

**Presentation of Petition for Change in Methodology for
Fixed PET to allow for Simulator/ Scanner
Proposed 2025 State Medical Facilities Plan**

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Introduction

Good afternoon. My name is Kyle Marek, I am President of Carteret Health Care. I have been the President for a year and have been with Carteret Health Care for 25 years. My roles have included VP of General Services and CIO.

Thank you, members of the SHCC, for arranging this opportunity. I am here to ask you to support a petition we will submit today to modify Chapter 15F of the ~~2024~~²⁰²⁵ *State Medical Facilities Plan* to include change the Methodology for Fixed Positron Emission Technology (“PET”) Scanners to recognize equipment that can function as both a simulator for linear accelerators and as a regular PET scanner. This adjustment would also involve a reduction in the PET scanner performance standard for this dual use PET equipment. The expected number of PET-only scans from 2,080 to 1,040 by the third operational year.

Background

Carteret Health Care is a 135-bed, not-for-profit, community hospital, with a Community Cancer Center, diagnostic centers, and physician offices. Located in Morehead City, the cancer center also serves residents from Craven, Jones, and Onslow Counties. Our mission is “to provide Quality Health Care with exceptional compassion and respect.” To support that mission, we are constantly looking for ways to offer services locally, so that transportation is not an access barrier for residents. We also look for ways to keep costs down.

Current Situation

Today, Carteret Health Care provides PET scan services through a contracted mobile unit that comes once a week on Sunday. As you know, PET scanning technology involves radiopharmaceuticals with

short half-lives. Our mobile contract limits us to one isotope, FDG. However, PET scanning has advanced, and other organ specific isotopes are now available. Without them we cannot perform brain, breast, or prostate cancer scans. That means we are referring almost half of our PET scans out of county.

Even with the limitations, our one-day mobile PET service is busier than three of the fixed full-time PET scanners in the state. Last year, we provided 526 PET scans, and we have a two-week waiting list. This itself is an artificial number. The mobile contract limits us to 600 annual scans. The contract limits us to twelve scans a day. We are grateful that the service is available – but it is no longer enough to meet demand.

There is a type of PET Scanner that is perfect for hospitals like Carteret. As you may know, fixed PET scanners often involve combined imaging technology with PET and CT functions in the same unit. PET provides metabolic information. Computed Tomography (“CT”) provides the anatomic location for the affected metabolism. You may not know about Combined PET/ CT Scanner Simulators. They have been around for almost two decades, but they are just now moving from academic to community cancer centers. The Standard Methodology in the State Medical Facilities Plan and the related Performance Standards fail to acknowledge this equipment.

The standard methodology for Fixed PET Scanners, Part 2 provides for “major” cancers – hospitals with two linear accelerators and 12,500 ESTVs to show automatic need for a Fixed PET scanner. We are asking to reduce that threshold to 7,000 ESTVs.

Why?

PET scanning is now routine in cancer care management. It plays both a diagnostic and a treatment role. With some of the new isotopes, the PET scanner can be part of targeted cancer treatment. The old isotopes showed only glucose metabolism. The new ones show metabolic activity specific to brain, prostate, and breast cancers. A hospital cancer center that has approval for two linear accelerators should be considered a major cancer center for purposes of the Plan definition. Two linear accelerators automatically mean it has enough patient activity to demonstrate more than 6,750 annual ESTVs.

However, the 12,500 ESTV threshold is too high. Only exceptionally large cancer centers will treat that many patients.

On the other hand, Part 1 of the standard methodology will not show a need in these places. For example, Part 1 will NOT generate a need for a new fixed PET scanner in HSA VI because the four PET scanners in that very big, very rural geography operate at 17 to 55 percent of capacity and the threshold for a new scanner occurs when the area average is 80 percent. Part 2 was added to compensate for that shortcoming.

Adding mobile PET scanning time also does not address the problem. Mobiles offer only a few isotopes, most of the time it is only one, FDG. More than half of the people needing scans will still need another PET scanner located somewhere else. I have provided more about the isotopes in the formal petition.

PET/CT simulator technology has advanced, and the price of equipment is less than when the Fixed PET Scanner SMFP methodology was last revised. Hospitals like Carteret Health that are doing more than 6750 ESTVs and have DHSR approval for two linear accelerators should have the opportunity to complete their cancer treatment program – especially if they can do it efficiently with equipment that can serve two functions – as both a second simulator for the linear accelerator and a Fixed PET Scanner.

The savings from not leasing the mobile PET scanner and the income from simulations and additional PET scans – even at the reduced 1,040 scan capacity would offset the extra capital and operating cost over the equipment's useful life. Economically, it makes sense to any cost-conscious board. Keeping costs affordable to our community is one of Carteret Health's high priorities. Carteret Health rarely borrows money for improvements. We save and pay cash.

There is precedent in Chapter 15A of the Plan -- Shared Fixed Cardiac Catheterization Equipment-- one piece of equipment that does two functions: angiography and cardiac cath. Carteret Health has one and it works well. Qualified hospitals can apply for a Shared Fixed Cath Lab if they show a minimum number of caths done on a mobile unit, 250 annual scans per eight hours of weekly service. Applicants are held to a performance standard that is 25 percent of the standard for a full fixed cardiac cath lab. We request

that you treat the shared PET Simulator/ Scanner similarly. A threshold of 1,040 PET scans is half of the Fixed PET Scanner performance standard. That would be very reasonable.

Making provision for a dual-function shared PET Scanner/ Simulator would permit mid-size cancer centers like Carteret to make full-time, cost-effective fixed PET scan services available.

Plan Principle Consistency

This request is consistent with the Basic Principles of the State Medical Facilities Plan.

Access

- The methodology change would permit mid-size cancer centers to
 - offer PET services seven days per week, if necessary.
 - meet the patients where – and when – they are, instead of forcing them to choose between a limited schedule and traveling long distances.
 - offer a full range of isotopes and scan most cancer types.

Value / Cost Efficiency:

- The operating cost of the new dual-function scanner/ simulator will be less than the current mobile contract on a unit scan basis.
- There is precedent for dual-function equipment with even lower performance standards in Chapter 15A of the Plan.

Safety and Quality

- A hospital that meets CON standards for two linear accelerators
 - has expertise and knowledge that normally would not be available in every community hospital.
 - Is already held to exacting standards of performance by NC Licensure, CMS, the American College of Radiology, and the American College of Surgeons Cancer Program.

Thank you for your time. I am open to your questions.