STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD
GMCB-004-23con

UVM MEDICAL CENTER OUTPATIENT SURGERY CENTER CERTIFICATE OF NEED APPLICATION HEARING

May 20, 2024
9:01 a.m.

Hearing held Remotely before the Green Mountain Care Board via Microsoft Teams on May 20, 2024, beginning at 9:01 a.m.

P R E S E N T

BOARD MEMBERS:
Owen Foster, Chair
Jessica Holmes, Board Member
Robin Lunge, Board Member
David Murman, Board Member
Thom Walsh, Board Member
Susan Barrett, Executive Director
Laura Beliveau, Staff Attorney
Michael Barber, Hearing Officer
Kristen LaJeunesse, Executive Assistant

A P P E A R A N C E S

Office of the Health Care Advocate

Sam Peish

Eric Schultheis, Staff Attorney

Charles Becker, Staff Attorney

University of Vermont Medical Center

Karen Tyler, Associate General Counsel

Eric S. Miller, General Counsel

Thomas Morris, Principal, E4H

Scott Walters, Partner, Halsa Advisors

Susan Andersen

Mary Broadworth, VP Human Resources, UVMMC

Marissa Coleman, PsyD, VP Diversity, Equity & Inclusion (DEI), UVMMC

Chris Dillon, VT Integration & Strategy, University of Vermont Health Network

Sunil Eappen, Network President and CEO, UVMHN

Heather Harrington, MD, UVMMC

Eve Hoar, UVMMC

Stephen Leffler, President and Chief Operating Officer, UVMMC

Claude Nichols, MD, UVMMC

Mark Plante, MD, UVMMC

Hailee Reist, MD, UVMMC

Beth Seniw

Marc Stanislas

Rick Vincent

Patrick Bender, MD

AFT VERMONT

Deb Snell, RN CCRN, President AFT-VT Healthcare

NORTHWESTERN MEDICAL CENTER (NMC)

Peter J. Wright, Chief Executive Officer

COPLEY HOSPITAL

Joseph Woodin, Chief Executive Officer

Remote via Teams
May 20, 2024
9:01 a.m.

P R O C E E D I N G S

CHAIR FOSTER: Good morning. My name is Owen Foster. I'm the chair of the Green Mountain Care Board, and I'm calling to order our hearing of May 20th, 2024.

We have one substantive agenda item, which is a hearing on UVM Medical Center's Outpatient Surgery Center certificate of need application. We have everyone from UVM here and we have everyone from the Board. I thank you, everyone, for being here promptly for today's hearing. It could be lengthy, given all the materials.

Mike Barber is our general counsel, and he will be the hearing officer today, so I will turn it over to Mr. Barber.

MR. BARBER: Thank you, Chair. As you heard, my name is Michael Barber. I'll be the hearing officer for today's hearing. This is a hearing on the University of Vermont Medical Center's application for a certificate of need to develop an outpatient surgery center on Tilley Drive in South Burlington. The docket number for

the case is GMCB-004-23con. The hearing is being held pursuant to title 18 of the Vermont Statutes, Chapter 221, subchapter 5, as well as Green Mountain Care Board Rule 4.

Before we kind of go further, I just want to make sure I have the parties' representatives on the call. So I think I saw Karen Tyler and Eric Miller for the applicant, University of Vermont Medical Center. Karen or Eric, is there anyone else?

MS. TYLER: No. But Eric and I are both present.

MR. BARBER: Okay. Thank you. Thank you. And for the Office of the Health Care Advocate, I think I saw Sam Peish and Charles Becker on?

MR. PEISH: Yep. Morning. We're here.

MR. BARBER: Is Eric here as well?

Okay. Thank you.

And the other interested parties are AFT Vermont. I believe I saw Deborah Snell on the line.

MS. SNELL: Yes. I'm here.

MR. BARBER: Is there anyone else

I should mention here?

MS. SNELL: No.

MR. BARBER: Okay. And is someone from Northwestern Medical Center here?

MR. BILLINGS: Yes. Jonathan Billings is here, chief operating officer. And our CEO and president, Peter Wright will be going in and out as he moves through airports today.

MR. BARBER: Thank you. And the last interested party is Copley Hospital. Is there someone from Copley on?

MR. WOODIN: Yep. Joseph Woodin, and I'll be periodically in and out with some other issues, but thanks.

MR. BARBER: Okay. Thank you. Just want to quickly go over some housekeeping rules and reminders. The first and maybe the most important is please mute your lines when you're not speaking. There's a lot of people on the call and opportunity for a lot of feedback if that's not kept on top of.

The second thing is we may have disabled it, but if we haven't, please do not use the chat function in Teams. When you speak, please try to speak loudly and clearly and try

not to go too fast. We do have a court reporter here who's transcribing the proceedings. When speaking, representatives and witnesses should be on camera if at all possible. If you're not speaking, you don't have to be on camera.

If someone who is key to these proceedings has technical difficulties, for example, they get dropped from the call, we can take a pause so that gets sorted out. But I just need to know to do that. So if you see someone on your team that is having trouble, please speak up or send me an email or something to let me know that we need to take a recess or something to sort that out.

The basic schedule for today is going to be as follows. We're first going to hear from the University of Vermont Medical Center. They have a number of witnesses who are scheduled to speak. After UVMMC's presentation, interested parties and then Board members will have a chance to ask questions of UVMMC's witnesses.

I'll just let the parties know now that we are probably going to have brief executive session as part of the Board member

questions to discuss confidential portions of the record. So we'll have to sort that out.

After UVMMC's presentation and questions, interested parties will have an opportunity to speak and explain their position on the application. And then finally, Board members will have an opportunity to ask questions of the interested parties, if they have any. And then we will take public comment at the end of the hearing.

Unfortunately, I can't say with any certainty when we will get to the public comment. I would very much like to at least have the last hour from 4 to 5 for that. And of course, we will try to work in some breaks throughout the day.

Given the degree of public interest in this project, we have created a sign-in sheet for providing public comment today. That sign-up sheet can be accessed by going to the Board's website on the Board meeting information page. And so once we get to that portion of the hearing, I will start there with people who signed up. If there are members of the public here who don't want to stick around

until the end of the day to provide comments or can't come back towards the end of the hearing, you can always provide the Board with a written comments. Written comments are being accepted on this application through May 30th. And instructions for providing a comment are on the Board's website where you can call the Board and we can help you figure out how to provide a comment.

So before we turn things over to UVMMC, Title 18 of the Vermont Statutes Annotated, Section 9440a requires that any testimony taken today be taken under oath. So I just need to swear in the presenters for UVMMC. And given the number of speakers, I'd like to do this all at once to keep the flow going. So what I'm going to do is, I'm just going to call out the names of the individuals who I believe are scheduled to speak. And when I call your name, if you could just please take yourself off mute and say that you're present. And then once I've confirmed that I have everyone who I think I need, I will administer an oath. So is Thomas Morris with us?

MR. MORRIS: Present.

MR. BARBER: And do we have Scott Walters here?

MR. WALTERS: Present.

MR. BARBER: Susan Andersen?

MS. ANDERSEN: Present.

MR. BARBER: Mary Broadworth?

MS. BROADWORTH: Present.

MR. BARBER: Dr. Coleman?

DR. COLEMAN: Present.

MR. BARBER: Chris Dillon?

MR. DILLON: Present.

MR. BARBER: Dr. Eappen?

DR. EAPPEN: Present.

MR. BARBER: Eve Hoar?

MS. HOAR: Present.

MR. BARBER: Dr. Leffler?

DR. LEFFLER: Present.

MR. BARBER: Beth Seniw?

MS. SENIW: Present.

MR. BARBER: Marc Stanislas?

MR. STANISLAS: Present.

MR. BARBER: Rick Vincent?

MR. VINCENT: Present.

MR. BARBER: And Dr. Bender?

DR. BENDER: Present.

MR. BARBER: And did I miss anyone?

MS. TYLER: I don't believe so, but I think that's everyone.

MR. BARBER: Okay.

DR. PLANTE: I believe you may have missed me, Dr. Mark Plante.

MS. TYLER: Oh, sorry, Dr. Plante. We missed Dr. Plante.

DR. NICHOLS: And me as well.

DR. PLANTE: I would miss me, too.

MR. BARBER: It sounded like there was someone else. Sorry, who was that?

DR. NICHOLS: (Indiscernible).

MR. BARBER: Dr. Nichols.

Okay. If you could all please raise your right hand. Do you solemnly swear or affirm that the evidence you shall give relative to the cause now under consideration, shall be the whole truth, and nothing but the truth, under the pains and penalties of perjury?

Whereupon,

MULTIPLE PARTIES,

witnesses called for examination by counsel for the Board, were duly sworn, and were examined and

testified as follows:

MR. BARBER: Thank you. Okay.

Do any of the parties or Board members have anything we need to address or discuss before I turn things over to UVMMC?

Okay, Karen, floor is yours.

MS. TYLER: Okay. Good morning everyone. I am Karen Tyler, representing the University of Vermont Medical Center. And I will turn things over to Dr. Eappen to get us started.

DR. EAPPEN: Thanks, Karen. Thank you Chair Foster, Board members, for moving this proposal forward and welcoming us to this certificate of need hearing.

I want to just start by saying that everything that we do is guided by the principle of how do we best serve our patients and communities, and how do our patients access the care that they need and deserve. This project is a perfect example of that guiding philosophy.

We're proposing this project for one reason. It needs an urgent -- it meets an urgent patient need, and that need is only going to grow with every year we don't take action. As

a health system, we're here to keep our patients and communities as healthy as possible and to provide timely access to high quality, equitable care. As this Board knows, many of our patients do not have timely access to the surgical care that they need. The result of that lack of access is increased suffering and increased costs as some patients grow sicker waiting for care.

And as you'll hear today, without this proposed outpatient surgery center, access to surgical care will get far, far worse as our population grows and ages. Development of a multi-specialty outpatient surgery center is a key step we're taking to increase access to surgical care. It's really the only answer to that crucial question of how our patients access the surgical care they need and deserve today, ten years from now, and beyond that. Ultimately, I want our patients and everyone who lives in this region to view us as more than their health care provider. I want them to see us as their allies and their advocates in making our communities as vibrant and as healthy as they can be.

We're here today to simply

advocate on behalf of the people we serve in asking you to approve our application for the outpatient surgery center.

Finally, I just want to mention that I'm extremely proud of the team you're going to hear from today, as well as the team that's worked behind the scenes and persevered to get us to this moment. The experts presenting our plan to you are incredibly talented and dedicated to delivering the absolute best care to our patients. Because here at the UVM Health Network, we know we're serving our friends, our neighbors, and our family members.

Thank you all ahead of time for being here today. And I want to ask Steve Leffler, the president of the UVM Medical Center, to take it from here. Thank you, Steve.

DR. LEFFLER: Thank you, Dr. Eappen.

The truth is, we actually need the outpatient surgery center now. Over the past eighteen months, our clinical leaders in surgery, anesthesia, peri-op have done tremendous work to improve access to our operating rooms. We currently have twenty operating rooms on the main

campus and five at the Fanny Allen Campus. And you'll hear through the presentation today, that we've done many things over eighteen months to improve the efficiency of those ORs and get them to really about as much capacity as you can squeeze out of them. But even with that hard work, we're still building up patient backlogs.

This project will both address short term need right now we're feeling every day currently. But also into the future, our experts as well as the Green Mountain Care Board experts agreed that by 2030, without this project, more than 4,000 people who need surgical care will either have to wait too long, travel out of state, or potentially not receive care at all. That's 20,000 people over five years. And if you do the math, it just exponentially grows.

The proposed outpatient surgery center, on the day it opens, will have eight operating rooms, which five of them will replace five of the ORs at the Fanny Allen campus. And there will be three net new operating rooms.

The outpatient surgery center will allow us to treat more patients in a convenient outpatient setting. We know that's what our

patients want and prefer, to be able to park easily, get care in a timely fashion, go home that same day when it makes sense. And equally important, we know that our providers and our learners want and need that as well.

You're going to hear from one of our residents today. When residents choose the programs they go to, they want to make sure they've been trained with the equipment and space for how they're going to go out into practice. To continue to attract high quality learners to Vermont, we need to have high quality facilities to train them as they will see in their future. We know that many residents, after they train here, stay in Vermont across the state. It's important that facilities that will meet their training needs and their future needs.

Most of the volume -- I'm sorry. All the volume at the outpatient surgery center, cleared people will go home that day.

We also have major challenges on the inpatient campus. At UVM Medical Center, every day we have challenges doing all of the cardiothoracic, neurosurgery, and vascular surgery procedures that only happen at UVM

Medical Center in Vermont. We need more OR inpatient capacity for those patients. Moving outpatient surgeries that are now happening on the main campus to the OSC, will really help that capacity and make sure that our inpatient ORs are available for the sickest Vermonters who need them every day.

Across our region, patients are oftentimes waiting too long for inpatient procedures because our ORs are so full every single day. $130 million price tag is expensive, there's no question about that. Our experts and the Green Mountain Care Board's experts agreed, that's what a project of this size and scale costs. We spent years of planning for this project and have carefully reserved capital spending, to make sure we can afford this project. Building now it now with four ORs as shelf space is smart for the future. It preserves dollars that would otherwise be needed to add on to the project, and it keeps the project operating at full capacity rather than having to open and close parts of the project as we're doing additional additions.

I want to say that we are --

currently, we have a CON submitted to purchase the Fanny Allen Campus, and many people would ask, why can't you just upgrade your ORs at the Fanny Allen Campus? The ORs at the Fanny Allen Campus have served a great purpose for us and they're operating at full capacity right now. But they're fifty years old and they're small rooms. At best, they're around 450 square feet. Modern outpatient surgical facilities are at least 600 square feet.

There's equipment that we can't put in those rooms. We can't turn them over as quickly as we want to. We can't move different cases making out of the rooms in a timely fashion. They will never meet the needs of a modern outpatient surgical facility. The Fanny Allen Campus is a key part of our future mission, and the space that we're using it for the ORs now, will absolutely be repurposed to a better use. But those ORs not going to solve our 4,000 patient problem or be able to deliver the surgical care that Vermonters deserve over the next two to three decades.

Already right now, today, we are transferring and sending appropriate surgical

cases to Central Vermont Medical Center and Porter Medical Center. More than a hundred cases this year are going to go from the medical center just to serve at Central Vermont Medical Center. But that's around the fringes. They have a little over capacity on a Wednesday or a Friday afternoon. We have a surgeon and an anesthesiologist that can go back and forth. The small additional capacity to squeeze out of those opportunities will never meet the need for what Vermonters need over the next decades, just not enough capacity there. And we expect their ORs to get busier as well. Our projections show that in Chittenden County and the area that we serve, Vermonters are getting older. We do have increasing population in Chittenden County, and they will the need more surgery.

We'll show you that we can safely staff the new facility and that our staff will want to work there. It'll be a modern facility with good parking. It will meet the needs for us to be able to attract good people to work here.

We're very excited about what this project will bring for the patients that we serve. We know that we have access challenges

right now. Building this appropriately sized, current, modern space is one piece of addressing our access challenges. Over the morning, you're going to hear from Dr. Mark Plante, who's our chief of urologic surgery, sharing his perspective on the benefits of the proposed OSC.

Next, you're going to hear from Eve Hoar and Halsa Advisors on why this project is sized appropriately to meet the needs of our patients.

Next you're going to hear from Marissa Coleman, Beth Seniw, and Eve Hoar on why this project will be our patient population needs, our DEI objectives, and how we will be able to serve our populations there.

Mary Broadworth and Chris Dillon will talk about how to staff the facility.

Rick Vincent, Eve Hoar, and Marc Stanislas will discuss the finances behind this project, why it makes financial sense.

And finally, and actually most importantly, you're going to hear from our additional physicians, a patient, and one of our residents on the critical importance of this project for the patients that we serve. You'll

hear from Dr. Mark Plante, Dr. Claude Nichols, Dr. Heather Harrington, Dr. Patrick Bender, and Hailee Reist, one of our residents, the critical nature of this project to meet the needs of the patients that we serve. Thank you so much for allowing us to present this project today. We're proud of the work that went into it and proud to show what we believe will serve Vermonters for many years. With that, I'm going to turn it over to Dr. Plante.

DR. PLANTE: Thank you, Steve.

Good morning, I'm Mark Plante, urologic surgeon at UVM for twenty-eight years. I've served as the division chief of urology for now the better part of fifteen years. And most important for today, I became the surgeon lead on the peri-op management team, which was a team constructed three years ago to bring us out of the throws COVID where, as you may know, many of the ORs were shut down. This team is comprised of another physician, Dr. Patrick Bender, as the anesthesia lead, as well as a quality partner and the director of surgical services.

I want to take the opportunity to thank you for providing me the audience to echo

and amplify both Dr. Eappen and Dr. Leffler's comments and give you a high-level overview of what our team does, and you know, oversees in terms of all the operative services at the University of Vermont Medical Center.

It's an immutable fact that our population is aging, as well as growing in some areas, as well as the fact that the complexity of disease also is going up. What this means is that the cadre of surgical services that we're expected to provide as Vermont's only level I trauma center, and also the center that has to provide the complexity of disease regarding robotics, cardiothoracic surgery, and other elements as you've heard. What we've also seen is that our operative spaces are now fully subscribed. With historic numbers of cases compared to the last decade, we find ourselves overfull. There is no room at the (audio interference).

I also need to add that access issues certainly do exist, and they also exist in our inpatient spaces. So what this means for us is, everyday there's a 1 o'clock meeting where all the heads for the following day and weeks

looking at the schedule, have to play a very complicated game of Tetris to try and find space across what is a disparate number of rooms on the main campus as well as the Fanny, as you've heard, that sometimes are too small to be able to provide some of the complex surgeries.

I'm often quoted as saying, we are not a nip and tuck institution. We are actually providing a lot of the care that can't be provided at outside centers. I can tell you that the division of urology has been a partner with many of the community hospitals for these decades that I've been here. But it is the reality that there are many surgeries that cannot be done in smaller hospitals. So with that as the backdrop, I appreciate your attention to the following comments and certainly will be available for questions later.

DR. LEFFLER: Thank you, Mark. Next up, we'll hear from Eve Hoar and Halsa Advisors on the size of the project and the work behind that.

MS. HOAR: Thank you, Steve.

Good morning everyone. I'm Eve Hoar and I serve as the leader of the network

team that does strategic and business planning for all the partners in the UVM Health Network. It's my pleasure to talk to you today about how we estimated the size of the outpatient surgery center as we began this project. So as you heard from Dr. Plante, from Dr. Eappen and from Dr. Leffler, despite a lot of work to create more capacity and fit patients in the best that we can, we are essentially operating at capacity. And while we're working on, again, doing our very best to get as much out of the operating rooms as we can and doing the best with our surgical teams, we also know that the demand for care is increasing.

I'll go and spend a little bit of time about our forecast for the area population. It's been an interesting journey since COVID about population estimates. And I'll touch on that a little bit. And then, we'll start with that as the main driver and talk about the forecast for surgical care between 2019 and 2030. And then, I'll turn it over to my partner, Scott Walters from Halsa, and we'll translate that need for surgeries into the number of ORs that we estimated needed to be in the outpatient surgery

center.

So we focus on ten-year population growth estimates for Chittenden County. And remember that we started this journey kind of back in 2021, about three years ago, today. At that point in time, it would have been really nice to have the 2020 censes forecast available to us. But we were all waiting for those. So back in 2021, we actually took a look at two different population forecasts. One that looked at growth particularly in the northwestern corner of Vermont, very similarly in the way it had been done in the past.

And we decided to commission a second forecast with a group called Public Opinion Strategies. And given all the building that we saw going around us in northwestern Vermont, decided to use that -- if we'd stay on that slide, that would be great. So our estimate of the population growth in Chittenden County was six percent over the next ten years, significantly higher than had been previously forecast.

Recently, we updated the population forecast given some new Nielsen

Claritas population forecast data. And remarkably, that population growth estimate for the ten-year period remained at six percent. So we feel very confident about this growth forecast for the population.

Where we have a little bit of a difference in the forecast is the growth of that sixty-five and over population. And this is really key, because it's that population relative to other segments of the population is typically a higher utilizer of health care, as we know. And in particular, and surgical services is -- goes along with that. So we have a range of forecasts. We have a sixty-two percent, sixty-five and over growth rate over ten years from Public Opinions back in 2021. And much more recently, from our intelligence partner, Sg2 and Claritas, we see a forty-one percent growth rate in that sixty-five or over population.

I'll talk to the next slide about how that is significant and not so significant when we take a look at the surgical forecast over time.

Before I leave this slide, I want to mention though, it's not just Chittenden

County that's seeing this growth. We know growth forecasts predict population growth in Franklin County, significant population growth in Grand Isle County. And also the counties like Washington and Addison. So this is a northwestern growth population phenomenon that I'm sure you've heard about in other venues.

We can go to the next slide. Thanks.

So again, taking that population, one of the drivers, one major driver in this growth in surgical -- in our surgical estimate, looking at this graph here. So the bars you see here in gray are actuals. So we started with 2019, we're about 19,000 surgeries a year. And that's inpatient and outpatient surgeries combined. You can see the dip when COVID hit. And you can see the rise in volumes after that.

And these, as you might know, these volumes reflect COVID, the impact of a cyber-attack, and then the air quality issues we had in the Fanny Allen. So that trend is coming up a little more slowly than it would be in other places because of the circumstances for us, but that's the picture with the actuals.

Now, I want you to focus, if you would, for starters, on the dark green bars. So that is the projected growth of surgeries through to 2030. That's based on the Public Opinion Strategies' population forecast and the Sg2 forecasting model that we had in 2021.

And I want to say this, what I've learned about facilities planning is you need to start with how big the facility needs to be. And so getting an early estimate that wasn't an underestimate. So to figure out how big we needed to make this outpatient surgery center was really critical to bring forward to our facilities partners at the time.

So the dark green bars reflect a twenty-two percent in our total surgeries over this ten-year period. Okay?

And again, recently, the Green Mountain Care Board asked us to go back and based on more recent population forecasts and a more recent Sg2 forecast of surgical demand, to recast that demand. And so the light green bars reflect that recasting of demand. And again, this shows a slightly lower -- a seventeen percent growth over ten years in the demand for surgeries for

this region.

All right. The thing I'd also like to say is we make a pretty big deal in our CON application, that we assume that our market share stays the same. And you might wonder how we do this. And the reason is, is because we started with our own baseline volumes and grew those volumes by the expected growth for the entire region. And so it was a very important to us that we respect the role of our regional partner organizations to take advantage of market growth or to serve that market growth as their institutions allow them to do so. So I just want to confirm that because of the approach, I am very confident that we retain the same market share and that the surgical growth that we're showing is not dependent on stealing market share from any of our partners.

All right. So with this surgical forecast, the next job was to take that forecast and translate it into our need for ORs. Not a small job, because we have surgeries that last anywhere from thirty or forty minutes to two-plus hours. And so to do this, we turn to our partner, Halsa Advisors, and I'm going to turn it

next to Scott Walters to talk about that part of the process.

MR. WALTERS: Thank you, Eve. This is Scott Walters, partner with Halsa Advisors. And the way that we do that, the first step after you've reached agreement on the number of cases, is to calculate how many surgical minutes will those cases reflect five years out and ten years out. And just like Eve started with existing caseloads, we started with existing case lengths.

So step two is to get projected minutes by service line. We do all of our work by -- at service line level and separating inpatient and outpatient cases. So as the -- and we always start with the actual data. So everything was built initially off 2019 data. We looked at later years and the case length by service line by inpatient or outpatient held very constant over the period between 2019 and the more recent data we looked at, it was 2021. So we said, let's just stick with what we've got. So it's all based off of actual 2019 data.

And we took the minutes per case by service line and by inpatient/outpatient, and

basically applied those historical case lengths to the future case lengths. And the reason we stick with historical data versus trying to use any sort of a benchmark is, every institution is different. So the types of urologic cases, the types of vascular cases, the types of cardiac cases, and the mix that we have, it generally tends to be unique to an institution and again, generally tends to be fairly consistent over time.

The other thing that we -- changes that we don't assume are that what goes on within the OR with the surgical team, while the new ORs are going to make it more easy to assign a room to a team, it's going to be roughly the same team doing the same types of cases to the same types of patients. And the actual surgical process that the surgeons and the anesthesiologist are completing are going to stay roughly the same, whether it's in the current environment or the new environment. So we hold those case lengths constant. We multiply the new number of cases times the historical case length. That gives me total minutes of case time. So wheels in to wheels out, from the time the patient enters the

room to the time the patient leaves the room, for the total number of surgical cases within each specialty.

The next thing we do is we add a turnaround allocation to that. And here we have to make a choice. Are we going to go with the historical turnaround times that the institution has had, or are we going to use a benchmark? And the judgment we make there is if we look at the current facility and we can identify, one, that there is a discrepancy between their current performance and what a reasonable benchmark is. Generally, they're on the long side. And critically, two, we can identify a facility reason for that discrepancy, and we know that we can fix that issue with the new facility, then we'll go with the benchmark. Otherwise we'll go with the actual data.

And in this instance we looked at the actual performance, we looked at benchmarks, and they were very close. And in the case of the outpatient cases at the Fanny Allen, the actual performance and the benchmark performance were identical in a couple of years or plus/minus one or two minutes. So we went with the actual,

which also ended up being the benchmark.

So you add the turnaround time, that gives you your total minutes of demand by type of case and by service line. And the final step then is to say, okay, if I've got this many minutes of total demand, how many ORs do I need to meet that total demand? So we factor in how many hours of utilization per day. And what is the utilization percentage target that I have. So we assume that we would have 250 days a year, ten hours per day at all of the sites. These are fairly -- even the outpatient surgery center is a fairly large site. Larger sites we forecast a ten-hour day. Smaller sites sometimes struggle to staff a ten-hour day. So we usually use an eight-hour day at a smaller site. All of these are at the ten-hour. And we always use a seventy-five percent utilization target.

So that utilization target really does two things. In the inpatient side, it allows me to have a little bit of flex in the schedule so I can get add-ons, emergency cases, acute care surgery, acutely ill patients added, trauma patients added to the schedule. And we think there will be a few of those types of cases

at the outpatient center, things that can be done on an outpatient and things that it might need to be done tomorrow or the next day. It doesn't need to be done instantaneously. So a wrist fracture would be a great example of that, where it's actually beneficial to wait a day or two before you perform the case.

The other thing that that seventy-five percent allocation allows for are things that go wrong that cancel a case. So whether it's, you know, a snowstorm wipes out and a blizzard wipes out an entire day of production; whether it's, you know, other weather related, or whether it's patient related. This particular patient, we thought everything was going great. They came in the morning of surgery, their vital signs are inappropriate for surgery. The case is canceled unexpectedly. I'm not going to be able to backfill that time. And I need to have enough capacity to account for those things. I never know which case is going to be, but I know it's going to be a case. And if I've packed the center too tight and then I lose utilization due to those canceled cases, I can never make that time up. And I'm going to be short ORs.

So we use the seventy-five percent target. That's what I've used for complex, multi-specialty surgical centers for thirty years. And the same thing on the inpatient side, we've used that seventy-five percent target. And it's also a target that we've seen used frequently by other modelers, and also to align well with well-run departments. You can run a few percentage points over seventy-five for a while. But typically that -- sticking with that seventy-five percent is a safe, achievable, financially viable target.

And next page. So finally, we compared that against an outside -- Vizient did a study for the UVMMC after we put all of our modeling together. And as we looked at OR utilization and we looked at room turnaround times, the UVMMC's actual performance and the numbers that we used in the going -- kind of the go-forward model, fell between the fifty and the -- fifth and seventy-fifth percentile for the other similar academic medical centers that we were looking at. So we felt, you know, comfortable and vindicated, I guess that, you know, we've chosen wisely, we had reasonable

targets that are a good balance of achievable, providing adequate clinical capacity, but also being responsible stewards of our resources.

Eve, back to you.

MS. HOAR: Thank you, Scott.

Next slide please. Thank you so much.

So this table summarizes the work that we did on the forecast modeling. So again, the first column, scenario 3, shows our estimates in 2021 that formed the basis for the facility planning of the OSC that you'll hear about in a few minutes.

Again, that twenty-two percent growth in surgeries to 2030, to bring you bring it home with a number results in 23,800, around, surgeries in in 2030. That's about 4,000 more than we do today. With the Halsa OR model, that volume translates into the need for 5.6, or we better round up, 6 more operating rooms than we have today. And because we are assuming that we are closing down the outdated Fanny Allen ORs, it told us that we would need 10.6 or 11 ORs in this outpatient surgery center.

We fast forward to the most recent

kind of revised forecast based on Sg2 and the 2024 Claritas model, we get about 1,000 -- 900 to 1,000 fewer forecast surgeries by 2030. So remember -- so again, that seventeen to twenty-two percent growth results in about one OR's worth, if you think about plus/minus difference in the number of surgeries that need to happen by 2030. Using Mathematica's model for forecasting the number of ORs needed, their model suggests that it's six more incremental operating rooms needed to handle that 22,800 surgeries. Which brings us to a eleven ORs needed in the OSC.

Okay. And with that, I am going to turn it over to -- I don't know if it's to you, Dr. Leffler. I'm sorry, I'm forgetting, but I believe it is to introduce the next section.

DR. LEFFLER: Thank you so much, Eve. Next, we're going to hear from Eve again, Beth Seniw, and Dr. Coleman discussing the importance of this project for our patients, providers and our DEI objectives.

MS. SENIW: Great. Thank you. Can I get slide 10, Marie (ph.), please?

Good morning, everybody. I'm Beth Sinew, the network director of planning, design,

and construction for the health network.

The site for the proposed outpatient surgery center was strategically selected to be accessible, convenient, and familiar to achieve the best patient and provider experience. It was chosen after careful analysis of location, proximity to our medical center's main campus, adjacent pedestrian and public transportation access, proximity to utility infrastructure, and the site's capacity to meet initial construction size requirements as well as future growth needs.

UVM Medical Center currently holds a purchase option for this property. The proposed lot is 13.5 acres, located on the northern side of Tilley Drive in South Burlington. This is 3.3 miles from the main campus in Burlington. Only 10 of our 13.5 acres of this property will be developed as part of this project.

The site, as you can see from the map, is adjacent to UVM Medical Center's outpatient clinics on Tilley Drive, including orthopedics, cardiology, cardiac rehab, pain management, ambulatory infusion, and soon to be

dermatology and ophthalmology, which will be opening in fall of '24.

This location in South Burlington is served by enhanced public transportation systems and will have connectivity to a newly constructed Rec path, which will extend into the O'Brien farm housing development to the north.

Slide 11 please.

The site design for this project includes 270 on-site parking spaces for staff, patient, and visitors on the west and north sides of the building. The site slopes from west to east, allowing for at-grade access to the lower level of the building for back of house deliveries and staff access to the building. Patient and visitor access will be through the drop off canopy and the main entrance on the west side of the building.

Landscaping elements on the site include screening of abutting properties and in-parking islands. Two elevated berms will provide additional screening near the adjacent residential properties. A small exterior patio on the south side of the building will be provided for patients and families. And our

staff will have access to an outdoor area on the north side of the building.

Site utilities include electrical service from Green Mountain Power, natural gas. And we'll have two water lines serving the building. One for main service to the building and one for a fire department connection on the western side. Gravel stormwater wetlands will be constructed on the eastern portion of the site. And out back will be an exterior oxygen farm to provide medical gas to the surgical center.

Permit applications for the project site plan, water allocation, wastewater allocation have all been filed with the City of South Burlington. A zoning permit for this project was issued in November of '22. And the project has also received our ACT 250 approval from the state.

At this time, I'll turn it over to Thomas Morris from E4H to dive deeper into the building design.

MR. MORRIS: Good morning, I'm Thomas Morris with E4H. I'm a principal in this office. We're the architectural design team for this project. I'm going to go over the plans.

As Beth mentioned, the site allows an entrance at grade level on the lower level, and it also allows an entrance on the upper level on the west side of the plan.

So if you go to the next page -- actually let me just talk about this one a little bit because I think it's better to look at this than the floor plan.

In addition to the site plan specifics that Beth went over, there's going to be a drop-off and a pick-up on the west side of the project coming in off the Tilley Drive. So you'll approach the building, you'll drive underneath a drop-off canopy. You'll be able to drop patients off to proceed into the building. You'll also be able to pick up patients after they've had service, and then you'll be able to exit the campus.

Parking is going to be primarily to the north for staff. And then we kind of congregated the patient parking and visitor parking closer to the entrances for ease of access to the front of the building.

So the red arrow is the discharge, the green arrow is the entrance, and the blue

arrow around the back is employee entrance.

Go to the next slide, which is the lower level.

Okay. Well, this is the upper level. So as I mentioned, the green arrow is the entrance. You will come in at the ground floor and you'll -- admin will be in that area. There'll also be check-in for patient arrival. And there'll be a waiting area in that tan area. Adjacent to that is the outdoor patio that Beth mentioned. Those consult spaces for physician and patient discussions in that waiting area as well. So once you've checked in, you will proceed to pre-op. You can see the green arrow indicating the path of travel to pre-op. We have twelve pre-op stations set up for patient arrival and preparation for surgery.

Once you've gone through pre-op, you'll go into the OR area. You can see the green area indicates the eight ORs that were designated for the project now. The gray area to the south are the four future ORs.

Once you've had your procedure, you will start to move through recovery. The first one is stage one recovery where we have

fourteen bays established. Once you've established pass through stage one recovery, you'll move through stage two recovery where you will then be discharged. In addition to the stage two recovery, we do have the eight twenty-three-hour patient rooms for patients that need to stay over overnight.

If you go to the next page.

This is the lower level. So this is primarily for staff entrance, and shipping and receiving is all down at this lower area. In addition to the staff support spaces on the lower level, we have the obvious spaces down there, engineering, there's a bunch of mechanical spaces, and electrical rooms. The staff locker rooms are located in this area as well. And there is a staff classroom on this floor near the entrance.

But the biggest, probably, functioning space down here is the central sterile processing, which is directly below the ORs. So we have good vertical connectivity between bringing clean instruments up to the surgical floor as well as dirty case carts down for sterilizations and processing. You can see

the red boxes indicate vertical transportation from the lower level to the upper level. So we have things that align and stack very nicely with this given plan.

And I think the next image is just an architectural rendering of what the building looks like. So this is the northeast view at the drop-off. So you can see the set of double doors that are closest to you. Those would be where patients arrive. They're dropped off underneath the covered walkway. They proceed into the building, go through the check-in process. A little bit further to the right, you can see the patient patio that Beth spoke about. And a little bit in the background is the drop-off. So arrival and (audio interference), all under covered approaches.

Next image is kind of a straight-on view looking east at the main part of the building. And again, this is the covered drop-off area for discharge and arrival.

That's pretty much it for the architectural overview of the lower level and upper levels.

DR. LEFFLER: Beth, do you know

who's going to speak next? Is it --

MS. SENIW: Okay. I just wanted to make sure. So it's --

MS. COLEMAN: Good morning, everyone. So I'm going to speak about the health equity and DEI considerations for the outpatient surgery center. Health equity and DEI principles were considered in the project design. The facility will include gender neutral restrooms and changing areas, and private lactation areas. Design elements to support the patient privacy, the patient pre-op and recovery rooms are separated by walls and no longer curtains. They have a separate entry and exit doors as well.

Additionally, patients who have communication access needs or may have additional needs, will be identified in the pre-assessment screening and testing process, which allows time to secure appropriate resources to accommodate the patient.

Notably, there's direct interpreted call-in lines represented in thirty languages and on-call ASL interpreters for all sites through a third-party vendor, and that's available twenty-four/seven.

I want to note that the pre-assessment screening and testing process also identifies any transportation needs. And throughout that process, our patients who may need to use public transport or additional transportation support, that will be identified so that the assess -- the appointment can be scheduled to align with the schedule availability of different transportation options.

The project as a whole promotes health care equity by preserving local access to care. Insufficient local capacity will have the greatest negative impact on our lower income patients and those who cannot afford to travel to receive care elsewhere. We know that when people don't receive care close to home, the burden of that lack of access really falls disproportionately on our low income and least advantaged Vermonters, including and members of our refugee, immigrant, and BIPOC communities, as well as those living with a disability or our older adult Vermonters, as mentioned earlier.

If you do have means and you can't get timely care here, then you are able to travel to Boston or Albany or Dartmouth, even though it

costs you and our system more. And if you are financially restrained or lack transportation and you wait, sometimes you suffer while you wait. That result is not just and this project will help address that injustice.

If there are additional questions at the end of our presentation about this, I'm happy to answer them.

MS. TYLER: We're going to turn back to Beth Seniw briefly for one more comment.

MS. SENIW: Sure. Yeah. I just wanted to add, our design process from start to finish has had extensive input from our doctors, our registered nurses, our design team, as well as our patient and family advocates. This is a process that we do on all of our projects. We like to get input from all sides of the -- all sides of the table to provide the best facilities for our patients and community.

So we'll turn it now, I think, back to Eve, or Mary, or Dr. Leffler.

MS. TYLER: Actually, we'll turn back to Dr. Leffler to introduce the next speakers.

DR. LEFFLER: Thank you, Karen.

Our next speakers will speak to staffing the new outpatient surgery center. That will be Chris Dillon and Mary Broadworth. Thank

MR. DILLON: Thank you very much. If you can put the slides back up. Number 17 shows in a pretty basic table format how we're looking at recruitment from the provider and learner perspective for the next phase of the -- first phase of the OSC. You can see here for the department of anesthesiology; we're looking at adding 1.2 physician FTEs and 4 APP FTEs to help staff the incremental rooms.

Here, the department of surgery we referred to generally, and this captures the department of surgery per se, orthopedics, and OB-GYN. And we heard as recently as Thursday this past week, that we have surgeons in those departments still actively looking for incremental block time.

Block time, which I'm sure we'll talk more about later, is predictable recurring pieces of OR time allocated specific services or providers, and we do not have more of that to provide in current state. We're currently finding incremental OR time in the nooks and

crannies of our schedule. And so we believe that the current physician cadre can expand into this new access to provide more access for patients. So this is the provider and learner perspective.

And I will turn it over to Mary to speak about other components of our staffing.

MS. BROADWORTH: Good morning everyone. I'm Mary Broadworth. I'm the vice president of human resources for the medical center. If we can go to slide 18. I would like to share with you how we plan for the staffing model. To develop this plan, we look at benchmarks. We use the American Society of PeriAnesthesia Nursing benchmarks for perianesthesia staffing. And the Association of periOperative Registered Nurses' benchmark for our operating room staffing.

The eight operating room OSC will require 107 full time equivalents, and 57.5 of those will be new direct staff hires. As we discussed earlier, we anticipate a portion of our current employees will move over and we will have this new group to hire. When the two additional operating rooms open, we'll need an additional eighteen full time equivalents.

In our modeling, we assume twenty-five percent of the operating room registered nurses are full-time equivalents. Ten percent of our surgical tech FTEs and ten percent of our perianesthesia RNs will be traveling or contracted employees.

The eight operating rooms will require fifteen full-time equivalent additional ancillary staff or indirect staff to help manage the process in the building, and ten operating rooms will require two additional FTEs. We've implemented many initiatives to support workforce recruitment across the medical center and the UVM Health Network.

We've done many things to enhance our talent acquisition program, our staffing and sourcing, our marketing to potential employees through our career website, and expediated our application process to remove barriers for those trying to get in touch with us for opportunities. And for most of our positions, we have some sort of hiring incentive. We have a referral bonus for our employees, as well as some sign-on bonuses for positions where we have a high need.

In workforce development, we've

got a study stipend for LNAs who work part time while enrolled in an RN degree program and agree to work for us for up to two years. So these are our Vermont Agency of Health Services accelerated BSN pathway program, our Vermont Agency of Health Services master's in nursing pathway program, and we have several in-house programs, including our surgical technical pathways program.

And in addition, we know a challenge for potential employees moving to the area is simply housing and child care. And we have invested in both of those.

Just to share our recent experience, we have a net growth of 120 new nurses, our LPNs and RNs in the last 18 months into the organization. And we are experiencing lower-than-average RN turnover, six percent projected for this year versus a seventeen percent average in the northeast.

And we are starting to convert our travelers to full-time staff. We've had twenty-one recently hired in the last year deciding to stay with us full time.

In workforce development, we've talked about our programs to enhance education.

We've had forty-four students participate in the LNA to RN program. Eight in that accelerated -- the accelerated BSN program. And twenty-one in the MSN pathways program. So thank you for your time this morning. I'll turn it back to Steve.

DR. LEFFLER: Thank you so much, Mary and Chris. Next we're going to discuss the financials of the project. And so we're going to hear from Rick Vincent, Mark Stanislas, and Eve Hoar.

MS. HOAR: I will kick us off. Thank you very much. And we're going to go right to the capital expense summary, please. So next slide. Thanks, Marie. Great.

So this is a high-level table of the capital costs of the project. You can see that $94 million has been allocated to construction. Given the inflation that we were seeing as we were developing the plan on capital costs -- excuse me -- on construction costs, I want to note that the construction estimate includes a twenty percent contingency, which is significantly higher than contingencies that we had used historically. Land acquisition costs are approximately $5 million. Our equipment

budget is $22 million. That includes a ten percent contingency in that category, as well as in IT, where the estimated IT costs for this project are about $1.6 million.

So before capitalized interest, it makes the total project cost -- excuse me -- $123 million. And then with the $6.3 million of capitalized interest, makes our grand total $129.6 million.

A note on the equipment list, these costs are high, but it includes about $1.7 million to support equipment needed in our CSR unit. A quick note that we hired a number of experts to see if we could use the CSR area in the main campus to do the instrument sterilization for the outpatient surgery center. And we could save money in that way.

We consulted with two experts, and both of them came back and said, do not do that, for a number of great reasons. And so we made the decision to include the space and the cost of having that central sterile space and instrumentation right here on site. I think it can serve as a backup should anything happen to central sterile at the main campus. And nice to

have that redundancy for us, and that's so critical to the functioning of the UVM Medical Center as a whole.

Great. We can go on to the next slide, please. I'm going to bring this forward to the pro forma. I'll start and then pass it over to both Rick and Mark. So you've seen our pro forma and our CON application. And we've discussed the pro forma at length in the rounds of questions since then. So I'll give you a high-level overview here.

The incremental patient revenue that you see here, it has three components in it. So it has -- actually, let me step back and talk about an incremental pro forma. So while it may make sense to some, it may -- I think it's important to talk about what this is and what this isn't to everyone here.

So we're charged with helping our leaders understand the incremental additional financial impact of this project on the financials of the UVM Medical Center. So we look at incremental revenue -- or reimbursement, actually, and incremental expense from doing this project.

So it ties into the volumes that you saw before. It ties to the capital. And the staffing plan for the project and where we bring it all together. So I'll talk about this incremental pro forma.

We also submitted a full OSC project pro forma with our CON submissions to answer the question, as its own entity, does the OSC provide -- what's the impact or what's the contribution of the OSC as its own entity to the financials of the UVM Medical Center?

All right. So back to this incremental pro forma. Three components to the incremental patient revenue. The first is incremental outpatient volumes from incremental outpatient volumes that we can -- that we can achieve here at the outpatient surgical center. The second component is incremental inpatient volumes from that incremental inpatient volume growth that we projected to 2030 that we can't accommodate now, given our OR capacity and our current volumes.

And then the third component of incremental inpatient revenue was an adjustment for those cases, outpatient cases, which we now

do either at the main campus or Fanny Allen, that are shifting to the outpatient surgery center and will be reimbursed at a lower rate either through our Medicare reimbursement or through lower commercial reimbursement. And so that's the incremental patient revenue line that you see there.

On the expense line, we have incremental salaries and wages that we're paying pursuant to the staffing costs that you just heard about. The salary, wage and other line also includes some incremental surgeon compensation based on the additional surgeries that they will be doing on the outpatient basis.

Other department operating expense includes medical, pharmacy, and surgical supplies. It also includes some startup expenses for shutting down the Fanny ORs and making this transition to the outpatient surgery center. Other nondepartment operating expense includes the Vermont health care provider tax.

The next line shows direct costs for incremental, the incremental inpatient cases. That includes incremental compensation or incremental hiring needed for physicians to take

care of those inpatient cases as well as incremental staffing associated with that. Then we have the depreciation and interest line. So as you can see, our incremental operating margin after we subtract depreciation and interest expense gives a $28.2 million, five-year margin total. From an earnings before interest, depreciation and amortization standpoint, our five-year EBIDA is $83.2 million dollars.

Okay. And with that, I will turn it over to Rick. Rick. Thank you. Or maybe it's Mark.

MR. VINCENT: No. Yeah, I think it's me. Good morning. I'm Rick Vicent. I'm the CFO of the UVM Health Network. I'm going to talk a little bit about how the project fits into the overall financial framework. For those of you on the Board, I think you've seen our framework multiple times. We present this as part of a budget narrative every year. It's the metrics that guides our finances for the for the UVM Medical Center.

So one, operating EBIDA margin is the margin where we generate cash from our core operations. So it's the operating margin minus

all the noncash related items. For us, we're a nonprofit organization. So anything that we generate in terms of operating, even a margin, we turn back into the organization as reinvestment in patient care and taking care of our communities.

Debt to capitalization ratio, so what this tells us is, are we borrowing too much money, or do we have actually some capacity to potentially borrow some additional funds to help support our patients in our communities. Days cash on hand tells us whether or not we have enough resources to reinvest in the organization and also be able to absorb downturns in our business. We need enough of a reserve there to be able to take on unexpected events.

And then the last line, average age of plant, that tells us, are we reinvesting in the organization at a fast enough pace to ensure that we're meeting the needs of our communities, all of those metrics -- so operating EBIDA margin, what highlights a healthy A-rated organization is an operating EBIDA margin that's in the seven to nine percent range. Debt to capitalization, you want to be somewhere in the

thirty to forty percent range.

Days cash on hand, 150 is the minimum that you actually -- based on A-rated organizations need to be closer to 200. And then finally, average age of plant, a healthy organization, that ratio is between eleven and thirteen percent, which shows that you're reinvesting at a healthy pace.

You can see that the numbers that you see here, the projection years actually includes what we've just went through in terms of how this project fits within our overall framework. The operating EBIDA margin includes the 83 million that we're projecting. So it does have a positive impact on that.

In terms of days cash on hand, we will see a small decrease of about three days in that first half year of operating the OSC. And that's driven by the fact that, as I think you saw on a couple of slides prior, the total project cost for the OSC is $130 million, but we're only planning to borrow 100 million. So we're going to -- we're going to be using $30 million of that that days cash on hand reserve to fund the project in the first the first half

year. But then from then on, the project has about two days cash on hand per year based on that operating EBIDA margin.

Then finally, I think the last point, just to highlight here that even with this investment, you can see that the average age of plant is still climbing towards that higher end of that metric. We want to be within thirteen there. But we do -- when we get out to those future years, we do have a little bit more debt capacity. So 2024, we're at 24.8 percent, which we could, in theory, get up to 30 percent.

But we want to make sure that -- these are obviously projections. So we want to make sure we're actually generating these types of operating EBIDA margins in the years ahead, and that our cash does continue to climb. Because as you can see, we saw a significant decline in 2022 from the severe impact of the workforce crisis and the large sums of money that we had to pay for contracts, labor, and other items.

So with that, I think I'm kicking this back to Dr. Leffler.

DR. LEFFLER: Thank you, Rick.

Next, we're going to hear from our providers. First up, is hearing from Dr. Plante, again, the importance of this project.

Thank you, Mark.

DR. PLANTE: Thank you, Steve. Sorry for round two of me.

I, again, want to thank you sincerely for the opportunity to give another perspective. And I'm now going to use the lens of training people and what it means to our community.

So the backdrop on that is so I'm part of the faculty at UVM. I've been the residency program director for urology since the reestablishment of residency training over a decade ago. What this has meant for our community is that we actually have four urologic faculty that have been recruited to stay in the area, where without that residency training program, we probably would have more of a shortage of urologists.

This is not about urology. This is about every specialty, because that same narrative exists across all our specialties, whether surgical and nonsurgical. But when we

talk about surgical service delivery, then we're talking about -- so the carpenters need tools, and those tools are forever changing, and they're actually changing at a rate that is more rapid. We know that technological advancement is more rapid today than it ever has been.

So we're talking about robotics. We're talking about different types of cardiothoracic surgery. We're talking about endovascular procedures. So the reinvestment in terms of the backdrop of the operative arenas is forever necessary. And actually, again, more acutely needed than ever.

In terms of the OSC, specifically and granularly, what does it mean? It means that our operative need on the main campus for very specific and very complicated procedures means we need to decant a lot of the volume to an outpatient surgery center, a decantation that, as you've heard, is not possible with the Fanny Allen.

So hence, a newer space will allow for us to decant procedures that don't need to be on the main campus and then allow us to better accommodate on the main campus more complex

procedures. So veritably, it is a very, very important interdigitation of the more complex with a less complex for the needs of our community. I will be redundant and say, again, we're not a nip and tuck institution. A lot of the surgeries we're talking about are indeed cardiac, neurosurgical, complicated ENT, complicated urology, a lot of cancer surgeries, and an incredible plethora of orthopedic procedures as well.

Again, and again, to be not duplicative, but necessarily duplicative, in my statement, we have an aging population that brings with it a higher level of complexity of disease and a higher level of need for surgical treatment. Thank you, again.

DR. LEFFLER: Thank you, Dr. Plante. Next up we're going to hear from Dr. Claude Nichols, who's the network department chair, orthopedics and rehab medicine.

DR. NICHOLS: Good morning. Thank you for allowing me to speak. I've been at the University of Vermont Medical Center for the past thirty-nine years, the extent of my career. I've been network chair for the past twenty-five

years. And you know, the issue of surgical access has always been kind of paramount.

As other speakers have stated, the issue of block time is critical. And one of the things that that we've discovered in recent months due to some calculations by one of my colleagues, is that the orthopedic surgeons aren't working up to their capacity.

We have the ability to do many more cases than we are doing right now. And some of that's because of the availability of OR time, meaning block time. And some of it is due to the fact that doing outpatient procedures in an inpatient setting is just not an efficient way to deliver care to patients.

The typical orthopedic practice around the country is orthopedic surgeons working in the operating room two to three days a week and having teams that are designed to help them expedite the volume of cases so that the patients in their communities can be taken care of.

And unfortunately, in our community, that's not the case. We do have the ability to have surgeons that work two days a week, but that's not across the board. We have

backlogs in many areas that we've been able to work on through some special programs that we've introduced. But our problems are the resources in terms of the rooms and also the things that are available with the outpatient surgery centers, meaning specialty anesthesia, specialty nursing care designed to help expedite the cases through the system.

In terms of the aging population and outpatients -- as Dr. Plante just alluded to, the complexity is increasing over time. And it's not just the older population that's being more complex. It's just we have a younger population who are requiring procedures that used to be relegated to an older population, such as total joint replacement.

Total joint replacement now is being done in patients under fifty years old, and they're healthy and they can be done in an outpatient setting. But to do them effectively and efficiently, an outpatient surgery center provides the resources in terms of nursing, anesthesia, CSR, and all the other things that allow us to move cases through the system.

And if you look at a lot of the

data, the Sg2 data that has been evaluated, the primary growth area in orthopedics is now total joint replacement, given the growing -- the older population and also the younger population whose joints are just wearing out. And patients really want to have these issues done in a way that's most conducive to their lifestyles, which means going home same-day surgery for the most part.

And it's not just total joints. It's other issues like rotator cuff surgery, spine surgery. Spine surgery is becoming much common in the outpatient setting, even to doing the extent of more complex cases of one and two-level fusions.

The types of procedures that would be done in the outpatient surgery center from an orthopedic perspective would be total joints, meaning total hips, knees, and shoulders; pretty much all the sports medicine cases, foot and ankle, upper extremity; and spine procedures that don't require the resources that the inpatient setting could provide. If you look at what would be done at the medical center, it would be a very limited menu, meaning trauma, for the most part, complex revision total joints, and complex spine,

and also patients who have medical comorbidities that just don't allow them to be done in an outpatient setting.

And so given that, there would be a huge offloading of patients from the inpatient setting and opening up the resources of the medical center for those patients who are critically ill, who have cancers and other issues that that need to be addressed in a timely fashion.

One of the advantages of an outpatient surgery center in 2023 is the advantage of doing total joint replacement. This might sound like a broken record, but if you look around the country, total joint replacement on an outpatient setting basis is becoming much, much more common. The Fanny Allen cannot accommodate that. The rooms are small. The air handling systems are not adequate. And there's no capacity for a twenty-three-hour stay at the Fanny. And albeit we admit, in an outpatient surgery center, not all patients will go home the same day. There will be a small, very small percentage who might need to stay twenty-three hours, and but the fanny does not have that

luxury at this point.

And so having an outpatient surgery center that's designed for that kind of contingency would be very, very important. As far as the teaching mission, you know, one of the things that we found over time is that medical students want to go to medical schools that offer kind of state-of-the-art facilities. And you know, if you don't -- right now in 2023, outpatient surgery centers are state of the art.

Most hospitals, most medical, academic, medical centers, most community hospitals have available to them outpatient surgery centers. And if you can't attract the medical students, it will become more difficult to attract residents. One of the interesting things about our residency program is that it is a national program. We have patients from the Pacific northwest, from the southwest, from the southeast, New England, midwest.

And so you know, we attract residents from all over the country, given the nature of our program. We have a very competitive program at the University of Vermont, and we want it to stay that way as we want all

the surgical programs to remain highly competitive. And the only way we can do that is by training residents in an environment that they will be facing as they go out into the real world and work.

And if we can't provide them with that type of experience, then the next domino that falls is the fact that they will no longer seek us out as the residency education site that they would choose. So and if you look around the State of Vermont, there are many of our graduates who are staffing a lot of the community hospitals in the area.

And so we are a conduit for the musculoskeletal care for the State of Vermont. And so if you want to go backwards, if we don't have an outpatient surgery center that can train people in a way that's state of the art, we're going to stop, you know, being able to attract those quality residents who stay in our state to provide care to our citizens.

And so this is a very important project. And I hope that you will consider it in a favorable way. Thank you.

DR. LEFFLER: Thank you, Dr.

Nichols.

Next, we're going to hear from Dr. Heather Harrington, who's the network division chief of otolaryngology.

DR. HARRINGTON: Thank you, Steve. So like you said, my name is Heather Harrington. I'm the leader of otolaryngology, or as most people call us, ENT for the network. And today, I'd like to speak from two different lenses, and I apologize.

I will echo a lot of the things that Dr. Plante and Dr. Nichols already said. But I want to speak first as leader of ENT for our network, and then also from the perspective of a pediatric provider and pediatric ENT.

So just to give you a little bit of background, because not everyone is totally clear on what ENT does. We're a subspecialty that's mostly made up of outpatient and short stay surgical cases. So we take care of a really wide range of patients, from babies to the elderly.

We have a very diverse surgical practice, and we do everything from placing ear tubes, which is the most common surgical

procedure in the country, to cochlear implants to restore and establish hearing for patients. We do things like tonsillectomy that are super simple, but also robotic cancer resections and microvascular -- excuse me -- free flap reconstructions.

And while our complex airway and head and neck cancer cases need to be performed at the main OR for the post-op ICU care, you know, a lot of our straightforward head and neck cancer cases even, our sinus surgeries, our ear surgeries, and most of our thyroid and parathyroid surgeries can all be performed as outpatient or short stay cases at an OSC.

So like Dr. Nichols said, our problem isn't that we don't have enough surgeons. And we certainly have plenty of patients, but our wait times aren't acceptable. You know, even though the majority of our patients can be done as an outpatient in a setting that's more efficient not delayed by bumps in emergent cases in the main OR, we don't have the geography for that. We don't have the OR space for it. So this means that things that could be done as an outpatient are taking up space in the main OR

that could be used for our complex patients that do need ICU care.

It also means that for a lot of patients who can afford it and have the means, they leave the area to have these procedures done. They go to Dartmouth or Boston or Albany and they get it done much faster. But we also know that many of our patients can't do that. You know, our patients with the most limited resources end up with the poorest access to care.

I know that the Board already has access to our wait times and data, but just to sort of dial it down, I want to give you a very specific example. If you were to come into our clinic today, be recommended to have an ear surgery to fix a hole in an eardrum, help with hearing or a noncancerous ear tumor today, you would be booked into at least October for that surgery. And so for adults, that's a dissatisfier. It isn't great for quality of life, but it's not critical.

Where it really hurts us is when you look at young kids who have hearing loss, who need ear tubes, who are in the period of critical speech and language acquisition. This puts those

kids at risk for speech delay, and you know, imparts problems throughout childhood and into school age that then fall on our school systems and impact our communities in different ways. So initially an OSC would move adult outpatient cases from the main hospital and increase access for our complex patients at the main OR. Eventually, it would also allow access for pediatric patients as they're able to move pediatric cases there.

So just to sort of conclude, I have to say, from my perspective, for ENT, it's not the latest and greatest technology and flashy space that we need, but we're not able to provide basic surgical care to our population right now. We aren't able to ensure that our most at-risk patients have access to the care that they need. And we care about this as a group because we don't feel like we're giving adequate care to our patients.

One of my best mentors, who is one of our most flexible, creative surgeons who's been here for many, many years, says this was the worst care that he's ever provided to our patients, just for an access standpoint. And so

this is just about patients. This isn't about our trainees. It's certainly an issue for ENT, just like it is for orthopedics from a trainee standpoint.

But if we don't fix this access issue, it's going to become quickly compounded in the next years. And we're going to have a situation where we don't feel like we're practicing in Vermont in 2024, but feel like we're really, you know, triaging patients like it's the third world. So thank you for listening to my perspective.

DR. LEFFLER: Thank you, Dr. Harrington. Next, we have Dr. Hailee Reist, who's a fifth-year orthopedic resident.

DR. REIST: Thanks, Dr. Leffler, for having me. So I'm Hailee Reist, I'm one of the fifth-year residents in orthopedics. So I'll be graduating in just a few months and going out to Colorado to start a fellowship in total joint replacement surgery.

And when choosing total joint replacement surgery for my career, because these surgeries make such a great difference on the patients' lives, especially at a time in their

lives where mobility is key to their continued function and independence. And these surgeries dramatically reduce pain and improve function in surgery not years down the line, but days, weeks and months down the line.

And when considering options for fellowship location, the presence of an outpatient surgery center really did play into my decision. And the center I'll be training at Colorado does utilize actually a couple different outpatient surgery center locations. And this piece of total joint replacement training is actually key.

As more and more places across the country, more and more surgeries across the country are being performed in this setting, as Dr. Nichols had mentioned. I've had the opportunity to attend many orthopedic meetings across the country, both general orthopedics and total joint replacement specific meetings. And there have been a major focus of these meetings on the drastic increase that these procedures have been performed in outpatient surgery centers.

Every meeting has at least a few

different slide shows and talking points about outpatient surgery care. And so this is the way care is now being provided for many patients, that they can often lead to better patient care and provide it in a much more timely fashion. As a learner, it's essential to train in the setting that I'll be practicing in the future, just as Dr. Nichols had mentioned. For me, the clinical decision-making skills needed to determine to determine if they are even appropriate for an OSC setting is crucial for me to gain, as I need to be able to make that sound clinical decisions in my own practice in order to serve patients in a safe and efficient manner.

The increase in volume that does come with the utilization of an outpatient surgery center is also essential to learners like myself to have enough volume to be able to safely care for patients when we are out on our own in practice. And while I'm not sure where I will end up practicing, many medical students, residents, and fellows return to their training location. And just as Dr. Plante had mentioned with urology, many orthopedic surgeons practice here, both at UVMC and across (audio

interference) many of the students I work with did some portion or much of their training here.

And having an OSC will be a major attractor to many surgeons in the future, as they know they can provide better care to patients in this setting. Again, thanks for letting me provide my perspective. I'm happy for questions later.

DR. LEFFLER: Thank you, Dr. Reist.

And finally, we're going to hear from a patient who had total joint surgery in 2023, Susan Anderson.

MS. ANDERSON: Thank you. And thank you for letting me speak with you this morning. I wanted to be patient at UVMC for hip replacement, but the wait was too long. Both the initial consultation, took a little scheduling and then the scheduling for the surgery. I was in a great deal of pain, so much so that I had to use a walker.

And I was told they will be at least four months from the consultation time to schedule the surgery. I then tried Copley and was told the same thing. This forced me to go to

Dartmouth-Hitchcock, specifically Alice Peck Day Hospital, where I had my first hip replacement in June of last year and my second hip replacement in December of last year.

It was a long, painful ride in the car, and I had to do it four times for each hip, asking my son to come from Singapore to help take me there. It would have made a world of difference if I could have had this surgery here in Chittenden County and UVMC at an outpatient setting.

I mentioned that I was treated at Alice Peck Day Hospital, which is quite reminiscent of an outpatient setting. It's very small. For those of us that have to have work done, operations rather, we're in such pain. Going to a main campus setting can add stress for parking, for getting there, getting in and out. An outpatient setting is much more calm. I was much calmer going to a very small setting at Alice Peck Day.

Also, I want to mention that after my first hip replacement, I needed to stay overnight for some mild complications. They released me the next day, but it was very nice to

be there in a quiet, small setting. And then I was well enough to go home the next day.

I can't emphasize enough what it would mean to have an outpatient setting. Once we're in pain, it's moments are critical to us. Time is critical and four-month waits seem unfathomable. Thank you, and I'm happy to take any questions.

DR. LEFFLER: Thank you, Ms. Anderson. And I actually wanted to apologize on behalf of the UVM Medical Center. We failed you. And there's many, many other patients that we could have that could give the same devastating story. We are not getting all the patients scheduled as quickly as they need to be scheduled. You heard from our providers. You've heard from our patients that this project is critical.

I started with this presentation with we know we have access challenges. We take them extremely seriously. We have staffing challenges, equipment challenges, space challenges. This project, the outpatient surgery center, is a key piece of addressing our space challenges to get more people surgery in a timely

fashion and it's something that makes sense for them and our providers.

We're proud of this project. This project is all about our patients. So we'll stop with our formal presentation there and we're happy to take questions. Thank you so much for your attention.

MR. BARBER: All right. Thank you all. I think at this point, it would be good to take a ten-minute break and reconvene at 10:52. And we'll go to any questions the interested parties might have. And then the Board questions. Does that sound good?

MS. TYLER: Hearing Officer Barber, just one request. Ms. Anderson, who just spoke, is not able to return for the afternoon portion of the hearing. So if there are any questions for her, it would be great if they could be asked right away. And that may be the case for some of the physicians who spoke as well, Dr. Nichols, Dr. Harrington, Dr. Reist, and Dr. Plante.

MR. BARBER: Yes. You did email me about that.

MS. TYLER: I did.

MR. BARBER: And I forgot. Yes, that makes sense. So we'll take a ten-minute break. Ms. Anderson, if you could, are you able to stick with us for ten minutes?

MS. ANDERSON: Yeah. I will be happy to.

MR. BARBER: Okay. And then we'll take any questions there may be for those witnesses. Could you just say their names one more time so I have it?

MS. TYLER: Sure. So Ms. Anderson, Claude Nichols -- Dr. Claude Nichols, Dr. Mark Plante, Dr. Hailee Reist, and Dr. Heather Harrington.

MR. BARBER: Okay. Okay. So we'll --

MS. TYLER: Thank you.

MR. BARBER: -- take a ten-minute break and take any questions for those witnesses and then excuse them and then move on to any other questions.

Okay. So we'll see you back here at 10:54.

(Recess at 10:44 a.m., until 10:54 a.m.)

MR. BARBER: Okay. So I think we've got to let Ms. Anderson go here. Do any of the interested parties or Board members have questions for Ms. Anderson? Hearing none. Thank you so much. We can let you go.

MS. ANDERSON: Thank you for letting me speak. Bye-bye.

MR. BARBER: Okay. So next, we'll move to each interested party and Board for any questions of the physicians, Drs. Nichols, Plante, Reist, and Harrington. Does the Office of the Health Care Advocate have any questions for those witnesses?

MR. PEISCH: We have questions, but not for those witnesses specifically. Thanks.

MR. BARBER: Thank you, Sam.

And AFT Vermont, Ms. Snell, do you have any questions for these witnesses?

MS. SNELL: We do not have any questions for those witnesses.

MR. BARBER: Thank you.

Northwestern Medical Center, any questions for the physician witnesses?

MR. BILLINGS: We do not have any

questions for those witnesses. Thanks.

MR. BARBER: Thank you.

And Copley Hospital, any questions for those four witnesses?

MR. WOODIN: No, not the physician witnesses. Thank you.

MR. BARBER: Okay. And I'll move to the Board. Dr. Murman, do you have any questions for those witnesses?

DR. MURMAN: No. Just appreciation for their coming today and testimony. Thanks.

MR. BARBER: And Board Member Lunge?

MS. LUNGE: I have one question, which I'm not sure if it's best directed to the physician witnesses or not, so I'll ask it in case it is. Dr. Leffler mentioned in his opening remarks that the medical center has been focused on different ways to increase the surgical volume currently in order to maximize current capacity.

And I think some of the physicians who testified -- and again, I want to echo Dr. Murman's appreciation -- talked a little bit about some of the limitations of the current

space. I'm wondering if anyone can just give a little more color commentary on the types of efforts that you've been working on in order to maximize the current space?

DR. PLANTE: I guess, I probably would be one of the people that weigh in. So in terms of ways we increased our volumes. Obviously, reopening the Fanny was a huge one. Because that reinvigorated a lot of outpatient surgery that we just were not able to be providing. But then thereafter, it actually has been to run some rooms later during the day, which is very disruptive and it's very difficult in terms of accommodating those emergencies you've heard about.

The other things that we've done is we've created some ways to be more flexible in the schedule. But again, that then starts competing with what you've heard about block time. People just do not have enough block time. So what that does is, as you've heard from everybody else, it just pushes all the other elective cases to be in longer wait lines.

And I do also want to expound on one other thing. We are in a hyper competitive

market for physicians, medical students, residents. And we do struggle with recruitment at times. So again, and it is more specific to some specialties and specifically and especially orthopedics with respect to the idea that they need the environment to do up-to-date surgery. Outpatient surgical centers are a standard of care across the nation. I hope that -- I can delve into more detail if necessary. But again, thanks for providing the audience.

MS. LUNGE: Thank you.

MR. BARBER: Okay. Dr. Holmes, any questions for the four physicians?

DR. HOLMES: No.

MR. BARBER: And Dr. Walsh?

DR. WALSH: Thank you. A question for Dr. Nichols, I believe. Dr. Nicholas, you nicely described the use of specialty teams, anesthesia nurses who may focus on total joint replacements, for example. Are any of those teams up and functioning now, or is that something that would be part of the new outpatient surgical center?

DR. NICHOLS: Historically, we've had an orthopedically dedicated OR team. During

the pandemic, it disbanded just because of staffing issues. The total joint group and the spine group both have teams that they work with very closely who help move things along. So yes, those types of teams do exist in the present scheme of things. They're not perfect. They're not perfect, but they do exist.

DR. WALSH: Right. Not chasing perfection by any means. But how do they differ to what was in -- the teams that were in place pre-pandemic?

DR. NICHOLS: Pre-pandemic, we didn't have the same number of traveling nurses. We didn't have the same number of trainees. And so right now, we're in the process of trying to increase our OR staffing by having surgical tech trainees work with us and having nurses who want to work in the operating room, learn how to scrub and circulate.

And so that is different because we didn't have the same number of ancillary trainees that we're learning as we go, and what we found is that part of the growing process of training and increasing our number of FTEs that we can -- that we need, it slows us down a bit.

And so the teams just aren't quite as efficient as they were, and they still have a number of travelers.

DR. WALSH: That makes sense. Thank you. And thank you to everyone who's presented so far this morning.

DR. MURMAN: So before you go, could I just pop in with one more question for Dr. Nichols that I think actually might be more appropriate for him than for later, which is just you mentioned about shifting cases out of the inpatient setting to an outpatient setting.

And I'm trying to understand, do you think that those are changing from having patients as outpatient cases at the main hospital campus to the outpatient surgical center because of the ability of the operating rooms or actually less inpatient cases, where patients have to be admitted after the case, shifting that to an outpatient environment?

DR. NICHOLS: It's a combination of both. Right now, the spine service does not do any out cases -- or they do some outpatient cases, but they don't do anything at the Fanny Allen Hospital. But the number of cases that

they do as outpatients is limited. For the total joint service, the trend and this time frame is outpatient surgery for patients who are healthy and don't have medical comorbidities. And so that population is huge.

And the medical center just doesn't have the physical therapy facilities, the post-op nursing acumen to really make that happen on a regular basis. We do it, but it has to be kind of choreographed ahead of time so that everyone is on board. It's not the routine at this point.

DR. MURMAN: So do you envision, if the surgery center is built, that you would then be able to have all the resources organized with the clinic nearby and the surgery center right there to have more patients have outpatient total joints than you're currently having?

DR. NICHOLS: Yes, yes. Yeah. And the other the other huge issue with the total joints is post-operative pain control. I mean, that's been evolutionary over the past five years or so that we've been able to manage pain such that patients don't need those inpatient stays.

And so it's not just the

efficiencies in the operating room. There are other aspects of our care that have been improved as well. And allow us to do more invasive procedures as outpatients.

DR. MURMAN: Thank you.

DR. BENDER: If I could chime in around the anesthesia component of that question, especially as it relates to pain control, as Dr. Nichols was saying. So we actually within our department, you can do additional training in anesthesiology and regional anesthesia. And not only do those providers learn how to do the most advanced type of nerve blocks that do treat the perioperative pain associated with orthopedic surgery. As part of that training, they also learn how to be very efficient and (audio interference) that increases access to patients.

And one of the issues that we have now with orthopedics being spread across both the main campus here and the Fanny Allen is, our limited number of experts in that field are spread too thin to really be able to maximize that efficiency as well as just the Fanny isn't really designed for that efficiency, and having the outpatient surgery center will allow those

experts to have the optimal work environment and the consolidation of patients to really synergistically improve that efficiency and that pain control around orthopedic surgery.

DR. MURMAN: Thanks.

MR. BARBER: Chair Foster, do you have any questions for these witnesses?

CHAIR FOSTER: I do not. Thank you.

MR. BARBER: Thank you. So I'll just throw it open one last time. Any Board member questions for these four witnesses?

Any objection to me excusing them from the hearing for the rest of the day?

All right. Thank you. Thank you all so much.

DR. NICHOLS: Thanks to you as well.

MR. BARBER: And so now we'll move on to questions from the interested parties and Board members for -- it would be appropriate for the other witnesses.

If you can identify a witness, I think that would be preferable. But if not, I don't know if Karen or someone from UVMMC could

kind of field the questions to the appropriate people.

DR. LEFFLER: Mike, I'll do my best. So if they're directed to one person, that's fine. If not, I'll direct.

MR. BARBER: Thank you. Thank you, Dr. Leffler. So I'll start with the Office of the Health Care Advocate.

MR. PEISCH: Good morning. For the record, Sam Peisch. It's a tough last name. It's spelled P-E-I-S-C-H, from the Office of the Health Care Advocate. I just want to thank, at the beginning, everyone from the medical center for your presentation this morning and all your hard work and due diligence, responding to questions from the Board and from interested parties both throughout the application and today.

So we have four questions. Today I want to keep it brief because I know it's going to be a long day. And they're organized in chronological order, along with the redacted binder in case folks want to follow along. Hopefully, that makes it a little bit easier.

So I think folks are all aware one

of the conditions or requirements for CON approval is alignment with the health resource allocation plan. And one of those standards, 1.3, says "to the extent neighboring health care facilities provide the services proposed by the new health care project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate". And in your response to the medical center you wrote, "an expansion of the surgical capacity will better allow UVMMC to continue to engage collaboratively with other providers with respect to their patients' care, and avoid access constraints that make collaboration more difficult".

So the reason I ask is, I'm wondering if you could provide a bit more detail about how creating this outpatient surgical center would better allow the medical center to engage collaboratively with other providers.

DR. LEFFLER: So let me start at a high clinical level. Then I'm going to include Eve and Chris Dylan. So at a high level, I'm very confident that if you asked the leaders from Copley or Northwest Medical Center, one of the

greatest challenges they face every day is making sure that when they want to transfer an ill patient to the medical center, we have a bed and capacity for them. It's a major issue across the state.

We struggle every day to make sure we accept all patients who are truly sick and need tertiary care. The outpatient surgery center will help address that by moving some patients that are on campus now to the outpatient setting, by moving people who don't have to be admitted in the future to outpatient surgery, that'll help our capacity challenges.

We work with our partner hospitals across the state every day. The projections that we used to build this model looked at only the patients that we're serving now in the geographic area we're serving now. It didn't take in patients from Northwest Medical Center or Copley, and we expect their populations to age and grow as well and need patient capacity.

So I would say this project will free up some inpatient beds as we can do more cases of outpatients. And there's no easy way for us to send surgeons, surgical teams, or

equipment to other facilities don't have the same electronic medical record, same scheduling tool, the same way to manage on-call schedules or things. It's very complicated for which really fractional capacity in our ORs. So I'll stop here. I'm sure Eve can give a more detailed response, but I wanted to make sure that at a high level, inpatient beds and OR capacity for critically ill patients across Vermont is really important. And I do think this project is one piece, a small piece, but one piece of that work. Thank you.

Eve?

MS. HOAR: Yeah, thanks, Steve. Can you hear me okay? Am I good? Okay. Great. Thanks, Sam. Sam, I don't -- even though, like, I have turned out to be one of the numbers people on this project, I want to say that this is, like -- you heard it from the physicians here, but so much more than numbers. And all the little bits underneath really matter.

So it matters, like, where the growth is and where's the inpatient growth is and where the outpatient growth is. And if we're talking about complex surgeries or simple

surgeries, and so on and so forth. So I would say that that number one, as Steve mentioned, we really, really wanted to be able to stand up and say we were only growing our own slice of the market share and felt like -- and it was a -- that's both a pro and a con, right? So we were expecting, out of respect for our partners saying, your market share will grow as well.

And now it's for you for us together, whatever. For you, get first, whatever, first dibs, right, at expanding to meet that -- to meet that market need. I think the other piece of it is, Sam -- and I'm going to turn it to my colleague, Chris Dillon, who lives this every day -- is the number of physicians who can do the ENT surgery at a Northwestern or Copley may be different than the additional orthopedic surgeons that practice at Copley or Northwestern. So it's a kind of line-by-line kind of answer to this puzzle, if you will.

I think the other thing I'll say is, I'll point to history. When we had to shut down the Fanny ORs due to air quality concerns, we proactively did reach out to our partners at Green Mountain Surgery Center, and I believe it

was Northwestern. And Steve, you can pick this up if you want to, but -- and ask them, could you help us take care of these patients that we are not going to be able to take care of because we can't operate these ORs? So I think we do have evidence of collaborative partnership with our regional partners. And I'm going to now pass it.

Chris, do you want to take the floor for a minute?

DR. DILLON: I think I'm actually all set. I think Dr. Leffler and Eve covered it nicely, but I know Dr. Eappen had something he wanted to say. So go ahead.

DR. EAPPEN: Sorry. I was just going to jump in, Sam. And I'll tell you, one of the things that I've done is gone around to every one of the hospitals in Vermont and asked how we can be better partners.

And one of the key things that they've asked us to do is exactly what Steve mentioned, which is when they need us to take a patient, they would like us to take that patient, no questions asked. And one of the challenges that a number of the hospitals have brought up is around cardiac surgery.

So someone comes in with chest pain, they're suspecting that this patient is having a heart attack and is going to need cardiac surgery, and they want that patient to be able to just come, and ORs are jam packed because -- and this volume that's going on in there impacts the surgeons that you're not hearing from today that do inpatient surgery. We can't take that patient today.

And what that means for that hospital, whether that's neurosurgery, cardiac surgery and other complicated surgeries, is that then they scramble, typically out of state, but it means Boston, New Hampshire, New York, and it's a long ride or a long flight away from family. And it delays care. That's the number one thing that they want us to help them with. So just it's very, very tangible.

It's very real that we're not meeting the standard that we want to meet for our Vermont residents here on this piece. The other part that -- and I'll defer to the lawyers, but I'll bring it up, is that we have had no conversations, like, I think we're very careful about allowing residents to be able to choose

where they can go for surgery.

Like, I don't think it would be appropriate for us to meet with other hospital leaders and say, why don't we decide as leaders that you're going to do urology surgery in this place and we're going to do otolaryngology surgery here, so don't hire anyone. I think that borders or if it's not directly illegal, it's probably border. So we're really careful. And I can tell you that we didn't have any of those conversations.

I was really careful when people talked to me about it. I said, we'd have to go work through legal staff to make sure we can have the conversation when we were talking about that, so that maybe, maybe inappropriately anxious and nervous about having inappropriate conversations. But that's also something that was in the back of probably all of our minds when we're doing the collaboration of, like, how we want to work together. We want to be helpful to you, tell us how we can be helpful.

But that's a little different than figuring out, like, you do what you know here, and I'll do this there, piece of the

conversation. So thanks for letting me jump in there. I know it was unplanned.

MR. PEISCH: Thank you so much. Really appreciate it. Very helpful.

This next question, the reference is page 50 of the binder. And this is from the initial application, where the medical center, you wrote, "this project will not result in an undue increase in the cost of medical care or an undue impact on its affordability". And you talked about how you develop your annual budgets, which I think we're all familiar with. I'm wondering if you can speak a little bit about how the medical center interprets the concept or defines undue increase in terms of affordability, particularly to patients.

DR. LEFFLER: Rick, do you want to start?

DR. VINCENT: I'll start with the technical piece of that, Sam, is I think you can see in our budget presentations over the years and what we look at for cost increases or rate increases is a hundred percent dependent on the cost inflation that we are projecting for the coming year. So what we're projecting for staff

salary increases, what we think supplies are going to go up by in any given year.

So we tie those increases specifically to that. But then we look for opportunities, whether it's efficiencies, additional revenue streams to help offset the impact of those increases every year is something that we're looking at to try to impact positively affordability.

But it relates to this project specifically, hopefully, we've laid out the case that we've heard that cases shifting from inpatient and outpatient to this outpatient surgery center will decrease cost to patients, so it'll decrease it, as Dr. Nichols highlighted, from inpatient cases moving to outpatient. But even the current outpatient cases that do move into this OSC will drop the overall cost to patients. Hopefully, having a positive impact on affordability.

DR. LEFFLER: And Sam?

MR. PEISCH: Yeah.

DR. LEFFLER: What I would add just is remember that there is no good alternative to this project. Without this

project, by 2030, 4,000 Vermonters will either not get care. There's a significant cost to that. Delay in care, there's a cost to that. And some of those people will get sicker and end up in the hospital, or travel out of state for care, which to an individual could have significant cost. Having your family come home, to travel, return for visits. So there is a cost to not having access. Thank you.

MR. PEISCH: Thank you. Appreciate it. Next question. The reference is, this is on page 180 of the binder. This is in your responses to some questions from the Board. You wrote "to achieve the projected operating margins from FY 24 through '26" -- and I realize this might have changed throughout the process. So correct me if this is wrong.

One of the assumptions you make is that revenue rate approvals will continue to keep pace with cost inflation. And I'm wondering if the medical center has a contingency plan for the project if the Board decides, as it did last year, that reductions to the rate increase requests are warranted.

DR. LEFFLER: So Sam, I'm going to

start and then I'm going to have Rick do the fine details. So at a high level, this project's about patient care. We need this project to take care of people who need our services. It's a benefit that the project has a margin and returns a margin relatively quickly, because that allows us to use those dollars for other critical purposes that don't earn a margin. But at the end of the day, this project is about caring for people.

There's a lot of assumptions in any budget. But the root of this project is to help people get access to care in a timely fashion. And so I want to make sure that you and the Board hear that the margin is a positive, good benefit because we can use those dollars for other purposes. But we need to project whether the budgets get adjusted or not. So I'll let Rick add some detail to that. But thank you.

DR. VINCENT: Yeah. I think it's important to realize that we were asked to do two things as part of this OSC submission. So one is what Eve went through at the beginning, which shows the incremental increase of this project, and it came with a certain set of assumptions.

And then two, we were asked to look at the broader UVM Medical Center projections and how this fits into that broader projection. But in terms of that assumption of rate inflation keeping pace with inflation, that really is -- that's our broader kind of budget submission discussion, not really part of this OSC. So that's the assumption that we have today as part of our financial framework. But it isn't part of the assumption that we have necessarily tied to this OSC application.

MR. PEISCH: Okay. Thank you. And the last question, I think this builds off, Dr. Leffler, your comments. I'm wondering if you could speak to how the medical center weighs other health needs in the community, such as, you know, documented needs for mental health, and how you evaluate what projects to seek certificate of need approval for, either now or going into the future.

DR. LEFFLER: Sam, that's such a great question. We have so many challenges right now in terms of meeting the needs of Vermonters. We're behind in terms of the amount of building and space and equipment that we need. And so

we're working on a long-range master facility plan, which I'm sure at some point will be in front of this Board. This project was picked now for a couple of reasons.

Number one, we feel the need every single day right now. We've done tremendous work over the past 18 months to improve the capacity of our ORs and do more surgeries. We're setting records most months now, and we're still, even with all that work, building up a backlog. And Chris Dillon would tell you that we've about maxed out on what we can do on campus.

This project can come online relatively quickly with Green Mountain -- with approval from the Board; by May of '26 it could be online if we get approval this summer. And importantly, it does generate a positive margin, and those dollars can go to other parts of the mission that don't. So if we invested in something that was losing money first, that's detracting from other options. So for multiple reasons, this project is the right project now and sets us up for some other big, important things that need to be done in the, honestly, relatively near future.

MR. PEISCH: Okay. Thank you. I appreciate it.

DR. LEFFLER: Do you want --

MR. PEISCH: Yeah.

DR. LEFFLER: Okay. Thank you.

MR. BARBER: Okay. Ms. Snell, do you have any questions --

MS. SNELL: Yes, I do, please.

MR. BARBER: -- you'd like to add?

MS. SNELL: Thank you. Yes. And I would like to echo Sam in his thanking the Board and the UVMMC representatives here with this presentation.

And if you will bear with me, I just want to run over some data that was included in the original application and some of your responses. And then I think I only really have one question you indicated in question 11 that for every one percent increase in wages will reduce your OSC total margin by about $240,000 annually.

So in the original application on page 36, for direct care staff for fiscal year '26 to '27 and '27 to '28, for each year, you have a three percent increase listed. That same

holds true for indirect staff. At this point in time, indirect staff, I have to assume, is your central sterile processing, housekeeping, everyone that helps keep the facility running. And they currently have a five percent increase built into their next year. Actually, the next two years.

In question 2, on page 5, dated June 15th of '23, you listed pay increases for fiscal year '25 is four percent, '26 is four percent, and '27 as three percent, with zero percent listed for travel labor, and in this current presentation under salary and wages -- and I understand they are not broken down by direct, indirect or by physician, but by the category in general under salary, wages, and other. For fiscal year '26, you have listed a 3.9 percent increase total. And in fiscal year '27 to '28, only a 1.89 percent increase.

So I guess my question is, as we know, there are many contract negotiations going on currently, and is this a reasonable number to have, just three percent, when we're having so much trouble attracting staff to our facility?

DR. LEFFLER: Thank you, Deb. As

you mentioned, we are in nursing negotiations right now, and tech negotiations follow that that. We're hard at work with you working on a good contract. I can't comment on exactly what numbers were put in there. They were based on the percentage of inflation, I'm assuming. And I'll let Eve answer that. But we need to have this project and staff to staff it, and I think it's both.

And so we'll work to get good strong contracts that pay our staff fairly, and then like everything else, work around it in the budget. So Eve, do you want to comment on how the numbers were put in to the model?

MS. HOAR: Yeah, I'm going to start and then I'm going to turn it to Marc, who is my partner for estimating about cost increases. Deb, we spent a lot of time going through position by position, and this is back in '21 and '22, revisited in '22, and making sure that those starting -- so you talk about the growth, but we also wanted to make sure those starting salaries, that current state salaries reflected the current state of things, right? So for travelers and our expectations going forward

for nurses and different positions.

So I want to assure you that those starting baseline wages were done very thoughtfully and in full recognition of the kind of conversations that were going on at the time and our workforce challenges at the time. In hindsight, I would say that -- I just was looking at some of the traveler assumptions, and because traveler costs have come down, we probably overstated some of those wages for travelers, but I would rather have erred on the conservative side than on the aggressive side.

Let me turn it to Marc for the assumptions that that we put forward on the growth over the time frame.

MR. STANISLAS: Thank you, Eve. Let me just pull up the file so I can speak to it.

So Deb, you're exactly correct. And so in our models, and I will say this is a model, that about sixty percent of our costs, give or take, will relate to salary and fringe. And there was a higher percentage allocated to those salary and fringe categories. And then all of the other categories which accounts for about

forty percent of our expense, there's a zero to a three percent that was applied. And there's also med-surge and drug expenses that have a little bit higher percentage than the three percent.

But when you average all of this out across all of our expenses, the cost inflation was normalized in the three and a half to five percent range, depending on what year the projection was that you looked at. And I think to Eve's point, there's other components in this too that we do know our assumption on the traveler, since there was a higher utilization there, that there's a little bit of favorability in there also.

And then the other thing I think to consider, this is cost inflation. This project is going to create so many efficiencies. It's actually going to hopefully take some of the pressure off future cost inflation, because we can do services that we're doing today more efficiently. And at the same time, it's going to be better for the patients from an access perspective and also a cost perspective to the patients.

So there's other components than

just what the pure cost inflation is. Doing our jobs better today is going to relieve some of the pressure on future cost inflation. And at the same time, it is going to be more cost effective for the patients that we deserve. And I think, like Dr. Leffler said, we are committed to working with all of our staff. These are our assumptions.

Our financial framework is updated every twelve months, and every twelve months as more unknowns become true, it is updated. But this is the -- this is a commitment that we're not only making to our staff to make sure they're paid what they deserve and get paid for the services they provide. But also to bring the base cost as most efficiently as we can to our patients to reduce their cost also.

MS. SNELL: Thank you. So are you saying that -- you said that it's updated every twelve months. Is there somewhere in this presentation that you show the increase, especially for the indirect staff, their increase of five percent?

MR. STANISLAS: We provided a breakdown, I think, of all of the staffing

categories that was built into this model assumption, but the point of it being updated every twelve months is as we know more of what the actuals are, we update our projections. And then we model it forward for the next five years.

MS. SNELL: And have you looked at projections with higher wages to see what the reduction in your OSC total margin would be?

DR. VINCENT: So maybe I can jump in, Marc.

MR. STANISLAS: Yeah, go ahead.

DR. VINCENT: So I think, again, going back to the original ask of this, Deb, that was an incremental P&L or increase for the OSC specifically, I think we're mixing two things here because we're also talking about the broader UVM Medical Center budget.

MS. SNELL: Um-hum.

DR. VINCENT: So what Marc's talking about is those broader assumptions that are updated every year. But specific to the OSC, we were asked to just present, essentially, a point in time projection on what the incremental increase is.

MS. SNELL: I understand. Thank

you. Those are all the questions I have.

MR. BARBER: Thank you. So next, we'll move to Northwestern Medical Center. Mr. Wright, are you with us?

MR. BILLINGS: I don't believe Peter is on at this time. He's probably in the air, but I am here and we have no additional questions. Appreciate the presentation today. The team has done a really nice job laying this project out and explaining it, and we appreciate the conversation throughout the process. No questions from NMC.

MR. BARBER: Thank you, Mr. Billings. And Copley, Mr. Woodin, do you have any questions you'd like to ask?

MR. WOODIN: Yes. Thanks very much. Let me just express my appreciation for this process. It was a lot of work and everybody's involved. I'm glad it's not political, and we all try to work together to come up with the best answers.

Certainly we learned a lot through COVID. And I know Dr. Leffler, I've spoken to him a couple of times, as well as Dr. Eappen. The medical center's been very helpful. I think

we've been through a very difficult number of years, and we've never seen this in our career where we can't get access to the highest level of care.

So I think they've always been very gracious, very fair. And we usually join them in the lament when they're like, we can't accept or we're trying to figure it out. So a lot of hospitals in the state have been under a lot of stress with this lack of capacity. So a couple of questions I have. One of them is with regards to the forecasting that E4H provided, but anybody can answer it.

I noticed that when you look at the counties that sort of encompass and wrap around UVM, Chittenden, Washington, Grand Isle, Franklin, there was no addressing of Lamoille County where we are, or Addison County, which I thought was kind of interesting, because if you just sort of draw a line, those are the ones that you sort of draw from. And I just was wondering why those were absent? And particularly because there's the discussion of not trying to take away business from others, everybody's sort of growing, but those two counties were missing. So

I'm just curious why they weren't included in the assessment.

DR. LEFFLER: Eve, are you able to answer that?

MS. HOAR: I'd be happy to answer that. So Joe, I was asked to be brief. Everyone's going to laugh because I love the details. And I was asked to be brief in this presentation. We'd be happy to share those numbers with you. As you know, I think that we are seeing growth and probably the same is the same for Addison County and Lamoille County. Both annually and from a forecasting point of view.

But higher growth than was predicted prior to 2020, right? And the 2020 census gave us information that more people are moving to this area. That it's not just the Chittenden County area, it's definitely hitting the surrounding environment. So I'm happy to provide those numbers to you. But the themes are extremely similar.

MR. WOODIN: Okay. That's helpful. I was just curious that they weren't there.

The other issue is, so Copley is sort of a specialty orthopedics critical access hospital. I know over the years we've talked about centers of excellence in Vermont as we plan for health care, where some small hospitals or others might need to specialize. We don't do ENT. We don't do significant urology. There's a lot of stuff we don't do, but that is one of them that we do.

I know for years -- I worked at Gifford for seventeen years. They were known for their OB birthing center, absolutely considered a center of excellence for that. So when it comes to sort of the discussion about the competitiveness, which I'm sort of surprised about because we're small, we're only three percent of the budget slice of the state of Vermont. So we try to sort of hold our own.

But when you look at bed capacity or needs, so I think we have four beds out there from the Green Mountain Surgery Center that got awarded a few years ago. I don't know where those are. The only two sort of immediately near UVM would be ourselves and Northwest Medical Center. I know we are really close to being at

capacity. I know Northwest Medical Center, from what I understand, they might have some capacity and extra room.

I'm sure you're looking at Porter as well as Central Vermont Medical Center as well as Rutland, if you actually consider those counties that I mentioned that Eve said the data is there. So I'm just wondering, do we know the bed capacity and the future plans for those others that sort of ring around the medical center to make sure that we're not overbuilding? I only ask that because we have three ORs, and eight or nine ORs is like three times the number of ORs we have. Each one of our ORS takes care of about 2,500 cases, not the procedure rooms, but we do about 2,500 cases per OR. So just wondering about that thought, about the capacity analysis and looking at other hospitals. Thanks.

DR. LEFFLER: Eve, do you know what other work went into -- once again, what I know about this project, Joe, is kind of what you just said. We knew that Copley was about a capacity. We knew there may be some fractional opportunity at Northwest, but not enough to meet the 4,000-patient need. And we really looked at

our own service area, the people that are already coming to us.

So we're supportive of Copley having an orthopedic program. Great care happens there. We know it well. We're not trying to compete with Copley. We're trying to serve the patients in our region who need timely access to care. And as we already (audio interference), I firmly believe that the outpatient surgery center moving some cases from the medical center to the OSC will let CT surgery happen faster and neurosurgery happen faster on the main campus, which opens up beds to send your critical ER patient down today instead of tomorrow morning, which is really important. We know that. So I don't know. Eve, you've got fine details, but we're not competing with Copley on this project.

MS. HOAR: Correct, correct. And I think those people from Chittenden County, Joe, who do choose to go to Copley and to have your excellent surgeons do their orthopedic surgery, I would expect that you would see that market growth that we project for Chittenden County happening for you.

In terms of looking at capacity

from nearby hospitals, I think you'll see in our responses to the Green Mountain Care Board questions, I think particularly in Q-9, we talked about the very detailed look we took at our own partner hospitals. We were not aware of any excess capacity that was at Copley or Northwestern in specific terms. And as you know, you really need to get down to those specifics because, for example, you can take orthopedics, but you're not going to take ENT cases, right? So I think, if I got that right.

So it comes down to some of those details. So I think the other piece, Joe, is that we really thought a lot about access, timely access, and we thought a lot about health equity. And I think the OSC is not meant to take our special cases, it's meant to take lots of different orthopedic cases, lots of OB-GYN cases, and so on and so forth.

And so we wanted to make sure that we could give patients who lived in Chittenden County who might have transportation challenges the ability to go someplace that was close to home. And so that that was a big factor into our planning as well.

Chris Dillon, did I miss anything that we've talked about and talked about?

MR. DILLON: No. I would just add for CVMC and Porter, we looked at them extensively in collaboration with leaders of those organizations, and we believe that within five years we're going to be using all the capacity at those sites as well. It's also important to remember that a room is not a room is not a room.

So we know that one of CVMC's ORs is undersized, and we know that one third of the capacity at Porter is in their 285-square-foot procedure room, and we know that that's well below FTI guidelines for anything constructed new at this point. So yeah, I would just add those two points and agree it's sort of a yes and. We desperately need the project we're here to talk about today, and we need to continue to utilize our partners. Thank you.

MR. WOODIN: Great. Thanks for that. And last question, we learned a lot from COVID, which was helpful. And it's not that it's all gone, but as we plan in the future, I think the pressure on the tertiary care centers was

overwhelming. The inability for the small hospitals to handle a lot of things was overwhelming.

And I know we're trying to figure that out, not to overbuild, but to make sure. In my mind it's an issue of diversity to make sure that in different locations in Vermont, because I've heard this many times, if you closed a bunch of small hospitals, both for Dartmouth and UVM, they would just be overwhelmed and life would be horrible and nobody would want to see that happen.

So when we plan, it's always nice to make sure that we're holistically planning so that we have that balance so that if something does go wrong, whether it's the medical center. We certainly hate to send anybody there that we might be able to take care of because there's just too much demand. So I know that issue of looking at all the hospitals, allowing for centers of excellence, if that makes sense. And sometimes those just organically grow, I think is helpful. Hard to predict though.

But I have no other questions, but thanks everybody. It is a complicated process

and I know the medical center does need help. My first response might be that, well, the medical centers should build inpatient beds, so that they can take care of the most acute needs to put them up in the ICU and sort of manage them.

But I think they're doing that with this model because they're just trying to take out their outpatient business, move it aside so that their more acute inpatient care can be satisfied. So I get that. And that makes sense to me, because you wouldn't want to just build in the medical center. But thanks for your time. I appreciate it.

MR. BARBER: So unless there's any comments to what Mr. Woodin just said, I think taking a lunch break at this point in time before moving to Board questions makes sense, unless anyone has an issue with that. I propose we come back at 12:30. We're actually doing pretty good on time. So forty-five minutes for lunch, come back at 12:30, move to questions from the Board and take it from there. Okay. So let's go off record and see everyone at 12:30. Thank you.

(Recess at 11:45 a.m., until 12:33 p.m.)

MR. BARBER: So we'll move now to questions from Board members, starting with Dr. Murman. And just I'm going to offer to share -- if Board members have questions about portions of the record, like, that need to be put up on the screen, I can do that. I can share my screen. It might be easier than trying to direct people to portions of the record. So that's an option if you need to do that.

So I'll turn it over to you, Dr. Murman, for questions.

DR. MURMAN: Thanks. Well, I guess, thanks so much to everybody for this presentation. The topics, the incredible amount of work that's gone into preparing for this, the staff, the CON team, UVM. The application in itself was a heavy lift, and there's been a lot of interrogatories, which have been a lot of work for everybody. But I also think very helpful. A lot of information has come out through those, which have been very helpful for me in my analysis.

I think for me, I guess I'll just summarize some thoughts and feelings about the first part of the day, which is it's just very

heartening to know that the level of dedication and commitment of the UVM team, the providers, the administrators working to try to deliver the best that they can for their patients, the best they can for our community.

I see Heather Harrington is still on the line. I thought she was leaving, but I was going to call her out. Just saying, I think we're really lucky to have the Heather Harringtons of the world living in Vermont and their dedication to that level of specialty care to make it so our patients can receive that care here and at that quality.

I also was really struck by Dr. Coleman's comments, I think, about the impact of financial means on the ability for Vermonters to access care and especially in relationship to where they live. We have a very rural state. And for a lot of people, accessing care here on a daily basis is a challenge without transportation to get to even their local hospital.

With all of that, I actually, really was hoping to start with a discussion with Eve Hoar. And I think I appreciated your comment, but as you say, you like the numbers and

you want to go line by line, and there's a section of this that I just really feel like, from my understanding, I think it would just be really helpful to go line by line and some data. And I don't know, Mr. Barber, if you can put up the UVM slides easily, but slide 4 has a nice chart of the surgical demand forecast for UVM.

So one of the things that took me a lot of time to sort through, through initial submission and the interrogatories and consultant reports is this whole concept of what is the baseline and how to think about these forecasted growths over time. And part of that is the baseline kind of has been referred to a few times, but different numbers.

I mean, it all sounds like it's around 19,000 patients. The workbook says the actual for 2019 is 19,000. The narrative says 18,749. And a supplement to Q-008, question 5 shows 19,152, excluding trauma, and excluding these other rooms that don't seem to be being used anymore. There's two procedure rooms that were closed with Fanny Allen and three of the procedure rooms, I believe, at the main campus, which are used for things other than what is the

scope of this application.

So I guess my first question is, what is the actual number of inpatient/outpatient surgical cases that was performed in 2019? Is it the 18,749?

MS. HOAR: Dr. Murman, so thank you for that. So I believe I was just looking over that yesterday, and we gave you that 18,749 number in one of the rounds. I can't remember which round anymore.

But here's the reason for the disparity between the 2019 volumes, okay? So one is, don't forget, we identified this set of general purpose ORs that we were using, right? So we excluded our special cardiology rooms and so on and so forth. So I have to say that there's a little bit of discrepancy sometimes, if you, like, added the -- just because I'm not sure this is the right example, but if a trauma room was added in one or not. But on the whole, it's the right number.

The second thing we did, Dave, was we took all these growth forecasts and our actual volumes. And we tortured every single chair with looking at those numbers with us on the inpatient

and the outpatient side and said, are these real? Do you -- like, let's talk about the baseline situation. And then we talked about the Sg2 growth rates for inpatient and outpatient and said, what do you think? What's going on here? And then we talked about wait lists and so on and so forth.

So the delta between that, let's say, roughly 19,000 number and the 19,452 is slightly adjusted for waitlist volume that we knew was over and above an acceptable waitlist amount. We were conservative about that. But here's the catch. If you don't include that waitlist volume, that's demand, right? Even though you can't do it, it's demand.

And if Sg2 says the demand is going to grow by X percent, if you don't include some of that excess waitlist volume, you're going to miss demand and you're going to miss the growth of that demand. So sorry, I may be getting --

DR. MURMAN: No, that's actually --

MS. HOAR: I'm looking at you to see if I gotten too deep, because you know me

about that --

DR. MURMAN: No, no.

MS. HOAR: -- from way back when.

DR. MURMAN: No. I appreciate that. Yeah.

MS. HOAR: It's very selectively done. Yeah. And by the way, Dave, so there's times when you can say, oh, on average, we have an X percent waitlist and then you apply it to every single specialty. That doesn't work here because these cases are different. The story is different. So we did it line by line going down there to ask that waitlist question. So it's only adjusted in a couple of cases. Does that answer your question?

DR. MURMAN: I think it's quite helpful. Yes.

MS. HOAR: Okay.

DR. MURMAN: And I do that the -- I think one of the other take-homes from both this morning, but really reading through all of this material, is that an OR is not an OR is not an OR and a case is not a case is not a case.

MS. HOAR: Yeah.

DR. MURMAN: And so which creates

a lot of complexity when you're trying to figure out all of this forecasting.

One of the other issues that I think I kind of realized in reading through the submission is the complexity of trying to build this forecast in '21 and '22, I guess, '22 effectively, which is sort of nearing the end of this incredible disruption to our health care delivery system nationwide, but also then addition the Fanny Allen issues that were around that time as well.

And so when I look at this chart that you have up here FY '29 and FY '23 look fairly about the same volume. I think the FY '23 volume actuals, I don't have right in front of me, it was 19,300 or so if I remember correctly.

MS. HOAR: I'll go back and look. But yeah.

DR. MURMAN: Regardless.

MS. HOAR: You can go ahead with your question, but it's a little bit higher than before. But yeah.

DR. MURMAN: Yeah. So my question kind of gets into to this, which is when we kind of start going line by line, we see this big jump

between '23 and '24 in this forecast, which I know the forecast was really made in '22, but I'm trying to understand how comfortable we are with this jump, which I believe is sixteen percent outpatient and nine percent inpatient. Sorry. I have that backwards. Sixteen percent inpatient and nine percent outpatient that's supposed to happen between FY '23 and '24 to then regain this 1.1 percent inpatient growth, and I think a two percent outpatient growth.

MS. HOAR: Oh. Yeah. So I think, so you're quoting growth rates that are based on I think, I think it's the Ascendient expert report, if I'm remembering that correctly, I think you --

DR. MURMAN: Yeah. Or you can --

MS. HOAR: Yeah. Number one --

DR. MURMAN: I went through the --

MS. HOAR: Going from the --

DR. MURMAN: I went through the workbook --

MS. HOAR: Yeah.

DR. MURMAN: -- and just sort of calculated them. And that's basically what they were --

MS. HOAR: Yeah.

DR. MURMAN: -- for the most part. I think the outpatient had a little higher the year after this and then kind of settles into two percent for the subsequent years.

MS. HOAR: Yes.

DR. MURMAN: And the inpatient was, like, kind of 1.1.

MS. HOAR: Yes. So here's what we believe. So this is, number one, actuals to projected.

DR. MURMAN: Yep.

MS. HOAR: So 2023 is actuals, right? And so there's a little bit of -- Chris, we're bringing the little bit of the Fanny Allen ORs, one more OR going online, so a little bit dampened.

But this is about believing that demand for health care services, despite COVID and despite our ability to deliver, Dr. Murman, was growing, right? So if we had never had COVID, if we hadn't had a cyber attack and had to close down the Fanny Allen ORs, we would have seen demand growing kind of in that linear way as our population grew.

DR. MURMAN: So the assumption was that there would be a steady increase in demand with a baseline year of 2019. And what we're seeing in 2024 is as if that steady increase had started in 2019.

MS. HOAR: I think you're catching up, and the easy way to think about this delta here is our growing waitlist, right? And despite efforts to, as Dr. Plante says, to kind of do the nip and tuck and find nooks and crannies where we can get these surgeries done, in part, that gap is the growing waitlist.

DR. MURMAN: And the waitlist that I saw -- I've only seen one waitlist, I believe, unless there was something I missed in the interrogatories, which was, like, for some reason, I remember off the top of my head was like September 8th, 2022 or something like that. There was a one data point in time where there was, like, 441 cases. But do you have an updated waitlist? Is that something you continued to monitor?

MS. HOAR: Yeah. I'm going to -- I'm going to give it to -- our master of waitlist data is Chris Dillon.

DR. MURMAN: Okay. Great.

MR. DILLON: So as of May 16th, 2024 we had 524 total patients waiting sixty days or more. 304 of those are waiting ninety days or more.

DR. MURMAN: Okay. Okay. So it's up seventy-five patients from, I think, when the submission waitlist was. Okay.

And I think I think Dr. Harrington sort of mentioned that there's a lot of nuances to this as space is available and whatnot. Okay. Okay. So when I'm looking through -- I look through the workbook, which I think this is a -- is this a document that you're -- is this -- this seems like a valid document to look at, right? This UVMMC certificates capacity volume projections model. This is, I believe, something you gave us, correct?

MS. HOAR: I just want to make super clear I know what you're referencing.

DR. MURMAN: I don't know, Mike, can you get it? It's the 8/15/2023, we had a workbook that I think was given to Mathematica to look, which has the scenario projections from the Sg2 adjusted factor. I have it as, like, an

Excel sheet.

MS. HOAR: Okay. I'm familiar with that, I'm sure, but I might be the only one else in the room who are familiar with that.

DR. MURMAN: Okay. So there's --

MS. HOAR: But yes, I know that vividly. Go ahead.

DR. MURMAN: So I guess there's a few things that stuck out to me in that, which is sort of what I wanted to kind of look at that other chart based upon, is essentially, there's this -- and I think Cindy (ph.) had called this out, which is there's a sixteen percent increase in surgical cases from '23 to '24 for inpatient demand.

And the way I looked at this workbook, it looked to me that there was a nine percent increase in outpatient demand, basically from last year to this year. And in that, there was some interesting trends that kind of stuck out to me that I was curious if we had some data to support. The big trend was that projection general surgical inpatient cases for '23 is 533, but almost triples in '24. It's 2.75 times maybe, at 1,491.

So it's a massive increase of almost 900 inpatient gen surg cases. And then also, like, a fifty percent increase in inpatient ortho cases from 1,200 to 1,800, which drives, like, a huge portion of growth, actually, and especially because it hasn't been consistent with more recent data.

Do we know whether or not there's some external factor or more general surgeons or what's driving this inpatient ortho and gen surg growth that seems to be driving the inpatient growth?

MS. TYLER: Hearing Officer Barber, I'm sorry to interrupt, but I'm concerned that we might not be clear about what part of the record we're referring to. So I wonder if we could pin that down and maybe project the relevant data.

I think we're talking about the response to the Board's Q-5 dated August 15th, 2023.

UNIDENTIFIED SPEAKER: Yeah, Mike --

MS. TYLER: And if we could pull up the specific information that Member Murman is

referring to, that would be helpful.

MR. BARBER: Yeah. Give me a second, so.

DR. MURMAN: You're on this email, Mike. But I can forward it to you. Got it.

MR. BARBER: Q-5, granted response; is that it?

DR. MURMAN: It says, actually, Q-6, and it's a -- it was this workbook that was referenced, I think, in a bunch of the consulting reports. I just emailed it to you.

MS. HOAR: I'll recognize it immediately.

MR. BARBER: I just need to know, is it Q-5 or Q-6?

MS. HOAR: It should be Q-6, I think. I think it came to us in August. Does that ring a bell, Dr. Murman? And I think we --

DR. MURMAN: I kind of just sort of --

MS. HOAR: Due to vacations and such, I think we didn't get it back until Octoberish, November.

DR. MURMAN: This is something I didn't follow along with previously.

MS. TYLER: Hearing Officer Barber, I think it's our response to the Board's Q-6 that's dated November 16th of 2023. And the workbook was submitted in response to question 2 of that set.

MS. HOAR: Right.

MR. BARBER: Okay. So is there an exhibit number? I'm not seeing any sort of notebook.

MS. HOAR: And if you go beyond this equipment listing, I think it might be on there.

MR. BARBER: I see financial assistance.

MS. HOAR: Nope.

DR. MURMAN: I just forwarded it to you.

MR. BARBER: All right. Let me get this. Yep.

MS. HOAR: Does this involve confidential information?

MS. BELIVEAU: No. This was not submitted under seal.

MS. HOAR: Great.

DR. MURMAN: Thanks, Laura.

MR. BARBER: I'm not seeing an email come through from you, Dave. I can go to the website. It may be part of that. It looks like it didn't. Are you all seeing this in real time?

DR. MURMAN: Yep. Yep.

MR. BARBER: No. It's the same document. Tara, all right. Any ideas?

MS. BERDICE: It may be in our e-files as a separate Excel workbook, so it would not -- maybe not part of --

MS. HOAR: It's called capacity and volume projections model.

UNIDENTIFIED SPEAKER: Here it is.

DR. MURMAN: Hold on, I closed it on my side. Yes.

MS. BERDICE: It's just slowly.

DR. MURMAN: Thanks, everyone. Sorry, Mike. I should have given you the heads up on this one.

MS. BERDICE: This document?

DR. MURMAN: Yeah. If you go down. Yep. If you go to the next tab. There we go. There we go. Mine's not colored. Oh, I see projection. I was looking at the yellow tab

here.

MS. HOAR: Yeah. Inputs. Yep.

DR. MURMAN: Yep.

MS. HOAR: And then scroll down.

DR. MURMAN: A little bit. Yep.

MS. BERDICE: Further?

DR. MURMAN: Yeah. So you could go just a little bit more, about there is perfect. Okay. So and you can see in line 50, if you go over through actual cases 736, 533 and you go back --

MS. HOAR: Yeah.

DR. MURMAN: -- to 2019 baseline, and you stay --

MS. HOAR: Yeah.

MR. BARBER: -- at the 2019 baseline assuming no growth in gen surg cases. So line 55 ortho, so you're having sort of a downtrend-ish and inpatient info. And then 2024 goes back up to the, it looks like, my guess is you had a projected increase trend starting in 2019. And you're catching it all up between '23 and '24.

And so from the inpatient demand modeling to me, you know, of course there's going

to be some variability in this, right? This is totally makes -- like, there's something in here that doesn't make sense to me, which is, like, your surg onc cases were like 27, 28, 34, 86, 137, 28. Like, I assume you're not planning on declining, like, decreasing the amount of surgical oncology you do. In fact, I imagine part of this is to be able to have the capacity to do more surgical oncology cases.

MS. HOAR: Okay. Yeah.

DR. MURMAN: I can totally appreciate that I appreciate that. But in the context of the gen surg cases and the ortho cases, they're really a huge amount of the drive of the increase in sort of baseline, this sixteen percent bump in inpatient volume. That really kind of kind of drives over time, when you apply the growth factors that, nearly -- it's over 1,000 surgeries. So I was just trying to understand if we have any reason to believe that, whether or not we've been understaffed in general surgery and we're going to have more general surgeons, and you can take more acute volume, because I assume most of the inpatient general surgery cases are acute volume; I may be mistaken

on that.

And then inpatient ortho kind of bucks the trend that that I think Dr. Nichols was discussing.

MS. HOAR: Yeah. Okay. All right. Here we go. So a couple of things. Number one, backstory is that -- and Chris Dillon and others, keep me straight on this. But we switched the systems by which we managed our EHR for our ORs, somewhere in the '22-ish time frame. So that the categories -- we noted this in our response. But this was a long time ago, the categories. So gen surg, you're going to see those volumes do one thing, but you're going to see weird additional volumes in other lines.

So the way a surgery might have been categorized as gen surg back in the 2021 time frame versus surg onc or some other spot are a little bit different. So we noted that and we just -- it wasn't -- to take the time to make everything mesh between our legacy OR system and our Epic OR system didn't seem worth the delay getting the numbers back to you guys. That's the way I'm going to explain that the general surgery delta that you see.

And I think if you look down in general, if you kind of combine all those things, it looks good. On the orthopedic side of things, and I don't know if Dr. Nichols is still on, or Chris, you want to comment on this, but boy, that is a great example of people really putting off surgery during COVID, right? And having those delays really play themselves out in those years.

So we had COVID problems in 2020 and we had COVID problems in 2021. And I know a lot of people who didn't need to have orthopedic surgeries, didn't have them. So that's what I'm looking at, that decrease in the orthopedic volumes. But to your point, we used 2019 as the baseline, simply because it was the last normal year where we felt like health care systems were working normally. People were getting surgeries in a timely way. And between 2021 and 2022, because of the triple whammy of things that happened to us, we just didn't feel like that was a valid baseline to be using for estimating demand.

DR. MURMAN: Yeah, I can understand that. I did a quick lit search and a quick lit search is a dangerous thing to do

because you may not get everything, but the quick lit search I found was that for most surgical volume nationally, by the end of '21, they were back to their 2019 baseline. But I think with Fanny Allen issues and the cyber issues, that could have significantly impacted --

MS. HOAR: Yeah.

DR. MURMAN: -- UVM for '21. But then we get into '22 and '23 and we sort of seem like we're stabilizing on a lot of those things.

MS. HOAR: May I pass it to Chris, my colleague Chris Dillon to comment on that for just a quick sec?

DR. MURMAN: Yeah.

MR. DILLON: I was just going to briefly add. I put my hand up quickly. I think the question you were originally asking was, is the 2024 projection realistic given recent years and the jump from '23 to '24, correct?

DR. MURMAN: Yes. Yes.

MR. DILLON: Fundamentally, that was your question?

DR. MURMAN: Yes.

MR. DILLON: So FY '24 budget, right, we have 21,804 as our projected cases

between the main and the Fanny, 21,804, which I think is roughly in line with that graphic that you had referenced from the presentation. As of May 1st, we were twenty-three cases ahead of that budget.

DR. MURMAN: Okay.

MR. DILLON: So right on that line, which suggests that, to me, the 2024 budget is realistic or the projection here is realistic. What I don't have is where you were going here with the breakdown between different specialties in inpatient versus outpatient. This this total OR numbers across main and Fanny. But I thought maybe that could be helpful in putting 2024 in context.

DR. MURMAN: That's super helpful. Do you have main and Fanny broken out at all?

MR. DILLON: I'm sorry. Can you repeat? I heard somebody else pipe in there. I didn't hear your whole comment.

DR. MURMAN: I'm sorry. Do you have the main campus and Fanny split for the 2024?

MR. DILLON: Not in this number set that I have right here. That can be

something we can provide to you after the fact. I don't have it right now.

DR. MURMAN: And because I've seen a lot of different number sets that include different procedure rooms, is that number set that you have specific to the ORs that we are talking about in regards to the CON?

MR. DILLON: I believe it is. Yes. That would be something I'd have to cross-reference as well.

DR. MURMAN: Okay.

MR. DILLON: And we can follow up this one.

DR. MURMAN: Okay. Yeah, because that came up a little bit in, like, the table 7-C submissions, where one was included endoscopy cases and ECT cases and some other cases. And then the projections were quite a bit higher. And then when it was resubmitted and those cases were removed, the projections were more in line with these projections. So I just would want to make sure that --

MR. DILLON: Yeah.

DR. MURMAN: -- the numbers that we received --

MR. DILLON: Endoscopy is definitely not included in what I just shared. I would have to check on ECT and some others.

DR. MURMAN: Okay. To me, it's really important, because if 2023 is really like 19 and change and 2019 is like 19 and change, and there's discussion throughout the narrative about how surgical volumes were essentially flat from 2015 to 2019, then we have a much flatter trend.

I think the lived experience that we were shared with this morning is we don't have a flatter trend. But then again, I think we also, I think, really identified that an OR isn't an OR isn't an OR. And there's a difference between numbers of ORs and types of ORs available. But I think that if 2016 was, I think, from one of these, this is Q-002, page 20, looks like it's 18,888. 2017 was 19,066. 2018 was 19,055. And 2019 was 18,749, which you had that month where Fanny was closed. So it was probably would have realistically been 19-something. That sounds like a fairly flat trend.

And so until 2023, we're still kind of trending fairly flat compared to 2015, 2016. Would you do you agree with that, or does

that seem -- maybe it's different in '24, but at least for how we're counting cases. 18,888 to 18,847 to 19-2. I get a point -- I calculated from 2016 to 2023 a .33 percent annual growth rate, 2.3 overall. Should we put up this figure from Q-002, page 20?

MR. BARBER: Yeah. If you could just slow down and point me to the --

DR. MURMAN: Sorry.

MR. BARBER: -- pages in the document. Happy to share.

DR. MURMAN: Sorry, Mike.

MR. BARBER: That's all right.

DR. MURMAN: Q-002, page 20. There's just so many -- like, there's just so many different places where these volumes are documented in there. They're a little different in different places. So as we can see, I took the liberty to add the totals. So they're not listed on this figure. But they basically range within two percent of each other or less, including 2023.

MS. HOAR: Dr. Murman, is your point that you're not seeing demand increasing over this time period due to these numbers?

DR. MURMAN: Demand is a different thing than --

MS. HOAR: That's right.

DR. MURMAN: -- what's actually performed.

MS. HOAR: That is correct.

DR. MURMAN: I think you've discussed the wait times. Although wait times I don't think were collected until 2019. I'm not sure if they were collected before that, but I wouldn't say that I don't think demand is increasing. But I don't think that's what this is saying. What this is saying is the amount of cases performed, it seems to be flat.

MS. HOAR: Correct. Yes.

DR. MURMAN: And to sort of complicate this issue, I think that right before this period of time or in 2016 there was the ASC application and there was a sworn statement from Dr. Brumsted that in that time that said that -- I can actually find a quote here, but essentially paraphrasing, that there's plenty of capacity for now into the near future. And at that time, it appeared that at least Fanny Allen had a fair amount of capacity.

But I think the issue is -- or I guess, what do you think is the issue with that? I mean, if Fanny Allen at sixty-six percent capacity, I think in the 20- -- geez, now, I got to get another document you sent me.

Hold on a second, Mike. It's the one I had sent you this morning, which was the reference back from the Q-008. I apologize. Give me a second. I'll tell you the name of it. It's the attachment on Q-008.

MS. HOAR: Yep.

MR. BARBER: Just give me a minute to get there. Thank you, Tara.

DR. MURMAN: That one, if you go down, I mean, UVM looks like it's above capacity there in 2019. Can you go back up to the top? Yeah. Seventy-four percent capacity, seventy-seven, seventy-nine, seventy-seven, seventy-eight. It just is -- and then if you go down, though, Fanny was at sixty-something percent capacity. It's just interesting that at the time, that was described as ample outpatient surgical capacity by Dr. Brumsted. Would you agree with that?

MS. TYLER: I'm uncertain, Hearing

Officer Barber, about what we're looking at right now. Could we clarify that in the record?

MR. BARBER: This is an attachment that came -- attachment to Q-008. I believe it references --

MS. HOAR: I think it's Q-6.

MR. BARBER: -- question Q-6.

DR. MURMAN: That's Q-8 and reference for question 5.

DR. LEFFLER: So Dave, I'm going to take a -- I'm not going to get into the fine data with you. But I will say that when we commented on the application for the Green Mountain Surgery Center and we said that we could handle the excess volume, we were wrong. That was a mistake. We should not have said that. We can say -- and we know. Because when we try to close the Fanny Allen and bring the outpatient surgery capacity over here by working evenings, nights, weekends. We couldn't do it.

We know the Green Mountain Surgery Center is completely full. We actually work well with them now. We're grateful they're in the community. But we did not have the capacity that was projected at that time in '18. There were

some other assumptions in there in terms of population growth and so on. But we know from looking backwards now that was an error in terms of capacity at what we had available to meet that need. I'm not sure if that exactly answered your question, but I felt like that's kind of where you were going, I thought.

DR. MURMAN: I think, if you thought you had enough capacity then and you have similar capacity now and you're having troubles then that doesn't make sense. So one of the two doesn't work. So I think that's the --

DR. LEFFLER: I can tell you that now -- we can let Dr. Plante talk, but we are completely maxed out and full right now, using every possible space that we can and still building up a backlog. That's the reality of 2024.

DR. PLANTE: And maybe I'll take the opportunity. I'm going to put on the practicing surgeon hat and share that for more than a decade, I and my division have not had enough block time. So we've had waits. We've lost patients to surrounding area centers. You've heard the encumbrance on patients having

to travel.

I also want to make sure all my comments are with full understanding, David. I would be in your position doing the same, taking hard inventory. So now I have to take off the practicing surgeon hat, and I'm going to put on the peri-op management team hat and I'm going to share with you the here and now.

The here and now for now is that over the last three years we indeed have seen our numbers go up. And I got to share with you, our team has seen an incremental and iterative and baby step process to take on every extra operative space we can. We scrub the schedule regularly with Chris and team. And I also have to remind everybody, health care is the ultimate team sport. It's not just about one team or certain set of people. It's a lot of people.

And we scrub the schedule regularly, looking at volumes, looking at every place we can find to put more patients on the schedule. I need share with everybody under oath that this very year, FY '25 projection, FY '24 actual, our team now has to look and say we can't really do much more. Every space is full. And

the last comment I'm going to make is -- and I think it's very important that we remember it's not cases, it's patients, it's human beings, and it's all of us that God forbid, we need that surgical care.

But I also have to remind everybody that some of that care is, in fact, pediatric dental, not done many other places, if any. And it's also we, and I'm going to say my team, are laser on making sure that we continue to offer the mental health service access, and that probably will increase with an increase in cadre of treatments that should be available to our mental health patients.

And lastly, we're the institution that is expected to provide twenty-four/seven access to all specialties. And I could spend a day talking about the encumbrance of that. But with that as a backdrop, I hope it provides some insight as to the numbers.

DR. MURMAN: That is super helpful. I'm sorry, I'm having a weird audio thing. I'm just going to disconnect and -- sorry. Back. Yeah. That's better.

Dr. Bender?

DR. BENDER: Yeah. I mean, I was largely going to say what Mark said, but I would just add that when you're looking at these numbers from '15 to '19 that are posted right here, we've actually taken things out of the main campus and moved them over to the Fanny more recently to make more room for things that needed to happen at the inpatient.

So what we're doing at the Fanny is different now, but there is a restriction. An OR is not an OR, so there is occasional room at the Fanny, but there are no patients or surgeries that are appropriate for it. So when you're looking at whether or not there's space in our ORs, it's the type of space.

We've already talked about this, but we've decanted everything that we can to the Fanny to open up on the main campus. But we've done that to the maximum ability. And there's -- I think that's an important point that we haven't quite made yet. We have moved things around.

DR. PLANTE: Maybe as an extra element of detail. And Patrick is the best team member you could ever have. Maybe an extra element, is there is no HEPA filtration at the

Fanny. So that's the way the air is circulated and filtered. We certainly can do the cases we're doing there now, but that's an extraordinary encumbrance, amongst others.

The other thing I should share is when we're scrubbing our schedule, our relative utilization is well over eighty percent on a regular basis. And as you've heard, that's over the tipping point of where you're able to be open for the heart attack patients, all the other critical care.

DR. MURMAN: Thanks for that. While we're talking about Fanny briefly, what's the plan for Fanny? Are you going to continue to do procedures at Fanny? Is Fanny going to be decommissioned from a procedural standpoint?

DR. LEFFLER: Dave, we're working through that right now. So those ORs will absolutely be repurposed. We have so many space challenges. Exactly what we do there depends on a number of factors. But I will commit to you that we will be using that space for some kind of patient care need, but we haven't quite sorted it out yet.

DR. MURMAN: Okay. And just while

we're talking about spaces, other network hospitals in Vermont. I know that -- you know I know a lot of ED docs, so I hear talks of discussion of new emergency department down at Porter. Is there any intent in building operative space down at Porter with that renovation?

DR. LEFFLER: Not that I'm aware of. I'm seeing shaking heads. I don't want to -- not that I'm aware of.

DR. EAPPEN: Yeah. Not that's come up network-wise. I mean, I don't know if someone at Porter has been talking about it.

DR. MURMAN: No. I just heard ED renovations.

DR. EAPPEN: I have not heard -- yeah.

DR. MURMAN: The new ED, that's something you're not aware of, or?

DR. EAPPEN: Nothing about additional operating rooms in Porter that I've heard about. Since I arrived here, folks at Porter have been talking about the need for ED construction, mental health beds, specifically in the emergency room and what it would take to be

able to create those. I am not familiar with any anything beyond that conversation. I haven't heard anything come back up to me, anyway.

DR. MURMAN: Okay. Any conversations about expanding operative capacity at Central Vermont Medical Center?

DR. EAPPEN: No. No, other than what we've already been trying to do, and maybe Chris can talk about that, but we've been trying to move appropriate cases, where there are surgeons that are willing to go down, and there's appropriate anesthesia care, to be able to move those cases from the University of Vermont Medical Center to Central Vermont Medical Center. So I know we've been trying to do that, with variable, success as much as we can. There's obviously, as you know, lots of logistics associated with that.

But if you're moving kids, you want to make sure you have pediatric anesthesiologists, but Chris or Patrick, you might have more detail about that. But I know we've been trying and I've been pushing both Steve and Anna (ph.) to try to make that happen, because I know that -- just what you heard from

Dr. Harrington earlier, that there's a need. And so whenever we can try to -- whatever we can try to do, is essentially what I've been pushing, but.

MR. DILLON: Right. I would add that we have weekly meetings, sometimes twice weekly meetings to triage the schedule at CVMC. And we started that process in February of last year. We had identified an average of thirteen open rooms per month on their schedule. The last several months going into the month, one or two open rooms.

So we significantly closed the gap in their available capacity. Those one to two open rooms are used for add-ons, partial day blocks, things like that, to help CVMC patients gain access to those hours. So that's been the work -- that's been the work ongoing.

DR. MURMAN: I want to pivot to a different topic. This actually kind of speaks a little bit to Dr. Coleman's comments. But also to sort of a general other concept, which is the in-migration/out-migration of patients.

In your submission, I believe you said about -- I think it was 51.4 or so percent

of patients who receive outpatient surgical care, I believe, at University of Vermont Medical Center comes from outside the HSA. That's a pretty substantial portion.

It appears, again, this is -- it was appeared there's a report at least of 2015 or so 2016, that said there's about twenty percent in-migration, are you guys aware of any significant increase in your in-migration over the last decade? People coming from outside of the region to get surgical care here at UVMMC?

DR. LEFFLER: Dave, I'm going to start at a high level, but I think Dr. Plante can give detail. We know that our surgical specialists, Dr. Harrington, Dr. Plante, orthopedics, are doing many more after-hours cases from across the State of Vermont. We have a lot of volume coming from all over our region where they just don't have coverage after 5 p.m. or on weekends.

So there's very many weekends where our orthopedic doctors work all weekend covering ortho for the State of Vermont and upstate New York. Our urologists commonly cover urology care after 5 p.m. for the State of

Vermont. EMT -- I could give you example after example. I think that, at a high level, is part of it. I think, Mark, I don't know if you want to add to that.

DR. PLANTE: I add to that fully. I mean, we're seeing it across those very specialties. And cardiothoracic is probably the most poignant example of where we have patients in wait in an acute need, but that certainly exists over other specialties as well.

DR. MURMAN: Okay. So what my impression is what you're saying is the increase in in-migration is largely due to emergent cases or transfer cases?

DR. BENDER: I certainly believe that.

DR. PLANTE: Yes.

DR. BENDER: Mark, sorry. But I would also note that those cases are largely going at midnight, right. Because there is no room in the schedule for them to go during the day. And so it's not great for them and it's not great for our surgeons and our anesthesia and our nursing staff.

And it's very, very common for

your patients that you're caring for overnight to be from North Country or what have you. I mean, they don't often get care during the day because we're so full. Our boxes are so full, but they are a large percentage of the patients. They get care at midnight or 2 a.m.

DR. MURMAN: I think I just want to make sure the term in-migration is. So what I mean by is patients who live outside the HSA receiving care on an outpatient surgical basis within the HSA.

DR. PLANTE: So David, I think I can help you understand as well. There's also the patient demographic which has transitioned. So where you used to have your radical prostatectomy for prostate cancer at any of a number of hospitals. Now, the standard is robotic radical prostatectomy, period. Full stop. So larger centers have robots, smaller centers don't. That holds true for so many other surgical specialties and procedures. So there is actually a transition to a lot of surgeries as a result of the technology that land in the larger center, hence us. So if that answers the question, it's another thread. There is in-

migration without question.

DR. MURMAN: Okay.

DR. PLANTE: And it's either that -- we started, we were one of the last -- and I'm sorry to interrupt. But we're one of the last centers that adopted robotics in the area. And no sooner we had one and suddenly we need two. And I can tell you the service expansion that happened very recently is robotics was generally urology and women's.

Now, we have acute care surgery, ENT, thoracic, general surgery, colorectal all needing access to the robot. So again, the transition is also even within our own institution. And I hope that that helps.

DR. MURMAN: I think it helps in context. It's hard from a data standpoint from these large swaths of the population. But I think it helps in context. So thank you.

Oh, I've got a lot of questions. I think I'm going to just do a couple odds and ends that were from the beginning, and then pass it off to somebody else and see if my other questions are asked by other Board members.

But just one little -- one

question, Dr. Eappen mentioned patient needed an OR for an MI transfer. Are cardiac cath labs included in this analysis? I didn't think they were.

DR. EAPPEN: No, no. David, I was just I was referring a very, very specific sort of cases that were brought up by folks when I was traveling that they would come in, they would appear to be having an MI, the ER doc or the doc that was covering the ER -- they may not have been an ER doc at that place, but would say, we suspect that this patient is going to need to go to the OR is going to need to go to the cath lab when we think they're going to need to go to the OR because there was some prior history that they already had. And it made it very difficult to -- because we didn't take those patients on a number of occasions from these outside hospitals.

The reason we didn't take them was because we didn't have room or space where there was fear we would not be able to do the case. And so it was judged, deemed to be better not to take that patient and let that patient then find another location or have that emergency room find another location. So I can't tell you that we

knew at the time that they were definitely going to go to the OR, but that was the fear that was happening according to the outside, if that helps at all.

DR. LEFFLER: And I'll just build on that.

DR. EAPPEN: Does that clarify that?

DR. LEFFLER: And Dave, the other situation which I'm sure you're familiar with is we will take someone, they get cathed, they get a triple bypass. But the next available -- it's Monday. We take them today from CVMC and they come up and get cathed and they do a triple bypass. But the next available OR slot the CT surgeons have is Friday. That person is going to sit in the bed this entire week waiting for their bypass.

If that case can go tonight or tomorrow, then that bed is -- and they move through the system, then we're available for someone else. That happens all the time. If they're stable after their cath, but they're waiting for bypass, they can sit on the floor a long time, which is not good for anybody.

DR. MURMAN: And my impression reading through this is that your CT surgery ORs are included in these general purpose ORs; is that correct?

DR. LEFFLER: Yes.

DR. MURMAN: Okay. Great. I am going to -- I'm going to tap out for a little bit. I might come back later and ask a few more questions if they're not answered. But thank you.

MS. LUNGE: I think I'm next. So I'll just go right ahead and jump in. Hi, everyone. Thank you. I have a just a couple of questions for the open session. Most of my questions relate to confidential materials. So those will wait until we're able to do it in executive session. So I just had a couple of clarifications.

So in the application on page 9, I have -- I'll just note that my case numbers don't seem to be matching other people's stated page numbers. So this is the page that has the charts from service line, fiscal year '19, patient origin, and the payer distribution. And I wanted to make sure that I was following the changes in

the payer mix calculation throughout the course of the binder.

So in the application, the fifty-three percent commercial, twenty-six percent Medicaid, fourteen -- sorry -- twenty-six Medicare, fourteen Medicaid, seven other. In a later question, I believe it was clarified that that is both inpatient and outpatient payer mix. Is that correct?

MS. HOAR: Member Lunge, this is Eve. I will say that this this reflects our payer distribution by number of cases, not by dollars.

MS. LUNGE: Okay. Great.

Ms. HOAR: Okay. And you'll see this is about the makeup of the shifted cases. Yeah.

MS. LUNGE: Perfect. Thank you.

MS. HOAR: You're welcome.

MS. LUNGE: And so then later in the -- there's a later discussion in response to the Ascendient report in your submission, which -- let me get there and I can tell you what that was dated.

Okay. So your response was

dated --

DR. LEFFLER: Robin, would you --

MS. LUNGE: -- April 25th.

MS. HOAR: Yep.

DR. LEFFLER: Would you like me try to pull that document up and share it?

MS. LUNGE: I don't think so. I think, because it's not a chart or anything, it's just I wanted to confirm that I'm understanding the payer mix that's explained there. So on page 8 of that response, and this is not in the confidential materials. But in the last full paragraph, it indicates "for outpatient cases alone, the payer mix split is seventy-five percent commercial, eleven percent Medicare". I believe that is based on dollars; is that correct?

MS. HOAR: Marc, I'm going to just confirm with you. This is dollars?

MR. STANISLAS: Yeah. Without seeing the exact numbers up on the screen, Robin, I believe that is dollars. We made that reference.

MS. TYLER: Hearing Officer Barber, could we display that page so that we're

sure everyone is talking about the same thing?

MR. BARBER: What page is it?

MS. LUNGE: It's page 8.

MS. TYLER: It's page 8 of our submission, dated April 25th of '24.

MR. BARBER: Page 8?

MS. LUNGE: There you go. Yep. You have it.

MR. BARBER: Okay.

MS. LUNGE: Okay. So in the in the full paragraph above the partial redaction the last sentence, "for outpatient cases alone, the split is seventy-five percent commercial and eleven percent Medicare".

MR. STANISLAS: Yes. Those were based upon NPR dollars.

MS. LUNGE: Okay. Great. Thank you, Marc. Do you happen to recall whether Medicare Advantage is included in commercial in this split?

MR. STANISLAS: Yes, it is.

MS. LUNGE: Okay. Thank you. All right. And actually, the other question that I had already was answered in response to one of Member Murman's. So let me switch to -- just

checking a couple more. Done. Okay. That was answered.

My other question, I think, is for Ms. Hoar. So in the discussion of the equipment list, you mentioned that you consulted with two experts who indicated it was not advisable to shift the sterilization to the main campus. Could you just explain why? I guess, I can probably guess, but it would be nice to just have in the record why that's a bad idea.

MS. HOAR: It was a question. I'm going from my memory, Member Lunge, but my takeaway was that it was a question of capacity, that we couldn't add -- without putting the service and timely responsiveness to the main campus ORs at risk, we could not add the additional capacity to serve the OSC to that equipment there.

Anybody remember differently than that? Chris, any nuance on missing that's important? Okay.

MR. DILLON: Nothing further.

MS. HOAR: Thanks.

MS. LUNGE: Okay. Thank you. The rest of my questions are in the confidential

materials, so I'll pass it on.

MR. BARBER: Thank you, Board Member Lunge. Dr. Holmes?

DR. HOLMES: Am I on or am I off? Okay. There's my camera. Sorry. I think I hit the camera instead of the mute.

Well, thank you all. This is obviously been a long process and even a long day, so I'll try and ask my questions briefly, although I have a fair number of them. My first question is, when UVMMC set out to build the Miller building, it set a goal for $30 million in fundraising, and I think 1,400 people donated. And I'm wondering, in the initial OSC business plan, there was reference to setting a philanthropy funding goal. I think that was on page 4. I'm curious as to understand why there wasn't a philanthropy goal set, or why there were no fundraising efforts to support this initiative?

DR. LEFFLER: Jess, we've started that work. So we have set an internal goal. We're going to try and raise, hopefully, thirteen million. I've been out and about a lot talking about it. We didn't want to start a hard

campaign until we ideally have a CON approved. We don't want to raise a bunch of money that maybe couldn't be used for this project.

So but I have been talking about it a lot with people in our community, and I have a lot of other meetings this summer, and we've been pretty clear about the need for it and all of our needs. And also wanting to make sure that we have a certificate of need before we can start bringing in dollars for the project. But we'd like to raise ten percent of the cost of the project, thirteen million.

DR. HOLMES: Okay. And would that come out of the debt financing or would that come out of the operating cash?

DR. LEFFLER: I have not talked to Rick about that. Rick?

MR. VINCENT: At this point, with our debt capacity, Jessica, I think we'd take it out of the cash just to keep the base cash on hand.

DR. HOLMES: Okay. Great. Thank you. One argument that's cited, I think it's on page 5 that I have of the original CON application, is that sending patients out of

state -- this is a quote -- "sending patients out of state for procedures they could receive at home is often more expensive to payers".

So I'm just wondering if there's specific data that you have that supports the expected lower per-unit cost of the OSC surgeries relative to, say, out-of-state facilities. Dartmouth-Hitchcock Outpatient Surgery Center, for example, which might be the most common other option for Vermonters. So I'm looking for a reimbursement comparison to out-of-state OSCs that would support that that argument.

DR. LEFFLER: Eve, are you aware of anything we have like that, or Marc? Cost of care at an outpatient OSC compared to us. I mean, we know we're an extremely low-cost Medicare provider. Right.

DR. HOLMES: It would probably be more than commercial. My focus would be more on the commercial reimbursement being lower cost out of state.

MS. HOAR: I don't have any data to share with you today, but we can pull some together.

DR. HOLMES: Okay. That'd be

great.

DR. EAPPEN: I can share a personal anecdotal. So my wife couldn't get care here. She wound up getting care at the Brigham. And you can only see what the what the -- I could see the reimbursement from our Blue Cross health insurer, which was I just it was considerably higher for that same, and same thing for a mammogram was considerably higher than what we would have gotten from Blue Cross.

I can only tell you that that's us, self-insured on the Blue Cross. So I know it's a little -- so I know it's a belief that we have that it -- certainly going down to Boston that it cost more. But I can't tell you, like, statistically what that is. The other part of that, that I think it's just worthwhile to remember is that we do use those commercial payers to offset the differences between what it costs and what we get from Medicare or Medicaid.

And so when those dollars leave the state, it doesn't now offset the cost, the shift that we're trying to make on those as well, right. Because those dollars leave and it's not offsetting the Medicaid/Medicare costs that we

are trying to help with on our commercial side when it leaves the state like that. So just a couple of things. I know I'm not answering your broader question, but just to keep in mind that the real issue there.

DR. LEFFLER: And we also lose providers that --

DR. HOLMES: Let me ask you this. How might the finance team, or you, Dr. Eappen, how would you suggest the Green Mountain Care Board ensure that this idea of keeping patients local at the OSC instead of sending patients to an out-of-state OSC, will, in fact, be more affordable for commercial payers. How can we as a Board ensure that that's true?

DR. LEFFLER: I don't know what -- I guess the only way to do it is to find out. You'd have to ask Blue Cross if they'd be willing to share that information as the biggest commercial payer about what it costs them to do it out of state. The constant danger whenever we do that is if you cherry pick particular cases that, if you just take those cases that are going to be less expensive to do out, then you're left with a subset of a population that's probably --

there's a reason why they're not being done elsewhere, and they're more expensive here as well -- or more expensive elsewhere. So you have to be really careful. And we try really hard to look at them in bulk because of that.

So just keep that in mind as you start doing it. That's the big challenge with ambulatory surgery centers that are for-profit or are equipped to do very specific cases, right? All the other stuff that happens with it doesn't get covered. So an emergency, the bleeding that happens in the evening or the weekends or the follow-up that has to happen. There's no follow-up there. They're going to come back to us or our local, whoever the local provider is.

We take everyone, so doesn't matter if they're complicated, they need a particular device that's expensive. If you're if you're a standalone surgery center somewhere, you just say, we don't provide that device. We don't cover that kind of a patient. We don't take the complex patients, right? So you have to be really careful. But I think it's a good question. Overall, how would we look at that? I defer back to Mark and Rick from the philosophic

if we can get more granular.

DR. EAPPEN: And one other comment, just I hope we're not thinking that we should ask 4,000 Vermonters who have Medicaid, Medicare, and commercial to have to travel as far away as New Hampshire, Albany, or Mass General to get outpatient surgery. That seems not like a good plan for people who need care. As I think about the AHEAD model, potentially Vermont signing on, not being able to provide that care here at the medical center would make that model extremely difficult, because we'll have to pay the Medicare rates to those other hospitals when those people are leaving. So I just can't imagine that using surgery centers out of the State of Vermont is in the best interest of the people who need care. (Indiscernible) I think.

DR. HOLMES: Okay. Yeah. Mr. Vincent, did you want to say anything, or -- I saw your hand raised.

MR. VINCENT: Right. Yes. I think there may be a way for us to do this, Jessica. The other thing I'll just highlight is, you know, even though the focus or the question was on commercial, for Medicaid patients as you

know, we have a fixed prospective payment program. So really anything that does go out of the state from a Medicaid perspective, that is increased out of state spend that does -- it does hit our target. That's not part of the -- that's not part of that fixed payment.

DR. HOLMES: Let me just see, Mr. Stanislas testified earlier about that. The project will generate, quote, so many efficiencies. And I'm wondering if you can talk a little bit about, so there's also on page 7 of the application, I believe, it talks about the OSC will support higher provider productivity, greater patient access to care, which we've heard a lot about all day today. And I appreciate the efforts there.

I'm a numbers person, so I'm trying to get a handle on the materiality of this. And so is there a -- do you have, for example, benchmarked percentile work RVUs for clinical FTE of your current surgeons and then what you're expecting to see in terms of those productivity numbers with the new facility? I know there's some SullivanCotter benchmarks that are referenced, I think at some point in the

interrogatories. But I'm looking for a sense of the before and after productivity projections to determine the magnitude of the improved efficiencies. Is there a way to do that?

MS. HOAR: I'm going to start, Member Holmes, and let some folks jump in. So one of the things we were hesitant to do for the pro forma is to model lots of efficiency, which would have -- or unrealistic efficiency because of a couple of things that are happening. So one is we are taking -- we've talked a little bit about the shift from inpatient to outpatient, but basically we're taking more complex cases and moving them out of the main ORs, inpatient and outpatient, and putting them in this outpatient surgery center.

And so I think it's fair, I'll say, as a nonclinical person, that this is new territory. And while we believe there are opportunities for efficiencies, to model those efficiencies and a pro forma from the get-go when this will be somewhat new territory for us, we didn't think was honest and fair. And so you won't see super-duper efficiencies modeled in that pro forma.

We think there's opportunity. And then I don't know if Scott Walters is still on, but we believe there's opportunity once we get a year or so under our belt to do that. I think the other thing we learned from our Vizient friends, and I'm sure Dr. Plante lives this and Dr. Bender lives this every day. But the longer the surgery, a little bit of variation is mathematically more minutes. And so the stakes of being over-zealous about the efficiencies that you could gain, particularly when we compare ourselves to Vizient benchmarks, didn't seem to be responsible from the pro forma point of view.

Rick Vincent, you're on.

MR. VINCENT: I think the surgeons may be able to give you a sense of that, but just concretely, in the back and forth with the consultants, we did highlight the -- or they highlighted, actually, the need to add some additional cost for increased work productivity. So not necessarily that we're going to add more surgeons, but that it may result in a higher salary level. So that alone, there is a piece there that we can highlight for the Board on what we're expecting.

DR. PLANTE: In terms of the efficiency --

DR. HOLMES: Okay. But to the extent -- oh, sorry. Go ahead.

Dr. PLANTE: No, no. Thank you for the question. And I would say I'm a numbers person as well. In terms of the efficiencies from a pure standpoint, we're also looking at a facility that's built to 2024 and on standards, that means that the rooms are bigger. They're going to allow for more flexibility of equipment maneuvering. There's a pre-anesthesia room.

So you're preparing the next patient for surgery as you're completing the surgery where the prior patient is in the room. So it actually, you know, much has changed in surgical care delivery that we just can't put into the Fanny. So there's an actual physical space upgrade that is very, very significant.

DR. HOLMES: That makes a lot of sense. And so would it -- and I understand how it's hard enough to build a pro forma going out five years. And I can appreciate all of the assumptions that have to go into it. And not having a full sense of all the efficiency gains

that are possible would make it challenging, but -- even more challenging. So is it fair then, to say, since not all the efficiencies are modeled and throughput may be higher and costs may in fact -- cost per unit, cost per case may in fact be lower just because of the efficiency gains. Is it fair, then, to say that the revenue may be underestimated, and the costs may be overestimated if all of the efficiencies were considered?

DR. PLANTE: I mean, I can chime in and say --

DR. EAPPEN: Mark, I was going to say yes.

DR. PLANTE: I was going to say yes as well.

DR. HOLMES: Fair enough. That's all I need is a yes. It's okay. I know we're short on time, but yes is fine. Thank you.

DR. EAPPEN: It's a really good point. It's nuanced and it's complicated because the reasons that Mark said, that I don't want to just go off server, right? If you take the exact same kind of cases and you move them over and you just do them. So I'm going to use the example of

cataract surgery. Just take the same cases and move them over, you will do more cases per OR per day. Okay. So you'll say yes, the cost will go down. Productivity will go up. If you move more complicated cases that you weren't before prior doing in an ambulatory surgery center, the number of cases may stay the same, may even go down.

And so when you look at that, I mean -- and I'm just saying just taking cataract surgeons and what they're doing, that same person may you may look at them and go, well, they're not being as productive or they're only being equally productive because you're not accounting for the comorbidities and the complexities associated that now we can do in an ambulatory surgery setting.

So but having just the nuance that's there, but having said all that, I'll just still answer your question yes. I think we were conservative. I really do. But Eve can answer that better.

DR. HOLMES: Okay. So actually, so given what you just said and given all the possible efficiencies that could be gained, that'll increase throughput and hopefully reduce

the wait times that I think we've heard a lot about today and have heard about for years.

I guess my similar question would be, I don't know if you still use Vizient for benchmarking wait times, if I'm getting that right, but I'm wondering where are you currently at with your surgical wait times benchmarks, percentiles, and then what do you expect you'll be able to achieve in terms of the percentile if this OSC would open?

Now, again, I'm looking for magnitudes of impact on patient access. And if there's a way to measure that or if you've thought about a way to measure that, what would success look like? What is your percentile wait time now and what would it look like if all the efficiencies are gained and throughput is realized?

DR. LEFFLER: Patrick Bender, you probably know the Vizient data as well as anyone on the screen. Have you seen Vizient data around surgical wait times?

DR. BENDER: Not in terms of the average amount of days that you're waiting. The way that we've been measuring it is what Chris

alluded to earlier, which is how many people are waiting more than X amount of weeks out, right? So right now we're doing sixty and ninety days. But Vizient, I mean, I used to be chief quality officer in Vizient does not have that, like, average amount or percentile. Sorry.

DR. HOLMES: That's okay. So go ahead.

DR. LEFFLER: So Chris Dillon may have something. Chris, did you have --

MR. DILLON: No. Not from a benchmarking perspective. I was just going to repeat the numbers that we cited when Dr. Murman asked and just say our goal is to get those ninety-plus cases down -- ninety-plus days down to zero. Like, we don't want people waiting more than ninety days for any surgery. Obviously, there are some surgeries that need to go much sooner than ninety days. And we triage those under Dr. Plante and Dr. Bender's leadership.

But certainly those ninety-plus days we want to see very few, if any patients waiting that long.

DR. HOLMES: So the potential is 304 now that are waiting ninety-plus days. So

you would hope that that's zero. And then of the sixty-plus, there's 524 sixty-plus.

MR. DILLON: Yep.

DR. HOLMES: What would that look like if this was successful, this OSC?

MR. DILLON: Certainly significantly reduced would be our goal. We haven't set a hard target for what we want in terms of our patients waiting in the neighborhood of sixty days, but once we accomplish our ninety-day target, we're going to refocus on sixty-day and keep going.

DR. HOLMES: Okay. Okay. Again, I guess I'm asking a lot of questions about benchmarking, but it looks like you or potentially Stroudwater, I think, used Intellimarker benchmarks to look at reimbursement rates. Intellimarker appears to also compute twenty-fifth, fifth, seventy-fifth, and ninetieth percentiles for operating expenses for ambulatory surgery centers per case and per OR. And I'm wondering how your projected cost per case or cost per OR compares to those benchmarks in Intellimarker?

DR. LEFFLER: Eve, is that

something that you have?

MS. HOAR: No. It's not something that I have. And we could get that back to the Board. I want to be really careful about case mix, right, within those specialty lines. Yeah. I'll just leave it at that. As you know, as a numbers person, Member Holmes.

DR. HOLMES: That's fair. And also comparing it -- I also understand comparing it to an academic medical center, surgery center would also be helpful. I just wondered if there was any -- I'd love to just see some cost per case, cost per OR comparisons against benchmarks. And it looked like Intellimarker had some of that. So that would be really helpful.

Okay. Fanny Allen, a couple questions about Fanny Allen. Will there be any opportunity to repurpose any of the equipment in Fanny Allen for the new OSC, and is that repurposed equipment then factored into the cost of the equipment in the new OSC?

DR. LEFFLER: Beth?

MS. SENIW: I would have to go back and refer to our equipment list. Dr. Bender, do you have a comment on that?

DR. BENDER: I do. We have upgraded the central sterile reprocessing equipment at the Fanny Allen, which is what is responsible for cleaning the operating room instruments, as well as the equipment from some of our clinics. And that was bought with the main purpose of being able to transport them over to the OSC if and when we build that. So at least from that standpoint, yes, there is some OR equipment that will be moved from Fanny to the OSC.

DR. HOLMES: And it would already have been factored into that equipment expense, or?

DR. BENDER: That one, I'm not sure. That's probably an Eve question, but I can tell you that when we purchased that, we picked this stuff that would be useful for -- we need it now anyway, but we knew that it would be useful for the OSC as well, because it will still have many years and cycles left in its capabilities.

DR. HOLMES: Yes.

MS. SENIW: And the items that we are reusing at the OSC are indicated on our equipment plan.

DR. HOLMES: Okay. So then Ms. Seniw, they are affected into the financials, the cost savings? Sounds like yes. I just want to make sure.

MS. HOAR: Yes. Yes.

DR. HOLMES: Okay. Okay. Perfect. Thank you.

MS. HOAR: Can I say one more thing?

DR. HOLMES: Yes.

MS. HOAR: According to our facilities partners, our last major renovation of the Fanny Allen ORs was thirty years ago. So I'm going to say yes, some reuse, but given the fact that the last renovation was thirty -- major renovation was thirty years ago, I am going to acknowledge that the opportunity to reuse a lot of the equipment that's sitting in those ORs or probably in those peri-op areas, is not huge. I don't have the numbers behind that, but I wanted to be honest with you. I think that sets the context fairly.

DR. BENDER: In reality, Eve, that's probably the sterile reprocessing and some of the newer equipment that we have purchased to

do cases of the Fanny that we haven't historically done there that we've just purchased, and then we'll eventually go to the OSC. But you're right, it's small buckets.

DR. HOLMES: Thanks, Dr. Bender.

DR. PLANTE: The operative word, some.

DR. HOLMES: Okay. For that which you are not going to repurpose, is there an opportunity to sell to anybody else on some secondary market, any of the equipment that you're not going to use? And is there potential revenue opportunity there? That's not calculated into the pro forma?

DR. PLANTE: So I'm not an expert in that space, but I can tell you specific to Eve's comments about thirty years, I think the opportunity for us would be to find a center that would be in need of the equipment. Not looking to sell it for --

DR. HOLMES: So donation?

DR. PLANTE: Yes.

DR. LEFFLER: Or our own network hospitals.

DR. PLANTE: Or definitely our own

network. But again, not leaving any piece of equipment behind.

DR. HOLMES: Okay. Dr. Leffler mentioned the Fanny Allen being repurposed for patient care a little while ago. So if it's patient care, would it be safe to assume that there might be additional incremental revenue generated from freeing up that Fanny Allen space due to this project?

And there might be some -- obviously, some cost associated with that. But how do how do you think about that in terms of the incremental pro forma, if that space is going to be used, say, for patient care with potential revenue opportunities?

DR. LEFFLER: Depending on what the project was, I think we'd have to think about a CON if we had to upfit it for something else. So I'm confident we're going to use that space because we need it. We're so space constrained for everything that we do. Exactly what goes there, we really haven't gone into in-depth conversation yet, although I will tell you, I get a lot of emails from people with good ideas for what they want.

Clinicians want to put a lot of different things there, I'll tell you that. So I think there is potential, yes, to generate revenue there, because I think we will be doing patient care activities, but I think it's too early to know exactly what that looks like and whether it requires CON, and what the revenue from that would be or the cost potentially. We could put something there, if it's the right thing to do, that would lose money.

DR. HOLMES: Okay. Okay. Mental health? I'm just going to throw that out there.

DR. LEFFLER: Yeah.

DR. HOLMES: So the staffing numbers reflect an assumption of, I think it's twenty-five percent travelers and for OR RNs and then ten percent for surgical tech and perianesthesia RNs. And again, I'm actually trying to get a benchmark assessment here to see how those numbers might compare to other high-performing OSC's. For example, does Intellimarker benchmark the percent travelers in surgery centers? Is that a reasonable percentage?

DR. LEFFLER: Mary, want to --

MS. BROADWORTH: Thank you. Sure. Hi, Jessica. This is Mary Broadworth. Just to kind of share the way the health care staffing works is that we always have travelers in our equations because of leave of absence, coverage, a variety of things. Ten percent would be a real good average, right? So that's kind of what we put in for the ancillary staff. Twenty-five percent for OR RN specifically, because you have to get that specialty skill depending on the service line.

And so we're going to have to have more travelers, likely, in those places. And that's why we assumed a higher rate there. It's getting the right skill mix. We can't necessarily move internal folks because they may not have the skill area.

DR. HOLMES: Yeah. I'm just trying to get a sense of is that high for other. I recognize there's always some percent travelers, but I'm trying to get a benchmark assessment of what would be -- what is expected or what is what is typical, I guess, in other outpatient surgery centers. We've seen a huge variation across hospitals in the percent of

nurse travelers. So I'm trying to get a better sense of this benchmark.

DR. LEFFLER: So Mary, why don't you give that update on the current Fanny Allen situation, which is probably --

MS. BROADWORTH: Yeah.

DR. LEFFLER: -- our best projection.

MS. BROADWORTH: So Fanny Allen, which has outpatient surgery and we have RNs there for perianesthesia. So pre- and post-op RN's, we're down to very few travelers. I think it was four as of this week. And we still are using quite a few OR RN travelers across both campuses --

MS. BROADWORTH: To answer your question, Jessica, I think what's hard for everyone to predict is nothing is quite settled back to normal regarding staffing. And so I don't think anyone, our peers or any other staffing agency, has a benchmark for OR RNs by service line that we would find reliable right now.

DR. HOLMES: Okay.

MS. BROADWORTH: So I think

twenty-five percent is very conservative and probably about right.

DR. HOLMES: Okay. So I -- let me ask you a little bit about the conservativeness of it because it is -- it's a big cost, right? We know that travelers cost more. There was information in the -- in the submission that suggested they do in fact cost more. And I think Dr. Nichols actually just suggested, perhaps in his testimony, that it may actually reduce efficiencies to some degree to have high proportions of travelers.

So I guess in the 2023 -- I think there was some data that was in -- it was in question 5 on Page 3. Five of the nine months reported in 2023 had, actually, less than twenty-five percent OR travelers for nurses and six of the nine months were below the ten percent for the other categories. So it does seem conservative to somewhat -- to me if one for, you know, more than half of the months you were actually below that already.

And I think I heard earlier testimony that the rates, the traveler rates, have come down even more. So I guess I would say

it seems like that might be a high estimate of the cost -- a conservative estimate of the cost. In fact, the travelers go down and in fact you're already most of the time below the twenty-five and the ten.

And there's a lot of testimony today and also in your submission about all the efforts being done to reduce contract workers. And so if those efforts work as designed and you know the traveler costs continue to come down, it seems like this is an overestimate of costs.

DR. LEFFLER: So I would say --

DR. HOLMES: I'm trying to get a sense of that as well.

DR. LEFFLER: I would say, in general, yes to all of that. It is a conservative estimate. We wanted to make sure to build a model where we could staff it to care for people. Because once again, our north star on this was to get those 4,000 people care. And so if that requires a certain percentage of travelers, that's what we're going to do.

I think everything you said is true, that that's a very conservative estimate in terms of the numbers and the costs. But if this

project is approved and we open it, we want all eight of those ORs going at full speed and not being held up because we don't have enough of a certain type of provider to have the room run efficiently.

DR. HOLMES: I couple of other -- I'm actually close to being done. So in the initial business plan, it stated -- and this I'm just going to need some help walking through. Because I was trying to pull it all together in the various parts of the submission. And it related to how ancillary services are treated in the pro forma.

So in the initial business plan, I think, on page 28 it said, "some related cost and revenue impacts have been excluded from the analysis. A cost and revenue for pre-surgery and post-surgery services, for example, imaging, labs, office visits, are not included in the financial pro forma. Margins from those services would like further increase the margins in the financial analysis."

And then it seemed like the CON initially was consistent with that exclusion. But then I saw an evolution and subsequent

interrogatories regarding assumptions about utilization of ancillary services, although I don't think they went as far out as the financial projections. But it did seem like there was then a bump up on one percent or two precent of utilization for some of those ancillaries.

But then question 2 on page 12, it was June 23. It did say again, "with respect to project-related increases, no volumes for nonoperating room services are included in the financial pro forma for several reasons. One of them being our analysis indicates that we are already capturing the vast majority of diagnostic lab and post-procedure follow-up and therapy evals related to outpatient surgeries for patients who ultimately seek surgery services outside of UVM due to our limited surgical capacity."

So I was kind of having a hard time tying this all together, trying to figure out -- it sounds like utilization is expected to perhaps increase, but then maybe it isn't. And then I wasn't sure if, at the end of the day, whether those ancillary volumes associated with the increased surgeries and procedures that are

going to potentially happen at this OSC, if it's opened, are included or not included in the financial modeling.

So hopefully, I asked that question in a way that's understandable. But it seemed like I couldn't quite follow the dots through the very large binder that I have about how those were treated, what were the utilization assumptions, and whether those utilization assumptions are an underestimate of potential revenue that could be generated from ancillary services and whether they ended up in the pro forma or not. Hopefully, that is a clear question.

DR. LEFFLER: Eve, are you able to take that?

MS. HOAR: I'm going to try. I'm going to split this up into a demand answer and a -- and a pro forma answer, if that makes sense. So in terms of demand, we did not estimate the additional need for lab services or imaging services that are associated with this increase in volume. And in particular, we did that because Sg2 forecasts for a future demand on imaging.

For example, the 3T MRI business plan that we gave you. Take the demand for imaging that's associated with injuries or other conditions that will require orthopedic surgery down the road, they already take that into account. So if we added our own estimate of need for that imaging and put it on top of Sg2, we might be overstating demand.

So if that makes sense, that's the way we went. On the pro forma, we all know that inside a CPT code that there's some -- there are charges for services that are post-surgical and so on and so forth. So again, what we wanted to do is to keep it as clean as possible so that we could see the impact of opening this OSC. So we have captured those downstream costs that are associated with the CPT code in the pro forma under the direct costs and likewise on the inpatient side.

But we did -- and we kind of drew the boundaries there, Member Holmes, and then said, okay, if there's other costs and revenue associated with labs that happened, you know, months before your surgery, imaging that happened a month before your surgery, we're going to --

we're going to leave that outside the scope of this thing.

And again, it was our attempt to be true and, I guess, conservative about the financial impact of just this decision. Because as you can understand, it might lead you down the road to other things. It's kind of related to your Fanny Allen question where it's -- where you choose to draw the boundaries of the business -- of a pro forma business plan itself and its impact. Did that answer your question?

DR. HOLMES: Yeah, that answers my question. So to the degree that patients are returning to the HSA, who perhaps had been seeking care elsewhere because they couldn't get into to see the specialist because they weren't going to be able to get to their surgery, potentially that's revenue that could be recaptured that's not included. Office visits two months earlier, labs, or --

MS. HOAR: Correct.

DR. HOLMES: -- diagnostic imagining, things like that? Okay.

MS. HOAR: Correct, yes.

DR. HOLMES: Okay. And my final

question is -- so in the responses, there is repeated reference to expected increases in commercial insurance commensurate with cost inflation. And I think we heard Mr. Vincent talking about that as well earlier. So two questions related here. On page 6, in response to question 5, there was an estimate of cost inflation of 5 percent for 2024, 4 percent for 2025 and 2026, and 3.5 percent in 2027.

The first question is -- I don't think that those cost inflation estimates align with the year over year operating expense projected in table 3A in the submission for UVM, the sort of table 3A UVM level operating expense growth. So I wanted to first understand that.

DR. LEFFLER: Rick, are you able to take that?

MR. VINCENT: Yeah, I was trying to get to the page. But let me answer it high level and then Eve and Marc can get to that page, just to make sure that we directly answer it. So I think -- so costs -- so total operating expenses includes both cost inflation and any increases that we have.

So you saw the staffing grid. For

example, we're going to have to add staffing to the center to be able to take care of the patients. And any other implemental volume related increases are also part of the total expense increase. So cost inflation was one component of that piece.

DR. HOLMES: Right, I'm actually -- to clarify, I'm talking about table 3A, which is -- I don't have it open to me, but that is UVM's overall -- not for the surgery center. It's looking at your operating expenses year over year, which I thought was how typically cost inflation was backed out for the hospital. It was looking at expense growth over time for the -- you know?

MR. VINCENT: And it's question 6, Josephine (sic)?

DR. HOLMES: Yeah. And then so question 5 -- on page 6 of the question 5 interrogatories, you -- not you. Sorry, I shouldn't say you. The response was cost inflation was predicted to be 5 percent, 4 percent, 4 percent, and 3.5 percent. So I was just trying to understand -- I was trying to marry up the cost inflation estimates overall

with the expense -- operating expense growth that I saw projected.

MS. TYLER: Hearing Officer Barber, can we pull up the growth assumptions that were just mentioned, which are, I think, on page 7 of our -- actually, I'm not readily finding them.

HEARING OFFICER BARBER: And which question is it?

MS. TYLER: So I think we were looking at our responses to question 5. And I'm not sure which page we are looking at.

DR. HOLMES: I have page 6 in my notes, so.

MS. TYLER: Okay. No, you're right.

DR. HOLMES: (Indiscernible) my binder is --

MS. TYLER: Yep, it's question 8. So it was the response to Q-8 of Q-5. So that's one set of inflation assumptions that we were looking at. And then I would also like to pull up and display our table 3 that we're referring to because we submitted that table more than once. And I want to make sure --

DR. HOLMES: Oh, I may be --

MS. TYLER: -- we're considering the same --

DR. HOLMES: -- looking at an outdated table of that.

MS. TYLER: -- version of it.

DR. HOLMES: Yeah, it's entirely possible that I'm looking at different -- the wrong versions of 3A or what. But I'm trying to -- I'm just trying to understand cost inflation because then I have a secondary question related to this. But I want to make sure that I'm understanding where your cost inflation is coming from.

So that's one of the data points I was looking at. And then the second -- so that's five, four, four, and three and a half. And then I was looking at a table 3A -- it might have been an earlier table 3A. So if we can pull up a table 3A -- one of the many.

MS. TYLER: I think the last table 3A was submitted on June 15th of '23 in response to the Board's Q-2.

MS. JERRY: That's correct. It's Q-002, June 15th.

HEARING OFFICER BARBER: Okay. I got Q-002 response. What page are we looking at?

MS. TYLER: This one has been an attachment to the responses. And it is our C01 table conforms to the financial framework for the hospital.

(Pause)

DR. HOLMES: Table 3A, there you go.

HEARING OFFICER BARBER: So which percentages on here, Jessica, are you looking at?

DR. HOLMES: So for example, if you look at 2025, the total operating expense percent change, it looks like it's 3.2. For 2026, it looks like it's -- I can't see, maybe three point something. I'm just trying to -- I was looking at the expense growth and trying to marry it to some degree with this table.

Like for 2025 -- let's take 2025. That was -- 3.2 percent is the percentage -- projected percentage change in operating expenses, right? But you had four percent in 2025. So that's an example. So is that where you're getting cost inflation? As an estimate of cost inflation from your percent change and

operating expense or is it some other method of calculating cost inflation?

MR. VINCENT: So I'll just make sure that Marc can validate what I'm about to tell you, but that total percent change in operating expenses are a combination of both volume and cost inflation-related items. So it's not just purely cost inflation.

DR. HOLMES: Okay. So that would include the volume additions that are potentially anticipated for 2025 --

MR. VINCENT: Right.

DR. HOLMES: -- and 2026? This is pure price -- this is purely price inflation? Because I feel like we've had -- we've had back and forths about this over the years and I've always felt like your cost inflation includes volume and my cost inflation is price only. So I -- and that's -- and if --

MR. VINCENT: Yeah. And Marc, if you could just validate that, that I'm reading this chart correctly?

MR. STANISLAS: Yeah. So those cost inflations that were listed on that previous file that was up that we saw the individuals per

year. That was pure price inflation, Jessica.

DR. HOLMES: Okay. Okay. So in some years, your price inflation is higher than your price times volume inflation?

MR. STANISLAS: We're kind of splitting hairs on percentages here. So you know, yes, if you look at the exact number, this is a model.

DR. HOLMES: Okay. Alright, there --

MR. STANISLAS: If you look at the difference between 3.5 and 3.8 percent, when we're looking out. Keep in mind that we submitted this over a year and a half ago, too.

DR. HOLMES: Fair enough, I'm just trying to understand where these numbers come from.

MR. STANISLAS: But yes.

DR. HOLMES: So --

MR. STANISLAS: To answer your question, it's price inflation, Jessica.

DR. HOLMES: Okay. So my second question is -- and this may have to go into executive session. And if that's the case, that's fine. I'll just leave it at this one. We

can follow up. But I'm wondering, what are the assumed effective commercial rate increases for each of those years, as assumed in the financial projections for the OSC given those cost inflation assumptions? Knowing that there's a difference between effective commercial rate and cost inflation.

DR. LEFFLER: You want to go ahead and answer that, Marc?

MR. STANISLAS: I think that I can say is at this time what we really don't know, the biggest -- when we look at what we expect rates to cover from a cost inflation perspective -- and I'll just call out that there's a lot of conversation about that. And this is -- this is a deep conversation that we have in the annual budget process. But the biggest indicator on, or impact on commercial rates is what happens with the other patient populations, too.

You know, we've been very transparent about the calculation, and we have this conversation annually. And there is a connectivity there. So you know, to the extent that the other payers, meaning Medicare and

Medicaid, can keep up with cost inflation the impact of commercial will be less. So (indiscernible)--

DR. HOLMES: No, I'm just wondering what assumptions you made --

MR. STANISLAS: -- say something.

DR. HOLMES: -- in the pro forma. Because there are revenue projections so there must be --

MR. STANISLAS: The assumption that we made -- the assumption that we made in the pro forma that that was applied equally to all payer categories.

DR. HOLMES: Okay. So the assumption was the cost inflation would be -- so Medicare would increase --

MR. STANISLAS: Yes.

DR. HOLMES: -- it's reimbursement by five percent, Medicaid would increase its reimbursement by five percent. Okay. So if they don't, then the Medicare/Medicaid revenue expectations are too low and the -- if the Board does not give the commensurate effective commercial rate that would be needed to keep cost inflation covered then the commercial revenue is

underestimated as well? Yeah, or no?

MR. VINCENT: So not necessarily. So again, going back to the -- how much of the OSC makes up of our total MPR. Right now, this is planned and is about three percent of our total MPR. So when we look at rates, as the Board knows, we're submitting a request for an overall commercial rate.

And then we work with our payers to work out are we applying that to E&M code, are we applying that to surgeries inpatient versus outpatient. So we're working within the overall parameters of --

DR. HOLMES: Sure.

MR. VINCENT: -- of a commercial increase. And so exactly how that's going to work out in the future related to this OSC, we don't know.

DR. HOLMES: I guess I'm just trying to understand what is actually in the pro forma. What is the underlying commercial rate growth expected in the pro forma? It sounds like there isn't that level of detail?

MR. VINCENT: We applied the same percentage across all roles.

DR. EAPPEN: Can I just -- does that make sense? So all of them we made the same assumption that they're all going to grow the same percentage, .1, .2 -- it's about three percent of our overall, when you look at the surgeries, just the ambulatory surgery center part.

And then the negotiations that go on with the commercial payers and how, in any given year, it could be that they are going to fund a little bit more for cancer therapy for surgical care. It's the total bundle that winds up mattering to us in our overall margin. So when you try to look at that portion of your commercial rates that are only going into this ambulatory surgery center -- let's say it goes up, they're going to bring it down someplace else so that the net at the end of the day is going to be whatever the negotiated overall rate was.

So I guess I'm just trying to make the point it's hard to come down and say, for this population, what is it going to be three years from now, four years from now.

It's hard to do it for next year because of that variability that comes across

when you're negotiating the overall rate and how the insurance companies -- there's a lot of factors that play into how they want to increase their rates or decrease their rates in particular areas.

They may be thinking, gosh, we want to really drive rates down for mammograms, but we're willing to go a little bit higher over here because we think that the patient population -- we're going to do some work on trying to get them to do -- the outpatients to do something different. So all of those things are factoring in. So it's really hard -- and so we just made the assumption -- I think Marc said -- or Rick said, they're all going to go up the same amount.

DR. HOLMES: Okay. Let me just ask you one follow-up question then to that. Because I know you've done some work with telemarketer reimbursements and reimbursement levels. And I'm just wondering if you have a starting point estimated for the weighted by volume and case average percentile price for the OSC? What percentile are you thinking that the OSC would start at relative to other OSCs? What

percentile would it be -- weighted average across all services offered?

DR. LEFFLER: Eve, do you have that, or is it Marc?

MS. HOAR: It would be me and I have to admit that we did it service line by service line member homes. And I never did the average, probably in part because so many of these ASCs are single-purpose. Right? But we could weight it. I think we could find a reasonable way of doing that. But no, I'm sorry to say we didn't do that.

DR. HOLMES: Okay. That would -- it would be helpful if we could see that, if you think there is a way that you can calculate that -- where are you starting from in terms of the benchmark to other -- you know, on average, how expense relative to other OSCs will this OSC be for the commercial pair. And I'll end there because I think I've taken up more than my time. So thank you very much for answering all of my questions. I appreciate it.

MR. WALSH: I'll jump in. I'm next. I want to thank all of our team for all of their work on this. It's a large project. And I

want to thank you again for all of your work. I appreciate your dedication to your community. And I've been impressed by the work that's gone into this application.

My role in this process is different from yours. I need to put this application into both a community context and a statewide context. And so all that is to say, I'm trying to work at least as equally hard in my role as you have in yours. I'd like to start -- and as with Robin and Jessica, my binder numbers might be a little bit different. But I'll try to summarize what I'm looking at. And I don't have any tables that we need to dive into.

So the first thing that I wanted to start with was the certificate of meeting statutory criteria 2B. It's on page 473 of my binder. But it says, "the project will not result in an undue increase in costs of medical care or an undue impact on the affordability for patients." And so I'm wondering if you did an analysis of how this project would affect the cost of medical care, not just the procedures and surgeries in the OSC, but medical care for Vermonters?

DR. LEFFLER: So I'll start by mentioning that we're not finance people in terms of how we did that. We work very hard to balance access and need to care with the cost of procedures and the affordability. And what we can tell you is that cases that can be done on an outpatient basis typically cost less than the ones that stay overnight.

Cases that can be moved from the main campus to outpatient surgery centers, the facility fee is less. And so on an individual basis, it's better for patients if they can get patient -- in an outpatient surgery setting and they don't have to be admitted to the hospital. We know that that for any one individual will keep the cost of care down.

Also, because this project has a positive margin, we don't have to cost shift the dollars from something else. In fact, we can use these dollars for other things that lose money. And so this project being better than even frees up dollars, as Jessica was joking about, for potentially mental health care or thing that we know do not generate a positive margin.

The details behind that, I'm going

to turn over to the finance people. At a high level, outpatient care is cheaper. Care that is not delivered in the hospital -- either Fanny Allen campus, which is counted as inpatient, or the main center campus -- is less.

People going home get lower charges and typically have less complications and recover more quickly. So at a high level, I think, for our individual patients, they want outpatient surgery and it's typically better for their finances.

Rick, do you want to add more of the detail?

MR. VINCENT: And Member Walsh, just to give you some concrete numbers. So in terms of the cases that are being moved from one outpatient setting to the new outpatient setting we would project a two percent decrease in commercial rates. So back to the starting point question that Member Holmes was asking. Just that shift alone, when we move an outpatient case from the main ORs or Fanny Allen to this new outpatient surgery center, commercial rates are going to go down by two percent.

Any cases that we move from what

Dr. Nichols -- any cases that we move from the inpatient setting to the outpatient setting, commercial rates go down by fifty percent. For Medicare, same thing. Rates go down by about fifty percent from inpatient to outpatient. And then finally, Medicaid rates moved from inpatient to outpatient go down by twenty-five percent.

MR. WALSH: Thank you. So it's -- and rightly so it's the cost per case and the affordability for the patient who receives care in the facility? The cost per case is projected to go down compared to being in a hospital. And that would make it more affordable for that patient. I understand.

And the statutory criteria number 1 is that the proposed project aligns with statewide reform goals and principles. I'm wondering if you conducted an analysis of the statewide impact of this project? And I understand how you can look at it through an individual lens, but have you -- I didn't see any of this in the submission. But I want to make sure I haven't missed anything. Has there been an analysis on -- within your submission, looking at the statewide effect of this proposal?

DR. LEFFLER: Well, I mean, we know that for the population that we serve, this outpatient surgery center will allow more than 4,000 more patients who need care to be able to receive that care in a timely fashion close to home. And so we were very focused on the population that we serve in our HSA that we're serving now. And we firmly believe that getting those people the care they need is the right thing to do. So we focused on that need, and I believe that's a statewide approach. I believe that's making sure that people have access to high quality care in a timely fashion.

MR. WALSH: And the 4,000 patients that come up, I want to make sure I understand that. Is that a total of 4,000 patients by 2030, or is that 4,000 per year? I'm trying to make sure I follow that.

DR. LEFFLER: By 2030, without the outpatient surgery center, more than 4,000 patients per year will not get surgery in a timely fashion.

MR. WALSH: Okay. Okay. Thank you for clarifying. I understand that better.

This was brought up earlier, I

think, by the Office of the Health Care Advocate. This is the HRAP certificate of need standard 1.3. "To the extent neighboring health care facilities provide services that will be provided by the new project, the applicant shall demonstrate a collaborative approach".

And in the earlier discussion, I appreciate the tension between this standard and antitrust concerns. But still, I'm wondering if you -- if there was any type of analysis about how this project would impact neighboring health care facilities?

DR. LEFFLER: I'm going to start at a high level, but I'm going to ask Eve to give detail behind that. This project was focused on the population that we serve, but we do know that our consultant analysts that looked at this, did project that Northwest Medical Center by 2030 would be at capacity. We already heard Copley's at capacity and that was confirmed. I can tell you right now, we are sending patients to CVMC and occasionally Porter. And the ability to get big volumes of patients down there, just isn't easy to do with the limited times you can slot people in. It's actually a major job to get a

hundred patients down there this year. And we're going to do it, but it's complicated.

And also, I'm telling you that if you look at Dr. Plante, right? He wants to have a full OR day. Having him go back and forth between the medical center and even the Fanny, honestly, has an impact on how many cases he can do in a day. So it works much better if we say to Dr. Plante, hey, the whole day you're going to be at the OSC or the main campus, because going back and forth actually is -- car time is not good surgeon time.

So we do know at a high level that we believe that all of the ORs around us will be full by 2030. But even more importantly, having our providers get in the car and drive to Northwest to do cases, and they're not on the same electronic medical record, they may not have the same equipment. Who's going to take call? Are they the add-on case? Did they get the OR time? Are we going to displace one of their surgeons who has a case? I'll just tell you, Member Walsh, I've learned a lot about this year. Using CVMC, our partner, as an example, its complicated.

MR. WALSH: And there's a lot of friction. There's a lot of friction.

And earlier Dave and Dr. Plante discussed some changes in patient migration patterns. And Dr. Plante mentioned that some growing inflow for certain specialty care. For example, if robotics are more -- if that's current, the state of the art for current technology and there aren't robots in surrounding communities, more patients would be coming into -- there'd be more inflow. I think that that's something that we, as a Board, have to just -- we have to try to keep in mind.

And another other earlier discussion just with Jess a few moments ago, it was mentioned that care out of state for Vermonters is more expensive. It was asserted that care out of state is more expensive than within state for Vermonters. And it wasn't clear to me what data that was based on. So could someone just describe to me how you compared the cost of care for Vermonters at UVM versus if that patient had the same procedure done in New Hampshire, or New York, or Boston.

DR. LEFFLER: We're going to have

to pull that data for you. I think we said we don't exactly have that yet but we will work on that.

MR. WALSH: Okay. Great. And I'm wondering if you have any contingency plans if you see shifts in migration patterns. If you see an outflow, you're losing business to surrounding areas or you're gaining a lot of business from surrounding communities? Do you have any contingency plans on how that -- what you might do for the good of the state depending on what was happening?

DR. LEFFLER: I can tell you that over the past eighteen months, under the leadership of Dr. Plante, Dr. Bender, and our nursing leadership, we've been running sprint rooms on the main OR campus here. So we looked at where our greatest backlog was, greatest need. And really smart people like Chris Dillon figure out, hey, we can do more total joints right now. We're going to dedicate a sprint room to that a certain number of days per week. We're going to increase the number of cases we can do in a day. We work down the backlog. And then go to the next one and the next one.

I can also tell you we have to do more around weekend care. Many weekends, we're stretching our surgeons, the anesthesiologists, and learners to the absolute limit because many, many cases from across Vermont are ending up here. And we'll have people that, you know, some weekends we do thirty-plus cases with crews that are, you know, really on call.

We actually think the OSC will help that a little bit, because I think a lot of times you ask the surgeons, they say, well, I'm just going to get it done on Sunday late night because I'm worried about the add-on problem for Monday. And the OSC may help with that. But we have to build a better plan, the AMC, to deal with the volume across the state that shows up here. I will tell you, I'm proud that we serve that purpose, but it is at the expense of people working really hard on weekends. It's not sustainable.

MR. WALSH: Right. Yeah. That brings me to my next question. These are related to the Mathematica report that came to the (indiscernible). And I appreciate the conversation earlier between Dave and Eve

regarding the various interpretations of what is an OR, what's a procedure, and what's a case, and what is demand? The different definitions, you'll end up with different explanations depending on the definition that you start with.

This morning I asked Dr. Nichols about the use of specialty teams, the anesthesiologists, the nurses who commit fully to doing hip replacements or spinal fusions and the efficiency with that. And he talked about a relative lack of efficiency, especially post-pandemic. So I'm just trying to get a sense of your current capacity in utilization and how the estimation of future needs came about. So other than saying you're full, what's the current utilization rate for ORs and procedure rooms at UVM facilities?

DR. LEFFLER: Chris Dillon is probably in the best position to answer that.

MR. DILLON: Sure. So last month, April 2024, 80.1 percent across the main and the Fanny; March 2024, 80.9 percent; February 2024, 79.1 percent. So significantly above seventy-five percent, hovering around eighty. There are occasional months where we're pushing up into the

eighty-two, eighty-three percent. These are just the last three that we had for you today.

MR. WALSH: All right. Thank you. And are all of the current operating rooms and procedures rooms open during standard weekday hours, 7:30 to 5? I know in a lot of facilities, there'll be a procedure room that's a procedure room from 7:30 to noon, and is something else in the afternoon. But I'm wondering, in your facility, are all of the current ORs and procedure rooms open during standard weekday hours?

DR. LEFFLER: Patrick, go ahead. I see you nodding. Dr. Bender?

DR. BENDER: Sure. So the complicated answer is yes and no. So there are -- we run twenty-five ORs every day. We actually have small procedure rooms that count as operating rooms. But there are days when we don't have the -- where those really small rooms, which are proverbial shoe boxes, they're 350 square feet compared to the 600 and some we really, don't fit the equipment and the case types of the patients that we have. So there are occasional times where one is not being used, but

it's not from a lack of staff or desire. It's from a lack of operational ability from the equipment standpoint fitting in there.

MR. WALSH: Okay. Thanks. I appreciate you explaining that. What percentage of your ORs and procedure rooms are open during evenings and weekends? You've spoken anecdotally about surgeons fitting things in on Sunday evenings and such. And I know that that's not often. I'm not trying to advocate for creating exhausted surgeons, right? I understand that's not great for anybody.

DR. BENDER: Sure. I can give you a general sense. I'll try to be as concise as possible. We do plan to run several ORs late into the evening on weekday evenings, three or four that are scheduled to go late just by the nature of the surgery. If you're going to do two heart surgeries, it's probably not going to be finished by 5 p.m., et cetera. A long plastic surgery case may not finish. So we staff and plan accordingly to that. So on average usually we'll have five or six operating rooms running till 7, 8, 9 p.m. or so on weekdays. And overnight, really talking about 11 o'clock or

after, we usually can run two operating rooms, plus labor and delivery, which is an OR that isn't even involved in this discussion. On weekends, during the daytime hours, we run three ORs and labor and delivery. And then at night, it reflects the same as on weeknights. So we try to get as many people through during the daytime for patient satisfaction, but also for provider well-being and staffing goals. And then we do pare down and really become a urgent and emergent situation only, you know, from 11 o'clock until 7 a.m..

DR. PLANTE: I do want to quickly amplify the weekend situation from the surgeon's side. You know, it would be no surprise to anyone during this hearing, that weekend work, whether it be from a staff, or surgeon, or anesthesiologist perspective, is not a big satisfier. We also talk to patients, and it was a big patient dissatisfier as well.

MR. WALSH: I agree, in my experience, you know, consulting with a lot of different facilities, especially elective outpatient procedures. Nobody wants to have their spinal fusion start at 10 p.m. on a Friday,

right? I get it. I'm trying to just drill down into what is the actual capacity right now and the utilization.

DR. PLANTE: Absolutely. And those were situations where we were forced to look at where else can we fit volume? So we totally understand the question. Thank you.

DR. BENDER: And it also should be reflected that that does not impact that eighty-two percent or eighty percent that Chris just rattled off for the last three months. After 5 o'clock, those hours are not counted in that utilization. Because utilization is 7 -- at least at the medical center, 7:30 to 5 o'clock. So that's the denominator. And then afterwards everything else is additional cases beyond our denominator.

DR. LEFFLER: And Member Walsh, I'll just add that when we were forced to close the Fanny because the air quality issues, we actually tried to run Saturday ORs to make up some of the volume and patients didn't want to come. We would say, look, we can get you in and we have providers, like Dr. Harrington was one of our providers was willing to sign up and do cases

on weekends, and we couldn't fill the schedule.

MR. WALSH: No, I do understand and I am sympathetic to that. So yeah, just I'm trying to get this a big picture.

And the next thing kind of goes to the same thing with the staffing. There's been discussion about your capacity is full and it's not because you don't have the people or the patients, it's because you don't have the space. But I'm wondering, as you look toward having an OSC, can you tell me a little bit about what you see as the challenges for having enough physicians, surgeons, anesthesiologists, nurses? There was a conversation earlier with Jess. It sounded like you're anticipating a relatively high number of travelers to ensure their specialty knowledge. What percent are travelers now? And what do you see happening in the near and medium future?

DR. LEFFLER: Mary, do you want to start?

MS. BROADWORTH: Sure. I'm happy to. Again, you know, we talked about part of the ecosystem is having some percentage of travelers, and we talked about our assumptions in the

submission. And we're, you know, we are still using travelers, depending on -- I would say depending on the service line. So it is very dependent on the skill mix and level. We are seeing, as I mentioned in my comments earlier, you know, better performance for us hiring nurses in particular. So we're adding net nurses to our overall. As well as our ability to retain within the system. So during COVID and I'm sure you're all aware we had some significant turnover and that has come down and is much more manageable. So we have much more predictability, which is great for everybody.

So you know, we are going to assume somewhere between the ten percent and twenty-five percent. And I, you know, as I mentioned earlier, perianesthesia, the pre- and post- traveler numbers we have at Fanny Allen are really low right now. But those can change depending on the mix of employees. So we want to have the right assumptions in the plan. So does that answer your question?

MR. WALSH: Yeah, I think it helps. It sounds like recent experience is ten to twenty-five percent of certain staff type are

travelers. And it was mentioned earlier that in the new OSC, that you're currently anticipating that it'd be on the high end of that, that around maybe as high as twenty-five percent, while you're trying to find the people with a specialty knowledge.

DR. LEFFLER: I would actually say a little differently.

MR. WALSH: Okay.

DR. LEFFLER: I actually believe that the OSC will likely fill. The OSC will be a desirable place to work. It has on-site parking. It's Monday through Friday. We have the Fanny Allen people who will almost certainly almost all go over there. And there's a number of staff and nurses at the main campus who are doing mostly outpatient surgery that'll be very happy to go to the OSC and work there.

Overall, though, we will probably need to add some travelers. Once again, we made a very conservative projection in the pro forma. Our recruitment retention is improving. And so I think twenty-five is the high end, but I think it very likely could be -- I think the OSC may be nearly fully staffed, has the Fanny Allen is, we

may feel a little more the pressure on the main campus with some people choosing to go to the outpatient setting. But we committed to staffing it to have the rooms be open. And so we put a high number in there to be conservative.

DR. PLANTE: I would quickly echo that, if I may, Steve. So that's what we saw. For decades, I've seen the Fanny has always been staffed well. But there's two quick threads I want to add. One is we also, in parallel, our training our own peri-op staff. So we have a peri-op one-on-one program for nurses. We also have a surgical tech training program. And its kudos also, Mary, your team, you and team, the traveler rate has come down so much that now we're starting to see travelers want to sign on and become permanent staff. That is actually a very, very poignant shift. Whilst it's not large numbers. It's an important trend I think we can seize upon.

MR. WALSH: I just want to follow through with this a little bit. If the new facility is the shiny new place, right? It is possible that there would be a shift, a lot of people would rather work there. Some of the

material presented to us by UVM to our consultants talked about the added inpatient volume that would be allowed by having an outpatient facility. That added inpatient volume is what would make -- that would drive the profitability of this project.

Do you have a contingency plan if you're not able to have enough staff inpatient to create that volume? Have you thought through that, and can you share with us what your thinking is? Got an outpatient facility humming along, but inpatient's not staffed fully. But the inpatient is what was going to make this profitable in the early years.

DR. LEFFLER: So as we've done since start of the pandemic in 2020, we've staffed the medical center to care for those who need us to the extent that we could. The only thing that's ever constrained us has been space. If we needed to bring in travelers to care for everyone who needs it, we've done it up to using every room, double occupancy, and so on. So to your really good points, as we move people to the outpatient setting and we have some capacity on the main campus, we will make sure that we're

staffing to take care of those patients that are here.

And from a margin standpoint, the big cases that'll be filling those ORs and traveler rates coming down, those cases should have a margin. But even if they don't, we're going to care for Vermonters who need us. That's why we're here.

DR. BENDER: In addition, Member Walsh. I would just add, so I do cardiac anesthesia. Right? And right now, it's often that those rooms are going until 9 or 10 o'clock at night. And that takes a toll on the nursing staff quite significantly. And I talk to them and the reason that there can be some turnover, and that is they get tired of being there at 9 or 10 o'clock every second or third night. When you have additional inpatient operating rooms to take care of those inpatients, and now their days are done at 5, it becomes much easier to not only recruit people into those specialty positions, but also to retain them. And so there are multiple people that have left where in a better hourly working circumstance, that would not have been the case. And so I see that there's

potential benefits in that regard as well.

MR. WALSH: Yep, I get it. And you all are describing these situations that, you know, would contribute to burnout, would -- all kinds of things. Earlier in the day when we were just -- you were discussing the demand forecasting, the Sg2 model, the Claritas, Sg2, the kind of the inner workings of a kind of the proprietary and that makes it somewhat opaque. There's the Hesla (sic) model that you -- or Halsa, H-A-L-S-A.

MS. BROADWORTH: Halsa.

MR. WALSH: And I was listening to that information and then also thinking about Dr. Nichols and the conversations with Dave and Jess and others about some of the inefficiencies that have arisen following COVID. And in that discussion of the Halsa model, there was a discussion of, do we use our current time stamps -- when we start, when we end, when the turnover is, or do we look at a benchmark? And it seemed like most of the time the choice was to look at the current function, current reality over the benchmark. But I'm wondering, doesn't that bake into the calculation some of these

inefficiencies where it's slower to turn over a small room, for example. And so doesn't the use of the current status kind of bake in the inefficiencies that have been described?

DR. LEFFLER: I'm going to go to Eve.

MS. HOAR: Thanks. Member Walsh, I'd like to go back for one quick second, and then I'll promise you, I'll remember your question and answer that.

MR. WALSH: Okay.

MS. HOAR: But I'm going to respectfully disagree, as we did with Ascendient in our response to their assertion that it was the inpatient margin that carried this project. And here's why I disagree with that. I don't think it's, from a financial analysis point of view, fair to skim off the top and then say, oh, the rest is left for the incremental outpatient surgeries, which is the way that Ascendient approached that.

First, for this audience, we have to keep in mind that of the eight ORs in this OSC, five of them are replacing thirty-year old ORs that are too small to do the surgeries. And

in an incremental pro forma, there is no margin for replacing surgeries that you're just going to do in a better, more appropriate clinical space. So it's the one -- in fact, that Dr. Sanders and I've had back and forth about different ways of looking at this. But from a five-year incremental pro forma standpoint, it's always a loser. You'll see when we replace an MRI, it's the same thing. Like unless we get super-duper efficiency, there's no new revenue, and there's never enough to make that positive. So I just wanted to set the context there for the discussion.

For those inpatient cases where our costs may go up. So in the case that Steve talks about, we might, like, take nurses from the main campus and use them in the outpatient surgery center. One of the beautiful things about this pro forma is, if we have to replace those with travelers, that increased cost is actually already built into the pro forma. Right? Because now we're backfilling the inpatient nurses that we left behind with travelers, at about the same rate as we would have paid at the OSC.

The other thing I'll say, and this comes back to Member Holmes' comment of why maybe, perhaps we were overly conservative, is the direct inpatient cost that you see in the pro forma reflects nursing costs as of FY '22, which is the time we were finalizing that pro forma. And then they grew by cost inflation, you know, to make their way into the years that you see.

But I think we have covered fairly the direct or indirect impact of staffing the OSC fully. Not that I'm not giving Mary a giant headache because you might have to go out, and you know, find some, some more great folks. But anyway, I hope that that talks about the cost of those travelers and wherever we need them, they're represented in that pro forma. I owe that to Rick Vincent, my boss, when we do these things. All right.

So now onto your --

MR. WALSH: Before you go on, could I just ask a follow-up, please? Because this is very helpful. You mentioned the incremental addition of basically three ORs for this project. You used an example of an MRI, a new MRI. We're talking about an additional MRI

or replacing the existing?

MS. BROADWORTH: Sorry, I was talking about a replacement MRI business plan.

MR. WALSH: Okay.

MS. BROADWORTH: And how that would, you know, if you're already operating at a capacity, just replacing it because it's old and it's breaking down, you're not going to going to see a lot of incremental reimbursement. Right?

MR. WALSH: Thank you for clarifying.

MS. BROADWORTH: Yeah. Sorry. Went pretty fast through that one.

MR. WALSH: No, no, I followed, I just wanted to make sure that I heard it correctly.

MS. BROADWORTH: Bring me back to your -- the question that you followed.

MR. WALSH: It was about the Halsa model and that --

MS. BROADWORTH: Yeah.

MR. WALSH: -- there's been discussion of inefficiencies, you know, basically post-COVID and jam -- screwed everything up, right?

MS. BROADWORTH: Right.

MR. WALSH: And so with the choice of the Halsa model to use current performance measures instead of benchmarks, doesn't that bake in the inefficiencies in the projections of what you're going to be able to do?

MS. BROADWORTH: It might have if we had used turn times that were from post-2019, but we actually used that -- coming back to that 2019 baseline where we were humming along. And I think Dr. Nichols referenced teams happening back then. So we did it for two reasons, Member Walsh. We did it because 2019 was kind of our most recent normal year. Right? Perhaps you could have you could argue that 2023 was a pretty normal year. But we were sitting in '21 and '22 when we were looking at that. So we looked at turn times and we looked at case lengths from 2018, 2019. I think we've shared with those with you and in one of our rounds of questions that we had and they were actually remarkably consistent.

And then we compared those actual times. So let's be very clear. We don't think about inpatient turn times and outpatient turn times. We think about turn times by site. So we

know in our main ORs, where there's all sorts of stuff going on. I'm just looking at Dr. Plante. He's probably cracking up listening to me talk about this in such a nonclinical way. But there are all sorts of stuff going on, emergencies coming in, you name it. So that turn time is thirty-seven minutes per case, if my memory is correct.

Contrast that with the Fanny Allen. Should you get healthy patients, you get predictable stuff going on, and it's twenty-five minutes a case. Those are also simpler cases, right? So if you have a case go over by five percent, it's a few minutes versus a long case that happens in the main ORs. So that's the way I've learned from listening to all these smart people on the screen to think about those turn times.

In the OSC, we use the Fanny Allen twenty-five minute case turn time. Okay? Compares favorably to the Vizient benchmarks. Now we think about adding more complex, longer cases to that same setting and said, boy, you know what? That's going to introduce a little bit more variation, longer, more complex

patients, even though we have great new surgical techniques and so on and so forth to handle them. We felt like, again, sticking with that Fanny Allen performance turn was the right thing to do for right now. Doesn't mean we're not going to try to be better, but we felt like it was the right thing to do given the joints that we're going to bring over there and so on and so forth. Did I half answer your question or are fully answer your question?

MR. WALSH: I think that's good. I think it's -- I don't know that there's -- because of the choices that we make about the variables and our inputs into the models. Now, I feel like I'm talking to someone who knows more than I do about this. But when you make -- you create definitions, you have assumptions. I don't think it's possible to come to a concrete answer. So I'm just trying to understand all the thinking that you all put into these decisions.

MS. BROADWORTH: Yeah.

MR. WALSH: Yeah.

MS. BROADWORTH: Could I give Scott Walters a chance to chime in here, because he's really our expert and the creator of the OR

model and does this for lots of clients around. Scott, I didn't mean to take your stage there.

MR. WALTERS: No, you answered almost exactly as I would have. And you know, the two things we really want to do are we want to be a little bit conservative and in facility planning, conservative is in unlike finance, we're always kind of in opposition with the finance people on our definition of conservative. The building, we want to make it just a little bit bigger. And by using those assumptions, I think you're going to beat them.

You know, we have absolutely not baked into the operations, the same old way of doing business. So the building is programed and designed to be more efficient and to work better than the Fanny and to have the right ratios between prep, OR, phase one, phase two, extended overnight recovery, which we do not have at the Fanny in any way.

So the building ought to function better than the Fanny, which means you have the opportunity to beat those numbers. And but I don't want to -- until I can prove how much better it ought to be, I don't want to take

credit for it in either the operating -- the demand assumptions or the financial assumptions.

So I think we've got more good guys than bad guys that are hiding out there. We're going to go looking for all those good guys, and we're going to manage away the bad guys. So I think we're going to beat it. But I can't tell you by how much we're going to beat it. Are we going to beat it by three minutes, two minutes, five minutes? I think any of those is plausible, but I don't want to count on it and then be wrong.

MR. WALSH: I understand.

MR. WALTERS: I just know I can hit that twenty-five minute number.

MR. WALSH: I've just two more questions. As part of the justification for the additional capacity, you noted that over sixty-five population in Burlington was projected to increase by a lot, initially, sixty-two percent in the original submission. Earlier, we presented a new analysis with Claritas using forty-one percent growth. The U.S. census forecasts about a thirty-six percent increase. Vermont's state projection is thirty-one to

thirty-nine.

And I appreciated it earlier that you walked through how the surgical demand model changes with different population growth estimates, but it's unclear how that worked. Right? You asserted that a sixty-two percent population growth would lead to a twenty-two percent increase in surgical demand. And a forty-one percent population growth would still yield a seventeen percent increase. So a twenty point drop in population growth would only be a five percent loss in surgical demand. But I want to just consider an extreme example. What is the contingency plan if the population growth -- your population growth estimates are off by fifty percent?

MS. BROADWORTH: So we asked ourselves --

UNIDENTIFIED SPEAKER: Please go ahead.

MS. BROADWORTH: All right. So Thom, excuse me. Member Walsh, you're specifically saying if --

MR. WALSH: That's okay. I prefer Thom.

MS. BROADWORTH: Okay. If you're saying if those sixty-five and over estimates are indeed forty percent growth in ten years and not sixty-two percent growth in ten years?

MR. WALSH: Or if they're thirty-one percent as the state -- the low end of what the state recommended.

MS. BROADWORTH: So is that for the state or for Chittenden County?

MR. WALSH: It's for Burlington.

MS. BROADWORTH: Okay. So what I can tell you is that we so far -- that we have been in terms of population projections and the latest estimates, so I go to the Department of Health website and look at the population estimates sixty-five and over, under sixty-five for Chittenden County. And right now since 2019, we've been tracking really, really close to those estimates for Chittenden County.

I've been doing this job for eight years. I have seen national forecasters, including the Census Bureau prior to 2020, really underestimate what's going on in Vermont. We're almost too little sometimes, I feel like, for anybody to care about. So I hear you. You know

what? So what we know is that at forty percent growth at the sixty-five and over population, our growth in inpatient surgeries goes from ten percent to five percent. Far less than that than the growth in the sixty-five and over population. Okay? In part because we're able to do some surgeries outpatient that we used to be able to do inpatient. And we see a similar decline in the outpatient surgery growth.

But I spent a lot of time particularly thinking about the conversations that are held with the Green Mountain Care Board about access. I also think about the other problem. What if growth is higher than we think? Because I think that's the problem we got into before. And so with a three or four-year runway to building capacity, it really influenced the kind of conversations we asked ourselves about what if we're wrong? Like, don't we need to look at a couple of different forecasts?

And I was happy to update for the Sg2 forecast. But I'm equally concerned with what if we're wrong and we need more health care services than these forecasts project? Which is kind of what led us to the, you know, you could

look at the numbers and you could say, you should be building out all four of those shelled ORs right now. You say, you know, Mathematica says you need eleven. And I feel like that's probably not right. And I think we're thinking about that concern that, you know, what if this is a little overestimated. And having those shelled ORs to be able to build more quickly should we need them sooner than we thought.

MR. WALTERS: If I can add the explanation for why that's true, everybody is looking at sixty-five plus. That is a gross oversimplification. In five years, the last baby boomer is going to turn sixty-five. So when you're looking at those ten-year projections, you've only got five years of boomers aging into the sixty-five. And then you've got my generation, the teeny tiny nobody was born then generation, aging into sixty-five. So the sixty-five-plus growth is going to continue fairly strong for five, then it levels out. But if you look at how people utilize health care -- and Sg2 misses this; their model only looks at sixty-five plus. You got to look at seventy-five plus and eighty-five plus. Seventy-five-year-olds use

health care fifty percent more than sixty-five-year-olds, eighty-five-year-olds use health care twice the sixty-five-year-old. Those boomers are still moving into the seventy-five, and they're now moving into the eighty-five. And that's what they're missing. And that's what when you just look at sixty-five-plus, you are missing that those boomers are now moving into the not just the 100 percent growth, but the 150 growth and the 200 growth. And if you're only looking at sixty-five-plus, you're missing that. And that is a big, big, big thing to miss. It will -- it is going to bite us hard. And most people aren't waiting for it. And it scares me.

DR. LEFFLER: Yeah. So Thom?

MR. WALSH: Yeah.

DR. LEFFLER: I like questions so much because it's so hard to predict the future, and we haven't always got it right in the past. So here's how I think about this. I am extremely confident we need eight ORs right now, today. If you look at our backlogs, our efficiencies, what we're doing, if we could open the three extra ORs tomorrow, we would do it. And I'm confident they would be full. Down the road, building a shell

space for four additional ORs, allows us when the timing is right and when we need it, to use that space or delay it for a long time if we don't. So what's good about this project is it allows some flexibility for the future. It's once again we realized and other projects that we've done, we haven't exactly got it right.

MR. WALSH: Uh-huh. It's hard to get right. I've seen it a number of places. And so just quickly, my concern about this, right? If the growth is higher than we've been talking about, and every place is filled to capacity, that increases the volume of care, that decreases the backlog for patients in Chittenden County, and the Burlington HSA and surrounding areas.

But that increased utilization then contributes to driving the medical trend higher for the state, which increases the premiums that Vermonters would feel. And most people -- and that would be for patients across the state, people across the state, whether they use health care or not, whether they go to UVM or not. Most people feel affordability with their premiums and deductibles, not hospital prices.

So if the demand for this facility

just takes off, that could impact people across the state. If the growth estimates are too slow, right? The population growth levels off, people don't keep coming to Vermont the same way they were during the pandemic, and the facility is not used to capacity. The response then, I'm not sure you all would do it, I haven't seen you this way, but in experience other places, when you're not at capacity, you could advertise and try to compete more regionally.

And if this project is pulling -- if the inflow increases, then area hospitals are losing profitable outpatient surgeries, that could destabilize the functioning of the entire hospital. And area communities could lose access to all the services provided by the hospital, not just outpatient surgeries. So whether it's too high or too low in the extreme examples that I've outlined, it becomes problematic from a statewide level. So I'm just trying to understand where this is and think critically about what it means across the state.

So just one more question. And this, you all talked with Jess a little bit about this, and Sam with HSA. You assume that the

price increase is approved by the Board will keep pace with inflation. The method that I've seen in the last two years that you all use when you submit your increases, if inflation, for example, is not -- there's not a page to turn to over this. But let's imagine that medical inflation is four percent. Medicare and Medicaid don't usually keep up. Medicare may approve one percent, so three percent less than inflation. And what I've seen with how you all budget, you would then ask us for a seven-percent increase to make up the difference. So what you're asking for is well above what inflation is. And so I'm just wondering if you have a contingency plan for the possibility that the full rate increases you request, are not approved?

DR. LEFFLER: Rick, you want to start?

MR. VINCENT: Yeah. So I think it's the question that we, you know, we ask ourselves before we even submit our overall budget to the Board in July, Member Walsh. And we have to plan for that. Obviously the costs are real. So the inflation that we -- you know, salary increases that we provide to our staff,

the cost of supplies, they're real. And if not everybody pays for it, then, you know, obviously that, you know, that'll negatively impact, you know, the plan. And not just for you know, not just for UVM, but every single, you know, hospital in the state, every, you know, every hospital across the country.

So obviously we're constantly looking for ways that we can minimize that increase. And at the end of the day, we do have to just then take a look at what, you know, where is it that we need to focus our resources to ensure that we have, again, going back to my slide on the framework, to meet the needs of the community, we need to be able to generate a margin to reinvest in the organization for the community. And so we, you know, we need to look at places where we can invest, where we can't invest. If we're not able to keep pace with the cost of inflation.

And there are opportunities, I think, you know, even with -- certainly with Medicare, there are opportunities there. But you know, we've been trying to tap into in the last couple of years to try to relieve some of the

pressure on commercial insurance. So we don't, you know, we don't go into a budget season thinking that that's just completely off the table. You know, we're trying to do some things beyond just what Medicare is in terms of fee schedule increases to kind of help the costs to the Vermonters. But that's, you know, at the end of the day, it comes down to what you're offering, you know, for services and where can we -- where can you afford to continue to offer those services.

MR. WALSH: Thank you. Like I started off with, I appreciate all that you guys are putting into this and really trying to think about what's best for your community. And I appreciate you helping me think through some of the things I've got to think about about your community and the state. So thank you for taking the time to answer my questions.

Back to you, Chair Foster.

MR. BARBER: I'm actually going to -- before we move to Chair Foster, suggest we take a five-minute break. So come back at 3:22. We'll see everyone then.

(Recess at 3:17 p.m., until 3:23 p.m.)

MR. BARBER: So turn to questions from Chair Foster. Go back to, I think Dave Murman wanted to ask -- opportunity to ask questions at the end briefly. And then there's still an executive session to get to and comments from the interested parties. So there's a bit of ground to cover. And then public comment, although there's not a ton of people who signed up so far. So that's what we have to get through. Just saying it out loud. And I'll turn it over to you, Chair Foster for questions.

CHAIR FOSTER: Thank you. I wanted to talk a little bit about the impact on other providers in Vermont. And the forecast was for no additional market share to UVM as a result of the outpatient surgery center. Is UVM planning any marketing or media campaigns relating to the outpatient surgery center?

DR. LEFFLER: The first word you used got cut off. I'm sorry. So I heard media campaign. What was the other thing you said? I'm sorry.

CHAIR FOSTER: Marketing. Marketing or media campaigns relating to the outpatient surgery center?

DR. LEFFLER: We're not planning any marketing or media campaigns to try and increase market share. I mean, we're doing work now to tell people that we're trying to improve access, but nothing beyond that.

CHAIR FOSTER: It would seem like having a brand new, state-of-the-art facility would be attractive to patients, which is probably a good thing. But it would seem like that would naturally draw from surrounding areas. Why do you think that would not be the case?

DR. LEFFLER: I think that the hospitals in each community and Vermont are important to their communities. I actually don't worry about small hospitals doing more. I worry about them doing less because we are so full. So I believe the outpatient surgery center will be full. But I equally believe that the community hospitals will be full. There are people that want to stay local. That's where they can get care. That's where it's easy for them to access care. And so I'm not really concerned that we're going to have a significant material impact on Northwest, Copley, et cetera. I think they're going to be busy, too. And I think, importantly,

what you heard this morning was us being more efficient, let's them get their critical patients down here in an easier way. That's actually probably the most important thing. I mean, we have some patients now in the Burlington HSA that go to Copley to get total joints. I actually expect that to continue, Chair Foster. I think there's people that choose that and we understand that.

CHAIR FOSTER: I want to take you to Exhibit 4 to the application. Mike, maybe page 34.

MR. BARBER: Is this the page you're looking at?

CHAIR FOSTER: Yeah. And I understand this is old and attached to the original application, so it might not be current. But this section is about integrated communications and engagement strategy. And to my eye, it looks like there's an engagement strategy in connection with developing the CON and getting the CON through that process. And then there's a section here on page 34, "tactics by plan phase". And I wasn't sure what these things were or if they're still part of the plan.

Go down to the next one. Yeah. Grand opening. Yeah. That one. So there's a cost here, estimated $100,000 for social media, paid content placements, and ad for newspapers, paid search capture campaign relative to competitors, community and referring provider outreach, and some other things. Are these something that you're still planning on doing, or are these something that were an initial plan that are no longer part of the plan?

DR. LEFFLER: I can't comment on a number of these because I wasn't part of this process. We haven't really run TV ad trying to pull market share since I've been the president of the hospital. We're not trying to take anyone's market share. We're not trying to take cases from Northwest Medical Center or Copley.

And so I do imagine that we'll highlight the building. We'll be proud of the building. We'll be proud of the care that we can deliver there. And so there's some balance between how we use our tools to do that. I think some of these are likely outdated, to your good point.

CHAIR FOSTER: I wasn't familiar

with a couple. What is "paid search capture campaign relative to competitors"? What is that?

DR. LEFFLER: I don't know. Does anyone know this on our team? Know what that means?

CHAIR FOSTER: And then another question. I do recognize this document several years old so maybe a lot's changed. But if there's such significant demand --

DR. EAPPEN: Chair Foster?

CHAIR FOSTER: -- it looks like there's a hundred and -- yeah?

DR. EAPPEN: This is Sunil Eappen. I'll just say that we've been very, very consistent. I've been very consistent with our team around the fact that we need to communicate what we do in our area so that our patients know, that's important. We want to -- in all of our areas. And that's been that's been actually asked for by patients. When you're in Porter, when you're in Middlebury, people want to know, what are we doing in Middlebury that we can -- so we don't leave the area to go to Burlington if we can get that in Middlebury. Can you tell us about that?

So I think that awareness is important, but I can tell you repeatedly, we've had the conversation that we do not need, and we should not market to try to attract more patients. It is not what we need to do. When I traveled around the state and I talked to each hospital president. I said, what can we do to help you keep the patients that you need to keep here? What can we do to help you to do that? That is a direct sort of line that I have, because my goal and Steve's goal is we really want those community hospitals to thrive and take care of the patients that they should be taking care of. And how can we help you to do that, is has been our motto. So just want to reemphasize that. Yep. I don't know -- I don't know what these mean, but these obviously came out before I started as well. It isn't what we would need to do here.

CHAIR FOSTER: Okay. Yeah. Yeah, I'll move on because I maybe it's dated or inconsistent with what you're planning on now. But it didn't seem necessary to spend, you know, 130 or so thousand dollars on marketing given the demand. Right? There's such overflow, according

to the presentation today, it wouldn't seem like you'd need to spend money for advertising. I get the awareness point.

DR. EAPPEN: Yeah, I think you're absolutely right. I think you're absolutely right.

CHAIR FOSTER: That sort of goes to my point that this might be outdated.

If you go to the next page, Mr. Barber. Government and community relations; "this project will require local and state engagement prior to and concurrent with the CON submission. The opportunity to explain its benefits during and post-construction". It has pre-announced that pre-filing stakeholders, GMCB chair and members. Then a number of other types. To my knowledge, I've never spoken with you concurrent to the CON submission about it, have I?

DR. EAPPEN: Not that I can recall. I think I would have been happy to talk to any one of the Board members about the project, because I think it has so much value, and I want to just make sure that everyone understands that. But I don't think we actually

have engaged with any anyone about that, that I'm aware of.

CHAIR FOSTER: And then on page 33, the last question, I'll move on from this document, because I don't know if it's that pertinent today. The top paragraph, Mike.

MR. BARBER: I think I'm there.

CHAIR FOSTER: Yeah. I'll move on.

Yeah. No it's fine. It's not that pertinent. I want to go to a different topic, which is the population growth estimates. Do you have any sense of how reliable those estimates are? I'll give you the reason why I'm asking is, you know, the State of Vermont, for twenty-five plus years, has been trying to increase our population pretty significantly. We haven't really done that to date. And the projections are pretty significant. So is there any way to pressure test the accuracy of these population estimates?

MS. HOAR: Want me to go? Should I take that one?

DR. LEFFLER: Please.

MS. HOAR: Yeah, Chair Foster, it

is really interesting how pressure testing really is -- for example, I mentioned the Department of Health website shows the estimated population as recently and only as recently as 2022 for the under sixty, I think it's by age cohort, but sixty-five and over versus under sixty-five is what I fact-checked that against. And so that's the best tool I have, which was, okay. So once we kind of know what the population is, how well did the forecasters we use forecast that?

I think this is tricky right now because we have different parts of the state growing at different rates. I'm probably telling you something that you already know all too well. But that's the best way I know how. The other thing I would say is I've asked around to my strategic planning colleagues around the country about what forecasts they use, and I've asked Sg2 why they base their forecast on the Nielsen Claritas forecast. And the answer I get, in a nutshell, is it's just widely recognized as one of the best, if not the best around.

CHAIR FOSTER: Do you know if those projections took into consideration our severe housing challenges here in Vermont?

MS. HOAR: I don't know if they took those into account. I would assume that that's --

CHAIR FOSTER: If you could get that to us, I'd appreciate it.

MS. HOAR: Yeah. Yeah, happy to do that.

CHAIR FOSTER: And then in terms of staffing and the challenges with staffing, is there any modeling or analysis done of the ability of UVM to meet its staffing needs for this project?

DR. LEFFLER: Mary, do you want to talk about staffing? Thank you.

MS. BROADWORTH: Sure. You know, as we submitted, you know, we believe we're going to have much of -- at least half of the current staff move over. And then our ability to backfill is based on our, you know, our current experience around our ability to net hire, meaning we're able to outpace turnover. And again, we're seeing that to be improved, especially in the last year. So you know, we are doing all of the strategic workforce planning techniques that we possibly can. But I think,

you know, the biggest positive of this will be our experience with Fanny Allen. People really like working in that environment. There's good parking. It's easy to get in and out. It's a predictable schedule. I would say, of all of the staffing complexity we're dealing with, this outpatient surgery center is going to be one of the most desirable locations for us. It'll be new. And I think it will definitely attract employees.

CHAIR FOSTER: Do you track your ability to net hire month over month or year over year over year?

MS. BROADWORTH: We do. And we're just getting much better at that data analysis this year. We have much better ability to see those numbers. And so again, we're tracking our ability to recruit. But I think important for a lot of what we've discussed is retention. Because once we have people in the area that got housing, they're learning the skills. It's really important that we retain. And we are seeing, again, as I mentioned in my comments, better than industry, you know, regional averages regarding retention.

DR. LEFFLER: Chair Foster, I would just add that prior to the pandemic, retention was unbelievably high. There was lots and lots of people here that committed their whole careers to the UVM Medical Center. The pandemic really stood that on its head for those middle years where we lost a lot of people to all kinds of reasons. We're not back to pre-pandemic. I don't want to say that, but we are trending back in the in the right direction.

So at the peak of the pandemic, we were losing twenty percent of our nurses a year. And last year, our turnover was about six percent, is what I think you shared, Mary. And we really wanted to be as close to zero as it can be. We really want people to come establish their roots here, raise their families here, and be here for their careers. And so we're committed to doing that hard work because holding on to people is how we will ultimately refill the medical center back to the point where we need we need the least number of travelers possible.

CHAIR FOSTER: Thank you. So if you modeled out based on your net hire capabilities, how long it will take to fully

staff the OSC if it's approved?

MS. BROADWORTH: I don't have that number in front of me. We'd have to do that modeling. I would just say, you know, the way we've submitted anticipates the need for travelers in the interim. And our goal, of course, is to hire full time. And so that will be the focus.

CHAIR FOSTER: In assessing your ability to staff the OSC, did you take into account the changing demographics that were forecasted in connection with the demand projections?

MS. BROADWORTH: So if you're saying the population growth is really an older population and whether that population will be employable, is that the question?

CHAIR FOSTER: Yeah. Whether or not the changing demographics into the plus-sixty-five category in Chittenden County is being considered in your capability of fully staffing the OSC?

MS. BROADWORTH: Yeah, we live that reality now and we're always looking at how we can do our workforce development. Again, our

biggest opportunity is our current workforce. That's why we're investing in those programs to develop our current staff. Again, they're already here, they have housing. We have a large -- you know, one of the beauties of a large employee base is we can plane that career growth, and you know, really teach our own. But it will be an ongoing challenge to relocate folks, and they will have housing challenges. And so that's why we're also investing in the housing we have here close to the campus.

CHAIR FOSTER: Are you -- I get the traveler piece, but as of day one of opening, are you projecting being fully staffed or partially staffed? And when do you anticipate being fully staffed?

DR. LEFFLER: So day one --

MS. BROADWORTH: Go ahead. I'm sorry.

DR. LEFFLER: Sorry. On day one, we'll open all eight ORs. We'll use the exact number of travelers that we need to open all eight ORs. The model, which was conservative, said it'd be twenty-five percent travelers. I firmly believe it'll be less than twenty-five

percent, but that's how we modeled it out.

CHAIR FOSTER: Got it. Okay. So your projection is day one, you'll be fully staffed, fully operational, and it could be up to twenty-five percent of the staff would be based on travelers at that time, but that's conservative?

DR. LEFFLER: That's how we built the model. Yes, yes.

CHAIR FOSTER: Ms. Coleman, I see your hand is raised. Marissa Coleman?

MS. COLEMAN: Yes. Hi. I wanted to just jump in and add that I know that we were talking about workforce utilization with older adults, but we are also activating a more diverse workforce that has historically been underrepresented at UVMMC. So I just wanted to point that out for that to not be underestimated in our projections.

CHAIR FOSTER: Great. Thank you. On that and a related topic, there was a note about expanding the training program with the college, with the University of Vermont. I was wondering if you could flesh out for me what that expansion looks like and how many additional

staff you think that these two projects will yield?

MS. BROADWORTH: Yeah, I would say we always are partnering with the University of Vermont College of Life Sciences and Nursing. They are our, you know, partner in all of this. They're right across the campus from us. So we continue to do that. Many of the programs that I mentioned earlier today are partnering with several campuses, including Norwich and others. And most of those campuses are constrained by volume related to their nursing faculty.

So I would say with UVM, our biggest partnership project is exchanging talent both ways and helping the faculty have more support from our seasoned nurses on the faculty side, and also that those nursing students have access to clinical experience. So I don't have University of Vermont numbers in front of me. But we hire as many new grads as possible. And I know this season overall for RNs, we're on track to hire at least 120 new grads starting between now and the middle of the summer.

CHAIR FOSTER: Okay. That's helpful to know. Discuss a little bit

affordability, the affordability criteria relating to the CON process. How do you at UVM measure how expensive your services are on a commercial basis? What do you look at?

DR. LEFFLER: Do you want to start, Rick?

MR. VINCENT: Okay, so we're close to having access to similar data sets that the payers have access to. Which is a vendor that takes all the publicly available price transparency data and essentially makes it a much more usable fashion. We just barely signed a contract, say, in the last month or two with them where we'll have a better sense of kind of where we stand from a commercial basis more specifically.

Beyond that, what we have today is just, you know, national reports that we have to kind of comb through and try to get down to the true apples to apples comparison because of the age differences across states and other factors that don't always make those comparisons equal. But hopefully in a not too distant future will have much better data to rely on.

CHAIR FOSTER: Who's the vendor?

I'm just curious if anyone here if I or anyone is familiar with it?

MR. VINCENT: I need to -- give me a couple minutes. I'll look it up and I'll send it to you.

CHAIR FOSTER: And then in terms of the national reports, what data are you looking at from the national reports?

MR. VINCENT: So we're obviously looking at the same reports that the Green Mountain Care Board is using as part in their budget deliberations. So we comb through the RAND reports and try to figure out exactly what they tell us. Again, trying to create a more apples to apples comparison across different parts of the country.

CHAIR FOSTER: I am familiar with the RAND data. Have you been looking at the RAND 5.0 data? And have you made any adjustments to the RAND data to assess the commercial costs at UVM?

MR. VINCENT: I have not looked at the RAND 5.0 data yet.

CHAIR FOSTER: So if my memory is right, I think UVM was the top decile, most

expensive hospital category in the country. According to RAND, I think it was around 420ish percent of Medicare. I know that you might have manipulations or adjustments you want to make. But from that, at least the RAND data that's published, it appears very, very expensive. And so I was trying to understand, you were talking about how if you go from inpatient to outpatient, it's quite a bit more affordable. And I was trying to understand how that would -- how we could compare UVM outpatient, by some markers that appears quite expensive, versus other options that could be available if there are any?

MR. VINCENT: As I said, we haven't reviewed that data yet but obviously it's something that the Green Mountain Care Board is going to be using, so we'll dig into it. I think one of the variables that was highlighted last summer in that data that wasn't highlighted by -- wasn't highlighted by the UVM Health Network. It was highlighted actually by consultants that gave a presentation last summer that's a key piece that needs to be factored in is the average age of Vermont commercially insured patients. I think that that's definitely something we'll take

a look at the 5.0 data to see if that's a key variable that needs to be factored in.

CHAIR FOSTER: In terms of comparison to other outpatient options in Vermont, whether it be Green Mountain Surgery Center, Northwestern, Copley, do you have any sort of sense of how expensive your proposed outpatient surgery center would be?

MR. VINCENT: No, we we're not able to share that data amongst ourselves. Again, even when we have access to the data, it's going to be very much, you know deidentified data to give us a general sense of where we're at. But that's not something that we can do.

CHAIR FOSTER: So one of the things we're really concerned about in the state is the affordability of health care. I'm sure you've all seen the commercial rate increases we've had the last several years, and again this year the request is very, very, very significant. And if we were to approve this CON, I'd be curious what strategies you think we could use to make sure that the approval doesn't result in a very high cost place for these surgeries.

MR. VINCENT: So I think I can

start the answer, Chair Foster. So I think one of the things that we finalized was that the outpatient surgery center is going to shift patients from the inpatient setting to the outpatient setting. So that's one thing we certainly would be able to monitor over time to see how that transition happens. You'll be able to certainly kind of take a look at our commercial rates during the budget review process. We typically don't get down into the service by service level detail. But you'll see our overall budget and be able to determine whether or not our rate requests are -- hopefully be able to determine whether our requests are good.

CHAIR FOSTER: What would you think if the Board were to consider benchmarking your prices at the services you're proposing to a lower threshold? Basically, reference based pricing, the services that you're providing to a more appropriate level, if they were deemed high?

DR. LEFFLER: Would they be for a similar matched population of age, risk adjusted, same comorbidities? So would the population that we serve, match the population you're referencing

us against?

CHAIR FOSTER: Well, I'm trying to come up with ideas with you to see how we could best make sure that the price impact doesn't have a negative impact on, you know, that other side of our job, affordability. So you know, so the colonoscopy cost X at Green Mountain Surgery Center, should it cost the same at UVM; or it cost X at Northwestern, should it cost the same at UVM?

DR. LEFFLER: So the colonoscopy that happens at the Green Mountain Surgery Center is selected differently. So that's a different population of patients that are able to get it there, than the ones that we -- we do some like that. But we also do people that are much sicker, who can't get it there, who need an expert anesthesiologist, who need a general surgeon, who need other things. So you have to look and make sure the population that you're serving is the same. The Green Mountain Surgery Center serves a very important purpose, and there's many people who can get it there. But they'd be the first to tell you there's people that can't.

Also, we provide the ER coverage for them at nighttime. We've offered after-hour services if they have a complication in one of their patients. The same for a lot of the other sites. If there's a complication at Copley at nighttime, it's very possible that patient will end up at our hospital. So I understand the question. It's a good one. But you have to make sure that there's other costs that are built into the care that we're delivering because we're delivering to a different population.

CHAIR FOSTER: So how would we best calculate those additional costs?

DR. EAPPEN: I think, Chair Foster, I think this is a much more complicated question that we'd love to work with you on, on how to fairly benchmark all the care that we deliver. So again, I don't -- I think it's not a fair comparison to look at this in isolation, just like Dr. Leffler just described on the colonoscopy piece or cataract surgery piece, when you cherry pick the patient population and the procedures that you do and don't have to provide emergency coverage, evenings and weekends, may even select for non-Medicaid, non-Medicare --

non-Medicaid patient populations, which are easier to care for and cost less. And then say, look, we do colonoscopies much less expensively than you do. I don't think that's a fair comparison.

I think what you really, just on a global scale, have to look at all the care that we provide and that we are asked to provide. Look at that comparison. We could probably -- and this is a larger question that our federal legislators are also looking at that we're trying to work at, which is if -- and this is a broader issue, and you can stop me if I'm going too far on this.

So in a broader issue, when a private equity based company comes in and finds a market that they want to provide care into, the larger question is how do we appropriately look at are they caring for all the patients in that patient population? What's the cost of providing emergency services? What's the cost of providing weekend services when they can't provide it? It's a question that's being asked right now. And the question is really then how do we tax that for-profit entity that's taking the niche of

the market away appropriately, to capture those costs. It's a really difficult question to be able to answer, but not impossible. And we could probably work on something to get us there to do that.

But here, I think the real question that we've been challenged with is we know that we have an access issue. You've told us that and you've asked us, how are we going to take on this access issue? And what we've tried to do here is say, look, here's a first step for us to take on this access issue that we know is real, and our patients are feeling, and they're telling us about. And we want to provide that service.

We have many more of these that we want to take on, and you'll be seeing us bring these forward in a way that I hope is meaningful in the coming months to years. I think that's the focus here. The estimates that we've received, the estimates that your consultants have gotten us to, we seem to pretty much agree that we have the need. I think Thom asked some really good questions about what happens if, you know, the volume doesn't get there? Yeah, we're

worried about that, too. We always worry about that. I think that makes sense in the context of what we're doing. I had a pretty simple answer. We wouldn't open up the operating rooms that were unopened. We'd be able to not use travelers to a great extent. I think our cost would go down if that really happened. We would manage to that because that's what we're called to do.

I'm much more worried about what Eve said, and I'm much more worried about what teachers are showing us that if they try to increase the population in Vermont by 100,000 or 150,000 in the next five to ten years, how are we going to manage the care?

Positive, great workforce coming in. I think that's fantastic. Negative, I'm worried about are we going to be able to escalate the ability to care? That's a much bigger concern for me because I'm betting on Vermont that it's going to grow. People want to come and live here. I think we're moving in that direction. I'm much less worried about how we're going to deal with the negative side.

But here's the reality today. I want to bring us back. We've got a need for this

today. Everything that tells us is that need is going to grow in the next five to ten years and continue to grow. That's what we're trying to address here. I think we've put forward a really good plan to try to address what our community and our patients need here. And I'd love to focus on that. I'd love to work on those other things. I think they're important because we care about that. We want to drive down health care costs overall. We want to be the model for doing that. So I'd love to work on that. But today, this is what we're here for.

Sorry, Steve. I didn't mean to interrupt you.

DR. LEFFLER: Yeah. No, no, I appreciate the great comments. And I'll just say one last thing, Chair Foster, I think it's important to keep in context. You can definitely figure out ways to reimburse us less for the care we deliver at the outpatient surgery center, and we will have less or no margin. But we're nonprofit, so every dollar we earn at the Green Mountain Surgery -- or the outpatient surgery, I'm sorry, is going to get reinvested into other things that we're losing money on. If we don't

make any money on this project, we'll have less money to invest in dialysis patients, mental health service patients, patients who need pediatric surgery care, and other things that we're not making money on. We lose money on many, many things. There's a relatively small number that we actually make a margin on. If this project gets squeezed down to where it's not making a margin, it's still important to do for our patients. We'll have less dollars for other important work that we're trying to do.

CHAIR FOSTER: Thank you. So I appreciate that. Two things, so affordability is very important for Vermont. And so what I'm trying to understand is, you've forecasted -- it might be confidential. So I won't say the number, but very, very, very significant profits off of this outpatient surgery center. And most of that profit I presume would be coming -- not profit in, you know, I understand the nonprofit distinction, but additional revenue above costs. Am I correct that that margin would be, if not entirely, very predominantly, coming from our commercial market?

DR. LEFFLER: Rick, I don't have

that in front of me. Do you know where the dollars are coming from? It probably is mostly coming from commercial, I would guess, but I don't have it in front of me.

MR. VINCENT: Yeah. I don't have to breakdown either, but we can certainly break that down for you. That it's really coming from all payers. So we're, you know, we're increasing access and capacity across all the payers. And so the commercial definitely is a large chunk of that. But it's not the only ones.

DR. LEFFLER: But I think it's also --

CHAIR FOSTER: Does Medicare provide you -- sorry. Does Medicare provide you a margin on these services?

MR. VINCENT: Yes. It's pretty close to break even, small, small margin on the care.

CHAIR FOSTER: Okay. So if there's an operating margin, if you're breaking even on Medicare, pretty close to break even. It's coming from commercial, right?

MR. VINCENT: But commercial is also offsetting the loss that we have on Medicaid

patients and other consumers.

CHAIR FOSTER: Understood. Okay.

DR. EAPPEN: And it's not different than our overall margin. Right? I mean, our margin is coming from our commercial payers. By and large, I think you hit the nail on the head. Not on just this three percent that we're talking about, of what's coming into the University of Vermont Medical Center. But on everything that we do, we try to make money on everything that we do. So we can -- whatever Medicare opportunities we have to be able to make money on, we will. But you're right, Medicaid we lose money on. And that gets made up with commercial payers.

CHAIR FOSTER: Is there any information in this submission as to how much money you anticipate losing on Medicaid patients in connection with the OSC services?

MS. HOAR: Chair Foster, this is Eve. I don't have that, but from a health equity lens, it's kind of not the way we think about approaching it. We think about all of our patients who have needs together, and then we think about all of our reimbursement from the

various sources that we have. I suppose it could be done, but we just -- it's not the way we approach this at all.

CHAIR FOSTER: I'm trying to understand how much commercial is needed to make up for the loss.

DR. EAPPEN: Are you suggesting that we should provide care differentially there? Only do enough Medicaid patients that the commercial wouldn't have to make up for a big loss. And so we would limit the number of Medicaid patients in this surgery center? Is that -- I'm not sure if --

CHAIR FOSTER: Not at all. I'm just trying to understand.

DR. EAPPEN: Okay.

CHAIR FOSTER: My question was, how much of a loss do you have on the Medicaid patients that needs to be made up for it in commercial?

DR. EAPPEN: It seems like something we should be able to do and get back to you. But I don't want to promise something that we can't do. And I want to make sure that it's relevant for the decision making too. But Rick

or Marc is that, or Eve, is that something we probably --

MS. HOAR: I think we can commit to trying and -- yeah, I think we can try.

MR. STANISLAS: It's not readily available data. I think to Eve's point, that it's not readily available data. And you know, we can commit to try.

DR. EAPPEN: I think the challenge goes back, Chair Foster, in the way that commercial payers contract, that it's not a straightforward equation because of what we were discussing with Board Member Holmes before, because they look at the total cost of what they're going to put out for the year, and they can go up and down in particular areas, and they do.

And that could be based on a huge variety of things. There could be a national standard to pay X for something, but they know that their overall is going to be Y, and so they're going to reduce something else or increase something else. It isn't rational or consistent with what you might think would be. We should be paying much more for mental health

because of all the time that goes in. And substance use disorder, from commercial payers. And that would if they were to do that, they would lower something else, typically, in order to be able -- so it's really hard when you just isolate -- again, and I think this is a challenge and I know I'm getting out over my skis on this, but -- and Rick and Marc and others can speak more to this, but that's why it's hard to isolate -- when Marc says we can try, but it's because of that. Right?

We could say that, for example, Blue Cross could say we're going to pay the same as Medicare rates in the ambulatory surgery center. And we would say, okay, but would you be willing to pay more for cancer care? And they might say yes on that. So their overall cost is going to be whatever they figured it was going to be by the number of patients that they had. But you could artificially lower your outpatient surgery center cost there, and it would look as though it's equilibrating, you know, does that -- right? So it's not a -- that's why it's hard to do it.

CHAIR FOSTER: Yeah, I get that

dynamic. So the reason I'm asking these questions is there's a huge amount of margin and financial benefit to the network, which is a good thing for the network. But that will be coming out of commercial at a time when our commercial payers are really, really, really struggling with the cost of health care and commercial insurance.

So part of this decision is whether or not it has an undue increase in the cost of medical care or an impact on affordability. And so these questions are lined to try and understand how much money you actually need to operate this and provide this access. So understanding the loss on Medicaid would be helpful to understanding that, because essentially the decision we're making, if we approve it at your current rates, is we are going to shift tens and tens and tens of millions of dollars from Vermont commercial payers to UVM Health Network.

And I understand the point that Dr. Leffler very eloquently made, which is, hey, we're going to use all that money as a nonprofit to do other good things for the community, right? And that's laudatory. But at the same time, we

need to consider that in context of the affordability crisis we have in Vermont. So that's why I'm trying to probe and understand that amount of data.

DR. EAPPEN: So I have a question. So can I ask a question, Chair Foster? You're assuming that those commercial insured patients don't need the care, and that if we don't build this, they won't get it, which I think is untrue.

CHAIR FOSTER: No. Incorrect.

DR. EAPPEN: I think they might go somewhere else.

CHAIR FOSTER: Let me pause you. Incorrect. I'm assuming they don't need to pay that much for this care.

DR. EAPPEN: So where would they go to get the care and pay less? And who are the people? You're saying the commercial payers would go elsewhere and they'd be able to pay less?

CHAIR FOSTER: I'm hoping they could go to you and pay less.

DR. EAPPEN: But we would have to build something to be able to do that.

CHAIR FOSTER: Understood.

Correct.

DR. EAPPEN: So okay. So you're just you're just arguing about the cost of -- the overall cost here. And I guess the easiest way to keep our costs down would be to prevent the access. That would certainly keep the cost down. But if we're going to provide the access, we're saying that the access is going to be less expensive to do it here than it would be to do it in the existing facilities.

I'll use the analogy of the Fanny Allen. It's going to cost us, I forget what -- don't hold me to the cost of it, because I don't remember. But let's say it's $20 million it's going to cost us to purchase it. But over the long run, it saves us money compared to what we expect the rent to be. So yes, it's going to cost us twenty million up front, but we're actually going to make out on that exchange. Right? We're going to be able to actually save money by putting out the $20 million.

This is a more sophisticated, complicated way of providing the access away from our hospital, that at the end of the day, allows us to take care of our patients at a lower cost

than if we could, like somehow, you know, operate twenty-four hours a day in the operating room at the main campus and do this. Right? And that's the way we're thinking about it. We have a clinical need. There's an access issue. We've got to deliver it. And it's the least expensive way that we can think of to do it.

And then we, at the end of the day, have been able to show that at the -- if our assumptions are accurate and if we get to that, that we can actually make a margin that then we can reinvest to put in towards taking care of the patient population in other areas where we know we're not going to be able, because of the vagaries of our payment system, that we're able to do that -- largely, again, for Medicaid and Medicare patient patients there.

CHAIR FOSTER: I get all that.

DR. EAPPEN: Okay.

CHAIR FOSTER: The decision that is -- the point I'm making is you could do this at, like, let's say a fiftieth percentile outpatient surgery center. I'm making up numbers here because we don't have them available. You have tens of millions of dollars of excess margin

that's coming from commercial with this projection that you have here, right? If you did that at a the fiftieth percentile rather than the ninetieth or the hundredth percentile, Vermonters would save a lot of money. You could still move it from the hospital to the outpatient surgery center. The difference is you wouldn't have the forty, hundred, whatever the number is, millions of dollars that you could reinvest elsewhere.

DR. EAPPEN: I think that's probably fair to say, with the vagaries of our commercial payers, of how we would negotiate for that, there's probably something you can say about that. But that would mean that when we look at trying to hire people to do primary care and mental health, that they just won't be able to move forward, right?

Because at the end of the day, we know, as Rick alluded to, we have to make a margin because we have to go back and make sure our elevators are working, the pipes that are bursting are getting taken care of. We have to reinvest. It's going to cost us money to do that. And so we've got to make a margin one way or the other. The way that we will get forced to

do it is to eliminate services or prevent the -- or not prevent, but we'll be unable to get the access that we need to provide the care. So I don't -- if you have a better solution, we're so transparent about the way that we put the dollars in there that we're open to have those conversations, totally, of how we can better do this.

We think that this, though, answers the question in front of us today, which is we know we have an access issue. We can deliver the access, and we're doing it at a place that's going to cost us less and make us more efficient. It's still expensive because medical care is expensive. And you're right, commercial payers pay more than Medicaid and Medicare, and they do in every one, every line of our business. And they'll do that here too.

CHAIR FOSTER: Right. I mean, what I'm really getting at is that at least according to RAND, and I know you may have some quibbles with the data, but at least according to RAND data, you're the top decile, most expensive outpatient services in the country, right? Now, that might be different once you age, adjust, and

do the changes. But they're very, very expensive.

DR. EAPPEN: Can I just interrupt -- can I interrupt you? I just pulled it up just while we were talking. If you look at the total, if you look at inpatient costs across where we are, we're right at national benchmark. Right? So I'm just -- my point is that you -- and maybe because our outpatient services are offered at an inpatient site today if we're looking at the same thing. I have it at 238 percent versus 240 percent for our inpatient price versus federal benchmark. And the state benchmark is at 227 percent. So they're very, very close. And it's a longer conversation.

But so when you pull that out though, I mean it's just a really clear example of you have to really know the patient populations that are being used, the communities that are being served, the kind of hospital that you're comparing, that it really makes a difference. And we're in a very, very unique situation where we're the only hospital in this region, in the state, north country, that provides the kind of care that we do. We could

choose not to do those things, and we could deliver care at a lower cost. But that comes at a real cost for our communities, and that's what we're trying to avoid. We're always looking. I mean, I'm telling you, we are always looking for how to do this better, more efficiently, and continue to attract providers at all levels to be able to do this. If there's a better way to do it, we want to do it.

But I don't think going down this path is going to get us there. As much as I'd love to have the conversation. I'd love to take this offline and say, let's look at this and figure out, if they're doing it better than we are. How are they doing it? I want to do it that way. Let's do it. I'm not opposed to it at all. I know Steve isn't either. But I don't know if that's the right conversation to be having today. I'm happy to have it. It's your time. But --

CHAIR FOSTER: Yeah, I'm really just getting at the affordability criteria. So if there's any information you want to share with the Board as to what the right amount of additional margin on this project should be

consistent with our goal of improving affordability for Vermonters, I would appreciate it. That's making up Medicaid, if that's some reasonable amount of margin, how much additional money. If you're going to use this additional money to care for the patients, how are you planning to use it? What is it going to subsidize?

Because the argument of we get more money and we're going to use it for all these great things, I appreciate and is fair, but it's uncapped. And you can always say that. There's no limit to it. Right? If we're butting up against as a Board, twenty percent rate requests every single year these days, we need to be thinking about where that additional money is going and what you're using it for before we can say yes to it. Does that -- is that fair?

DR. LEFFLER: So Chair Foster, I believe that's what we do in the budget every year. So I feel like it's kind of drifting into our budget for '25 now. So I agree with everything that you said. Every year we submit a budget. We work with the Green Mountain Care Board on what the budget will be, what the rates

will be for commercial. And then you have very clear information on how we spend literally every single dollar. So I agree in principle with what you're saying. And what I would say is for the outpatient surgery center, it's one piece of our overall work that we do to serve Vermonters. I think you heard its three percent total of our revenue. So a relatively small piece. But you're going to see our budget soon and you'll be able to regulate like you do every single year, on how every single dollar of expense that we spend is.

CHAIR FOSTER: Right. So you're right, this could be drifting a little bit. But just to focus on this, if we're approving this, I want to know what the rates are going to be, the costs are going to be. And I want to know why it needs to be that expensive. Okay? Because I don't at this time want to really increase the cost to commercial. We don't have it. They can't afford it. So our approving it gives UVM more money, which might be used for amazing things, but it's a decision that we need to make. So I just want to be cognizant of that.

DR. EAPPEN: But Chair Foster,

we're just using the current rates. We're not we're not making them up. Right? We're using with the Medicaid, Medicare, and commercial rates are for what we're doing. And then we're estimating that they're going to go up by -- I can't remember now 4.55, or 5.45, whatever it was, there's nothing -- so those are already existing today that that's what we're using. We're not adding anything. We're not -- right? We're just using what's out there today.

CHAIR FOSTER: Yeah, I understand. And what I'm getting at is I think that would have a negative impact on affordability using your current rates, because they are very high.

DR. EAPPEN: Okay.

CHAIR FOSTER: So I need to understand what the right, appropriate level would be given the crisis in affordability we have in the state.

DR. EAPPEN: Fair. I guess I can't answer that today.

CHAIR FOSTER: Thank you. It was a good discussion, so I appreciate it. I'll go quickly just so we can move on here.

I want to talk a little bit about

the collaborative approach that UVM has taken to sending this potential demand to other providers in Vermont. So let me give you a reference. So page 39 says, it says, "other network affiliate hospitals cannot be expected to absorb growing demand". And I was curious if there's any steps taken to date to send this demand elsewhere.

DR. LEFFLER: So I'm going to start at a very high level, but I'm going to rely on Chris Dillon. I'm going to rely on Chris Dillon to help more.

So as you've heard over and over again today, the medical center's ORs are completely full. And so Chris Dillon is one of our network leaders of the medical group, has worked hard to move cases when there's capacity and other ORs that makes sense for the provider and the patients. It's tricky finding the right case that can be moved, provider to go with, and the patients are able to is actually really complicated work. (Audio interference) center this year's moving at least a hundred cases (audio interference) Vermont. We've moved, I believe, other cases to Porter when it makes sense. I will tell you, some patients choose not

to do that, others do. So we have done work internally.

A couple key things, Chair Foster, you can't really do it very easily until you have a common medical record. You have to have a record where the provider can sign on from anywhere, and access the patient's chart, do orders from anywhere. And it gets really tricky around call, what if the patient has a complication? As I said, is your case and add-on, if it's Dr. Harrington or Dr. Plante, what is their early part of their day? What time are they going to show up down there? Are they coming back here to do other care?

It's really complicated to move surgeons around to different locations. And I would say almost impossible to other sites unless you share a lot of commonality in terms of what's in the operating rooms, what's the equipment they would use, what's the important teams that care for the patients? So you heard Dr. Nichols say that, you know, the ortho team is very important. He has his team, even the team here, it's not the same all the time. He at least has some -- understands that group. He's an amazing surgeon.

It would be hard for him to go to Copley tomorrow and do a total joint with their equipment. I think they have a different robot than we do, et cetera.

So Chris, do you want to give some further background on the important work you've done to move cases throughout the network?

MR. DILLON: Sure.

CHAIR FOSTER: Let me interrupt, because I think -- sorry, sorry, I'm actually going to move on. Just in the interest of time. I think I got that point well enough. I apologize for cutting you off. I just don't want to belabor it too much.

I just went off video because I think my internet's breaking up a little bit.

So just my last couple of questions about Fanny Allen. The services that you propose, I believe are on page 16 of the submission, your application. And part of the rationale is that a lot -- for the new surgery center is that a lot of these services require larger rooms for operating purposes. And I was wondering which of these services that you plan on providing require these larger rooms?

DR. LEFFLER: So Patrick, do you want to jump in?

DR. BENDER: Certainly, certainly orthopedics is a big one because of the fluoroscopy machines that are needed during -- intraoperatively as well as -- Marco (ph.), what else? What else needs to be even bigger? I mean, it's largely going to be ortho, but it's yeah, gynecology as well with the laparoscopic surgeries that we'll be doing at the outpatient surgery center, because that requires gas lines and monitors that can't be really mounted in Fanny Allen. So -- go, please.

DR. PLANTE: Yeah. No, you're spot on. I mean, in essence, what we're talking about outside of orthopedics is when we work in the words minimally invasive surgery, then you're bringing on all kinds of equipment, whether it be booms, towers, screens. As Patrick alluded to, gases, you know, a robot, and actually robots are used in orthopedics as well. And that requires a larger size room. So and you know, vascular procedures that, again, we say endovascular, that means minimally invasive. They're done through the groin.

You know, the breadth of what is done medically today is not always heralded as it should be. Sadly, it's very expensive, and I'm not here to try and argue that it couldn't be cheaper, but it's expensive. And you know, I don't need to tell anybody that vendors aren't looking to save us money, generally. And that's the landscape we have to compete in. And this is the expectation of our population as well. They don't want their aortic valve replaced through a big bone cutting chest incision anymore. They want it through their groin. And I would want mine that way too. But unfortunately, that requires cost, it requires equipment, and not infrequently in much larger room. So I hope that sort of gives scope without drowning you in detail.

DR. BENDER: And the only other thing I would add is the anesthesia footprint. For all of those bigger cases that can be done at the outpatient surgery center is necessary too because it requires more anesthesia equipment as well.

DR. PLANTE: Let the record show that the surgeon forgot about anesthesia, again.

DR. BEDNER: Shocking.

CHAIR FOSTER: Hopefully never in practice, doctor.

DR. BENDER: Never.

CHAIR FOSTER: All right. So I think my last question is, did you consider renovating any of the Fanny rooms to provide the services that do not require these larger spaces and building a smaller outpatient surgery center to save on cost?

DR. LEFFLER: We did. It's very complicated to run three different OR sites. So then you'd be running the main campus, Fanny Allen campus, and some smaller version of the outpatient surgery center. You'd be running three CSRs, three facilities teams, EVS teams, all those things. Once again, you might have a case for Dr. Harrington where she does the first two cases of the morning at the Fanny, because that's the right room. Then have to go to the outpatient surgery center and the main campus. It just it's extremely complex to try and run three sites in in today's world.

DR. BENDER: And asides probably from surgery, the smaller the sites are, the less

efficient staffing is. Right? We can cover more as a bigger group having larger sites -- fewer of the larger.

CHAIR FOSTER: I don't know the answers at all, but is it theoretically possible to add an addition onto the Fanny?

DR. LEFFLER: So I asked that myself. My understanding is that the ORs are so old, and actually the building is so old, that the equipment that we would need for air turnover, for the gases, or so on, makes it nearly impossible to make them modern ORs.

I'm speaking for her, though. Beth, do you want to add some detail to that?

MS. SENIW: No, I think you nailed it with that. These ORs that are at Fanny are over fifty years old. And to stay up to date with FGI guidelines, with air changes in all of the rooms, we'd have to substantially upgrade all of the mechanical equipment and infrastructure for those spaces.

CHAIR FOSTER: Yeah, I was getting sort of just gutting it. Gutting it, building bigger rooms if you need more space. Is that more expensive or less expensive?

DR. LEFFLER: Someone told me more, but I haven't seen the actual pro forma.

DR. PLANTE: I can chime in and say that our team, even before we reopened the Fanny, walked through the Fanny. The existing physical footprint of the Fanny would not accept that. We would have to build additional square footage that I don't -- you know, again, renovation versus new build is a, you know, is a rabbit hole. But unfortunately, renovation is a huge cost.

DR. LEFFLER: And in addition, there would be -- sorry. Go ahead.

MR. WALTERS: I was going to say you'd also need a steel structure. The column grid in that building can't accommodate rooms of the size we need the rooms to be without having a column going right through -- pick one side of the OR. So in order to -- I mean, it's just not physically possible to construct the room size we'd be looking for in a dimension that made sense.

DR. LEFFLER: I think you'd also have to have -- yeah, go ahead.

CHAIR FOSTER: I have no other

questions at this time. Thank you. Thank you all for responding and being here and for your submissions and materials.

MR. BARBER: Okay. It looks like we're going to be here till after 5. I have a hard stop at 5:30, that I can't go past. So I'm going go back to Dave Murman for any follow-up questions. Plan on a hopefully brief executive session. And then I think what I would like to propose to the interested parties is, if you have any comments that you were going to share, if you could put those in the writing and submit them by the end of the week. And then it sounds like there need to be some follow-up questions that go to UVMMC. And I would propose that UVMMC could respond to any of the interested party comments when they submit their responses.

So Karen, you can think about that while we move through the rest of this.

So Dr. Murman, do you have any additional questions you'd like to ask?

DR. MURMAN: I just have a few rapid fire questions. There was a mention, and I think it's somewhere in the narrative, that if the OSC was not open, 4,000 patients per year,

would not get the care they need by 2030. Is this including with the Fanny closing or staying open?

DR. PLANTE: Staying open.

DR. MURMAN: Staying open. Okay. That's fine. That was my recollection too. Capacity, we talked about 80.1 and 80.9 percent capacity, but the denominator being for a 9.5 hour day. But in the application it's a ten-hour day. So when you're saying that 80.1, 80.9, is that 250 days at nine and half hours for all twenty-five ORs?

DR. PLANTE: I can tell you, in fact, it's more. It's to block, utilization is to block. And some block times actually go past 5 o'clock. There are some rooms that actually intentionally are run later to improve access. So think of it as a 7:30 start, going to either 5 or 7, times all the rooms.

DR. MURMAN: Okay. But in the denominator of the calculation, denominator was indicated that it was 7:30 to 5?

DR. PLANTE: For some block time it's actually additional.

DR. MURMAN: Okay.

DR. PLANTE: Starts at 7:30 and often we -- a couple of them are blocked to run later. So your denominator is 7:30 to whatever the block time of each of those rooms. So every day we look at the schedule and see what the block time was for that particular service or surgeon. And that's what goes into the denominator. It can be a little bit different day-to-day based on if there's two -- you know, two surgeons that have till 7 p.m. block time. So it can be a little bit day-to-day variability. But everything is open until -- all rooms are blocked at least until 5, and start at 7:30. And so a couple of them are blocked a little bit later.

DR. MURMAN: Okay, okay. Is there a way that in follow-up information we could get the current or most recent separation between UVM and Fanny in the OR utilization rates and what makes up the denominator?

MR. DILLON: Yes. Yes, we can provide that in follow-up.

DR. MURMAN: One other quick question. Hopefully a quick question. In the narrative, there was discussion that part of the

advantage of the OSC is that you can shift patients to the OSC and thus renovate your inpatient ORs. Do you have any expected number of ORs that you intend to renovate and the cost of those renovations?

DR. LEFFLER: Not yet. Not yet. I can tell you that we desperately need another CT surgery room. And the State of Vermont, the second hybrid OR. I'll just say the State of Vermont, needs a second hybrid OR. We have the only one right now. It's actually getting repaired, refurbished right now. So once we have the OSC online, everything is going smooth, then we would start that work.

But those high acuity areas that we talked about in the application, CT surgery, neurosurgery, endovascular, Vermont needs more capacity in all three of those. And that's what we would be able to grow on the main campus. But as Dr. Plante told you, a hybrid room actually is two rooms. So we'd have to make some adjustments to do that. It's just so much equipment.

DR. MURMAN: And any migration of cases from the main campus to the Fanny Allen that can go to the derm-optho building?

DR. LEFFLER: Which building?

DR. MURMAN: The dermatology ophthalmology building that was approved? There's procedure rooms in there, I believe, right?

DR. LEFFLER: Yes. Yes. So I believe all those procedures are happening now in the derm offices. Right, Beth? Isn't that -- yes. So it's just moving --

MS. SENIW: Yes.

DR. LEFFLER: Yes.

MS. SENIW: (Audio interference) clinic and dermatology have procedure rooms within their clinics now. And those will be transferred to the 350 Tilley site.

DR. MURMAN: And then with wait times, do you track reasons for waiting?

DR. BENDER: We've gone down that road a little bit, and one of the first things that we did is we actually had a narrative of even more patients in the greater than ninety day queue. But it was patient choice, that they decided to postpone their surgery until they went to Florida for the winter or whatever reason. And so we now have a better, more detailed system

of that they have been seen, that the patient agrees that they're ready for surgery, that they're medically cleared for surgery, and that the case is requested in our depot (ph.). So that's been cleaned up.

Asides (sic) from patient choice coming out of there, that's probably the biggest cleanup that we've done. We also track, you know, if somebody gets sick and the day of surgery cancellations and things like that. But -- and then the only other issue really is prior authorizations that we have to go, you know, a step that we have to go through as well when somebody can be -- when a surgery is requested, but it still has to go through the prior authorization process. And sometimes that takes time and can be a barrier. But the biggest one that really pared it down was the patient has to agree to be ready for surgery as well.

DR. MURMAN: Great. Those are my little hit list of questions. I appreciate you entertaining them. Thanks.

MR. BARBER: Thank you. So it sounds like there were some questions about the confidential materials in the application or in

the record? Excuse me. And because we hold these hearings kind of as part of the meeting, typically -- or goes into executive session to ask questions about confidential portions of the record. So let me just pull up the statute. So 1 V.S.A. Section 313(a)(6) allows the Board to go into executive session to consider records that are exempt from the Public Records Act provided that discussion of the exempt record does not itself permit an extension of the executive session to the general subject to which the record pertains. So I think that would be the basis for a motion to go into executive session. And we have another line set up that I think the UVM folks, and the Health Care Advocate, and all the Board staff, and the court reporter have an invite to.

So any Board member would like to make that motion? Oh, I see Karen has her hand raised. Yes?

MS. TYLER: I just had a question about what part of the confidential information would be covered, which may influence who joins the executive session for the hospital. So the confidential information concerns rates of

reimbursement, the reimbursement adjustment that was made for shifting cases to the OSC, salary information, traveler rates of payment, and the Sg2 proprietary model.

MR. BARBER: So start with Board Member Lunge. So you're the only one who I heard who had a question. Oh, I think Chair Foster had questions too. So Robin?

MS. LUNGE: Yeah.

MR. BARBER: General subject?

MS. LUNGE: Sure, the general subject was rates of reimbursement and the reimbursement adjustment, for my question.

MR. BARBER: Thank you.

Owen, did you have questions about the confidential material?

CHAIR FOSTER: I may have some on that topic as well, but that's it.

MR. BARBER: And does anybody else have any questions about other confidential topics?

Does that give you what you need, Karen, to figure out who needs to attend?

MS. TYLER: It does. Thank you.

MS. LUNGE: And I'm ready to make

a motion when you're ready, Mike.

MR. BARBER: I'm ready.

MS. LUNGE: Okay. I move the Board go into executive session to take testimony on documents that have been determined to be confidential under 1 V.S.A. Section 313(a)(6), specifically around rates of reimbursement and reimbursement adjustments in the filing.

MR. BARBER: Any discussion or questions? Sorry, I thought I heard somebody.

UNIDENTIFIED SPEAKER: I seconded.

MR. BARBER: Oh, thank you. I forget about that. Okay. So there needs to be a two-thirds vote in favor. So all those in favor, please say, aye.

IN UNISON: Aye.

MR. BARBER: Any opposed?

Okay. So in terms of who goes over, like I said, Board members, Board staff, Health Care Advocate can be there. They have signed a confidentiality agreement.

And Karen, do you want to just identify who would be going over from the medical center?

MS. TYLER: I think we'll need Dr.

Leffler, Dr. Eappen, Eve Hoar, Marc Stanislas, and Rick Vincent and other folks who are here for the hospital are welcome to join, from my point of view, but wouldn't have to.

MR. BARBER: Okay. And sorry. So why don't we all switch over? When we come back out of the executive session into this session, like I said, my plan would be to take public comments and get any comments from the interested parties in writing because of the time.

So I think with that, so we're going to leave this session, hop over to the executive session and put up a notice about what time we're going to expect to come back to this public session. Thank you.

(Executive session at 4:38 p.m., until 5:12 p.m.)

MR. BARBER: And Karen, I see your hand is raised?

MS. TYLER: I just have a couple administrative questions. Let me know the right time to cover those. We're almost at our 5:30 adjournment point.

MR. BARBER: Yeah. Go ahead.

MS. TYLER: Yeah. So there have

been a few requests for follow-up information after the hearing, and I'm asking, assuming, I guess, that there would be a written set of requests for that information from the Board. Is that what you have in mind as well?

MR. BARBER: I would, yes, I would prefer to get these questions to you in writing so that --

MS. TYLER: Yeah.

MR. BARBER: -- there's no misunderstanding. And --

MS. TYLER: Yeah, I agree. And the time that we'll need to respond to them will naturally depend on what they are. So we'll have to wait until we see them talk about the timing.

The second thing I wanted to cover, you'd said earlier that you would ask the interested parties to submit any statements they had planned on making at the hearing in writing, which is fine. I just wanted to state, as we discussed at the pre-hearing conference, that the interested parties did have the opportunity to submit written statements on April 25th and none of them elected to do so. So I wouldn't expect to see any new facts, any new sort of evidence in

the written statements that the parties would submit after the hearing. I would expect to see just a statement of their opinion of the project with reference to information that is already part of the record.

MR. BARBER: I would agree.

MS. TYLER: That's all I have. Thank you.

MR. BARBER: Thank you.

Any concerns with that approach? I don't -- I have a hard time seeing if the interested parties are still with us. Any concerns with that from the interested parties, submitting any comments you have in writing at the end of this week?

MR. PEISH: No problem. From us at the Health Care Advocate. Thanks.

MR. BARBER: Thanks, Sam.

Anyone from Northwestern still on?

Is anybody from Copley still on?

Okay. I'll follow up with an email, then, to the parties.

With that being the plan -- and then I think the next thing we need to get to is public comment. There were only three people who

put their name down for public comment. And I'm not sure if any of them are still with us after this long day. So let me just see, is Ms. Gutwin (ph.) here?

Ms. Elaine Brunette (ph.), are you here?

Kate Loud (ph.), are you here? Sonds like not.

And I'm wondering, Kristen, would it be possible to follow up with these people via email so we could get their comments? Kristen, is that something we can do?

MS. LAJEUNESSE: Oh, yes. Sorry, I can do that. Yes.

MR. BARBER: Okay. Thank you.

And then, Karen, I believe you had said at the pre-hearing conference that you have some recorded comments from physicians that you would like to share. Is it possible to submit those somehow electronically to us?

MS. TYLER: We had actually decided not to, you know, play that recording during the public comment session. So yeah.

MR. BARBER: Okay.

MS. TYLER: Whether we would want

to submit it subsequently, I'll have to talk with folks about that. But if we're interested in doing that, we certainly could.

MR. BARBER: Okay. Well, it's up to you. Just let me know what you decide.

MS. TYLER: Okay.

MR. BARBER: And so with that, if there's no public comment. We will -- I'll speak with the Board. We will get a set of questions out to you as soon as we possibly can. And then we can talk about the timing of that response. And I will send an email to the parties regarding the submission of comments by the end of the week. And I think that's all we need to do.

But I see your hand is raised, Owen?

CHAIR FOSTER: I had one just clarification question, but is it better to put it -- can we put a question in the written submission, or do I have to put it on the record?

MR. BARBER: We can put it in the written questions, but if you want to give folks here a heads up --

CHAIR FOSTER: Sure. Yeah.

MR. BARBER: -- as to what it is.

Yeah.

CHAIR FOSTER: Yeah. No, big deal. It's just Exhibit 2 from the application has a staffing report, two tables on Exhibit 2, page 14 is one of them, which is without the project. And there's another one with the project. And I was trying to understand the numbers as travelers and FTEs. I was trying to line that up with the staffing expectations that were provided. What I was seeing was the physician FTEs and the traveler FTEs didn't really move with or without the project, and I was trying to understand that.

And then the only other part of the question, which we can just put in writing, because that'll be simpler, is I wanted to understand how UVM was doing to date on the budgeted staffing numbers. Thank you.

MR. BARBER: Okay. Anything we need to take care of before we adjourn?

Okay. So Maggie, can we please go off record?

And I will turn it back to you, Chair Foster.

Oh, sorry. Dr. Eappen?

DR. EAPPEN: I just wanted to say thank you. I really appreciated the conversation, appreciated the nature of the questions and the conversation, so thank you. I know you -- it sounded and felt like you put a lot of time into looking at all of the documentation and I know that's a lot of work. And so thank you. I appreciate it.

MR. BARBER: Thank you all. Thank you all for spending a very long day here with us.

And so I'll turn it back to you, Chair Foster, to adjourn the meeting.

CHAIR FOSTER: Thank you.

And I would just echo, Dr. Eappen, the thanks back to you and your team. And gratitude for the really strong submission and the work that went into it. It's an incredible volume of work. So we appreciate your collegiality and cooperation in doing all of this as well.

Any old business or new business for the Board?

Okay. And I will move to adjourn.

MS. LUNGE: Second.

MS. HOLMES: Second.

CHAIR FOSTER: All in favor say, aye.

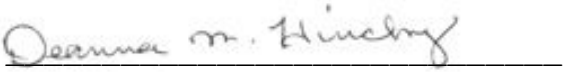
IN UNISON: Aye.

CHAIR FOSTER: All right. Everyone, have a nice afternoon and enjoy the beautiful day. Thanks.

(Whereupon, the proceeding was adjourned at 5:20 p.m.)

C E R T I F I C A T E

I, Deanna Hinchy, certify that the foregoing transcript is a true and accurate record of the proceedings.



DEANNA HINCHY

CDLT-254

eScribers, LLC

7227 North 16th Street, Suite #207

Phoenix, AZ 85020

(800) 257-0885

Date: May 30, 2024