Concord Eye Center
Our Vision is Better Vision for You

February 10, 2017

Comprehensive Ophthalmology
Cataract Surgery
Bradford S. Hall, M.D.
Maxwell A. Snead III, M.D.
Mark A. Szal, M.D.
Peter Wasserman, M.D., MBA

Glaucoma
Comprehensive Ophthalmology
Andre d'Hemecourt, M.D.

Cornea and External Disease
Cataract and Refractive Surgery
Erin S. Fogel, M.D.

Retina/Vitreous
Medicine and Surgery
Paul G. DeGregorio, M.D.
Eliot D. Foley, M.D.
Lloyd M. Wilcox, Jr., M.D.

Oculofacial Plastic Surgery
David A. Weinberg, M.D., F.A.C.S.

Pediatric Ophthalmology
Adult Strabismus
Christie L. Morse, M.D.
Maynard B. Wheeler, M.D.

Optometry/Contact Lenses
Douglas P. Benoit, O.D., F.A.A.O.
Jacqueline A. Rheault, O.D.

Dear Members of the Green Mountain Care Board (GMCB),

This letter is in support of ACTD's application for a Certificate of Need (CON) to establish and operate a 'general purpose,' community-based ambulatory surgery center (ASC) in Colchester, Vermont. I worked in the Division of Ophthalmology at Fletcher Allen Health Care (FAHC, now UVM Medical Center) for 10 years (1995-2005). During that time, I had the opportunity to see some of the challenges of a city with only one hospital. It created a monopolistic situation in which that hospital alone completely controlled and regulated access to the operating room (OR). As a faculty member of that hospital, I found that it was sometimes difficult to obtain timely access to the OR during daytime hours, and I am told that it was even harder for non-FAHC surgeons to gain such access. Due to limited OR capacity, surgical backlogs were frequent, often forcing surgeons to do time-sensitive cases in the evening or over the weekend. It was noted that the usual OR staff who worked with us during daytime hours were often unavailable during those 'after hours' cases, which were instead staffed by on-call OR staff who were often less familiar with certain surgical procedures and the equipment required for them.

In addition, 'after hours' cases required patients to be NPO, with nothing to eat or drink for an extended period of time. Because these cases were not being done in the daytime surgical block-time, they were frequently 'bumped' (delayed) by other surgery add-on cases due to a limited number of operating rooms. It also appeared that surgeons who were not employed by FAHC found access to the operating room even more onerous, which may have required them to do more 'after hours' cases. While OR access was challenging for these surgeons, ultimately it was their patients who suffered most.

Having trained and practiced in a variety of cities in Ohio, Connecticut, Michigan, Pennsylvania, California, Vermont, Maine, and New Hampshire, I have had the opportunity to observe several different healthcare delivery-system models. The worst models were found at hospitals that completely controlled regional healthcare access. Lack of competition usually promotes 'bad behavior' by such hospitals, and they often feel less compelled to provide the best possible service since they are the 'only game in town.' These hospitals will also frequently go to great lengths to block the entry of any competition into their regions, including independent ambulatory surgery centers (ASCs), to maintain their economic advantage.

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Timely and affordable care are extremely important for patients. In general, hospital fees are usually much higher than identical services provided elsewhere in the community, resulting from facility surcharges on top of physician fees and costlier operating-room procedures at hospitals. Without regional competition, hospitals tend to charge higher fees for medical and surgical services, often with limited patient access. I believe that the best care, in terms of cost and access, can be found in regions where there is more than one regional hospital and where independent ASCs are available.

Ambulatory surgery centers provide improved access and, almost always, at a much lower cost-of-care for patients. This has been recognized by a number of insurance companies who have offered patients financial incentives (in the form of lower co-pays) for having their surgeries performed at ASCs. ASCs even the playing field for non-hospital-employed surgeons, who otherwise find themselves at a disadvantage, relative to employed surgeons, in obtaining access to hospital operating rooms. Furthermore, ASCs are widely known to be run more efficiently than hospital operating rooms. In Maine, and currently in New Hampshire, I have had the opportunity to work in ASCs, and I believe they greatly enhance access to the operating room during daytime hours. I have seen facility fees for procedures performed in hospital operating rooms that are at least 2 or 3 times the cost of identical procedures performed in an ambulatory surgery center.

In summary, having one or more ASCs in a community greatly enhances patient access to surgical care and significantly reduces the cost of medical care for both the patient and the healthcare system as a whole. Ideally, there should be access to at least one multi-specialty ASC, and not just a single-specialty ASC, as all of these issues apply to the full range of surgical specialties. For the aforementioned reasons, I strongly believe that the GMCB should approve the ACTD ASC CON.

Please feel free to contact me if you have any questions.

Sincerely,

David A. Weinberg, MD, FACS

Hospital Campus 248 Pleasant Street, Suite 1600, Concord, NH 03301 • 603.224.2020 • Fax 603.228.0248 • 1.800.557.5100
South Campus 2 Pillsbury Street, Suite 100, Concord, NH 03301 • 603.228.1104 • Fax 603.228.7061 • 1.800.427.1302