UNIVERSITY HEALTH SYSTEMS
of Eastern Carolina

August 1, 2008

State Health Coordinating Council
Dr. Dan Myers, Chair
c/o Medical Facilities Planning Section
North Carolina Division of Health Service Regulation
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: RESPONSE TO REQUEST FOR COMMENTS – PROPOSED 2009 SMFP

Comments on behalf of:
Pitt County Memorial Hospital, Greenville
Bertie Memorial Hospital, Windsor
Chowan Hospital, Edenton
Duplin General Hospital, Kenansville
Heritage Hospital, Tarboro
Roanoke-Chowan Hospital, Ahoskie
The Outer Banks Hospital, Nags Head

Dear Council Members:

Thank you for requesting feedback on the basic principles and on several changes outlined in the proposed 2009 State Medical Facilities Plan (SMFP). The comments below are made on behalf of the seven hospitals in the University Health Systems' Corporation. These comments support the concerns of not only our system hospitals but of the people living in the communities within our 29-county service area.

Basic Principles Governing the Development of the SMFP (pp. 2-5 of proposed 2009 SMFP)

The work group did an exceptional job of tackling a very challenging task -- the restatement of the basic principles on quality, access and value. While the updated principles are thorough and timely, we believe there is a need for more clarity if these principles are to be used as a reference for policy or methodology changes or as a means by which to evaluate competing certificate of need applications. Overall, the restatement supports the following:

- The need to define and track evidence-based, standardized, measurable, and consistent quality metrics,
- The importance of using rational criteria to compare the value of supporting existing providers who offer comprehensive services to a disproportionate share of the medically underserved and the value of encouraging new providers who may wish to provide a specialty service to a disproportionate share of well-funded patients, and
- An expanded view of the impact of the principles beyond the local level or in the short-term view, especially when the state must compare the cost-effectiveness and benefits of programs designed to meet the needs defined in the SMFP.

We encourage you to support the following action steps, many of which are embedded in the restatement of basic principles. In fact, in order to give these action items appropriate emphasis, we suggest revising the restatement to include only the core value statements for each principle in the SMFP. We believe the action items should be listed separately and provided to the small work group that will be appointed to help create a more concrete implementation plan.

- Establish the small workgroup as soon as possible to develop the implementation plan. Include in this workgroup members from DHSR, experts in the area of healthcare quality measurements, and providers who can appropriately represent the needs of the medically underserved. Balance rural and urban market representatives on the small group.
- Provide the opportunity for public comment at public hearings once an implementation plan is developed.
- Recommend changes to CON special rules, applications and review criteria to assure these tools are integrated with, and support, implementation of the basic principles.
- Define the publicly available, standardized measures for quality and safety that should be reported at least annually by any service provider approved by CON. Strongly consider implementing measures that would require current holders of regulated services to report similar data. Defined metrics must support comparisons among providers in order to evaluate, track and sustain compliance.
- Define publicly available and standardized measures for patient satisfaction that should be reported at least annually by any service provider approved by CON. Strongly consider implementing measures that would require current holders of regulated services to report similar data. Defined metrics must support comparisons among providers in order to evaluate, track and sustain compliance.
- Identify standard definitions and quantifiable economic measures for charity and under-compensated care and the medically under-served. Any measures of access used to secure CON approval should be reported annually and tracked against generally accepted standards and definitions for these measures.
- Continue to acknowledge the special needs and circumstances of rural community providers who are the sole providers of comprehensive care and emergency services when evaluating costs and value.
- All required public reporting by providers should be readily available to the general public (e.g. website postings, public notices, etc.).

Step 4 – Inventory of Operating Rooms (pg. 58 of proposed 2009 SMFP)

We strongly support continuing to exclude one operating room for Trauma Centers when determining operating room need in an OR Service Area with a state-designated Level I, II, or III Trauma Center. Pitt County Memorial Hospital (PCMH), the only Level I Trauma Center in eastern NC, has at least one operating room readily available at any given time to serve trauma patients. However, this does not mean there is only one distinct room that is always used or available for trauma patients. Because PCMH must routinely have one operating room (or the equivalent capacity) available for trauma patients, the hospital cannot use this available operating room capacity for other patients. This requirement limits the overall

operating room capacity for PCMH. The exclusion of one "trauma" operating room when determining operating room need is essentially diluted when the hospital must also exclude trauma cases.

For that reason, we request the SHCC consider not excluding the trauma cases if there is need for additional operating rooms in an OR Service Area with a state-designated Level I, II, or III Trauma Center. If the state desires to continue to exclude trauma cases in this situation, we propose using a standard definition for calculating excluded cases. One recommendation is to define excluded trauma cases as follows: Patients that are defined as a "trauma patient" by the state Trauma Registry who are sent to a hospital operating room directly from the hospital's Emergency Department for life or limb-saving surgical intervention.

Tiered Operating Room Data (pp. 79-102 of proposed 2009 SMFP)

We support the use of a tiered approach to evaluate operating room need across the state. We support a small group revisiting this and the remaining recommendations made by the last OR Work Group. In concept, if the tiered approach is designed to group like institutions and allow calculation of median resource hours and case time, then we suggest the state consider creating an academic medical center tier. These facilities are unique in terms of the types and complexity of patients each center serves, variables that significantly impact the use and need for operating rooms. The current Tier 1 contains a number of hospitals that vary substantially in terms of beds, services and complexity. An analysis of the resource hours and case time specific to academic medical centers is needed to determine if different resource hours and case time are needed for these institutions.

Please feel free to call me if you have questions or need additional information concerning our healthcare system's comments. Thank you in advance for your careful consideration of our input.

Sincerely,

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