Response By PCMH to Novant's Petition To Repeal or Amend Policy AC-3 in the Draft 2011 State Medical Facilities Plan

This Response is filed by Pitt County Memorial Hospital, Incorporated ("PCMH") related to the request filed by Novant Health, Inc. ("Novant") with the State Health Coordinating Council ("SHCC"). On August 2, 2010, Novant filed its request with the SHCC to amend the 2011 State Medical Facilities Plan ("SMFP") by seeking to repeal or substantially modify Policy AC-3, a statewide policy related to Academic Medical Centers ("AMCs").

PCMH believes the petition should be summarily dismissed since it was not filed in a timely manner. Novant requests a change in a basic policy, Policy AC-3, in the SMFP, which has a statewide impact. Thus, per the SMFP's filing deadlines noted on pp. 9-10 of the 2010 plan, Novant's petition was required to be filed on or before March 3, 2010. The petition was not filed until August 2, 2010.

However, even if Novant's request were timely filed, PCMH opposes any repeal of, or modifications to, a long-standing SMFP policy (AC-3) without any compelling reasons. In the discussion below, PCMH refutes each point raised by Novant as a reason to repeal or modify Policy AC-3.

In the petition, Novant cited several reasons for the elimination or change to Policy AC-3. Specifically, Novant argued:

1. **Policy AC-3 is No Longer Necessary because:**

- *Healthcare has changed dramatically since 1983.* Novant argues that the evolution of healthcare has decreased the gap between AMCs and non-MCs in terms of technology and the sophistication of services offered. Novant cited an example to illustrate their point. Novant stated, "Comparing a hospital like Forsyth Medical Center (FMC) with an AMC such as North Carolina Baptist Hospital (NCBH) is especially revealing, as it shows that the "service gap" at that level is indeed very small."

PCMH Response

While the gap may be closing between AMCs and non-AMCs in terms of services offered, Policy AC-3 is not intended to address the equitable distribution of healthcare services and resources to assure geographic access by all. This is handled by the traditional SMFP and Certificate of Need ("CON") process that is equally applicable to all providers in North Carolina, regardless of AMC status. Policy AC-3 is solely focused on education and research. And while the "service gap" may be closing, the "education and research gap" that exists between AMCs and non-AMCs is still very larger.

AMCs devote a significant amount of attention and resources to education and research. It is a major component of their mission and their business. For non-AMCs, education and research is secondary or not a part of the

mission at all. In fact, each of five AMCs[1] in North Carolina identify education and research in their mission, vision, and/or value statements. According to their website, education and training are not even mentioned in Novant's mission, vision, or value statements.[2] AMCs accept the responsibility of not only focusing on the patient, but also training future providers and researching better ways to provide care.

In addition to organizational focus, there is also a significant gap between AMCs and non-AMCs in terms of willingness to train residents. According to Table 1[3] below, 87% of all residents FY08 received their training at an AMC. Using Novant's own example, while the "service" gap may be small between FMC and NCBH, there is a significant gap in the commitment to teaching between the two hospitals. According to Table 1 below, NCBH trained over 18 times more residents that year than FMC.

Table 1: 2008 IME Residents by NC Hospital

	Hospital	FY08 IME Residents
AMCs	Duke Unviersity Hospital	530
	North Carolina Baptist Hospital	507
	University of North Carolina Hospitals	494
	Pitt County Memorial Hospital	291
	Carolinas Medical Center	194
	Subtotal (AMCs)	**2,016**
Non-AMCs	New Hanover Regional Medical Center	63
	The Moses H. Cone Memorial Hospital	48
	WakeMed Raleigh Campus	47
	Mission Hospital, Inc	44
	Durham Regional Hospital	28
	Forsyth Memorial Hospital, Inc	27
	CMC Northeast, Inc	20
	Cape Fear Valley Medical Center	20
	Margart R. Pardee Memorial Hospital	8
	Union Regional Medical Center	4
	Subtotal (Non-AMCs)	**309**
	TOTAL	**2,326**

Source: CMS 2008 Cost Report Public Use HCRIS Data Sets

Moreover, AMCs do much more than provide a training site, they are Sponsoring Institutions for residency and fellowship programs. Sponsoring Institutions assume the ultimate financial and academic responsibility for a

[1] Carolinas Medical Center ("CMC") is an AMC for SHCC purposes; however, CMC cannot currently use Policy AC-3

[2] http://www.novanthealth.org/about_novant_health/company_information.jsp

[3] Table 1 includes Indirect Medical Education medical resident counts per FY 2008 cost reports for all North Carolina hospitals. Note that cost report resident counts weight the FTEs and only account for resident's time in the hospital setting.

program, assuring the programs are in substantial compliance with the Accreditation Council for Graduate Medical Education requirements. Sponsoring Institutions' responsibilities include resident assignments at all participating sites. This means that Sponsoring Institutions develop the resident rotations, assuring that residents receive adequate training to meet the specific residency program requirements. If Sponsoring Institutions or participating sites do not have a service or lack adequate access to a service or technology other participating sites must be added to the rotation. Having the flexibility to expand or obtain new services or technologies as residency requirements change or programs are expanded are very important. The SHCC understood this need when the AMC policy was developed. While the policy requires the AMC apply for the CON and meet specific teaching and research requirements, it doesn't require there be a need in the SMFP or that the AMC file a petition for an adjustment to need.

PCMH used the AMC policy when it added pediatric and traumatic brain injury rehabilitation beds to its rehabilitation hospital. Prior to adding the beds, Physical Medicine and Rehabilitation residents had to go to Charlotte or out-of-state to gain access to pediatric or traumatic brain injury patients, since the PM&R residency program requirements required residents to treat these patients.

While some Sponsoring Institutions are not AMCs, in North Carolina most Sponsoring Institutions are AMCs. Table 2 below shows the Sponsoring Institutions in North Carolina and the number of residents and fellows participating in each Sponsoring Institution programs. As noted, 91% of residents and fellows trained in North Carolina are sponsored by AMCs.

Table 2: 2010 Residents by Sponsoring Institution

	Sponsoring Institution	FY10 Residents
AMCs	Duke University Hospital	867
	University of North Carolina Hospitals	683
	North Carolina Baptist Hospital	614
	Pitt County Memorial Hospital	325
	Carolinas Medical Center	223
	Subtotal (AMCs)	2,712
Non-AMCs	New Hanover Regional Medical Center	65
	Mountain AHEC	54
	Moses H. Cone Memorial Hospital	49
	Womack Army Medical Center	23
	Carolinas Medical Center Northeast	22
	Southern Regional AHEC	21
	Naval Hospital - Camp Lejeune	18
	Skin Surgery Center (Winston Salem)	1
	Subtotal (Non-AMCs)	253
	TOTAL	2,965

Source: www.acgme.org; Acreditation Council for Graduate Medical Education, Search Programs and Sponsors

As noted in the more detailed Exhibit A at the end of this document, the numbers of programs sponsored by the AMCs are extensive. Each residency or fellowship program has specific education requirements, which must be met to retain accreditation.

The level of commitment to education and research aside, Novant ultimately failed to recognize that the "service gap" at many North Carolina hospitals is closing due to the physicians (who are mostly trained at AMCs) applying what they have learned once they leave the AMC facility. Physicians bring the knowledge received from their AMC education to the non-AMC setting. As a result of their training and exposure to state-of-the-art research, technology, and facilities at AMCs, physicians are in fact able to take the knowledge they have gained and apply it in a non-AMC setting. This is ultimately what has narrowed the "service gap". However, this gap could not have been narrowed if not for the research and education received at the AMCs. Using Novant's own example, a rough survey of FMC's medical staff as posted on the "physician finder" section of their website indicates 56% of the medical staff went to medical school and/or attended an internship, residency, and/or fellowship program at one of the North Carolina AMCs.[4] FMC has obviously benefited from the education and training over half its medical has received at North Carolina AMCs as evident from the identified reduction in the "service gap".

In reality, all hospitals in North Carolina benefit from Policy AC-3, not just the four qualifying AMC facilities. The SMFP can not unduly constrain the ability of AMCs do this training and research, which is why the AC-3 exemption exist...to allow AMCs to expand capacity in order to train or perform research, regardless of need established in the SMFP.

- *AMCs Do Not Need Policy AC-3.* Novant's argues, "the relative lack of activity under Policy AC-3 suggests that the AMCs do not rely heavily on Policy AC-3 to address their teaching and research needs or other healthcare activities." Novant also argues that AMCs can, with "relative ease", misuse Policy AC-3

PCMH Response

Novant's arguments are completely contradictory. The relative lack of activity under Policy AC-3 would suggests that AMCs do not misuse the AMC policy and that the policy requirements as written are very stringent to prevent misuse. AMCs still must apply for a CON, demonstrate sufficient demand for teaching and/or research, prove that the requirements of the policy are met and the project is financially feasible, among other things.

[4] Based on a sampling of 72 physicians with the last names beginning with A-D. Sample represents almost 10% of the 745 physicians listed on the website.

Novant cited several avenues in which an AMC could add needed services through the special needs petition, N.C. General Statute 131E-179, and traditional CON processes instead of using Policy AC-3. The relative lack of activity under Policy AC-3 combined with the number of CONs filed under the traditional process and the number of special needs petitions filed show that the policy is used only after all other avenues are exhausted.

2. Policy AC-3 Gives Academic Medical Centers an Unfair Advantage.

Novant's petition states that Policy AC-3 gives AMCs three unfair advantages, including:

- Policy AC-3 allows the AMC to avoid the need determinations in the SMFP
- The exclusion of volume from services granted under the AC-3 Policy could suppress the identified need for additional services
- Policy AC-3 can be used for any SMFP-limiting service, not just limited to education and research activities.

PCMH Response

AMCs are not given an unfair advantage. First, Policy AC-3 does not allow AMCs to avoid the need determinations in the SMFP. The SMFP identifies needs for services and equipment to treat patients. AMCs are held to the same standards as all other hospitals when it comes to the equitable distribution of needed healthcare services throughout the State. However, Policy AC-3 has nothing to do with equitable distribution or identification of needed healthcare resources for the provision of care. Policy AC-3 references only resources needed to support education and research, which, as noted above, is primarily concentrated in AMCs.

Second, the exclusion of volume from services granted under the AC-3 Policy actually do not suppress the identified need for additional services. Training and research take time. As a result, the maximum capacity of a service or piece of equipment will be lower at an AMC compared to a non-AMC. The SMFP has specific volume thresholds in order to trigger a need. The reduction in volume due the increased time required for training and research could essentially keep total volumes from reaching the required threshold.

Thirdly, as stated above, Policy AC-3 specifically is written to support education and research activities. Therefore, Policy AC-3 cannot simply be used for any SMFP limiting service. It can only be used for those services that directly affect

educational and research activities, which, for different AMC, could be different resources depending on the focus of the institution.

3. **Policy AC-3 Is Inconsistent with North Carolina's Health Planning Process.**

   Novant states that the "NC Health Planning Process and its CON program are designed to ensure that only new institutional health services that are actually needed are built". Novant argues Policy AC-3 is inconsistent with this process.

   PCMH Response
   As stated above, the purpose of the SMFP and CON process is to assure the equitable geographic access of cost efficient, high quality healthcare services throughout NC. Policy AC-3 compliments this purpose by assuring the equitable distribution of resources used for education and research to the facilities that assume the majority of the responsibility for these initiatives (AMCs). As stated above, the service gap seen between AMCs and non-AMCs can partly be attributed to the education and training healthcare providers receive mostly at AMCs. Without these trained providers entering the non-AMC environment, many of the more sophisticated services could not be offered locally. As a result, the equitable geographic access of cost efficient, high quality healthcare services throughout NC could not have been realized. Therefore Policy AC-3 is not inconsistent with the process; it assures process can be successful.

In summary, PCMH believes the petition should be summarily dismissed since it was not filed in a timely manner. However, PCMH strongly opposes any repeal of, or modifications to, a long-standing SMFPO policy that:

1. Allows NC AMCs to meet their dual missions of both healthcare provider and healthcare educator,
2. Recognizes the inequitable burden AMCs have in providing education and research opportunities when compared to non-AMCs,
3. Is stringent enough to deter misuse, yet flexible enough to enable the future development of research and education activities, and
4. Compliments the long-standing efforts of the NC Health Planning and CON processes.

Exhibit A: 2010 Residents by Sponsorship Program

Program	AMCs	Non-AMCs	TOTAL	% AMC Sponsorship
Allergy and immunology	13	-	13	100%
Anesthesiology	151	-	151	100%
Adult Cardiothoracic Anesthesiology	11	-	11	100%
Pediatric Anesthesiology	4	-	4	100%
Dermatology	38	-	38	100%
Dermatopathology	2	-	2	100%
Procedural Dermatology	-	1	1	0%
Emergency medicine	162	-	162	100%
Pediatric emergency medicine	7	-	7	100%
Family medicine	116	145	261	44%
Family medicine rural	7	9	16	44%
Sports Medicine	5	3	8	63%
Medical Genetics	2	-	2	100%
Internal Medicine	391	45	436	90%
Cardiovascular Disease	65	-	65	100%
Critical Care Medicine	9	-	9	100%
Endocrinology	11	-	11	100%
Gastroenterology	26	-	26	100%
Infectious Disease	25	-	25	100%
Nephrology	24	-	24	100%
Rheumatology	11	-	11	100%
Geriatric Medicine	12	2	14	86%
Interventional Cardiology	11	-	11	100%
Clinical Cardiology Eletrophysiology	3	-	3	100%
Hematology and Oncology	55	-	55	100%
Pulmonary Disease and Critical Care Medicine	42	-	42	100%
Transplant Hepatology	1	-	1	100%
Neurological Surgery	33	-	33	100%
Neurology	40	-	40	100%
Neuromuscular Medicine	3	-	3	100%
Child Neurology	10	-	10	100%
Clinical Neurophysiology	6	-	6	100%
Vascular Neurology	1	-	1	100%
Molecular Genetic Pathology	1	-	1	100%
Nuclear Medicine	3	-	3	100%
OB/Gyn	123	37	160	77%
Ophtalmology	33	-	33	100%
Orthopedic Surgery	103	-	103	100%
Adult Reconstructive Orthopedics	1	-	1	100%
Foot and Ankle	3	-	3	100%
Orthopedic Trauma	3	-	3	100%
Hand Surgery	5	-	5	100%
Orthopedic Sports Medicine	3	-	3	100%
Otolaryngology	41	-	41	100%
Pathology - anatomic and clinical	67	-	67	100%

Exhibit A: 2010 Residents by Sponsorship Program (continued)

Program	AMCs	Non-AMCs	TOTAL	% AMC Sponsorship
Blood Banking/Transfusion	1	-	1	100%
Cytopathology	5	-	5	100%
Forensic pathology	2	-	2	100%
Hematology	4	-	4	100%
Medical Microbiology	1	-	1	100%
Pediatrics	199	-	199	100%
Pediatric Critical Care	11	-	11	100%
Pediatric Cardiology	9	-	9	100%
Pediatric endocrinology	6	-	6	100%
Pediatric hematology/oncology	11	-	11	100%
Pediatric nephrology	1	-	1	100%
Neonatal-perinatal medicine	25	-	25	100%
Pediatric pulmonology	7	-	7	100%
Developmental-behavioral pediatrics	1	-	1	100%
Pediatric rheumatology	3	-	3	100%
Pediatric infectious diseases	4	-	4	100%
Physical Medicine and Rehab	42	-	42	100%
Plastic surgery	24	-	24	100%
Preventive medicine	11	-	11	100%
Undersea and hyperbaric	2	-	2	100%
Psychiatry	130	-	130	100%
Child and adol pyschiatry	25	-	25	100%
Geriatric psychiatry	2	-	2	100%
Forensic psychiatry	1	-	1	100%
Radiology - diagnostic	119	-	119	100%
Abdominal radiology	4	-	4	100%
Neuroradiology	13	-	13	100%
Nuclear radiology	2	-	2	100%
Musculoskeletal radiology	3	-	3	100%
Pediatric radiology	1	-	1	100%
Vascular and Interventional radiology	5	-	5	100%
Radiation Oncology	22	-	22	100%
Surgery	163	11	174	94%
Surgical critical care	6	-	6	100%
Internal Medicine Pediatrics	69	-	69	100%
Internal Medicine Emergency	10	-	10	100%
Internal Medicine Psychiatry	14	-	14	100%
Vascular surgery	11	-	11	100%
Vascular surgery integrated	2	-	2	100%
Thoracic surgery	16	-	16	100%
Urology	29	-	29	100%
Sleep Medicine	4	-	4	100%
Pain Medicine	8	-	8	100%
Hospitce and palliative medicine	1	-	1	100%
GRAND TOTAL	**2,712**	**253**	**2,965**	**91%**

Source: www.acgme.org; Acreditation Council for Graduate Medical Education, Search Programs and Sponsors