Questions from Metro Board of Health about the University of Louisville and University Medical Center

Note: These questions were gathered from the community by the Jefferson County Board of Health in the fall of 2011 and were answered jointly by University Medical Center, University of Louisville, Jewish Hospital & St. Mary's HealthCare and Saint Joseph Health System in October 2011. The answers to the questions have been revisited by University Medical Center, University of Louisville and KentuckyOne Health in light of a new proposed partnership in November 2012. Because of different nature of the current agreement, some of the language in the questions is not relevant. Specifically, references to "merger" or "NewCo" are not correct, as the current partnership is a Joint Operating Agreement. Additionally, questions about movement of services to Baptist Hospital East or other locations are not relevant because UMC is retaining the services in question. In order to stay true to the original community questions, however, we have chosen not to alter the wording of the questions.

1. **Women's and Reproductive Health Issues**

   A. Where will tubal ligations be performed?

   Women's health services, including tubal ligations, will continue to take place just as they are today - at University Hospital's Center for Women and Infants staffed by University of Louisville physicians.

   We heard the community, and would not have started conversations with any partner who did not allow us to maintain all of our current services, including those related to women's health.

   B. Reproductive health care at affiliated institutions

   (1) **Will patients' prenatal records be available at Baptist East?**
   No longer applicable.

   (2) **How long ahead will a woman need to decide she wants a tubal ligation to make arrangements for University patients to deliver and have a tubal ligation at BHE? Can she decide 24 hours prior?**
   No longer applicable.

   (3) **If a UL indigent patient is transported to the alternative site at Baptist Hospital East (BHE) for needed reproductive procedures, how will BHE be reimbursed? Will UL pay their costs, will BHE not be reimbursed, or will a special fund be set up like the one for transportation?**
   No longer applicable.

   (4) **Will UL physicians providing prenatal care at UL clinics actually deliver the patient's baby at Baptist Hospital East?**
   No longer applicable.

   (5) **ULH, Kosair Hospital, and Norton Suburban each have neonatal intensive care units; Baptist East does not. What will happen in cases when a woman is scheduled for a post-partum tubal ligation and has a high-risk pregnancy, where the newborn may require intensive care? How will medical needs be prioritized?**
   No longer applicable.

(6) **Could the proposed outsourcing represent a threat to continuing or expanding federal, state or other public funding sources for UL or ULH?**
No longer applicable.

(7) **How will the burden of extra travel and the administrative burdens and hassles of using travel vouchers be managed so as not to be a deterrent to better clinical outcomes?**
No longer applicable.

(8) **Will there be specific policies to protect the privacy of patients who elect to have tubal ligations performed at Baptist East, especially for patients who need to be transferred from ULH for this specific purpose? Will these policies be written and available to the public before the merger is completed?**
No longer applicable.

(9) **Will BHE provide the same level of language access for limited English persons as ULH?**
No longer applicable.

2. **Where will vasectomies be performed?**
Vasectomies are an outpatient procedure and will remain so. They are not performed at the hospital.

3. **Can UL faculty still provide "prohibited services" in other facilities or are they personally bound by the ERDs?**
The University's School of Medicine faculty is not bound by the ERDs. There will be no reduction in services to any of the patient populations currently served.

4. **Will you be able to provide emergency contraceptives? Will SANE nurses be able to provide all the services they currently provide?**
Yes, Physicians and Sexual Assault Nurse Examiner program nurses will continue to provide counseling, care and emergency contraception to victims of rape. As is currently the practice, sexual assault victims may receive emergency contraception after appropriate testing to rule out a pre-existing pregnancy. The partnership will not change this current procedure.

5. **In the case of a rape victim coming to one of the NewCo hospitals, will patients be able to get the morning after pill, a prescription for the morning after pill, or neither?**
There will be no change in UMC's current policies and procedures, which provide that emergency contraceptives may be prescribed, after a negative pregnancy test and the prescription may be filled at UMC. There are numerous drugs appropriate for emergency contraception. As is the current practice, the patient and her physician will decide what is the best option.

6. **What about RU 486? Will there be specific written policies governing access to these medications?**

University faculty currently does not prescribe RU 486 at UMC. That policy will not change.

7. **If a female rape victim presented herself to Sts. Mary & Elizabeth Hospital today and requested emergency contraception, what will be the written policy for determining whether she is pregnant or not?**
   The policies at Sts. Mary & Elizabeth have not changed in regard to emergency contraception.

8. **Will you be able to counsel about family planning?**
   Yes, the physician-patient relationship will not change as a result of the partnership. University physicians and community physicians will continue to counsel patients about all family planning options available, which is current policy today.

9. **Will women and men be able to get birth control prescriptions or birth control pills from the hospital pharmacy? What about employees?**
   Yes. The agreement allows for prescriptions for birth control pills to be filled in the hospital pharmacy. UMC will retain ownership of the pharmacy.

10. **Who makes the decision on an issue if the choice is between the life of the mother or the baby? Specifically, post merger, if a woman presents in the ER and needs an "abortion" to save her life, who will make that decision and will the procedure be allowed?**
    The decision will be made between the patient and her physician. An abortion necessary to cure a serious pathological condition of a pregnant woman is permitted, where the abortion cannot be safely postponed.

11. **Will you be able to treat emergency miscarriages?**
    Yes. As is current policy and practice, miscarriage treatment can and will be provided as medically indicated.

12. **How will you treat ectopic pregnancies? Will efforts be made to save the woman's fallopian tubes or will the entire tube be removed when dealing with an ectopic pregnancy?**
    There will be no change in the manner of treating ectopic pregnancies at UMC. The medical and surgical management of ectopic pregnancy, including tube preservation, will be determined on a case-by-case basis by the physician in consultation with the patient, as is done currently.

End-of-Life Issues

13. **What about DNR orders – are they allowed/followed? Are there exceptions to this?**
    DNR orders are allowed and followed.

14. **How will this affect end-of-life decisions? Will living wills/advance directives be honored?**
    UMC's end-of-life care policies will remain unchanged. Physicians will continue to inform patients of all available options for end-of-life care, including hospice and palliative care.

"Do Not Resuscitate" (DNR) orders will be followed. Patients' advance directives (e.g., living wills, health care surrogate designations, durable powers of attorney) will be honored. Situations involving a patient in a persistent vegetative state who is not in the dying process are extremely rare and do not take place in acute care centers like University Hospital.

15. **Generally, will there be written policies regarding end-of-life issues and how they will be dealt with in the context of ERDs? Will these policies be available to the public prior to the merger's completion?**
Each hospital will continue to maintain their own current written policies and procedures, including for end-of-life issues.

Health Care and Access Issues

16. **Will same sex partners be recognized as immediate family members in terms of visiting policies?**
Yes, that is current policy today and it will continue.

17. **Will access to care be expanded, remain the same, or be reduced by the merger as compared with current access and as projected in the coming years given the financial situation of the merging organizations? What will likely happen to patients, hospitals and practitioners in the Louisville community if the merger is not successfully completed?**
Enhancing access to health care throughout the state is one of the primary goals of the partnership. This includes care for the poor, the at-risk and the uninsured. The depth of this commitment is evident in year-over-year increases in all of the partners' level of quantifiable community benefit, which includes charity care.

UMC for years has sacrificed much needed capital reinvestment to continue its mission of serving those who cannot afford care. This noble activity has taken its toll. According to the third party operational review conducted by Dixon Hughes Goodman in the spring of 2012, University Hospital | James Graham Brown Cancer Center cannot sustain itself operating as it has as a stand-alone, inner city hospital with an unfavorable payer mix.

The report identified key recommendations to improve operational, clinical, and financial efficiency. The "big picture" recommendation states that, even with operational and strategic improvements, the economic viability of University Hospital is questionable at best. The key recommendations were:

- Find a partner that enables UMC to increase access points and expand primary care physician base.
- Pursue 3 to 5 LEAN initiatives for operational, economic, and cultural improvements.
- Engage with ULP to promote closer alignment and integration.
- Pursue service line growth initiatives with support from University of Louisville Physicians.

The full report is available on University Hospital's website.

Given these findings and University Hospital's role as the key care provider in Louisville's health care safety net, if University Hospital | James Graham Brown Cancer

Center does not enter a partnership, the most vulnerable citizen in our community will be the first to feel the negative effects.

18. **Are you still going to provide indigent care? Will the indigent care provided be the same as the current level of care provided?**
Caring for the uninsured is core to the missions of all of our organizations. All partner hospitals will continue to care for uninsured patients in their communities. The partnership is designed to increase access to care, not limit it.

    Their commitment includes care for the poor, the at-risk and the uninsured. The depth of this commitment is evident in year-over-year increases in the levels of quantifiable community benefit, which includes charity care, by all of the potential partners. Together, we provided more than $270 million in community benefit, including indigent care, in 2009. UMC is the largest provider of indigent care in the state.

    For years, UMC, like many other institutions, sacrificed much needed capital reinvestment in its facilities so that it could continue its mission of serving those who cannot afford care. This has taken its toll. Without sufficient capital, the growth of UMC – in terms of physical plant, equipment and the increasingly sophisticated services the community demands – will be limited and current levels of service may not be available.

19. **Will Sts. Mary & Elizabeth Hospital lose inpatient beds as a result of the merger?**
The implementation of the partnership will not have an impact on the availability of services at SME

20. **Will you still be able to provide organ donations? Is it permissible in a Catholic hospital?**
Yes. Many organ donations originate in Level 1 Trauma Centers like University Hospital. Catholic hospitals are currently active participants in organ donation programs.

21. **How will this affect stem cell research?**
The partnership will not affect academic research. University faculty, physicians and researchers are not part of the new partnership. Clinical trials involving adult stem cell therapies can continue.

22. **Will you still be able to do in-vitro fertilization?**
Yes. In vitro fertilization is not currently performed at the University of Louisville Hospital. Instead, in vitro fertilization is currently performed at the offices of certain University of Louisville faculty. That practice will continue unchanged.

23. **Will ULH follow the Catholic ERDs? What if ERDs change in the future, i.e., become more stringent?**
UMC and KentuckyOne are entering a Joint Operating Agreement. Ownership of UMC is not changing, which is much different than the design of the original plan. All services currently provided at UMC will continue to be available. UMC is retaining full control of the Center for Women and Infants and pharmacy. While the ERDs are in effect at KentuckyOne facilities, they will not impact the practice of medicine at UMC now, nor for the life of the agreement.

24. **Will there be another location for women to go? Will it be "separate but equal"? Will all women go there or just the indigent? Won't that be discriminatory toward some women who can no longer get the service they want at ULH?**
We heard the community, and would not have started conversations with any partner who did not allow us to maintain all of our current services, including those related to women's health.

    Women's health services will continue to take place at the Center for Women and Infants, at the same location, provided by the same people as today.

    The new partnership provides $17 million in funding for the University Medical Center (UMC) to operate the Center for Women and Infants (CWI) and continue all services currently offered there. The CWI is already self-sustaining and with the $17 million up-front investment, those services will grow and benefit through the continued oversight of, and funding by, UMC. That includes the full range of reproductive services including tubal ligation.

25. **Wasn't there a hospital in Arizona that lost its Catholic affiliation and the head nun excommunicated because they did not follow the wish of the bishop?**
UMC will not become a Catholic hospital as a result of its Joint Operating Agreement with KentuckyOne, therefore the circumstances in Arizona do not apply to the current partnership. In addition, should a situation arise that restricts UMC from providing its current level of care, the Joint Operating Agreement can be unwound.

26. **What are the specific options you are considering?**
Not Applicable

27. **When do you plan to have a decision or solution?**
Not Applicable

28. **How does this impact the curriculum for medical students?**
The content of the curriculum for medical students will not change, and it will remain consistent with the national standards required for accreditation. As described previously, the partnership will markedly expand the opportunities for teaching and training medical students and residents.

29. **You've been looking at other organizations trying to cope with ERDs. Can you give some examples of where you are looking and what models fit here? Do any of them actually involve a public hospital and school of medicine merging with and/or having an affiliation with a Catholic health system?**
There have been affiliations between public hospitals and/or schools of medicine and religiously affiliated hospitals in other states. We are not privy to the specific details of each transaction, but feel confident that the Joint Operating Agreement in this instance will be a successful model.

30. **How can the "public mission" of ULH be assured and protected in the merger agreement?**

UMC's mission to the public comes in many forms: high quality patient care, research, and the training of health care professionals. This partnership will not only protect but enhance those missions with a statewide reach and perspective.

UMC provides more indigent care than any other hospital in the state. Caring for the uninsured of our community is core to the mission of the two organizations.

Beyond the cultural commitment, the partnership will be contractually obligated to provide indigent care by way of the QCCT agreement. When appropriately funded from the state and metro governments, QCCT ensures care for all Louisville Metro citizens and those from other areas in need of specialty care for trauma, oncology, stroke and high-risk obstetrics.

31. **How will the Affordable Care Act affect the merger and how will the merged entity help with being prepared for the changes ACA is bringing?**
The prospect of health care reform is one of the reasons we decided to partner, enabling UMC and our patients to have access to a statewide network. The Affordable Care Act favors larger health care systems, and will make it more difficult for smaller stand-alone hospitals to continue to do business. It envisions integrated delivery systems where all the services a patient receives are coordinated to ensure care that is consistently appropriate, efficient and of high quality.

The ACA also emphasizes improving the health of populations (versus just treating illness), as well as movement to new models of care, new payment methodologies and accountable care organizations (ACOs) formed by providers willing to accept risk in caring for individuals and communities.

32. **It has been said that the merger is necessary to support the level of uncompensated care taken on by ULH. Isn't it true that the level of uncompensated care will decrease dramatically as the Affordable Care Act is fully implemented and more people are covered by public or private insurance? In the ACA era, are the projections of uncompensated care valid?**
We believe that the ACA is a step in the right direction, but it falls short of universal access and coverage. Not all persons will be covered, and many of the underinsured will still lack adequate coverage. The federal government states that there are 49.9 million uninsured and more than 100 million underinsured. The bottom line is that the ACA does not address the limited existing capacity of the US and Kentucky health care systems. The ACA will add millions to the insurance rolls of the Commonwealth, but it will do little to increase the access needed to accommodate these people. Reimbursement levels to providers have trended downward for decades and there is little reason to expect this to change, especially with the challenges Medicare and Medicaid are facing.

If fully implemented, the ACA will not take effect until 2014. There are too many unknowns to say if the uncompensated care projections are valid (e.g. whether and to what extent reform measures are implemented, future state of the economy, certainty that some people will continue to fall through the cracks).