UNC REX Healthcare
Comments to OR Methodology Workgroup
November 10, 2016
801 Biggs Drive, Dorothea Dix Campus, Raleigh, NC 27603
Brown Building, Conference Room 104

Good morning. I am Sue Sandberg, Chief Operating Officer at UNC REX Healthcare here in Raleigh. I am here to address this workgroup concerning recommended changes to the OR methodology. Let me first say that my background is clinical—I am a registered nurse—so while many of my thoughts may involve the challenges with operating such a busy surgical service, my heart is always for patients and providing the best in patient care. Ultimately, I hope that is what we are all striving to do. Also, I have spent over 30 years in healthcare administration but am relatively new to North Carolina. My early career was spent in a CON state, Illinois, and my most recent 18 years was spent in a non CON state, Indiana. As a tax payer and a nurse, I personally support CON legislation, which has the ultimate goal of controlling quality and healthcare costs. However, I am worried about the current methodology used in North Carolina and

how it negatively affects the hospital that I have operational responsibility for, UNC REX. I appreciate the opportunity to speak to this committee today.

I believe the current methodology worked well for years in North Carolina, but it is now outdated. The environment we work in has changed significantly since it was developed many years ago. Let me give you some specific examples of ways in which I believe the methodology can be improved.

Growth Rates: Currently the methodology uses population growth. This is problematic in fast-growing counties like Wake, because the actual population growth often outpaces the more conservative projections developed by the demographers. For instance, the actual growth in the Triangle from 2010 to 2015 was 40%, versus the projected growth of 34%. In addition, this growth is compounded by growth in the demographic that utilizes healthcare services like ORs more frequently due to the natural aging of the human body—those 65 and older—and in this area, this

cohort is projected to double within 25 years, something the methodology does not consider.

Unused ORs: The current methodology factors in facilities that, as a whole, are underutilized; however, it does not account for ORs that are not being used. I understand that some facilities have licensed ORs in the inventory that are not regularly used. As a result, they are "counted" as being available to patients, but in practice, they are not. If the methodology were to exclude these ORs, the actual utilization of ORs in use could be determined, which would more accurately reflect the need.

Differences in how surgeries are performed and reported: At Rex, we strive to provide patients with the highest quality care in the most appropriate, lowest cost setting. As a result, we provide approximately 6,000 cataract surgeries, 3,000 circumcisions, and 8,000 endoscopy procedures in procedure rooms, where the cost is lower for patients. This volume is not included in our surgical procedures. We understand that some providers choose

to perform many of these cases in licensed ORs, even though they could be done in a lower cost setting, without using the more regulated OR setting. We could quickly demonstrate the need for more ORs by moving these cases to ORs, but that would only make sense if no other solution is developed. This discrepancy should be addressed so that we are not disadvantaged—and others advantaged—by our low cost, high quality approach to the patients we serve.

Differences in Case Acuity: Along these same lines, the current methodology provides no analysis of the differences in acuity among facilities. I believe the comments from UNC Hospitals included a discussion of the potential of using ASA classification to assist in determining case times and complexity. I agree that this would be a more accurate reflection of acuity than just assigning acuity and case times to certain types of procedures or cases.

I realize that adding something like ASA or another acuity measure might seem like a significant task, so I would encourage the Sheps Center to discuss with Truven if the Anesthesiologist's ASA rating codes for each case could be included in their data. The codes are reported by the anesthesiologist for each case and are included in the anesthesia billing. They are also recorded by the circulating nurse for each surgery and are easily obtainable via electronic records in use today. I believe we could easily report this data, as we self-report other data to Truven.

Maldistribution of ORs: The current methodology creates an uneven distribution of ORs, allowing facilities with need for more capacity to be at the mercy of those with underutilized ORs. While I understand the need to prevent unnecessary duplication, let me explain why I believe the methodology must be changed to address this issue. The most effective way would be to have need determined on a facility basis, rather than assuming that any OR capacity in the county is available for any patient

needing surgery. There are several reasons why this is not a valid assumption.

First, some of the highest "unused" capacity is in ASCs. Rex believes in ASCs for outpatient cases that can be performed there—over the past several years we have joint ventured with surgeons in Cary and Raleigh, and will soon do so in Wakefield, in order to move outpatient cases out of the hospital to a lower cost setting, providing capacity in the hospital for cases that need to be done there. For those cases that need to be done in a hospital, however, the capacity available in ASCs is not helpful, yet the methodology would consider this capacity available for our inpatients.

Second, even if capacity is available at other hospitals, this is not helpful to our patients. Currently, Rex operates its ORs far beyond the normal operating hours of other Wake County facilities—not because we think it's best for patients or staff, but because we must do so to handle our case load. These extended hours result in increased

hardship on surgeons and staff, increased costs of care delivery associated with off hour use and creates an environment with less-than-optimal timliness and patient satisfaction. While most OR's nationwide run 7 a- 5 p for routine scheduled cases, Rex schedules elective cases through 9 pm. I have never previously seen OR's run so late with scheduled elective cases.

Our utilization of 78% exceeds national benchmarks and limits OR availability for emergencies. Simply having surgeons move cases to available ORs in another facility is not in the best interest of patients nor surgeons. The most expensive labor in a surgical procedure is the surgeon. Surgeon productivity is maximized by minimizing their downtime between cases and would be severely impacted by requiring windshield time to another facility for the actual surgical case and for the subsequent daily follow-up post-surgery. This doesn't even consider the time a physician forced to staff another hospital would incur in mandatory nonproductive overhead activity- such as mandatory medical staff meetings.

Third, I am very uncomfortable with this high utilization and no ability to add ORs under today's CON methodology. Utilization this high means there is not an OR standing ready for emergency surgeries. This is increasingly problematic as UNC REX has become a tertiary referral hospital for hospitals between Raleigh and the coast. 5 years ago, we received around 300 incoming transfers per year of patients requiring a higher level of care at our hospital. We currently receive over 300 transfers in a month. From my office, I have a clear view of the helicopters bringing in critical care patients requiring urgent intervention. Our Medicare Case Mix Index, a reflection of the acuity of the patients we serve, has risen yearly. Our most recent report came across my computer as I worked on my comments for today. We were at 2.1051 in October. This is extremely high and also indicates a need for an open operating room at all times for the surgical emergencies such patients are at risk for.

My previous role in Indiana was also in a growth market. We began planning new ORs at 65% occupancy to ensure we could bring additional ORs on prior to 75% occupancy. I am extremely proud of my team at UNC REX. They are achieving turnover rates and first time on starts to increase efficiency that are benchmarkable throughout the nation. The performance improvement work they have been successful at to achieve maximum utilization out of our ORs is to be commended. At this time, we truly require a methodology that will grant us more ORs, as we have pushed efficiencies and hours of operation to the limit that we believe we can achieve. The population of the city of Raleigh and the demand to serve high acuity patients beyond Wake County continues to grow and we are unable to grow with the demand we are facing.

Fourth, and finally, the current realities of healthcare render the availability of ORs at other facilities useless to our patients. Rex is an economical choice in Wake County, yet we are constrained from expanding our ability to provide this benefit to patients due to the current

methodology. Rex received the lowest Estimated IP Medicare base rate payment, as reported in CMS MEDPAR data from 2013. Rex had a base rate of $5,675. Nearby hospitals were all higher. In Raleigh, other hospitals were up to 127% higher. Outside of Raleigh in Wake County, hospitals were up to 123% higher. This is very important to all of us as taxpayers.

Please understand—this is not about "us versus them." We are in a great area with a terrific group of healthcare providers. But the realities are that Rex is a low cost provider, and current insurance restrictions prevent patients from choosing other facilities. I want to end with a letter from a Rex patient that highlights this issue. I won't read it to you, but I will include it with my comments for your review. Her name and address have been removed to protect her identify per HIPPA. The bottom line is that patients are being directed to the various providers by insurance plans, among other factors, and expecting them to make a choice based on anything else is unreasonable. This recent surgical patient reached out because her

surgery was delayed at Rex due to the need to prioritize emergency surgeries, and she was told that we could not get more ORs at present. She clearly advocates for more capacity at Rex, and her insurance coverage limits her ability to go elsewhere. While the realities of healthcare planning are certainly not clear to most of the public, I think her letter speaks volumes about the impracticality of the current methodology and its impact on the lives of our patients.

Thank you.

October 28, 2016

Dear Ms. Sandberg,

I am a recent patient of Rex Hospital, where I received excellent care. I am writing—not to complain—but because I understand that Rex is having trouble getting more operating rooms for its patients, and I wanted to give you my perspective as a patient. I know there are many rules and regulations that govern hospitals, but to me, I just cannot understand why Rex cannot qualify for another OR. Let me explain.

I recently had surgery performed at Rex and had to stay in the hospital for a few days. My surgery was necessary, but not an emergency, and as a result, it got delayed several times. I was already in the hospital, I was not allowed to eat or drink anything, but had to wait until late in the day for my surgery. I was told that several emergencies had come in and caused mine to be delayed. I asked why there weren't more operating rooms, and was told something about the fact that although Rex had busy operating rooms, there were rooms available at other facilities, and Rex couldn't get more until those were full. The problem I have with that is that I can't use those other rooms. My surgeon only works at Rex. I chose her after doing a lot of research online and asking around, and I was happy to have my surgery at Rex.

I have a chronic condition which sometimes has acute flare-ups, but we've managed to keep things under control, mostly with medication. I've gone to the same primary care doctor for many years, and he works with the specialists I see to make sure my condition is well managed. A couple years ago, my doctor joined the UNC network, and the care has continued to be as good as it always has. The care between my doctor and my surgeon was well coordinated, and after surgery, I had one follow-up visit with the surgeon, and she turned me back over to my primary doctor. So I am very happy with my primary care doctor, the surgeon, the specialists and the care I got while at Rex.

Just a couple days ago, I received a letter from Blue Cross, my insurer. I have a plan that I pay for myself (no subsidy from Obamacare), and like the news has reported, my costs went up almost 30 percent for next year (although it's still called a "Blue Value" plan). The letter I just got told me that my plan would no longer include Wake Med (it already did not include Duke). For me, this really is not an issue since my doctor is part of UNC, and hopefully, I won't need surgery anywhere again, but if I do, I'm happy to come to Rex. But when I got this letter, it made me think of what I was told about the OR at Rex. My insurer said that I can still go to Wake Med or Duke, but that it will cost me more. So why is Rex being prevented from getting another OR, which would save me money? I'm sure some folks choose the Blue Local plan, but then they can go to Wake Med or Duke, but not Rex, so this issue is the same for them. I know you can't do anything to change this, but please let those in charge of this issue know that it doesn't make any sense to keep Rex from having more operating rooms. I don't think it's fair to expect me to change my insurance, which would require me to change the primary care doctor I've gone to for years, my surgeon and the hospital that took such good care of me. If I can help in any way regarding this problem, please let me know.

Sincerely,

BlueCross BlueShield of North Carolina

October 26, 2016

[redacted]

Dear [redacted]

Each year changes are made to the list of providers who are in-network for health insurance plans. Starting January 1, 2017, WakeMed Health and Hospitals will no longer be in-network for Blue Value.

It is important to know that you have choices.

For those who use WakeMed Health and Hospitals

- You can stay in Blue Value and change doctors if you want to get in-network coverage
- During open enrollment, you can join Blue Local with Duke Medicine and WakeMed to keep seeing your current doctor
    - This choice is available for all Raleigh/Durham area counties except Alamance, Franklin, and Lee
- If you stay in the Blue Value plan, you can see an out-of-network doctor, but you will pay more

We suggest checking to see if both your doctor and hospital are in-network before seeking health care as other doctors may leave the network. To find out if a doctor or hospital is in your network, visit ***BlueConnectNC.com*** and click 'Find a Doctor' to search by name.

If you want to change your health plan for 2017, open enrollment is the only time you can do so (unless you qualify for a Special Enrollment Period). December 15, 2016 is the last day you can change your plan and have health coverage on January 1, 2017.

Thank you for choosing Blue Cross and Blue Shield of North Carolina.

Sincerely,

Tarsha Rowland

Tarsha Rowland
Vice President, Customer Service Operations
Blue Cross and Blue Shield of North Carolina

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