PUBLIC COMMENTS RE STATE HEALTHCARE FACILITIES PLAN 2010

Given on July 21, 2009 in Wilmington, NC by
Charlie Furr COO of OrthoCarolina (Charlotte, NC)

Good afternoon. I am Charlie Furr, COO of OrthoCarolina, a large orthopedic group practicing in and around Charlotte. I am here today to speak in support of the Single-Specialty Ambulatory Surgery Demonstration Project because it will reduce overall cost, improve efficiency and integration of patient care, enhance the patient care experience, and maintain or improve quality.

We at OrthoCarolina have watched the development of this plan closely and have been impressed by the way that collaboration among the SHCC members has improved the proposal. We applaud the requirement that charity care be given, and would suggest that the same standard be applied going forward to all future CON applications. Because CON's create barriers to entry into healthcare markets, receiving one should come with a requirement to use it for the public good – and that requirement should apply to all CON's, not just the demonstration project.

Furthermore we applaud the intent to make certain that physicians who own such facilities continue to provide general hospital coverage. However the program must recognize that some practices, such as ours, have complex specialty-based call coverage programs that may divide up those responsibilities differently. As long as the group owning the facility provides coverage of area general hospitals, the objective should be met.

Convenience and integration into the physician's practice can maximize the benefit to a patient. Imagine a small child falling off the monkey bars at 5pm and breaks his arm. We have opened an Orthopedic Urgent Care that allows that child to be seen as late as 9pm in our office setting without having to encounter long waits or high fees in the ER. Imagine how much better it could be if that same child could not only be seen in the office but then be taken back to our ASC and have that fracture reduced right away. A

few hours after falling he could be home and on the mend without any ER charges and with much lower OR costs.

Some on the SHCC have raised concerns that physician-owned surgery centers or specialty hospitals may hurt the financial performance of general hospitals, that unnecessary surgery may be encouraged, or that these facilities will "cherry pick" desirable patients. Numerous studies have refuted those claims. In 2005 Woods showed in JBJS that the opening of orthopaedic surgery specialty hospital did not increase the surgical volume or the surgical rate for the surgeons who held a financial interest in the facility. Lu in CORR 2009 evaluated three specialty hospitals, included one in Durham, NC, and assessed their impact on surgical volumes and patient case complexity for five competing general hospitals located closest to the specialty hospital. They found no evidence that the entry of a specialty hospital resulted in declines of general hospital volumes or increases in their case complexity. And Schneider in 2007 Inquiry analyzed the effect of specialty hospitals and actually found the presence of specialty hospitals encourages greater efficiency on the part of incumbent general hospitals, calling into question the contention that specialty hospitals harm general hospitals financially.

Furthermore many studies have shown substantial cost reductions by moving site of service to the ambulatory surgery setting from the hospital setting. As one example, Paquette in the Journal of the American College of Surgeons showed a roughly 40% reduction in cost of outpatient cholecystectomy with no drop in quality outcomes, a finding consistent with Medicare claims data. Additionally quality measures favor specialty "focused factories" which have consistently shown fewer complications even when risk-adjusted, as in the study by Cram in JBJS in 2007 that showed adverse outcomes were reduced by one third to one half in specialty hospitals compared to general.

I realize that some may claim that results from other states in other settings may not be relevant here. Finally with this proposal, we will have the chance to show definitively that the same results can be achieved here in our practice settings in North Carolina.

From the very early stages of the operation of a new facility, we will be able to provide data that resolves any remaining doubts. I hope the SHCC and its members will do all in its power to make sure these projects are not delayed by appeals or other hurdles that would forestall the commencement of this study.

This is the promise of a single-specialty ASC. I thank you for finally bringing to North Carolina what the rest of the country has had for so long – specialty care with superior outcomes and greater convenience at a fraction of the cost.