UNC HEALTH CARE

August 1, 2008

Dr. Dan Meyers, Chair
State Health Coordinating Council
c/o Medical Facilities Planning Section
North Carolina Division of Health Services Regulation
Raleigh, N.C. 27699-2714

Re: UNC Health Care System's Comments on the Proposed 2009 State Medical Facilities Plan

The UNC Health Care System appreciates the opportunity to provide comments on the proposed 2009 State Medical Facilities Plan. We will be commenting on several things today: I) the quality, access and value principles; II) the operating room methodology; III) the cardiac catheterization equipment section; and, IV) the heart lung bypass machine section.

I. Quality, Access, and Value Principles

UNC Health Care supports the concept of relating quality, access, and value to the State Medical Facilities Planning Process. For clarity and implementation we have several suggestions: 1) the principles should be equitable and enforceable; 2) quality reporting should be consistent across provider types; 3) a history of providing access to medically underserved patients should be considered when evaluating applicants; and 4) the contributions of Academic Medical Centers should be reflected in the principles. We support the concept of a working group continuing to work on this initiative to ensure that these elements are presented in a fair and consistent manner. Specific comments for each of these suggestions follow.

1. The Principles should be Enforceable & Equitable

On page 2 of the proposed SMFP, the Basic Principles that are proposed to govern the development of the North Carolina State Medical Facilities Plan are presented. These Basic Principles are to "reliably serve as reference guidelines for the SHCC when it considers any policy or methodology inclusion, elimination, and/or modification." That concept is an excellent idea for overall policy making. The SHCC needs to clarify its intentions depending on its goals. If the SHCC wants to use this only as a guiding principal, what is in the SMFP is adequate. However, unless there are clear and equitable requirements that can be compared across CON applications, then they cannot be effectively utilized in the regulatory process.

As an example, consider the following Basic Principle: "When performance data on established quality and safety metrics as identified by the SHCC are available for a CON applicant, they should be required and considered by the CON Section in

evaluating the quality of service provided by that applicant." This statement is not enforceable by CON as presently stated and should be removed from the Basic Principles and addressed in the specific Policies within the SMFP or within specific rules in the CON Criteria and Standards. Another example under the Access Principle is the statement "The first priority is to ameliorate economic barriers and the second priority is to mitigate time and distance barriers, but CON applicants should address how their proposal will reduce all access barriers." Unless this is an action item that is moved to a Policy that an applicant must respond to, or to a Criteria and Standard that an applicant must respond to, we do not believe that the regulators can enforce the intent of this statement in reviewing Certificate of Need applications.

In addition, if rules are developed, they must apply equally to all applicants but in reality not all applicants have quality metrics or data. If one applicant has developed data, but another has not, is it fair to apply a required data reporting standard to the first applicant and not the other? We believe that the SHCC has a responsibility for assuring equal and consistent applicability of any metrics and data used in the regulatory process.

In summary, instructions and action steps for the SHCC in development of the SMFP are different than policies and rules that can be applied in making decisions in reviewing CON applications. Therefore we recommend that the two be separated with the Basic Principles stated in the annual SMFP and the action steps addressed through the SHCC's annual planning process, perhaps at the subcommittee or workgroup level.

2. Quality Data Reporting should be Consistent

With respect to quality, the SHCC has a responsibility to assure that any reporting mechanism the SHCC proposes is comparable, consistent, and measurable across all provider types. Currently, there is no data collection or reporting system that meets this standard. In addition, some providers do not currently collect quality data. It is not evident how providers who do not currently have quality data will be fairly evaluated against providers who do have that data. Just having one provider say it supports the quality principle while another is required to provide data proving it supports the principle does not lead to a fair comparison. It should be recognized that there is a cost to acquire and provide data on quality and value, and this needs to be considered as well.

In addition, we wholeheartedly agree that patient satisfaction is vital to helping us evaluate our success as an institution. However, we also know that providers are using very different patient satisfaction surveys and changing surveys has the potential to affect results. How will you create consistency in patient satisfaction data collection across all provider types?

In sum, if data is requested for the quality, access and value principles, then there should be a framework and rules developed for consistently providing that data across providers regardless of licensure status. The rule must apply to hospitals, physicians, physician groups, for-profit and not-for-profit entities equally.

Additional work is required if the SHCC is to implement the quality, access and value principles beyond a basic philosophy.

3. A History of Access for Medically Underserved Patients should be assessed

UNC Health Care is particularly interested in making sure patients have access to necessary health care services and that access issues are adequately reflected in the quality, access and value principles. We agree with the North Carolina Hospital Association's position statement that CON applicants with a documented history of service accessibility to the medically underserved patients should not be penalized if higher costs resulting from the services they provide are evident in a CON application.

4. ***The Value of Academic Medical Center's should be reflected***

As an academic medical center, we have an important charge of educating future health professionals and advancing the field of medicine through research. Like other Academic Medical Centers (AMCs), the costs and charges we have may be higher than our non-teaching hospital counterparts that do not have this societal contribution as part of their Mission and responsibilities. However, penalizing AMCs because of their higher costs has serious implications for our ability to continue educating and training physicians throughout the State? The SHCC needs to directly incorporate the importance of teaching and research in the value statement, and recognize the significant contributions of Academic Medical Centers to the health care system in North Carolina.

II. Operating Room Methodology

The proposed 2009 SMFP (and earlier SMFPs) incorporates excluding 1 Operating Room for each Level I, II, and III Trauma Center and 1 additional Operating Room for each designated Burn Intensive Care Unit. In the Draft SMFP, there is a request for comments on this part of the methodology. Because of the impact and importance of Level I Trauma Centers and the N.C. Jaycee Burn Center to the care of patients from across the State, we support the methodology as presently configured to provide these excluded Operating Rooms. Furthermore while the cases should be counted in the existing methodology, we believe there would be significant issues isolating these cases for reporting purposes routinely. Therefore we support the current operating room methodology regarding the Trauma/Burn Intensive Care exclusion criteria as reflected in the proposed 2009 SMFP.

III. Cardiac Catheterization Equipment

Table 9Q (pg. 187) of the proposed 2009 SMFP gives both pediatric and adult cardiac catheterization volumes. However, the table only lists UNC as having 3 catheterization labs. UNC Health Care operates a fourth cardiac catheterization laboratory that is dedicated to pediatric heart catheterizations. The volume from this fourth lab was included in the table; however, the lab itself was not included in the table. We request that table 9Q be footnoted to indicate that we have 1 pediatric catheterization lab in addition to the 3 adult catheterization labs already reflected in the table.

IV. HEART LUNG BYPASS MACHINES

Table 7B (pg 117) is designed to account for the fact that certain facilities (UNC and 4 others) provide heart lung bypass procedures on children under the age of 14. The table is supposed to multiply the number of procedures performed on children age 14 and under by two before adding it to the number of procedures performed on adults (reflected in table 7A). This is to account for the weighting for all procedures performed on young children.

Currently, table 7B reflects all procedures listed in table 7A and the number of procedures performed on children 14 and under has been added to that total. However, the table does not have the increased weight for the procedures performed on children under the age of 14 included. We believe this is true for all providers that perform these special procedures – not just UNC.

We request that table 7B be modified such that UNC has a total of 595 procedures listed.

- **Current table 7B justification: 375 + 110 = 485**
- **Corrected table 7B justification: 375 + 110 (multiplied by 2) = 595**

Thank you for this opportunity to comment.

Sincerely and on behalf of the UNC Health Care System,

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