North Carolina State Health Coordinating Council

Public Hearing on the *Proposed 2013 State Medical Facilities Plan*

August 1, 2012

Presented on behalf of: Southeastern Regional Medical Center

Good afternoon. My name is Dr. Andrew Schwartz, Vice President of Medical Affairs and the Chief Medical Officer at Southeastern Regional Medical Center. I'm here today, along with Dr. Robert Everhart, to speak on behalf of Southeastern's petition for a special need adjustment for cardiac cath equipment in the *Proposed 2013 State Medical Facilities Plan*. More specifically, Southeastern is requesting one additional unit of fixed cardiac cath equipment for Robeson County to be included in next year's Plan. While the petition itself will more fully detail the rationale for this request, we wanted to take this opportunity to discuss the petition in a public setting, and we appreciate the willingness of the SHCC members to attend the public hearings.

SRMC is the most recent provider in the state to initiate a new open heart surgery program, which puts us in a unique position. Some of

the existing open heart providers acquired multiple cardiac catheterization labs prior to 1993, which enabled them to forego the CON and SMFP-need determination restrictions on additional labs established with the statutory amendments to the CON law in 1993. As a result, SRMC is currently the only open heart provider in the state with only one cardiac catheterization lab.

Furthermore, as you know, the *SMFP* need methodology for cardiac cath equipment is similar to other methodologies in that it considers the units of equipment needed by dividing the number of weighted procedures by some percentage of the total capacity of the equipment—in this case, 80 percent. For cardiac cath, the capacity is 1,500 diagnostic-equivalent procedures, so 80 percent is 1,200 diagnostic-equivalent procedures. Where the cardiac cath methodology differs somewhat from others is in Step 5, which requires the number of units of equipment needed to be rounded to the nearest number. In other words, the need for a second unit of cardiac cath equipment is not generated until a need for 1.5 units is shown. Therefore, to trigger a need determination for providers

located in counties with only one piece of cardiac cath equipment, the existing cardiac cath equipment must actually perform 1,800 procedures per year, or ***120 percent of defined capacity***, before a need is triggered for additional equipment.

The reason this is not a tenable situation is that cardiac cath is a much different service than most of the other regulated services in that it is often used for emergency procedures. Most other equipment-based services, including MRI, PET, lithotripsy, gamma knife and linear accelerator treatments, are rarely, if ever used for emergency cases. Thus, with those services, when equipment reaches or exceeds capacity, patients may be inconvenienced, but rarely does it result in the delay of an emergency treatment as with a cardiac cath unit that is over capacity.

There are several other factors that support the need for another cath but since we discuss these in detail in our petition, I'll just mention them briefly today. In addition to being the largest county in North Carolina (approximately 950 square miles), Robeson County also has

demographic and socioeconomic factors that impact the cardiac service at SRMC.

In spite of improvements in death rates from heart disease, Robeson County continues to experience heart disease death rates that are significantly above those of other counties with open heart and interventional cath programs, as well as the North Carolina rate overall. Statistically, Robeson County's heart disease death rate is more than 1.5 standard deviations above the North Carolina rate, and nearly three standard deviations above the lowest rate in the state for Orange County. Clearly, the county continues to need improved access to cardiology services.

A significant contributing factor to the higher heart disease death rates is the high minority population, both Native and African American, residing in Robeson County. As I'm sure you are aware, unlike other ethnic groups, American Indians appear to have an increasing incidence of CHD, likely due to the high prevalence of diabetes. This disparity in morbidity and mortality from heart disease

affects Robeson County disproportionately, as over one-third (33.9%) of the total number of American Indians in North Carolina reside in Robeson County alone, and when the surrounding counties are considered, more than one-half of the state's American Indian population resides in the area.

We firmly believe that the evidence is clear: Robeson County is a unique circumstance that requires a special need adjustment for an additional cardiac cath unit in the county.

We appreciate your careful consideration of this petition. Please let us know if we can assist the Technology and Equipment Committee in your review of this petition.