Carolinas HealthCare System

August 7th, 2017

Christopher Ullrich, MD
Chairman
North Carolina State Health Coordinating Council
Health Planning and Certificate of Need Section
North Carolina Division of Facilities Services
809 Ruggles Drive
Raleigh, NC 27603

RE: Response to Petition for Adjusted Need Determination of 50 Additional Rehabilitation Beds in HSA III for the 2018 State Medical Facilities Plan

Dear Dr. Ullrich,

Thank you for allowing us to comment on the request for an additional 50 Acute Rehabilitation beds (IRF beds) for HSA III in the 2018 State Medical Facility Plan (SMFP). We have reviewed the petition and the multiple letters submitted from Novant and HealthSouth employees and physicians. We will not respond to any one letter of support as the majority were very similar in their language and for the most part expressed the same issues.

There are several key points that we believe to be important in determining the appropriateness for this bed allocation:

1. Need for additional acute rehabilitation beds in HSA III: Having a combined 36 years of active practice in Physical Medicine and Rehabilitation, we are both very familiar with the current trends in health care over the years, which focus on affordability, efficiency, and effectiveness of care. There have been dramatic changes in rehabilitation bed needs nationally, regionally and locally as evidenced by modest utilization growth over the past several years. The comments related to the need to increase HSA III by an additional 50 beds for acute rehabilitation in the 2018 SMFP are absurd and in direct opposition to what we are experiencing in our daily practice. Over the years, we have seen a significant shift of patients that were previously treated within our IRF's to more appropriate levels of care that provide for the specific needs of the patient at a less intense and lower cost level. These environments have included skilled nursing facilities (SNF), home health care, and outpatient care. The stroke patients described in the Novant/HealthSouth petition, is a prime example of this change. We have experienced a shift to the less intense levels of rehabilitation partially due to the aggressive emergency stroke care leading to improved overall function and prognosis, and allowing for discharge directly to home with specialized home health and outpatient rehabilitation programs. Additionally, transformation of SNF's to subacute rehabilitation providers with greater competency and training has provided high quality rehab programming for a much lower cost. Health care reform and "Stroke bundle" payment systems that require high quality and lower cost care,

have helped post-acute rehabilitation develop strong programs that are accessible and conveniently located throughout the community.

The letters also misinterpret the recommendations from the AHA/ASA 2016 guidelines for stroke care, which actually speak more to ensuring a "sustained and coordinated effort" from a multidisciplinary team, in an appropriate setting based on their medical and rehabilitation needs. The settings described are those noted above. It is clearly delineated in the guidelines that patients should be treated in the setting that best suits their medical and rehabilitation needs. There is no specific recommendation for increasing IRF beds in any community serving this population. And again, dramatically increasing beds especially for this population directly contradicts the national, state, and local initiatives focused on affordability, efficiency, and effectiveness of care.

2. Access of care for Novant patients at Carolinas HealthCare System (CHS) facilities: The perceived difficulties for access to care are not reality. Our physicians and admission liaisons treat all of our patients referred with an equal level of professionalism and respect for their medical and rehabilitation needs, regardless of referring facility (whether they come from Novant facilities, CHS facilities, or other regional, state, and national referral sources). Current rehabilitation facilities are conveniently located to provide the best access for all patients in our community for those that need an intensive rehabilitation experience. Carolinas Rehabilitation receives nearly as many referrals from non-CHS affiliated hospitals, including Novant, as we receive from CHS acute care hospitals. It is therefore imperative that we provide excellent and similar services to all our referral sources.

   We have reviewed our data regarding availability of inpatient rehabilitation services for patients from Novant after annualizing 2017 admission, during the 3-year period noted in the petition, Carolinas rehabilitation has admitted 990 patients. It should be noted, the conversion rate which is the number of patients admitted to inpatient rehabilitation when compared to total number of referrals made, was 43.5% for Novant hospitals while this same rate for CHS admissions was much lower at 37.9%. This data indicates that a substantial number of patients who receive care within the Novant system do indeed transition to Carolinas Rehabilitation for their inpatient rehabilitation needs, and a higher percentage of patients referred are actually admitted to Carolinas Rehabilitation compared to patients who are treated within our own health care system.

   An additional issue noted regarding access was related to receiving weekend admissions from Novant facilities to CHS related rehabilitation facilities. Carolinas Rehabilitation routinely admits patients on the weekend. If a patient admission is not possible on a weekend it is multifactorial and most often involves the need for pre-approval for inpatient rehabilitation services based on specific third party payers, which often remains a challenge due to their requirements for medical and functional updates prior to providing approval for admission. In addition, many of these payers only make these decisions during business hours Monday through Friday. Finally, collection and interpretation of this information by third party payers tends to delay approvals at times, and can lead to further delays due to the need for peer to peer interactions with their medical directors. The concern about Health Information Exchange with Novant facilities is a fallacy. As noted below, the ability for CHS and Novant physicians to

exchange medical record information has been available for more than a year with over 68,000 Novant queries in July 2017 resulting in health information exchange.

3. Delays in admission to CHS facilities: Our mission at CHS is stated as follows: Improve Health, Elevate Hope, and Advance Healing for all. We believe, and based on our data, that "all" describes all patients regardless of the referral source. Novant patients are admitted more quickly than CHS patients. In other words, our admission data reveals that patients originating at Novant transition to Carolinas Rehabilitation faster than patients from Carolinas HealthCare System. We do not show preference and have adequate access to promptly address the needs of the Novant patient population requiring rehabilitation services.

4. Difficulty in getting medical records and patient information after discharge: The transfer of health information has been resolved as Novant and CHS have partnered via the Health Information Exchange, which connects our two medical record systems. This partnership has been effect for over a year and even prior to the formal HIE agreement Novant granted Carolinas Rehabilitation case managers and physicians limited view only access to help improve care coordination. This has been a tremendous benefit to all providers and allows providers at Carolinas Rehabilitation full access to all of the patient's medical records from Novant. Likewise, it is our hope that Novant providers will use the HIE for real time information, collecting information from patients during the Carolinas Rehabilitation inpatient stay and any other CHS interface the patient may experience. Again, in July 2017 alone, Novant queried and successfully retrieved patient information on 68,000 patients in CHS' medical record system. It appears the comments regarding continuity of care at it relates to accessing medical records is an issue of training and competency for Novant providers.

The current bed allocation methodology for HSA III meets the needs of Novant, CHS, and other regional acute care providers. Our vision of the future of inpatient rehabilitation locally, regionally, and nationally is to establish an appropriate post-acute continuum that places the needs of the patients first, by placing them in the most appropriate setting for their medical and functional needs. The establishment of this rehabilitation continuum goes much beyond adding an inappropriate number of inpatient rehabilitation beds to HSA III, but towards developing multiple levels of care in the communities we serve, enhancing relationships between health care systems in the areas of coordination, collaboration, and communication, and increasing value and affordability of care for all patients regarding of the health care system they are most affiliated with.

Sincerely,

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