279                       | 1.99%                            |
| Centra Southside Community Hospital                                       | \$324,125,273           | \$5,447,210                        | 1.68%                            |
| Sentara Halifax Regional Hospital   | \$279,469,170           | \$3,668,115                        | 1.31%                            |
| CJW Medical Center  | \$7,560,037,769         | \$86,592,596                       | 1.15%                            |
| VCU Health System   | \$6,172,966,084         | \$69,698,687                       | 1.13%                            |
| John Randolph Medical Center  | \$1,032,491,952         | \$10,903,791                       | 1.06%                            |
| Henrico Doctors' Hospital   | \$4,859,466,138         | \$51,444,601                       | 1.06%                            |
| VCU Community Memorial Hospital   | \$317,168,977           | \$1,932,837                        | 0.61%                            |
| Bon Secours Southern Virginia Regional Med Center                         | \$183,898,466           | \$1,059,319                        | 0.58%                            |
| Bon Secours Southside Regional Medical Center                             | \$1,875,804,250         | \$5,837,542                        | 0.31%                            |
| Vibra Hospital of Richmond LLC  | \$145,408,947           | \$0                                | 0.00%                            |
| Cumberland Hospital for Children and Adolescents                          | \$54,279,874            | \$0                                | 0.00%                            |
| Total Facilities  |                         |                                    | 15                               |
| Median  |                         |                                    | 1.1%                             |
| <b>Total \$ &amp; Mean %</b>  | <b>\$28,085,022,444</b> | <b>\$373,973,444</b>               | <b>1.3%</b>                      |

Source: VHI 2020 Data

**(vi) At the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a project.**

Much of the application is founded on the premise that the patients from the zip codes projected to be Ashland Hospital's PSA are too far from other HDH/HCA hospitals they would like to go to and that EMS times to get them to their preferred HDH locations are too great. However, within the application, there is no direct evidence or data presented to corroborate the premise. There is also no argument given by the applicant regarding patients having access in general to emergency services in a "reasonable time" verses access to HDH-specific services in a "reasonable time." DCOPN asked on numerous occasions for data, or even testimony from EMS personnel directly working the calls, regarding the drive times to emergency services creating a patient care issue but was not provided this information.

**3. The extent to which the application is consistent with the State Medical Facilities Plan.**

**Note: Many of the sub-calculations presented below use HDH hospitals rather than all of the HCA hospitals within the PD as the project is proposed to function as a campus of HDH and the applicant asserts the proposed patient population will consist of only HDH patients.**

**12VAC-5-230 Part I, Article 1**

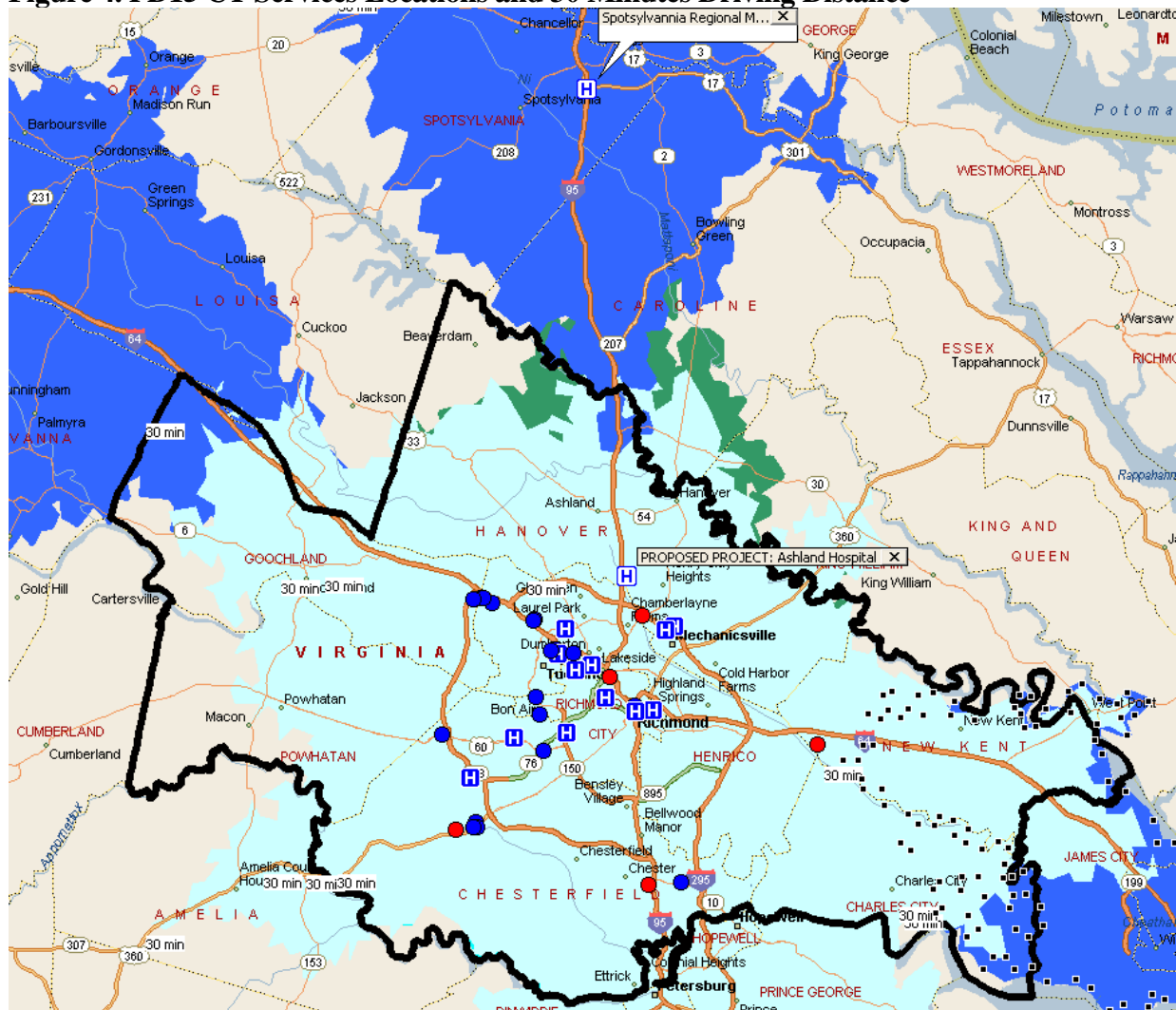
**Criteria and Standards for Computed Tomography**

**12VAC5-230-90. Travel time.**

**CT services should be within 30 minutes driving time one way under normal conditions of 95% of the population of the health planning district using a mapping software as determined by the commissioner.**

The light blue shaded area in **Figure 4** illustrates the areas in PD 15 that have CT services available within 30 minutes driving distance. The green shaded area in Caroline County (not in PD 15) and the green shaded area within PD 15 indicate the additional area the new project will provide service coverage for, while the dark blue illustrates coverage from providers outside of the PD. The three towns not within the shaded area include Cartersville (population 1,434 per 2020 Census), Beaverdam (population 14,374 per 2020 Census), and Macon (population 28,696 per 2020 Census), with a total population for the three being approximately 44,504 in 2020. The total PD 15 population was listed as 1,140,301 in 2020, meaning the three towns not within 30 minutes driving distance from CT services make up approximately 3.9% of the PD population, or that 96.1% of the PD is within the appropriate driving time. This is indicative of the PD 15 CT services being currently available according to the SMFP standard. The proposed project would not add meaningful coverage in the PD.

**Figure 4. PD15 CT Services Locations and 30 Minutes Driving Distance**



**Source:** DCOPN Records and Microsoft Streets & Maps

**\*Note:** The red dots indicate free-standing ERs, the blue dots are outpatient imaging centers, and the blue “H”s are hospitals with CTs, and the white “H” is the proposed site.

**12VAC5-230-100. Need for new fixed site or mobile service.**

- A. No new fixed site or mobile CT service should be approved unless fixed site CT services in the health planning district performed an average of 7,400 procedures per existing and approved CT scanner during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing providers in the health planning district. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of CT scanners in such health planning district.**
- B. Existing CT scanners used solely for simulation with radiation therapy treatment shall be exempt from the utilization criteria of this article when applying for a COPN. In addition, existing CT scanners used solely for simulation with radiation therapy treatment may be disregarded in computing the average utilization of CT scanners in such health planning district.**

Using 2021 VHI data, the most recent available data, there were 42 CT scanners, with an average of 111% usage per scanner (**Table 4**). Of those 42 scanners, 31 were located in acute care hospitals and had an average utilization of 135%, while the 11 freestanding units had an average utilization per scanner of 44% of the SMFP standard(**Table 4**).

The current DCOPN inventory accounts for 59 CT scanners, with 52 of them being available for diagnostic imaging (see **Table 5** footnotes for further details on the units not currently available).

Taking the above into consideration, and using the data that was available in 2021, (52 diagnostic scanners minus 4 scanners that were not operational/didn't report data=48 scanners), the utilization would have been approximately 7,212 procedures per unit, or 97.5% utilization per scanner. If we consider the 59 scanners minus the 4 scanners for the same reasons listed previously, the utilization would be 6,294 procedures per unit, or 85.1% utilization per unit. While these calculations are under the SMFP threshold of an average of 7,400 procedures, this does not account for the current volume, which has likely increased since 2021 VHI reported volumes as we have moved farther from the pandemic and elective procedures are gaining in volume. As volume increases, there are the two additional not-yet-operational scanners to assist with the volumes.

Considering the 2021 reported volumes of 346,165 total reported procedures within the PD, there is a calculated need for 48 CT scanner units. The projected growth in PD 15 between 2020-2030 is 6.84%, or 0.684% per year. Assuming the population rate affects CT growth rate similarly (a conservative approach as this calculation doesn't account for the additional increase in utilization as we move farther from the extreme time period of the pandemic), 2.052% would be three years' projected growth. This calculation would yield 7,104 procedures per CT scanner, or an average of 96% of the SMFP standard for addition of capacity.

The proposed location is approximately 8.0 miles, or a 9 minute drive, from Bon Secours Memorial Regional Medical Center (Memorial Regional). Memorial Regional's CT utilization is at 165% of the standard per scanner as of 2021. Bon Secours Richmond Community Hospital (Richmond Community) is approximately 11.1 miles, or 18 minutes' drive time, from Memorial Regional; Richmond Community's CT utilization is 75.0% utilization for their scanner. The new

location (not yet operational) that HCA is opening in Scotts Addition, a free-standing diagnostic imaging center, is to be approximately 15 minutes' driving time south, or 11.3 miles, from the proposed location.

As population increases, procedural volumes will likely increase; additionally, service volumes for a variety of medical procedures have increased as we move farther from 2020, the height of the pandemic concerns. As such, one additional CT scanner would not likely create significant harm regarding utilization for other providers, if placed at the proposed location. Although, as the 2021 VHI data illustrates, the hospital-based imaging is being utilized significantly more than freestanding center imaging; it is important to note that hospital-based imaging is more costly than outpatient imaging.<sup>13</sup>

**12VAC5-230-110. Expansion of fixed site service.**

**Proposals to expand an existing medical care facility's CT service through the addition of a CT scanner should be approved when the existing services performed an average of 7,400 procedures per scanner for the relevant reporting period. The commissioner may authorize placement of a new unit at the applicant's existing medical care facility or at a separate location within the applicant's primary service area for CT services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the health planning district.**

This provision is not applicable as the applicant is not seeking to expand fixed site CT services.

**12VAC5-230-120. Adding or expanding mobile CT services.**

- A. Proposals for mobile CT scanners shall demonstrate that, for the relevant reporting period, at least 4,800 procedures were performed and that the proposed mobile unit will not significantly reduce the utilization of existing CT providers in the health planning district.**
- B. Proposals to convert authorized mobile CT scanners to fixed site scanners shall demonstrate that, for the relevant reporting period, at least 6,000 procedures were performed by the mobile scanner and that the proposed conversion will not significantly reduce the utilization of existing CT providers in the health planning district.**

This provision is not applicable as the applicant is not proposing to add or expand mobile CT services.

**12VAC5-230-130. Staffing.**

**CT services should be under the direction or supervision of one or more qualified physicians.**

The applicant provides assurances that the CT services will be under the direction or supervision of one or more qualified physicians.

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<sup>13</sup> <https://www.hfma.org/payment-reimbursement-and-managed-care/pricing/52656/>

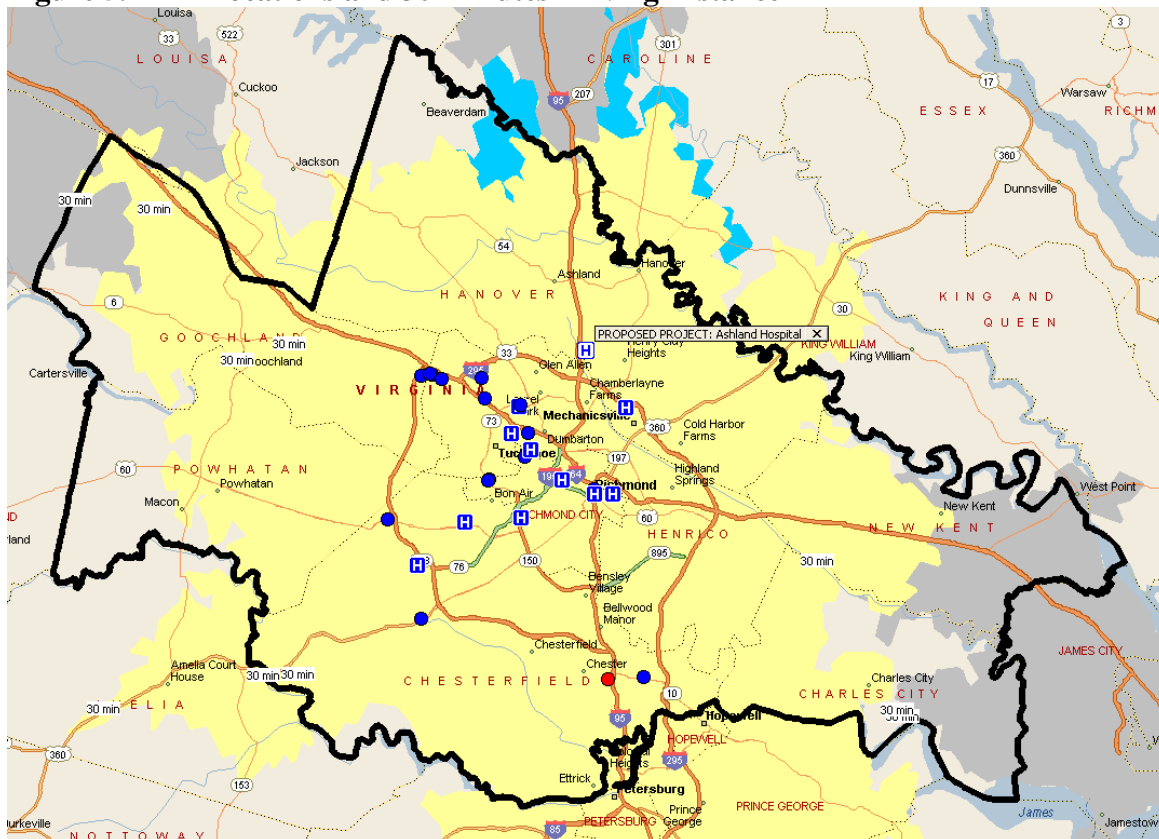
**12VAC5-230 Part I, Article 2**  
**Criteria and Standards for Magnetic Resonance Imaging**

**12VAC5-230-140. Travel time.**

**MRI services should be within 30 minutes driving time one way under normal conditions of 95% of the population of the health planning district using a mapping software as determined by the commissioner.**

**Figure 5**, below, illustrates the areas of PD 15 that are within 30 minutes driving time of MRI services (shaded in yellow are the areas currently covered, dark grey are areas that are covered by hospitals outside of the PD, while the blue area denotes the additional area covered through the addition of the new project). Similar to the CT services, MRI services are not within 30 minutes driving time of Beaverdam, Macon, and Cartersville; also, not included within the driving time radius is approximately half of Charles City and New Kent Counties. Charles City has a 2020 Census population of 6,758, making 50% of it 3,379 and New Kent's 2020 Census population is 23,069, making 50% of it 11,535 (**Table 1**). Total, approximately 59,418, or approximately 5.21% of the PD 15 population is not within 30 minutes driving time of MRI services (either within the PD or outside of the PD); approximately 94.79% of the PD is within 30 minutes driving time of MRI services. The project would not add any meaningful coverage within the PD.

**Figure 5. MRI Locations and 30 Minutes Driving Distance**



**Source:** DCOPN Records and Microsoft Streets & Trips

\*Note: The blue dots are outpatient units, while the blue "H"s are units available at hospitals, and the white "H" indicates the location of the proposed project.

**12VAC5-230-150. Need for new fixed site service.**

**No new fixed site MRI services should be approved unless fixed site MRI services in the health planning district performed an average of 5,000 procedures per existing and approved fixed site MRI scanner during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing fixed site MRI providers in the health planning district. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of MRI scanners in such health planning district.**

Of the acute care hospitals reported procedural volumes to VHI in 2021, there were 21 fixed units and 1 mobile MRI unit and the average utilization per unit was 76.0% of the SMFP threshold of 5,000 procedures (**Table 6**). For the freestanding MRI units, 13 fixed- and 2 mobile units yielded an average utilization of 67.0% (**Table 6**). For PD 15 as a whole, the average utilization is 72.5% per scanner, (not including VCU's one pediatric and one MRI-equipped Linear Accelerator as they are exclusive to specific populations and not available to all patients).

The three HDH locations- Forest, Parham, and Retreat- had an average utilization rate of 43.5% per scanner (HDH has 4 fixed MRI scanners). Retreat's utilization was 21.9% for its 1 MRI scanner and Parham's utilization was 48.4% for its 1 MRI scanner (**Table 6**). As discussed as a reasonable alternative, the average utilization per Forest MRI scanner is 51.9%; relocation of 1 MRI to the proposed site rather than introducing another excess MRI unit would more effectively distribute capacity.

Memorial Regional's MRI utilization is approximately 99.2% per scanner for 2021. Richmond Community's MRI utilization is 19.2% utilization for their scanner.

**12VAC5-230-160. Expansion of fixed site service.**

**Proposals to expand an existing medical care facility's MRI services through the addition of an MRI scanner may be approved when the existing service performed an average of 5,000 MRI procedures per scanner during the relevant reporting period. The commissioner may authorize placement of the new unit at the applicant's existing medical care facility, or at a separate location within the applicant's primary service area for MRI services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the health planning district.**

This provision is not applicable as the applicant is not proposing to expand fixed site MRI services.

**12VAC5-230-170. Adding or expanding mobile MRI services.**

- A. Proposals for mobile MRI scanners shall demonstrate that, for the relevant reporting period, at least 2,400 procedures were performed and that the proposed mobile unit will not significantly reduce the utilization of existing MRI providers in the health planning district.**
- B. Proposals to convert authorized mobile MRI scanners to fixed site scanners shall**

**demonstrate that, for the relevant reporting period, 3,000 procedures were performed by the mobile scanner and that the proposed conversion will not significantly reduce the utilization of existing MRI providers in the health planning district.**

This provision is not applicable as the applicant is not proposing to add or expand mobile MRI services.

**12VAC5-230-180. Staffing.**

**MRI services should be under the direct supervision of one or more qualified physicians.**

The applicant provides assurances that the MRI services will be under the direct supervision of one or more qualified physicians.

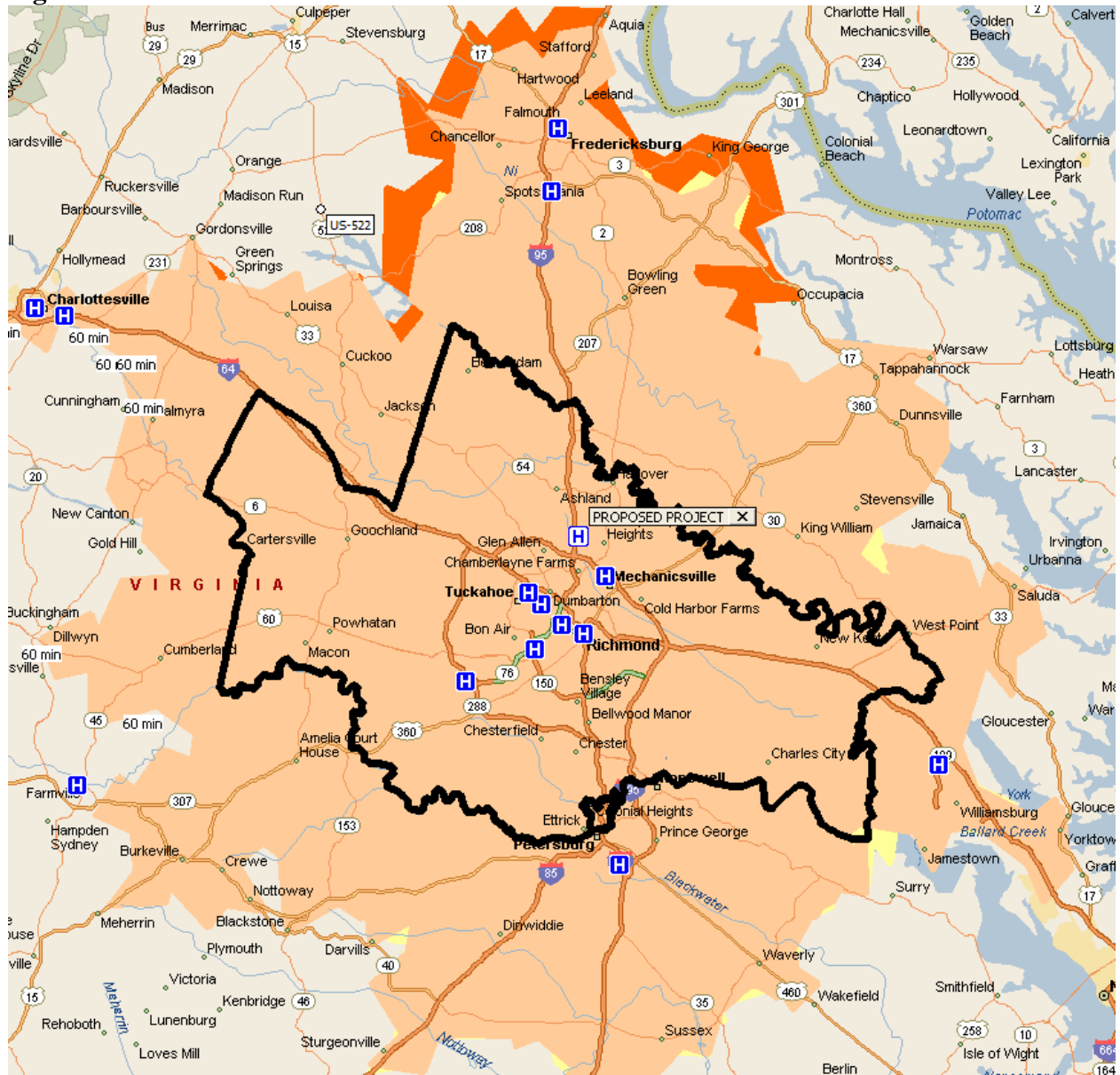
**12VAC5-230 Part IV, Article I**  
**Criteria and Standards for Cardiac Catheterization Services**

**12VAC5-230-380. Travel time.**

**Cardiac catheterization services should be within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.**

As illustrated below in **Figure 6** by the light orange shaded area, cardiac Cath Lab services are available within a 60-minute driving time for the entire PD 15 population; furthermore, it appears that relocation of a Cath Lab will neither alter access in a negative manner nor increase access substantially with regard to the 60-minutes driving distance SMFP criteria. The dark orange is indicative of a 60-minutes' driving distance radius from Spotsylvania Regional Memorial Center, and the yellow shaded areas are the new coverage areas that Ashland Hospital would create.

Figure 6. Cardiac Cath Lab Locations and 60 Minutes' Drive



Source: DCOPN Records and Microsoft Streets & Trips

**12VAC5-230-390. Need for new service.**

**A. No new fixed site cardiac catheterization service should be approved for a health planning district unless:**

- 1. Existing fixed site cardiac catheterization services located in the health planning district performed an average of 1,200 cardiac catheterization DEPs per existing and approved laboratory for the relevant reporting period;**
- 2. The proposed new service will perform an average of 200 DEPs in the first year of operation and 500 DEPs in the second year of operation; and**
- 3. The utilization of existing services in the health planning district will not be significantly reduced.**



- B. Proposals for mobile cardiac catheterization laboratories should be approved only if such laboratories will be provided at a site located on the campus of an inpatient hospital. Additionally, applicants for proposed mobile cardiac catheterization laboratories shall be able to project that they will perform an average of 200 DEPs in the first year of operation and 350 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district below 1,200 procedures.**
- C. Preference may be given to a project that locates new cardiac catheterization services at an inpatient hospital that is 60 minutes or more driving time one way under normal conditions from existing services if the applicant can demonstrate that the proposed new laboratory will perform an average of 200 DEPs in the first year of operation and 400 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district.**

The applicant asserts this provision of the SMFP is not applicable as the applicant is proposing to relocate a cardiac Cath Lab from another facility within the same PD. However, these services have not been offered in the proposed area and the Cath Lab the applicant is requesting to relocate has had 0% utilization for the 2021 VHI reporting period. Furthermore, there is not data given by the applicant to show that the Lab has been used since this time period, indicative of the Lab COPN not being authorized via the colloquially termed “12-month rule.” The 12-month rule, found in VA Code §32.1-102.1:3.B.5, (defining a project to include introduction into an existing medical care facility any, inter alia, Cath lab services “when such medical care facility has not provided such service in the previous 12 months.”) While Ashland Hospital is not an “existing medical care facility,” to relocate the Cath lab from Retreat, the Cath lab must be authorized and used within a 12-month period in order to still be considered in service. Therefore, it behooves DCOPN to address this as a newly provided service.

**Table 7** details the utilization of Cath Labs in PD 15, illustrating an average utilization of 50.73%, or 609 DEPs per laboratory. The applicant did not provide the projected DEPs for the proposed Cath Lab.

Also worthy of note, the applicant cites the decisions for COPN VA-04035 and COPN VA-04036 in which the Commissioner states that “[c]ardiac cath services are generally recognized as an expected component of a community or general hospital.” Rather than request an additional Cath Lab be introduced to the PD, the applicant is requesting for one to be moved from another of its hospitals within the PD. HCA states they will be relocating the Cath Lab from Retreat hospital for the project.

The two HDH hospitals with cardiac Cath Labs in PD 15 are HDH-Retreat (1 lab) with 0% utilization reported in 2021 to VHI, and HDH-Forest (5 labs), with 46.58% utilization, or 559 procedures per unit on average (**Table 7**). To be consistent with the aforementioned Commissioner’s statement regarding Cath Labs presented by the applicant, the Cath Lab would need to come from HDH-Forest as to not deprive a hospital (that the applicant asserts will remain operational) from having its only Cath Lab available. To move the *only* Cath Lab from one hospital to another hospital on the basis that the service to be relocated “are generally recognized as an expected component,” only applies the reasoning for needing a Cath Lab for

one hospital at the direct detriment of another- which is antithetical to the applicant's own argument for the Cath Lab.

**12VAC5-230-400. Expansion of services.**

**Proposals to increase cardiac catheterization services should be approved only when:**

- 1. All existing cardiac catheterization laboratories operated by the applicant's facilities where the proposed expansion is to occur have performed an average of 1,200 DEPs per existing and approved laboratory for the relevant reporting period; and**
- 2. The applicant can demonstrate that the expanded service will achieve an average of 200 DEPs per laboratory in the first 12 months of operation and 400 DEPs in the second 12 months of operation without significantly reducing the utilization of existing cardiac catheterization laboratories in the health planning district.**

This provision of the SMFP is not applicable as the applicant is not proposing to expand Cath Lab services, but rather to establish them through relocation.

**12VAC5-230-410. Pediatric cardiac catheterization.**

**No new or expanded pediatric cardiac catheterization services should be approved unless:**

- 1. The proposed service will be provided at an inpatient hospital with open heart surgery services, pediatric tertiary care services or specialty or subspecialty level neonatal special care;**
- 2. The applicant can demonstrate that the proposed laboratory will perform at least 100 pediatric cardiac catheterization procedures in the first year of operation and 200 pediatric cardiac catheterization procedures in the second year of operation; and**
- 3. The utilization of existing pediatric cardiac catheterization laboratories in the health planning district will not be reduced below 100 procedures per year.**

This provision of the SMFP is not applicable as the applicant does not propose to either add or expand pediatric cardiac Cath services.

**12VAC5-230-420. Nonemergent cardiac catheterization.**

**A. Simple therapeutic cardiac catheterization. Proposals to provide simple therapeutic cardiac catheterizations are not required to offer open heart surgery service available on-site in the same hospital in which the proposed simple therapeutic service will be located. However, these programs shall adhere to the requirements described in subdivisions 1 through 9 of this subsection.**

**The programs shall:**

- 1. Participate in the Virginia Heart Attack Coalition, the Virginia Cardiac Services Quality Initiative, and the Action Registry-Get with the Guidelines or National Cardiovascular Data Registry to monitor quality and outcomes;**
- 2. Adhere to strict patient-selection criteria;**
- 3. Perform annual institutional volumes of 300 cardiac catheterization procedures, of which at least 75 should be percutaneous coronary intervention (PCI) or as dictated by American College of Cardiology (ACC)/American Heart Association (AHA) Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories effective 1991;**

- 4. Use only AHA/ACC-qualified operators who meet the standards for training and competency;**
- 5. Demonstrate appropriate planning for program development and complete both a primary PCI development program and an elective PCI development program that includes routine care process and case selection review;**
- 6. Develop and maintain a quality and error management program;**
- 7. Provide PCI 24 hours a day, seven days a week;**
- 8. Develop and maintain necessary agreements with a tertiary facility that must agree to accept emergent and nonemergent transfers for additional medical care, cardiac surgery, or intervention; and**
- 9. Develop and maintain agreements with an ambulance service capable of advanced life support and intra-aortic balloon pump transfer that guarantees a 30-minute or less response time.**

The applicant asserts that they meet the provisions of this section of the SMFP: “meeting each of the requirements contained herein.” The applicant makes reference to the letter written by the intended medical director of cardiac catheterization laboratory services at Ashland Hospital, Dr. Robert Levitt, M.D. The letter from Dr. Levitt states, “I would like to confirm that Ashland Hospital’s cardiac catheterization laboratory program will meet each of the criteria set forth in 12 VAC5-230-420(A) for simple therapeutic cardiac catheterization services.” Specific information, such as likely tertiary facility agreement parties, ambulance services capable of advanced life support and intra-aortic balloon pump transfer guaranteeing a 30-minute or less response time were neither provided in the body of the application nor within Dr. Levitt’s letter. It is not clear within the application to DCOPN whether Ashland Hospital will be able to provide tertiary level of care.

The Virginia Office of EMS Regulation and Compliance Enforcement Division- in a publication dated March 17, 2022, states that Intra-aortic balloon pump maintenance or monitoring procedures are “specified as outside EMS Scope of Practice by MDC.”<sup>14</sup>; “MDC” is the abbreviation for Medical Direction Committee. This is indicative that traditionally licensed and trained paramedics (and EMTs and AEMTs) would not be able to provide the type of ambulance services needed to cooperate with item 9 listed above. The applicant neglecting to provide information regarding the items listed in this subsection confound a thorough analysis and accurate portrayal of the project for the Commissioner.

Moreover, the applicant makes mention in multiple locations throughout the application that local EMS services have a difficult time coming from the general Ashland area to HDH hospitals due to traffic congestion. The distances and driving times, without the traffic congestion (that the applicant makes extensive reference to), from the proposed site to the other HCA hospitals are as follows:

- Parham: 8.7-11.7 miles, 16-20 minutes;
- Forest: 13.0-14.7 miles, 18-20 minutes; and
- Retreat: 11.1-12.7 miles; 15-19 minutes.

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<sup>14</sup> <https://www.vdh.virginia.gov/content/uploads/sites/23/2022/03/Scope-of-Practice-Procedures.pdf>

In a verbal meeting between HCA representatives/applicant and DCOPN, it was discussed that their patients want to receive care from HDH facilities and the travel times for EMS personnel become significant due to the traffic congestion. Also discussed was the intent to stabilize, for example, severe trauma, stroke, or cardiac patients at Ashland Hospital before transferring them to the already established HDH hospitals for specialized/advanced treatment. Memorial Regional Medical Center is approximately 8.0 miles, or 8 minutes' driving time utilizing I-295, from the proposed site. It is unclear if the applicant proposes to coordinate care with Memorial Regional in emergent situations, or whether they would strictly have agreements with the HDH hospitals that could take much longer for ambulances to arrive to in high congestion time frames.

Traffic conditions and distance are cited as reasons this travel distance for Ashland area patients to travel are not acceptable to these patients. As the applicant is concerned about their patients' travel time, it would be important to consider the patient travel time to other locations from Retreat Hospital as the applicant proposes to relocate the only Cath Lab at Retreat. According to Google Maps, the distance from Retreat to:

- HDH-Forest is approximately 6.3 miles and 17 minutes' driving time;
- HDH-Parham is approximately 8.3 miles and 17 minutes' driving time;
- Chippenham Hospital is approximately 5.3 miles and 12 minutes' driving time; and
- Johnston-Willis Hospital is approximately 9.1 miles and 18 minutes' driving time.

HDH Forest is within a comparable distance and drive time from the new location and from Retreat to other HCA/HDH facilities in the PD. As the applicant proposes to relocate the only Cath Lab from Retreat (which reported 0% utilization in 2021 to VHI), it would appear that the patients in this area who need Cath Lab services are being expected to travel a similar distance to an HCA/HDH location that the Ashland area patients currently travel.

**B. Complex therapeutic cardiac catheterization. Proposals to provide complex therapeutic cardiac catheterization should be approved only when open heart surgery services are available on-site in the same hospital in which the proposed complex therapeutic service will be located. Additionally, these complex therapeutic cardiac catheterization programs will be required to participate in the Virginia Cardiac Services Quality Initiative and the Virginia Heart Attack Coalition.**

The applicant reports not contemplating complex therapeutic cardiac catheterization services, making this provision of the SMFP not applicable.

**12VAC5-230-430. Staffing.**

- A. Cardiac catheterization services should have a medical director who is board certified in cardiology and has clinical experience in performing physiologic and angiographic procedures. In the case of pediatric cardiac catheterization services, the medical director should be board-certified in pediatric cardiology and have clinical experience in performing physiologic and angiographic procedures.**
- B. Cardiac catheterization services should be under the direct supervision of one or more qualified physicians. Such physicians should have clinical experience in performing physiologic and angiographic procedures. Pediatric catheterization services should be under the direct supervision of one or more qualified physicians. Such physicians**

**should have clinical experience in performing pediatric physiologic and angiographic procedures.**

The letter and curriculum vitae provided by Dr. Levitt, proposed medical director of cardiac Cath services, detail adequate experience, and confirm Board Certification in both Cardiovascular Disease and Interventional Cardiology (as well as internal Medicine).

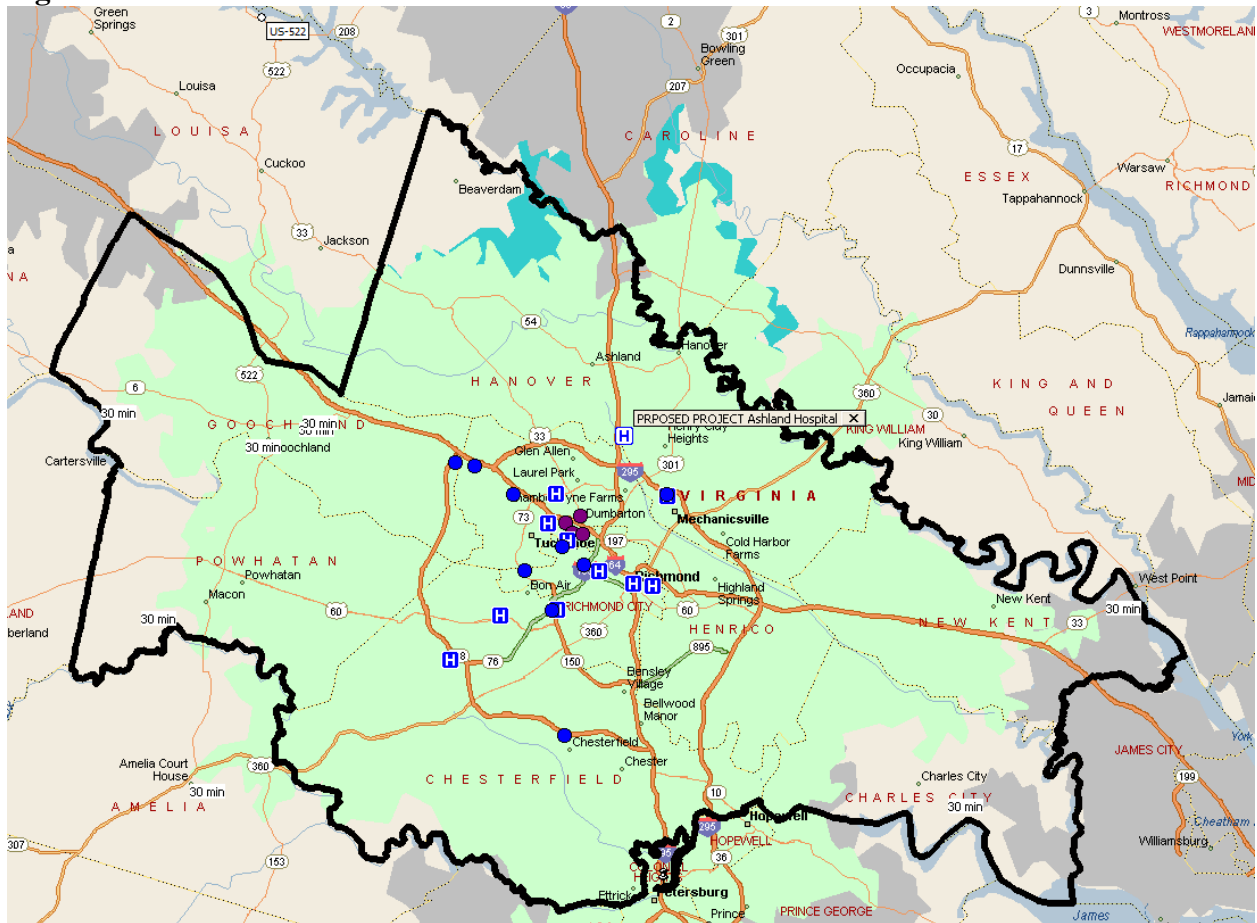
**12VAC5-230 Part V, Article 2**  
**General Surgical Services**

**12VAC5-230-490. Travel time.**

**Surgical services should be available within 30 minutes driving time one way under normal conditions for 95% of the population of the health planning district using mapping software as determined by the commissioner.**

Illustrated in **Figure 7**, the areas of PD 15 within a 30-minutes driving distance are in shaded green. The blue area is indicative of the added area that would be covered by the project (**Figure 7**). The dark grey illustrates the areas covered by services outside of the PD. The map is almost identical to the MRI services availability map, indicating that 94.79% of the PD is within the SMFP 30-minutes driving time standard, and 5.21% of the population of PD 15 is outside of this standard. The shaded blue area within PD 15 is very rural. Using the 2020 Census Data, 0.21% of the PD population would be 2,395; this is the population quantity that would need access in order for the 95% population accessibility standard of the SMFP to be met. Beaverdam, the closest town to the newly, potentially covered area, has a population of 14,374. The relatively small area that the proposed location would cover that is not already covered may include 2,395 individuals.

**Figure 7. Locations of GPORs and 30-Minutes' Drive Time Radius**



Source: DCOPN Records and Microsoft Streets & Trips

**12VAC5-230-500. Need for new service.**

- A. The combined number of inpatient and outpatient general purpose surgical operating rooms needed in a health planning district, exclusive of procedure rooms, dedicated cesarean section rooms, operating rooms designated exclusively for cardiac surgery, procedures rooms or VDH-designated trauma services, shall be determined as follows:**

$$\frac{\text{FOR} = ((\text{ORV}/\text{POP}) \times (\text{PROPOP})) \times \text{AHORV}}{1600}$$

Where:

**ORV** = the sum of total inpatient and outpatient general purpose operating room visits in the health planning district in the most recent five years for which general purpose operating room utilization data has been reported by VHI; and

**POP** = the sum of total population in the health planning district as reported by a demographic entity as determined by the commissioner, for the same five-year period as used in determining ORV.

**PROPOP = the projected population of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.**

**AHORV = the average hours per general purpose operating room visit in the health planning district for the most recent year for which average hours per general purpose operating room visits have been calculated as reported by VHI.**

**FOR = future general purpose operating rooms needed in the health planning district five years from the current year.**

**1600 = available service hours per operating room per year based on 80% utilization of an operating room available 40 hours per week, 50 weeks per year.**

This applicant asserts this subsection is not applicable as the applicant is not proposing to introduce new general purpose surgical operating rooms in the project. However, as the services have not been provided at the proposed location, the calculation for this provision will nevertheless be completed.

**Table 11. PD 15 GPOR Calculation Data**

| Year                   | Total In- & Outpatient GPOR Visits | Population       |
|------------------------|------------------------------------|------------------|
| 2017                   | 137,943                            | 1,091,586        |
| 2018                   | 135,993                            | 1,102,622        |
| 2019                   | 143,270                            | 1,113,770        |
| 2020                   | 211,429                            | 1,140,301        |
| 2021                   | 198,063                            | 1,148,101        |
| <b>Total</b>           | <b>825,698</b>                     | <b>5,569,380</b> |
| <b>Average</b>         | <b>165,140</b>                     | --               |
| <b>2028 Projection</b> | --                                 | <b>1,202,699</b> |

Source: Weldon-Cooper Population Projections and VHI (2017-2021)

Utilizing the data in **Table 10**, the following illustrates the calculations of the preceding formula:

|  |          |   |          |   |
|--|----------|---|----------|---|
| <b>ORV</b>   | ÷        | <b>POP</b>                                  | =        | <b>CSUR</b>   |
| Total PD 15 GPOR Visits<br>2017-2021                 |          | PD 15 Historical Population<br>2017-2021    |          | Calculated GPOR Use<br>Rate 2017-2021                     |
| 825,698  |          | 5,569,380                                   |          | 0.1483  |
|  |          |   |          |   |
| <b>CSUR</b>  | <b>X</b> | <b>PROPOP</b>                               | <b>=</b> | <b>PORV</b>   |
| Calculated GPOR Use<br>Rate 2017-2021                |          | PD 15 Projected Population<br>2028          |          | Projected GPOR Visits in<br>2028                          |
| 0.1483   |          | 1,202,699                                   |          | <b>178,361</b>  |
|  |          |   |          |   |
| <b>344,699</b>                                       | ÷        | <b>198,063</b>                              | <b>=</b> | <b>1.7404</b>   |
| Total In- & Outpatient OR<br>Hours for PD 15 in 2021 |          | Total In- & Outpatient OR<br>Visits in 2021 |          | Average Hours per OR in<br>PD 15 in 2021 ( <b>AHORV</b> ) |

$$\text{FOR} = \frac{((\text{ORV} / \text{POP}) \times (\text{PROPOP})) \times \text{AHORV}}{1600}$$

$$\text{FOR} = \frac{((825,698 / 5,569,380) \times (1,202,699)) \times 1.7404}{1600}$$

**FOR = 193.95 (194) General Purpose Operating Rooms Needed in PD 15 in 2028**  
**Current PD Inventory: 198 (Table 8)**  
**Net Surplus/(Deficit): 4 GPORs for 2028 Planning Year**

- B. Projects involving the relocation of existing operating rooms within a health planning district may be authorized when it can be reasonably documented that such relocation will: (i) improve the distribution of surgical services within a health planning district ; (ii) result in the provision of the same surgical services at a lower cost to surgical patients in the health planning district; or (iii) optimize the number of operations in the health planning district that are performed on an outpatient basis.**

The applicant states:

“The project is fully consistent with this subsection. HDH proposes relocating four general purpose operating rooms to Ashland Hospital to improve the distribution of HDH’s surgical services. HDH seeks to establish Ashland Hospital to better serve HDH’s existing patients without increasing the inventory of general-purpose operating rooms in PD 15. HDH plans to relocate four general purpose operating rooms from one or more HCA facilities in PD 15 and the decision will be made closer to the date Ashland Hospital opens based on the then-current operating room utilization data...”

The applicant then includes sections of multiple letters of support regarding the benefit local ORs will have on their practices.

PD 15 has 198 ORs, with 150 of them being in an acute care hospital setting. The average utilization per acute care general purpose OR using 2021 VHI data is 130.1%, and the average utilization per general purpose OR in PD 15 (including outpatient), is 127.8% (**Table 8**). Furthermore, the average utilization of general purpose ORs in the outpatient setting is 116.5% using 2021 VHI data (**Table 8**).

Extrapolating HDH data only:

- Parham: 11 ORs at 57.6% utilization;
- Retreat: 5 ORs at 68.0% utilization; and
- Forest: 21 ORs at 61.6% utilization.

The average utilization for HDH ORs in PD 15 is 62.4% utilization, which is significantly less than the PD acute care, outpatient, and total OR utilization (47.9% of the PD 15 acute care, 53.6% of the outpatient utilization, and 48.8% of the total PD ORs’ utilization).



Considering the other two HCA-affiliated hospitals, Chippenham, and Johnston-Willis Hospitals' ORs' utilization rates, 122.5% and 96.3% respectively, using 2021 VHI Data, are much higher than the HDH OR utilization, it is unlikely the ORs being relocated would originate from one of these hospitals.

To reiterate, the applicant has not stated which HCA hospitals the ORs will be relocated from and appear to be requesting for approval of the relocation without specifying which hospitals the ORs will originate from. Without identifying from which hospitals the relocation would originate, DCOPN is limited in its ability to analyze the impact, ultimately limiting the analysis with which the Commissioner has at his disposal for decision making.

**12VAC5-230-510. Staffing.**

**Surgical services should be under the direction or supervision of one or more qualified physicians.**

The applicant provides assurances the surgical services will be under the direction or supervision of one or more qualified physicians.

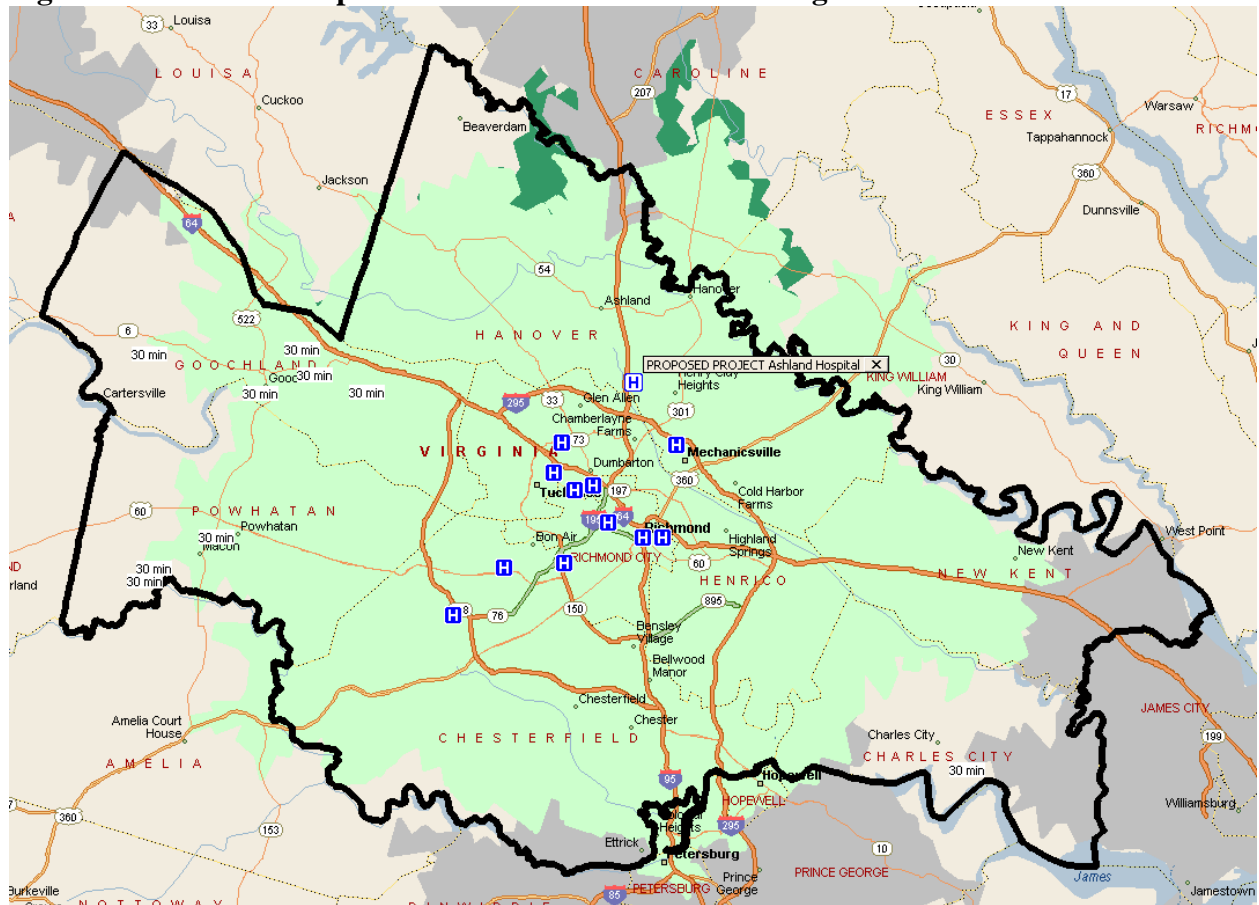
**12VAC5-230 Part VI, Article 2**  
**Inpatient Bed Requirements**

**12VAC5-230-520. Travel time.**

**Inpatient beds should be within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district using a mapping software as determined by the commissioner.**

As with the OR accessibility coverage, inpatient beds are available in approximately the same areas (**Figure 8**). The location of the project will provide additional coverage in the PD, illustrated below in dark green, may provide enough additional coverage to push the current estimated 94.21% of the population within a 30-minute drive of inpatient beds, to the SMFP standard of 95%. The light green shows the area covered by current PD 15 providers, and the dark grey shows areas covered by providers outside of PD 15.

Figure 8. Locations of Inpatient Beds and 30-Minutes Driving Distance



Source: DCOPN Records and Microsoft Office Streets & Trips

**12VAC5-230-530. Need for new service.**

**A. No new inpatient beds should be approved in any health planning district unless:**

- 1. The resulting number of beds for each bed category contained in this article does not exceed the number of beds projected to be needed for that health planning district for the fifth planning horizon year; and**
- 2. The average annual occupancy based on the number of beds in the health planning district for the relevant reporting period is:
  - a. 80% at midnight census for medical/surgical or pediatric beds;**
  - b. 65% at midnight census for intensive care beds.****

**B. For proposals to convert under-utilized beds that require a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection C of this section, consideration may be given to such proposal if:**

- 1. There is a projected need in the applicable category of inpatient beds; and**
- 2. The applicant can demonstrate that the average annual occupancy of the converted beds would meet the utilization standard for the applicable bed category by the first year of operation.**

For the purposes of this part, "underutilized" means less than 80% average annual occupancy for medical/surgical or pediatric beds, when the relocation involves such beds

**and less than 65% average annual occupancy for intensive care beds when relocation involves such beds.**

Section B of this provision of the SMFP is applicable to this project. The project proposes to relocate 60 inpatient beds that are underutilized (not utilized or staffed at this time), 6 of which would be specifically for ICU purposes. There is a calculated surplus of 247 beds in PD 15, but a calculated need for 85 ICU beds in PD 15. The average annual occupancy of all the converted beds is projected to be 69.1% and 70.5% for Years 1 and 2, respectively. The projected occupancy for the 54 Medical-surgical beds is projected to be 70.4% and 71.8% for Years 1 and 2, respectively. The 6 ICU beds are projected to be at 57.3% and 58.5% occupancy for Years 1 and 2, respectively. The projected occupancies are less than the utilization requirements set forth in this standard.

**C. The capital expenditure threshold referenced in subsection B of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:**

$$A \times (1+B)$$

where:

**A = the capital expenditure threshold amount for the previous year, and  
B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.**

**12VAC5-230-540. Need for medical/surgical beds.**

**The number of medical/surgical beds projected to be needed in a health planning district shall be computed as follows:**

- 1. Determine the use rate for the medical/surgical beds for the health planning district using the formula:**

$$BUR = (IPD/PoP)$$

Where:

**BUR = the bed use rate for the health planning district.**

**IPD = the sum of total inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and**

**PoP = the sum of total population 18 years of age and older in the health planning district for the same five years used to determine IPD as reported by a demographic program as determined by the commissioner.**

**Table 12. Bed Use Rate Calculation and Data**

| <b>Year</b>                   | <b>Population 18+ in PD 15</b> | <b>Inpatient Days Reported for PD 15</b> |
|-------------------------------|--------------------------------|--|
| 2017                          | 862,377                        | 852,319                                  |
| 2018                          | 873,907                        | 879,103                                  |
| 2019                          | 883,447                        | 898,132                                  |
| 2020                          | 857,872                        | 844,723                                  |
| 2021                          | 903,018                        | 900,098                                  |
| <b>Total</b>                  | <b>4,380,621</b>               | <b>4,374,375</b>                         |
| BUR = (4,374,375 / 4,380,621) |                                |  |
| <b>BUR = 0.9986</b>           |                                |  |

Source: VHI Data (2017-2021) & Weldon-Cooper Population Data

As tabulated in **Table 12**, the Bed Use Rate for PD 15 is 0.9986.

- Determine the total number of medical/surgical beds needed for the health planning district in five years from the current year using the formula:

$$\text{ProBed} = ((\text{BUR} \times \text{ProPop})/365)/0.80$$

Where:

**ProBed** = The projected number of medical/surgical beds needed in the health planning district for five years from the current year.

**BUR** = the bed use rate for the health planning district determined in subdivision 1 of this section.

**ProPop** = the projected population 18 years of age and older of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

$$\text{ProBed} = ((\text{BUR} \times \text{ProPop})/365)/0.80$$

$$\text{ProBed} = ((0.9986 \times 952,432)/365)/0.80$$

$$\text{ProBed} = 3,257.19 \text{ (3,257) Beds Needed for Planning Year 2028}$$

Available Beds in PD 15: 3,504

- Determine the number of medical/surgical beds that are needed in the health planning district for the five planning horizon years as follows:

$$\text{NewBed} = \text{ProBed} - \text{CurrentBed}$$

Where:

**NewBed** = the number of new medical/surgical beds that can be established in a health planning district, if the number is positive. If **NewBed** is a negative number, no additional medical/surgical beds should be authorized for the health planning district.

**ProBed = the projected number of medical/surgical beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.**

**CurrentBed = the current inventory of licensed and authorized medical/surgical beds in the health planning district.**

$$\text{NewBed} = \text{ProBed} - \text{CurrentBed}$$

$$\text{NewBed} = 3,257 - 3,504$$

$$\text{NewBed} = -247$$

**Calculated Surplus: 247 Beds in PD 15**

This applicant asserts this provision of the SMFP is not applicable; however, it is useful in understanding the picture of medical/surgical beds in the planning district. Therefore, DCOPN completed the above calculations. This calculation illustrates that relocation of the “surplus” beds from Retreat to Ashland Hospital perpetuates the surplus rather than addressing a need within the PD. Perpetuating the surplus furthers the strain on resources, to include staffing, without significant benefit.

**12VAC5-230-550. Need for pediatric beds.**

**The number of pediatric beds projected to be needed in a health planning district shall be computed as follows:**

- 1. Determine the use rate for pediatric beds for the health planning district using the formula:**

$$\text{PBUR} = (\text{PIPD}/\text{PedPop})$$

**Where:**

**PBUR = The pediatric bed use rate for the health planning district.**

**PIPD = The sum of total pediatric inpatient days in the health planning district for the most recent five years for which inpatient days data has been reported by VHI; and**

**PedPop = The sum of population under 18 years of age in the health planning district for the same five years used to determine PIPD as reported by a demographic program as determined by the commissioner.**

- 2. Determine the total number of pediatric beds needed to the health planning district in five years from the current year using the formula:**

$$\text{ProPedBed} = ((\text{PBUR} \times \text{ProPedPop})/365)/0.80$$

**Where:**

**ProPedBed = The projected number of pediatric beds needed in the health planning district for five years from the current year.**

**PBUR = The pediatric bed use rate for the health planning district determined in subdivision 1 of this section.**

**ProPedPop = The projected population under 18 years of age of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.**

- 3. Determine the number of pediatric beds needed within the health planning district for the fifth planning horizon year as follows:**

$$\text{NewPedBed} - \text{ProPedBed} - \text{CurrentPedBed}$$

**Where:**

**NewPedBed = the number of new pediatric beds that can be established in a health planning district, if the number is positive. If NewPedBed is a negative number, no additional pediatric beds should be authorized for the health planning district.**

**ProPedBed = the projected number of pediatric beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.**

**CurrentPedBed = the current inventory of licensed and authorized pediatric beds in the health planning district.**

This provision of the SMFP is not applicable as the applicant is not proposing pediatric-exclusive beds in the project.

**12VAC5-230-560. Need for intensive care beds.**

**The projected need for intensive care beds in a health planning district shall be computed as follows:**

- 1. Determine the use rate for ICU beds for the health planning district using the formula:**

$$\text{ICUBUR} = (\text{ICUPD}/\text{Pop})$$

**Where:**

**ICUBUR = The ICU bed use rate for the health planning district.**

**ICUPD = The sum of total ICU inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and**

**Pop = The sum of population 18 years of age or older for adults or under 18 for pediatric patients in the health planning district for the same five years used to determine ICUPD as reported by a demographic program as determined by the commissioner.**

- 2. Determine the total number of ICU beds needed for the health planning district,**

including bed availability for unscheduled admissions, five years from the current year using the formula:

$$\text{ProICUBed} = ((\text{ICUBUR} \times \text{ProPop})/365)/0.65$$

Where:

**ProICUBed** = The projected number of ICU beds needed in the health planning district for five years from the current year;

**ICUBUR** = The ICU bed use rate for the health planning district as determine in subdivision 1 of this section;

**ProPop** = The projected population 18 years of age or older for adults or under 18 for pediatric patients of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of ICU beds that may be established or relocated within the health planning district for the fifth planning horizon planning year as follows:

$$\text{NewICUB} = \text{ProICUBed} - \text{CurrentICUBed}$$

Where:

**NewICUBed** = The number of new ICU beds that can be established in a health planning district, if the number is positive. If **NewICUBed** is a negative number, no additional ICU beds should be authorized for the health planning district.

**ProICUBed** = The projected number of ICU beds needed in the health planning district for five years from the current year as determined in subdivision 2 of this section.

**CurrentICUBed** = The current inventory of licensed and authorized ICU beds in the health planning district.

The applicant asserts that this provision of the SMFP is not applicable as they are not proposing to add ICU beds to the planning district, however, this section is useful in analyzing the ICU bed status within PD 15 and the potential need as the hospital is proposing to have 6 ICU beds. Therefore, DCOPN will conduct the calculations as detailed above.

1. ICU Use Rate for the PD = 
$$\frac{\text{Sum of Inpatient ICU days for the Past 5 Years}}{\text{Sum of the 18+ Population for the same 5 Years as above}}$$

**Table 13. Sum of Inpatient ICU Days 2017-2021 for PD 15.**

| Facility Name  | 2021   | 2020   | 2019   | 2018   | 2017   | Sum of Days    |
|--|--------|--------|--------|--------|--------|----------------|
| Bon Secours Memorial Regional Medical Center         | 5,067  | 6,752  | 7,387  | 6,890  | 6,341  | 32,437         |
| Bon Secours Richmond Community Hospital              | 0      | 0      | 406    | 0      | 901    | 1,307          |
| Bon Secours St. Francis Medical Center               | 2,964  | 3,542  | 3,969  | 3,760  | 3,647  | 17,882         |
| Bon Secours St. Mary's Hospital                      | 5,080  | 10,657 | 11,542 | 11,518 | 10,758 | 49,555         |
| Chippenham Hospital                                  | 20,440 | 19,082 | 16,911 | 17,319 | 22,569 | 96,321         |
| Henrico Doctors' Hospital - Forest                   | 7,452  | 2,434  | 1,759  | 1,381  | 6,640  | 19,666         |
| Henrico Doctor's Hospital - Parham Doctors' Hospital | 2,636  | 640    | 397    | 587    | 1,626  | 5,886          |
| Henrico Doctor's Hospital - Retreat                  | 611    | 7,218  | 7,229  | 7,217  | 602    | 22,877         |
| Johnston-Willis Hospital                             | 7,428  | 7,744  | 7,545  | 8,159  | 3,832  | 34,708         |
| VCU Medical Center                                   | 38,598 | 36,852 | 37,967 | 37,254 | 34,621 | 185,292        |
| Vibra Hospital of Richmond LLC                       | 1,182  | 0      | 0      | 0      | 0      | 1,182          |
| Total for PD 15                                      |        |        |        |        |        | <b>467,113</b> |

Source: 2017-2021 VHI Data

**Table 14. PD 15 18+ Population Sum for 2017-2021**

| Locality in PD 15     | 2021    | 2020    | 2019    | 2018    | 2017    | Sum of 18+       |
|-----------------------|---------|---------|---------|---------|---------|------------------|
| Charles City County   | 5,653   | 5,836   | 5,939   | 5,889   | 5,913   | 29,230           |
| Chesterfield County   | 282,892 | 237,743 | 269,971 | 265,761 | 261,704 | 1,318,071        |
| Colonial Heights City | 13,899  | 13,229  | 13,267  | 13,534  | 13,558  | 67,487           |
| Goochland County      | 21,210  | 20,291  | 19,672  | 19,125  | 18,632  | 98,930           |
| Hanover County        | 87,530  | 84,905  | 84,419  | 83,667  | 82,363  | 422,884          |
| Henrico County        | 259,313 | 259,264 | 256,660 | 254,989 | 252,848 | 1,283,074        |
| New Kent County       | 19,239  | 19,036  | 18,489  | 17,902  | 17,336  | 92,002           |
| Powhatan County       | 25,446  | 24,667  | 24,280  | 23,866  | 23,319  | 121,578          |
| Richmond City         | 187,836 | 192,901 | 190,750 | 189,174 | 186,704 | 947,365          |
| Total PD 15           |         |         |         |         |         | <b>4,380,621</b> |

Source: Weldon-Cooper Data

ICU Use Rate for the PD = 467,113 / 4,380,621 = approximately 0.11

2. Projected ICU Bed Need = ((ICU Bed Use Rate x Projected Pop. In 5 years)/365)/0.65

Projected ICU Bed Need = [(0.11 x 952,432)/365]/0.65 = **442**

3. New ICU Beds = Projected ICU Beds – Current ICU Beds

New ICU Beds Needed = 442 - 357 = **85**

The calculations within this section indicate a need for 85 additional ICU beds in Planning Year 2028.

The applicant provides contradictory information regarding the need for the ICU beds. In the meeting with DCOPN, the applicant maintains a fundamental reason for Ashland Hospital needing to be constructed rests upon the need for a place to take stroke, cardiac, and motor vehicle-related trauma patients for stabilization, where they will later be transported to one of the



other HDH hospitals for further, specialized care. If this is the case, it is unclear to DCOPN why Ashland Hospital would need ICU inpatient rooms if the severe medical cases are to be transported. Additionally, DCOPN asked for an estimation of the quantity of patients expected to be transported (as that affects healthcare costs), and DCOPN was not provided with any clarifying information.

**12VAC5-230-570. Expansion or relocation of services.**

**A. Proposals to relocate beds to a location not contiguous to the existing site should be approved only when:**

- 1. Off-site replacement is necessary to correct life safety or building code deficiencies;**
- 2. The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;**
- 3. The number of beds to be moved off-site is taken out of service at the existing facility;**
- 4. The off-site replacement of beds results in:
  - a. A decrease in the licensed bed capacity;**
  - b. A substantial cost savings, cost avoidance, or consolidation of underutilized facilities; or**
  - c. Generally improved operating efficiency in the applicant's facility or facilities; and****
- 5. The relocation results in improved distribution of existing resources to meet community needs.**

The following information is provided by the applicant:

- Most of the rooms being relocated from Retreat were built in 1969 and to the applicable standards required for that time; these rooms are not currently up to current hospital design guides and is inefficient for optimal patient care. Inpatient rooms are smaller than 120 square feet of clear floor area standards; additionally, the rooms do not allow for the minimum 36 inches of clearance on either side of the bed and the foot of the bed. To alleviate these space limitations, significant and highly disruptive renovations would need to take place.
- The room layouts do not allow for computers to be in the rooms, resulting in providers having to return to the nurses' station to complete documentation of patient care. There is no material storage space in the rooms, requiring additional time and travel for providers to retrieve supplies for patient care.
- The rooms were also built during a time when communal patient showers were incorporated into the guidelines. The patient rooms only have a toilet and sink, which do not meet the current bathroom guidelines.
- Renovations of these units would require complete replacement of the medical gas system due to the use of soft copper, soft solder, and painted supply lines, all of which are not allowed under the current plumbing codes.
- Retreat is licensed for 227 inpatient beds, relocating 60 beds would leave 167 licensed beds at Retreat, which will remain operational after Ashland Hospital opens.
- The project will improve efficiencies across HDH's campuses while meaningfully improving access to existing resources for a significant number of HDH's existing patients.

- The strong community support for Ashland Hospital confirms that the project will result in improved distribution of existing resources to meet community needs.

Subsection 1: DCOPN clarified with the applicant that all remaining beds at Retreat will be in rooms that are larger than 120 square feet; the applicant stated the majority of the remaining rooms are in units that currently meet appropriate guidelines, although there would still be some beds in older rooms that met design standards at the time that they were constructed but are not fully consistent with current guidelines. The project appears to meet the standard outlined in subsection 1.

Subsection 2: Retreat Hospital patients will continue to have options for acute patient care.

Subsection 3: The applicant states that “most of the staff needed to operate Ashland Hospital will be relocated from other HDH and HCA facilities within the market.” Retreat, according to 2021 VHI Data, had 78 of their 227 beds staffed, indicating there is either not enough need and/or not enough staff available for the quantity of beds for which they are licensed. A letter sent to the House Energy and Commerce Committee by the American Hospital Association in March 2022 called the healthcare workforce shortage that hospitals were experiencing a “national emergency”, with shortages expected to continue<sup>15</sup>; this being said, the plausibility of the 293.25 needed FTE staff members at the Ashland Hospital coming from other HCA/HDH locations is questionable. To reiterate, while Retreat is licensed for 227 beds, in 2021, only 78 of those beds were staffed, whether due to staffing or utilization (or another unidentified) reason(s) is unclear. Moving 60 of 227 licensed beds from Retreat and (DCOPN assumes) still only staffing 78 beds will leave a remaining 89 unstaffed beds at Retreat; 89 unstaffed beds is more than 50% unstaffed for this hospital.

The beds will be taken out of service at Retreat following the relocation; however, the reality is they are not being utilized at this time, indicative of the lack of need of the beds in the PD.

Subsection 4:

The off-site replacement of beds will not result in a decrease in licensed bed capacity overall. The cost savings for relocation of the beds to a new hospital compared to renovation of Retreat is not clear. Retreat is underutilized and will continue to be following the project’s opening as the applicant has stated Retreat will remain operational. The proposed beds are reported to come from rooms that are not as efficient at retreat, which would increase modern medical facility guidelines for those 60 beds.

Subsection 5:

The applicant argues the relocation will improve access and ability to meet community needs in the Ashland area. The applicant estimates 43.7% of the patients are to come from Henrico, which already have access to two HDH hospitals.

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<sup>15</sup> <https://www.usnews.com/news/health-news/articles/2022-07-28/staff-shortages-choking-u-s-health-care-system>

- B. Proposals to relocate beds within a health planning district where underutilized beds are within 30 minutes driving time one way under normal conditions of the site of the proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.**

The applicant does not demonstrate that the proposed relocation will not materially harm other providers; one of the other providers that may be affected are within their own hospital group. Retreat is very underutilized, and it is not clear that Retreat will be able to remain operational following the opening of Ashland Hospital as the applicant suggests. Furthermore, Richmond Community Hospital is reasonably within a 30 minutes' driving time from the proposed location (in addition to Memorial Regional Medical Center, at approximately 75% utilization), significantly underutilized, and it is not clear how the project will impact this hospital. The applicant reports 7.5% of its patient pool is projected to come from Richmond City, yet stated to DCOPN that the applicant did not reach out to Richmond EMS due to the low volume projected to come from this area. Conversely, the applicant provided support from Caroline County EMS, who is anticipated to account for only 3.9% of the Year 1 volume. The reasoning provided by the applicant for not reaching out to Richmond City is counterintuitive to the support provided by Caroline County EMS.

**12VAC5-230-580. Long-term acute care hospitals (LTACHs).**

- A. LTACHs will not be considered as a separate category for planning or licensing purposes. All LTACH beds remain part of the inventory of inpatient hospital beds.**
- B. A LTACH shall only be approved if an existing hospital converts existing medical/surgical beds to LTACH beds or if there is an identified need for LTACH beds within a health planning district. New LTACH beds that would result in an increase in total licensed beds above 165% of the average daily census for the health planning district will not be approved. Excess inpatient beds within an applicant's existing acute care facilities must be converted to fill any unmet need for additional LTACH beds.**
- C. If an existing or host hospital converts existing beds for use as LTACH beds, those beds must be delicensed from the bed inventory of the existing hospital. If the LTACH ceases to exist, terminates its services, or does not offer services for a period of 12 months within its first year of operation, the beds delicensed by the host hospital to establish the LTACH shall revert back to that host hospital. If the LTACH ceases operation in subsequent years of operation, the host hospital may reacquire the LTACH beds by obtaining a COPN, provided the beds are to be used exclusively for their original intended purpose and the application meets all other applicable project delivery requirements. Such an application shall not be subject to the standard batch review cycle and shall be processed as allowed under Part VI ([12VAC5-220-280](#) et seq.) of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.**
- D. The application shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients.**
- E. A LTACH shall be established for 10 or more beds.**
- F. A LTACH shall become certified by the Centers for Medicare and Medicaid Services (CMS) as a long-term acute care hospital and shall not convert to a hospital for patients needing a length of stay of less than 25 days without obtaining a certificate of public**

need.

1. **If the LTACH fails to meet the CMS requirements as a LTACH within 12 months after beginning operation, it may apply for a six-month extension of its COPN.**
2. **If the LTACH fails to meet the CMS requirements as a LTACH within the extension period, then the COPN granted pursuant to this section shall expire automatically.**

This provision is not applicable as the applicant is not proposing to establish an LTACH.

**12VAC5-230-590. Staffing.**

**Inpatient services should be under the direction or supervision of one or more qualified physicians.**

The applicant provided assurances that inpatient services will be under the direction or supervision of one or more qualified physicians.

***Required Considerations Continued***

4. **The extent to which the proposed service or facility fosters institutional competition that benefits the area to be served while improving access to essential health care services for all persons in the area to be served.**

To reiterate, Retreat, the hospital from which the Cath Lab and 60 beds are proposed to relocate from, is approximately 11.1-12.7 miles, or 15-19 minutes' driving distance from the proposed location, and is generally an underutilized hospital.

Bon Secours Memorial Regional Medical Center is only about 6 miles, or 11 minutes southeast of the proposed location. VCU Medical Center, located about 13.6 miles, or 18 minutes' driving time, south of the location opposed the project. VCU states:

HCA cites extensively to certain findings within the Virginia Department of Transportation I-95 Corridor Improvement Plan regarding Hanover County ambulances and residents having to travel this area with traffic congestion and delays. While drive times are relevant to a public need analysis, traffic congestion is not dispositive of need, particularly when accessibility is well within the SMFP's drive time standard and HCA has not demonstrated any other indicia of need for its proposal. I-295 and I-64 are ignored by the applicant and also provide access for patients.

DCOPN review of geographic access and timeframes concur with this aspect of the VCU opposition letter regarding the already established access to essential health care services within the projected service area. The patient origin is also proposed to be largely within Henrico County (43.7% of its projected Year 1 PSA), where HDH already has locations. There is strong support from Hanover County, however Hanover is projected to account only for 20.6% of its Year 1 patient origin. Bon Secours Memorial Regional Medical Center is

located in Hanover County and is easily accessible by EMS providers in serious trauma scenarios.

The applicant makes mention numerous times that the access will increase for patients who prefer HDH hospitals in a “location closer to where they live and work.” Furthermore, the only Cath lab at Retreat hospital, which the applicant argues is a necessity in any acute care hospital, will no longer be available at Retreat. The project will neither notably increase access to essential health care services for all persons to be served nor foster healthy institutional competition.

**5. The relationship of the project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities.**

Approval of the project would unnecessarily duplicate services and reduce utilization of already underutilized services of other HDH locations. The applicant proposes to move some of the services, 60 beds and Cath lab, from Retreat, which is very underutilized in the COPN regulated services analyzed in this staff report. While the beds are proposed to come from beds that are not staffed/used at Retreat, the hospital is underutilized without those beds being in use currently, realistically duplicating services.

Furthermore, the imaging aspects of this project will be available for outpatient use, which will come at a higher cost to patients and insurance companies than if patients were to use an outpatient imaging clinic.

**6. The feasibility of the project, including the financial benefits of the project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital.**

The Ashland Hospital project’s anticipated total capital cost is \$233,633,000 (**Table 15**). The space allocation indicates a total building gross square-foot of 177,864 (estimated size of the entire project). Per square-foot, this would yield approximately \$1,314 of the total capital cost. Considering only the direct construction cost of \$158,830,000 for the 177,864 square-foot building, the construction costs would approximate \$893 per square-foot.

**Table 15. Total Capital Cost Summary**

|   |                      |
|---|----------------------|
| Part I-Direct Construction Cost                         | \$158,830,000        |
| Part II-Equipment Not Included in Construction Contract | \$43,528,000         |
| Part III-Site Acquisition Costs                         | \$14,500,000         |
| Part IV-Site Preparation Costs                          | \$5,000,000          |
| Part V-Off-Site Costs                                   | \$3,318,000          |
| Part VI-Architectural and Engineering Fees              | \$8,457,000          |
| <b>Total Capital Cost</b>                               | <b>\$233,633,000</b> |

Source: COPN Req. VA-8687

Statista, a statistics service, indicates that the average construction costs for building a general hospital in America averages \$700/sq. foot in 2022, ranging from \$437.50 to \$790.<sup>16</sup> Becker’s Hospital Review published an article April 11, 2022, stating comparable information to what Statista reported.<sup>17</sup> Comparing the Ashland Hospital project costs to the average American costs (as well as the extremes in both conservative and costlier options). Important to note, this comparison does not account for the projected inflation between the time of the writing of this analysis and the start of the project construction. The project at hand, comparing to current building trends, is high in terms of both direct construction costs and total capital costs.

Below, **Table 16** outlines comparison pricing among Ashland Hospital and two other projects resulting in COPNs VA-04793 & VA-04832. The projects were submitted in the February 2022 Batch Cycle and are the newest comparable projects with which to compare. While the services are different and the Inova projects include more CTs, MRIs, ORs, beds, and one includes radiation therapy and other services as well, the overall acute care hospital construction costs can be compared. It is important to consider the cost of living differences between NOVA (northern Virginia) and the greater Richmond area. **Figure 9** is from a cost of living calculator<sup>18</sup> and can be used to assist in this comparison.

**Table 16. Comparison to Prior Projects, VA-04793 (IAH) & VA-04832 (ISH)**

|   | Ashland Hospital   | Inova Alexandria Hospital (IAH) | Inova Springfield Hospital (ISH) |
|---|--------------------|---------------------------------|----------------------------------|
| Bed Quantity                            | 60                 | 192                             | 120                              |
| Square Feet                             | 177,864            | 915,000                         | 425,000                          |
| Total Capital Costs                     | \$233,633,000      | \$1,455,989,952                 | \$859,615,365                    |
| Direct Construction Costs               | \$158,830,000      | \$677,940,460                   | \$393,757,837                    |
| <b>Total Interest on Financing Cost</b> | N/A                | <b>\$417,858,192</b>            | <b>\$248,079,615</b>             |
| <b>Construction Costs per Sq. Ft.</b>   | <b>\$892.99</b>    | <b>\$740.92</b>                 | <b>\$926.49</b>                  |
| Total Capital Cost per Sq. Ft.          | \$1,313.55         | \$1,591.25                      | \$2,022.62                       |
| <b>Construction Cost per Bed</b>        | <b>\$2,647,166</b> | <b>\$3,530,939</b>              | <b>\$3,281,315</b>               |
| Total Capital Cost per Bed              | \$3,893,883.33     | \$7,583,281.00                  | \$7,163,461.38                   |

**Sources:** COPN VA-8687, COPN VA-8612&8613 Staff Report, Articles posted online regarding estimated sq. ft. of IAH and ISH.

Ashland Hospital will be entirely funded through accumulated reserves; no interest will be paid on capital needed for completing the project. The IAH and ISH projects occurred in PD 8/ HPR II, and both projects included substantial financing costs. In comparison to the Inova projects, Ashland Hospital’s estimated construction cost per sq. ft. falls between the listed projects, while the construction cost per bed is approximately 75% of IAH’s and 81% of

<sup>16</sup> <https://www.statista.com/statistics/830405/construction-costs-of-general-hospitals-in-us-cities/>

<sup>17</sup> <https://www.beckershospitalreview.com/capital/los-angeles-tops-list-of-12-most-expensive-cities-to-build-general-hospitals.html>

<sup>18</sup> <https://www.bestplaces.net/cost-of-living/fairfax-va/richmond-va/100000>

ISH’s construction cost per bed. Also of importance, the HSANV Staff Report for HPR II indicated the costs for IAH and ISH were substantial.

**Figure 9. Cost of Living 2023 Fairfax (within NOVA) vs. Richmond, Virginia**

| Cost of Living Indexes  | Fairfax, VA | Richmond, VA | Difference             |
|---|-------------|--------------|------------------------|
| <u>Overall Index</u> : Homeowner, No Child care, Taxes Not Considered | 148.2       | 96.1         | 35.2% less             |
| <u>Food &amp; Groceries</u>   | 114.1       | 98.0         | 14.1% less             |
| <u>Housing</u> (Homeowner)  | 238.4       | 92.7         | 61.1% less             |
| <u>Median Home Cost</u>   | \$654,200   | \$327,100    | \$327,100 (50.0% less) |
| <u>Utilities</u>  | 97.4        | 98.9         | 1.5% more              |
| <u>Transportation</u>   | 127.6       | 83.5         | 34.6% less             |
| <u>Health</u>   | 102.7       | 99.2         | 3.4% less              |
| <u>Miscellaneous</u>  | 114.2       | 105.4        | 7.7% less              |

**Source:** <https://www.bestplaces.net/cost-of-living/fairfax-va/richmond-va/100000>

Ashland Hospital’s Pro Forma is detailed below in **Table 17**. For Year 1, the applicant is projecting 4,134 discharges with an average net income per discharge being \$930; for Year 2, the applicant is projecting 4,216 discharges with an average net income per discharge being \$974.

**Table 17. Pro Forma Summary**

|                                 | <b>Year 1</b>      | <b>Year 2</b>      |
|---------------------------------|--------------------|--------------------|
| Discharges                      | 4,134              | 4,216              |
| Gross Revenue                   | \$705,156,121      | \$778,567,172      |
| Charity and Bad Debt            | \$11,287,992       | \$12,463,140       |
| Net Revenue                     | \$72,760,067       | \$77,539,935       |
| Total Operating Expenses        | \$68,912,765       | \$73,433,791       |
| <b>Net Income</b>               | <b>\$3,847,301</b> | <b>\$4,106,144</b> |
| <b>Net Income per Discharge</b> | <b>\$931</b>       | <b>\$974</b>       |

Source: COPN Req. VA-8687

For comparison, IAH’s and ISH’s Pro Forma for the projects resulting in COPNs VA-04793 and VA-04832, respectively, yielded the following:

- IAH Year 1: \$1,754 per admission income
- IAH Year 2: \$1,921 per admission income
- ISH Year 1: \$2,590 per admission income
- ISH Year 2: \$2,553 per admission income

Using Figure 9, healthcare costs in Richmond are 99.2% of the average in the United States, while Fairfax’ healthcare costs are 102.7% % of the average in the United States, leaving only a 3.4% difference for healthcare costs, further illustrating the vast difference between projected income for Ashland Hospital in comparison to other hospitals being constructed in the state.

It would appear that one of the following, or a combination thereof, may be occurring:

- the applicant is charging less for services;
- IAH and ISH are offering more expensive services;
- IAH and ISH are able to provide services more economically than the applicant, resulting in greater income estimates.

While the applicant’s total capital cost estimates are substantial and higher than average, they are comparable to the costs of other acute care hospital costs authorized within the state relatively recently, albeit in a more expensive area. Furthermore, the projected income is less than the projects used for comparison. The financial impact on the other HDH hospitals is not addressed, although this analysis is relevant as the applicant asserts the patients will come from HDH patient pool.

- 7. The extent to which the project provides improvements or innovations in the financing and delivery of health services, as demonstrated by: (i) The introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services. (ii) The potential for provision of services on an outpatient basis. (iii) Any cooperative efforts to meet regional health care needs. (iv) At the discretion of the Commissioner, any other factors as may be appropriate.**



The project does not provide any improvements or innovation in the financing or delivery of healthcare through the introduction of new technology that would promote quality, cost effectiveness, or both in the delivery of healthcare services. The project does propose to provide services, such as imaging, in an outpatient basis; however, the services will be provided in an acute care hospital at a higher cost. The project is supported by local EMS services in order to decrease times for emergency transportation for patients who prefer HDH hospitals. DCOPN did not identify any other discretionary factors, not discussed elsewhere in this staff analysis report, to bring to the attention of the Commissioner as may be relevant in determining the extent to which the project provides improvements or innovations in the financing and delivery of health services.

**8. In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served.**

**(i) The unique research, training, and clinical mission of the teaching hospital or medical school. (ii) Any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations.**

Per the applicant:

- HCA Virginia Health System has partnered with colleges, universities, and other initiatives and programs for health professional training. HCA Virginia Health System has 11 Graduate Medical Education (GME) programs with 210 physician residents training in a variety of fields. HDH has affiliation agreements for clinical rotations with a number of health professional education programs to include Brightpoint Community College, Chester Career College, ECPI University, Gallen College of Nursing, James Madison University, Radford University, Regis College, South College, Virginia Commonwealth University, and Walden University.
- HCA Virginia has recently partnered with the Galen College of Nursing to establish its first Virginia campus in Richmond. The Virginia campus opened in March 2022 and offers two programs specifically to increase the number of RNs in Virginia: a two-year Associate Degree in Nursing program for students wishing to become RNs, and a 15–18-month LPN/LVN to AND Bridge program for Licensed Practical/Licensed Vocational nurses who want to continue to grow their nursing career by becoming an RN. The initial class consists of 39 students, with the goal of supporting 400-480 students per year.

While not directly articulated within the application, HCA's agreements with many educational institutions for clinical rotations helps provide experience for future professionals, as well as provides additional assistance/task completion within the medical facilities the students are placed in.<sup>19</sup> However, ultimately, the project is not

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<sup>19</sup> <https://healthcare-digital.com/hospitals/hospitals-can-benefit-implementing-more-internships>

proposed by or will affect a teaching hospital associated with a public institution of higher education or a medical school in the area to be served.

### **DCOPN Staff Findings and Conclusions**

The applicant states repeatedly that Ashland Hospital is to be constructed for the purpose of assisting their own patient population with access as the I-95 corridor's traffic congestion limits their patients' access to their preferred providers. There is no mention within the application or communication following the application regarding the other routes of traveling to HDH hospitals. HDH hospital's utilization of the COPN regulated services analyzed in this staff report can be summarized as follows:

- CT: For 2021, HDH Forest (4 units) operated at 113% capacity, HDH Parham (1 unit) operated at 173% capacity, and HDH Retreat (1 unit) operated at 55% capacity. Collectively, they performed 50,283 procedures for 6 units, operating at 113.3% capacity per unit, or 8,381 procedures per unit. Additionally, HCA has another CT scanner relocating to Scotts Addition, which would yield 7 scanners in the HDH area. Using 2021 VHI volumes, each of the 7 units would average 7184 procedures, or 97.1% utilization. In total, PD 15 CT scanners operate at 111% of the SMFP utilization threshold. The addition of a CT scanner in the PD would not likely adversely affect the PD.
- MRI: For 2021, HDH Forest (2 units) operated at 51.9% capacity, HDH Parham (1 unit) operated at 48.4% capacity, and HDH Retreat (1 unit) operated at 21.9% capacity. The average utilization for MRI scanners in PD 15 is 72.5% utilization, using VHI 2021 data. Even allowing for consideration of lower volumes as a result of Covid-19 pandemic, there does not appear to be a need for additional MRI capacity, and especially not a need for additional HDH MRI capacity. The applicant does not address whether relocating 1 MRI from HDH Forest and utilizing HDH Parham, HDH Retreat, and the new location to distribute the concentration of MRI services from HDH Forest more evenly was considered.
- Cath Lab: For 2021, HDH Forest (5 laboratories) operated at 46.58% capacity, while HDH Retreat (1 laboratory) reported no utilization. The average PD 15 Cath lab utilization is 50.73% per laboratory. The applicant references a prior COPN decision where the Commissioner stated “[c]ardiac cath services are generally recognized as an expected component of a community or general hospital.” HCA proposes relocating the only Cath lab at HDH Retreat to Ashland Hospital. This argument and proposition create a juxtaposition on two fronts: (1) the removal of the only Cath lab, regardless of utilization, to the proposed site on the basis of the Commissioner's statement creates an antithetical effect for HDH Retreat, and (2) HDH Parham does not have Cath Labs, also in contrast with the proposed argument.
- ORs: For 2021, HDH Parham (11 ORs) operated at 57.6% capacity, HDH Retreat (5 ORs) operated at 68.0% capacity, and HDH Forest (21 ORs) operated at 61.6% capacity. The average utilization for GPORs in PD 15 was 127.8% per GPOR, which is significantly higher than the HDH system utilization. The other two HCA hospitals in the PD, Chippenham Hospital and Johnston-Willis Hospital, operated at 122.5% and 96.3% utilization per unit, respectively. The applicant requests for the proposal to be approved without indicating which HCA hospital(s) the 4 ORs would be relocating from. If this aspect of the application were to be approved, it would set precedent that applicants do not need to give the full project details to the Commissioner to make their decision, and

the analysis available will not be thorough as a result. Furthermore, the failure to provide the locations from which the ORs are to be relocated from makes it impossible to analyze the relocation of ORs' portion SMFP, specifically 12VAC5-230-500 (B). A reasonable option the applicant could have presented was the locations they would like to move the ORs from, and if the utilization were to change dramatically, requiring an alteration of this aspect of the project, the change could have been addressed in the COPN Extension process.

- Beds: For 2021, HDH Forest (340 beds) had an occupancy rate of 58.39%, HDH Parham (200 beds) had an occupancy rate of 46.51%, and HDH Retreat (227 beds) had an occupancy rate of 14.09% per licensed bed. The applicant proposes relocating 60 beds from HDH Retreat to Ashland Hospital, asserting that many of the rooms the beds will be relocated from are rooms that are neither to the standard of current inpatient room guidelines nor efficiently designed to use with modern technology. HCA states that the renovations needed at Retreat to make these rooms more efficient and to the current guidelines would be "costly." The proposed project's total capital cost is \$233,633,000; the applicant does not give insight as to whether the renovations would be more or less costly than the relatively expensive Ashland Hospital project cost.

Additional inconsistencies within the application and project as a whole include:

- The applicant provided EMS letters of support from many localities, including Caroline County. When asked why there was no Richmond City EMS support, DCOPN was advised that they were not contacted as such a small portion of the proposed PSA would be coming from Richmond City. However, Attachment IV.B.2 of the application indicates Ashland Hospital's PSA is to be comprised of 7.5% Richmond City patients and 3.9% Caroline County patients. Also worthy of note, Caroline County is not located in PD 15.
- The applicant and support letters make extensive mention of the "improved access" to HDH care, but neglects to address whether or not those patients are being denied emergency care by Memorial Regional Medical Center, located approximately 8 miles, or a 9 minutes' drive, from the proposed location.
- The applicant seeks approval of the application with an option to choose which ORs to relocate at its own discretion closer to the opening of the hospital. Additionally, the applicant provides a blanket statement that the hospital's Cath lab services will adhere to the nine requirements outlined in 12VAC5-230-420 but makes no effort to indicate how they will accomplish some of these, such as the ambulance service agreements. It appears HCA seeks approval of the project with extensive leeway and without adequately addressing how the project will meet the SMFP requirements.
- The Cath lab and 60 beds are to be relocated from a hospital with higher poverty rates (Richmond's poverty rate is 24.5%) to a new hospital in a county with lower poverty rates (Hanover County's poverty rate is 5.2%) under the guise of access difficulties (**Table 2**). The applicant and support letters make multiple mention of the I-95 corridor traffic congestion, but do not detail why alternative routes are not addressed (such as I-295, which circumvents the I-95 congestion). Access is typically more difficult for those without financial means. The resources at Retreat that are being proposed to be relocated were not utilized in 2021; however, due to their availability, despite their lack of use, the applicant argues the project should not be viewed as providing new services. DCOPN

finds it prudent to analyze the proposal to relocate previously unused capacity as new services as the unused services clearly show they were no longer needed in the PD.

- VCUHS' letter of opposition details the lack of support for the project as a reason for denial. The letter's intention to DCOPN with the word "support" was in regard to the lack of quantitative evidence for the need to establish Ashland Hospital. The applicant's response letter refers to "support" as the letters of support for the project, rather than providing quantitative data.
- HCA provides an estimate of 293.25 FTE staff needed for the operation of Ashland Hospital. There is a severe healthcare staffing shortage at this time. In a meeting with DCOPN, the applicant does not anticipate having difficulty staffing the hospital as many will relocate from other HCA locations. 293.25 staff is a significant quantity for staffing; how this will affect the other HCA locations has not been addressed. While a project has not been denied due to the likelihood of the inability to staff the facility, it is imperative to consider as appropriate staffing level decrease errors, increase patient satisfaction, and improve retention rates.<sup>20</sup>
- The hospital total capital costs are among the highest in Virginia, yet the return on investment is expected to be much lower than comparable projects. Furthermore, the financial impact on the other hospitals who are already underutilized was not presented in the application.
- The property the proposed project is on is not currently zoned for hospital use.

While the project does propose some possible benefits to the public, the application is overwhelmingly scarce with regard to supporting the assertions of needing to increase access for care, does not give the information the SMFP necessitates for DCOPN to analyze and present to the Commissioner. There are glaring inconsistencies, and even when given the opportunity to address them, they are not addressed.

### **DCOPN Staff Recommendations**

COPN Request No. VA-8687 – HCA Services of Virginia, Inc. d/b/a Henrico Doctors' Hospital

The Division of Certificate of Public Need recommends the denial of this project for the following reasons:

1. The proposal to establish a 60-bed, 4-OR, 1 Cath Lab, 1 CT and 1MRI hospital is not generally consistent with the applicable standards and criteria of the State Medical Facilities Plan and the 8 Required Considerations of the Code of Virginia.
2. The applicant has not demonstrated lack of access to their patients' preferred providers.
3. Maintaining the status quo is a significantly more cost-effective alternative and does not appear to have adverse effects on the projected service area.

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<sup>20</sup> Haddad LM, Annamaraju P, Toney-Butler TJ. Nursing Shortage. [Updated 2023 Feb 13]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK493175/>

4. The capital costs of the proposed project are not reasonable with relation to the relative benefit from the project's construction.
5. The proposed project is likely to have a significant negative impact upon the utilization, costs, or charges of other providers of inpatient services as it is a duplication of services.
6. There is known opposition to the project.