Talking Points for OR Work Group
Tom Siemers, President and CEO, Dosher Hospital
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- Thank Chairpersons Dr. Ullrich and Sandra Greene, PhD
- I am Tom Siemers, President and CEO of Dosher Hospital in Southport, NC, Brunswick County
- Dosher is a critical access hospital with a 24/7 operating room and two operating rooms.
- We do approximately 1,500 surgical cases a year.
- Brunswick has a population of approximately 124,000 people and two hospitals. It is also adjacent to New Hanover County
- Made the trip here because what you do today can affect us in ways that may not be apparent.
- For example, rounding up in the 2016 Plan took a calculated need for 0.37 rooms, made it one room and generated CON applications for freestanding surgical centers with capacity of three operating rooms when you consider that a procedure room can do surgical procedures.
- That simple rounding could put the long-term viability of Dosher in jeopardy because, even though we are a critical access hospital, Dosher is not protected. Medicare and Medicaid pay allowable costs, but we need revenue from other payers to make up for the costs that government payers refuse to recognize.
- At the same time the Plan put OR need in Brunswick, it put three more operating rooms in New Hanover and those applications are for facilities with much more capacity than three operating rooms.
- I do not believe that you can generate a methodology, or write an equation that anticipates all of the downside risk to a critical access hospital.
- For that reason, I am asking that you add a policy change with the methodology that requires applicants proposing to serve counties that have a critical access hospital to obtain a letter from that critical access hospital indicating that the project will not adversely affect its viability.
- Why have protected status?

- First, the statute Findings of Fact that the Plan should reflect , GS 131E-175 (3a) calls for protection of viability of critical rural facilities
- Designation of a hospital as a critical access hospital means that it is a critical rural facility.
- Finally, without such protection the Brunswick problem will repeat, in fact some of your methodologies will generate yet another operating need in Brunswick County
- Thank you, I will be happy to entertain questions

- A new policy, AC-7, would have the following wording:

  "To ensure the viability of Critical Access Hospitals in North Carolina, addition of one or more operating rooms to a service area in which a critical access hospital operates is only permitted if the certificate of need application includes a signed letter from an authorized representative of the Critical Access Hospital stating that the project will not have an adverse impact on the CAH's ability to provide comprehensive emergency, inpatient and outpatient medical services to residents of the CAH service area. This is consistent with G.S. 131E-175 (3a) which states that the needs of rural North Carolina should be considered in the certificate of need process."

- In a service area with a Critical Access Hospital, rounding up should not occur if the Critical Access Hospital itself does not report 90 percent utilization of its operating room capacity based on an assumption of 2,106 case hours per operating room per year. The hours assume 260 days a year 9 hours a day. This is reasonable and conservative; a hospital can extend hours to 10 per day and days to 6 a week.