Findings of the Central New York Regional Advisory Committee

November 3, 2006

Regional Advisory Committee Members:

John W. Deans*
Cynthia Hummel
Samuel Huston
Terrence Kane
Elizabeth Mullin-DiProsa
Michael O'Leary, M.D.
James Smith

New member appointed as of May 25, 2006, but did not participate in any meetings.

Commission on Health Care Facilities in the 21st Century

Introduction

This document outlines the specific preliminary findings of the Central New York Regional Advisory Committee (RAC). Included in these findings are facility specific recommendations as well as commentary on structural/policy issues that affect the stability and quality of health service delivery in the Central New York Region.

The findings in this report are based on extensive fact-finding activities throughout the 23 county region. These activities include public hearings held in Binghamton, Rochester, Syracuse and Watertown, extensive provider outreach meetings with acute and long term care providers and health related organizations, and consultation with Statewide and Regional Commission members and Commission staff.

Public Hearing Testimony
February 21, 2006 – Binghamton, New York (Broome County)

Jack Salo – Rural Health Network of South Central New York
Chris Calhoun – OGS Norwich Pharmaceutical
Denise Johnson – Vestal Nursing Center
Allen Pole – DCMO Boces
Ray Sweeney - HANYS
Gary Fitzgerald – Iroquois Health Alliance
Ron Lagoe – Hospital Executive Council
Julia Donnaruma – NYS Association of Health Care Providers
Dr. Rob Mackenzie – Cayuga Medical Center
John O'Neil – Lourdes Hospital
Dr. Drake Lamen – Chenango Memorial Hospital
Brian Mitteer – Cortland Memorial Hospital
Peter McGinn – United Health Services
John Nespoli – Guthrie Health
Maria Landy – Tioga Nursing Facility
Keith Chadwick – United Methodist Homes
Gary Breuilly – Elizabeth Church Manor
John F. Demske – Willow Point Nursing Home
Vicky Morabito – Ideal Senior Living
Dave Hall – Chenango County Chamber of Commerce
Julie Boden Schmidt – Family Health Network of Central NY
Michelle Berry – Broome County CASA
Michael Keenan – Good Shepard Fairview Home
Neil Eldred – Brome County Office for Aging
Arthur Johnson – Broome County Mental Health Department
Sharon Chesna – Mothers and Babies Prenatal Network
Connie Barden – Family Type Homes for Adults
DeeDee Camp – Aging Futures
Shelli Cordisco – Action for Older Persons
Bette Gifford – Lourdes Youth Services

Public Hearing Testimony
February 24, 2006 – Syracuse, New York (Onondaga County)

Jim Vitale – Empire State Association of Adult Living
Gary Fitzgerald – Iroquois Health Alliance
Bader Reynolds – New York State Association of Health Care Providers
Ron Lagoe – Hospital Executive Council
Janet Dauley Altwarg – Long Term Care Executive Council
Gerald Richmond – Central New York Health Systems Agency
Torre DeMar – New York State Nurses Association
Sally Johnston – The Consumer Directed Personal Assistance Association of NYS
Mark Rappaport – Lewis County General Hospital
Jonathan Lawrence - Little Falls Hospital
Brendon McGrath – Auburn Memorial Hospital
David Felton – Community Memorial Hospital of Hamilton
Mike Svendsen – Rome Nursing Home
Lisa Betrus – Valley Health Services
William Conole – Crouse Community Center
Dr. Ruben Cowart - Syracuse Community Health Center
Beata Karpinska-Prahn – Arise - Independent Living Center
Sara Bollinger - Enable
Agnes McCray – Private Consumer
Darryl Storie – Private Citizen
Norm Andrzejewski – Private Citizen
Jeffrey Corbett – Private Citizen
Ryan Guyder – Private Citizen
Matthew Barkley – Spinal Cord Injury Network in Central New York

Public Hearing Testimony
March 27, 2006 – Rochester, New York (Monroe County)

Charles Albrecht – Finger Lakes Radiation Oncology
Dr. Neil Scheier – Clifton Springs Medical Staff
Dr. Sidney Sobel – Private practice physician
James Dooley – Finger Lakes Health
Michelle Marto – 1199
Matt Tonsich – New York State Association of Health Care Providers
Marilyn Dollinger – NYSNA
Diane Ashley – Rochester Regional Health Care Association
Jane Shukitis - NYAHSA
John Nespoli – Guthrie Health
Marilyn Custer-Mitchell – Corning Hospital
Russ Woglom – Guthrie Clinic
John Galati – Clifton Springs Hospital
Linda Janczak – Thompson Health System
Anthony Cooper – Arnot Ogden Medical Center
Jim Watson – Ira Davenport Memorial Hospital
Darlene Burns – Rome Memorial Hospital
Pamela Urban – St. James Mercy Health System
Sister Marie Castagnaro – St. Joseph's Hospital, Elmira
Steven Goldstein – Strong Health
Samuel Huston – Rochester General Hospital
Jay Maslyn – Nicholas Noyes Hospital
Sandra MacWilliam – Unity Health System
Dennis Christiano, Sr. – Aaron Manor Rehab and Continuing Care Center
Robert Jones – Wesley Community
Betty Mullin-DiProsa – St. Ann's Community
Barbara Linhart – Oak Orchard Community Health Center
Angline Mastromatteo – Genesee Health Service
Michele Hannagan – Westside Health Services
Art Streeter – Finger Lakes Health Systems Agency
Chris Helderbrant – Center for Disability Rights
Tom Tranter – Corning Enterprises
Jack Benjamin – Three Rivers Development Corporation
Nancy Clarkson – Nursing Department Chair, Finger Lakes Community Center
William Hunter – Clifton Springs Mayor
Sherwin Cerini – Private Citizen
Paul Kimball – Town of Clarkson
Nancy Sacchitella – Private Citizen
William Guglielmo – Rome Chamber of Commerce
Judy McMaster – Interfaith Health Care Coalition
Stephen Uebbing – Canandaigua City School District
Dr. Daniel Biery – Private Citizen

Public Hearing Testimony
April 4, 2006 – Watertown, New York (Jefferson County)

Jessica Smrtic – New York State Association of Health Care Providers
Rod Rocarn – NYSNA
Elizabeth Patience – Northern Regional Center for Independent Living
Thomas Carman – Samaritan Medical Center
Roger Masse – Clifton-Fine Hospital
Charles Fahd – Massena Memorial Hospital
Walter Becker – Carthage Area Hospital
Mark Webster – Claxton-Hepburn Medical Center
James Stewart – Faxton-St. Luke's Healthcare
Corte Spencer – Oswego Health and Community Health Network
Chuck Conole – Edward J. Noble Hospital/Kinney Nursing Home
Richard Brooks – Samaritan Keep Home
Steven Reynolds – Sunrise Residential Healthcare and Rehabilitation Center
Stephen Knight – United Helpers Management Company
Colonel John Wempe – Fort Drum MEDDAC
Roberta Hagerty – Private Citizen
Michelle Appleby – Private Citizen
Patricia Bishop - Alliance
Sandra Guyton – Private Citizen
Alexander Kuehl – MSSNY Committee on Medicaid Reform
Greg Ostek – St. Luke's Health Services
Paul Kruger – former EJ Noble Gouveneur employee
Jim Cronk – Private Citizen
Jeanne Westbrook – Private Citizen
Eugene Datthyn – Private Citizen
Neil West – Private Citizen
Brendan Brady – Physicians of Ontario County

Central New York
Regional Advisory Committee **Provider Outreach Meetings**

Type of Facility	Name	County
Nursing Home	Willow Point Nursing Home John Demske - Administrator	**Broome**
Nursing Home	Bridgewater Center Warren Elsten and Keith Chadwick - CEO	**Broome**
Nursing Home	Ideal Senior Living Center Mary Motsavage-CEO	**Broome**
Nursing Home	United Methodist Homes Keith Chadwick –CEO	**Broome**
Nursing Home	Mercy Health & Rehab Center Steven Ash - Administrator	**Cayuga**
Nursing Home	Valley Health Services Lisa Betrus - CEO	**Herkimer**
Nursing Home	The County Manor Nursing & Rehab Center	**Jefferson**
Nursing Home	Presbyterian Home of CNY Tony Joseph – Administrator	**Oneida**
Nursing Home	Betsy Ross Rehab Center Grace Steppello –Administrator	**Oneida**
Nursing Home	Loretto Geriatric Center Jim Introne - Administrator	**Onondaga**
Nursing Home	Van Duyn Nursing Home Stan Wojciechowski - Administrator	**Onondaga**
Nursing Home	Sunrise Nursing Home Steven Reynolds - Administrator	**Oswego**
Nursing Home	Lakeside Nursing Home Mark Farchione - Receiver	**Tompkins**
Nursing Home	Long Term Care Coalition	**Onondaga**
Nursing Home	Jewish Health & Rehabilitation Center at Menorah Park Mary Ellen Bloodgood - Executive Director	**Onondaga**
Nursing Home	The Crossings Teresa Creedon -Administrator	**Onondaga**
Nursing Home	Unity Health System Tim McCormick - CEO	**Monroe**
Hospital	United Health Services Peter McGinn - CEO	**Broome**
Hospital	Our Lady of Lourdes Memorial Hospital John O'Neal - CEO	**Broome**
Hospital	Auburn Memorial Hospital Bob Berger	**Cayuga**
Hospital	Arnot Ogden Memorial Tony Cooper - CEO	**Chemung**
Hospital	St. Josephs Hospital Sister Marie Caftagnaro, CEO	**Chemung**

Type of Facility	Name	County
Hospital	Chenango Memorial Hospital Frank Mirabito/Dr. Drake Lamen	**Chenango**
Hospital	Little Falls Hospital Jonathan Lawrence - CEO	**Herkimer**
Hospital	Carthage Area Hospital Walter Becker - CEO	**Jefferson**
Hospital	Samaritan Medical Center Thomas Carman - CEO	**Jefferson**
Hospital	Community Memorial Hospital Dave Felton-CEO	**Madison**
Hospital	St. Elizabeth's Medical Center Sister Johanna & Matt Babcock	**Oneida**
Hospital	Rome Memorial Hospital Darlene Burns – CEO	**Oneida**
Hospital	Crouse Hospital Paul Kronenburgh – President & CEO	**Onondaga**
Hospital	SUNY Upstate Medical University Greg Eastwood - President	**Onondaga**
Hospital	Community General Hospital Tom Quinn - CEO	**Onondaga**
Hospital	St. Joseph's Hospital & Health Center Theodore Pasinski - President	**Onondaga**
Hospital	Clifton Springs Hospital John Galati – President & CEO	**Ontario**
Hospital	FF Thompson Health System Linda Janczak - CEO	**Ontario**
Hospital	Geneva General & Finger Lakes Health Jim Dooley – President & CEO	**Ontario**
Hospital	AL Lee Memorial Hospital Dennis Casey – Executive Director	**Oswego**
Hospital	Oswego Health and Community Health Network Corte Spencer - CEO	**Oswego**
Hospital	Claxton-Hepburn Medical Center Mark Webster - CEO	**Jefferson**
Hospital	Northern NY Hospital Association (5 hospitals as part of Association)	**St. Lawrence** **Jefferson**
Hospital	Schuyler Hospital Rick Stelsar - CEO & community	**Schuyler**
Hospital	IRA Davenport Memorial Hospital James Watson - CEO	**Steuben**
Hospital	St. James Mercy Hospital Pamela Urban - Interim CEO, David Capone, CFO, Daniel Callahan, VP of Mission & Wendy Dailey, Director of Planning and Strategy Development	**Steuben**

Type of Facility	Name	County
Hospital	Corning Hospital Marilyn Custer-Mitchell - CEO	**Steuben**
Hospital	SUNY Upstate Medical University/Crouse Hospital Paul Kronenberg, Greg Eastwood, Steve Scheinman, David Sandman	**Onondaga**
Hospital Consortium	Iroquois Healthcare Alliance Board Gary Fitzgerald – Executive Director	**Various**
Organization	Central NY Health Systems Agency Tim Bobo	**Various**
Other	Rochester Area Homes and Services for the Aging	**Monroe**
Other	New York State Health Facilities Association	**Albany**
Other	Onondaga County Executive Nick Pirro	**Onondaga**

Findings

Recommendation 1:
Crouse Hospital and Upstate Medical University Hospital (both in Onondaga County) should become an integrated organization. These facilities should become one operation with needed renovations and restructured debt. The integrated organization should reduce total operating bed capacity to a minimum of 500 beds and a maximum of 600 beds (removing approximately 250-350 beds from operation in the greater Syracuse area).

- **Background**

University Hospital is a 366-bed hospital with Syracuse's only Level-1 Trauma Center. University Hospital has more than 80 hospital-based clinics and emergency services. Specialty centers include the area's only Pediatric Emergency Center and ICU, the Clark Burn Center, Regional Oncology Center, Central New York Gamma Knife Center, and the Renal and Pancreatic Transplant Program.

University Hospital is the teaching hospital of Central New York's only academic medical center -- the SUNY Upstate Medical Center at Syracuse. It is part of the SUNY Upstate Medical University which also features the colleges of Medicine, Nursing, Graduate Studies, and Health Professions. The SUNY Upstate Medical University is Onondaga County's leading employer. It is where patient care, education, and biomedical research blend to benefit patients locally and worldwide. Construction of a children's hospital began in 2005 and is expected to be completed in 2007.

Crouse Hospital, a 576-bed acute care hospital, offers emergency, medical, surgical and intensive care, maternity services, inpatient psychiatric care, and numerous outpatient services. Crouse provides more than half of the area's obstetrical and neonatal care.

Despite having fewer certified beds, the average daily census at SUNY is somewhat higher than the average daily census at Crouse (269 at Crouse versus 294 at SUNY in 2004). This translates into occupancy figures of 46.7% at Crouse and 80.4% at SUNY in 2004 based on certified beds. However, in 2004 Crouse was operating only 463 of their 576 certified beds while SUNY was staffing all 366 of their certified beds. This boosts Crouse's occupancy to 62.3% in 2004 based on available beds.

In 2001 Crouse filed for bankruptcy protection with debts of $91 million. Crouse was able to emerge from bankruptcy in 2003 as a financially viable independent institution. A substantial part of the turnaround was debt restructuring that deferred payment of $62 million principal to creditors for five years. The value of debt deferral is estimated at $12 million. Many parts of Crouse are at least 30 years old and Crouse is in the early stages of an $88 million dollar capital spending campaign to upgrade facilities.

The two facilities are physically connected and have a history of collaborative discussions. The most recent talks ended when Crouse's union rejected the merger plans.

- **Rationale**

An integrated organization will reduce the duplication of services across the two facilities (e.g., emergency departments, medical surgical beds, operating rooms), create a larger patient base for medical education, reduce administrative inefficiencies, and minimize capital investment.

A HCRA restructuring grant has been made available to support merger discussions between the two facilities.

Potential barriers to successful integration include community concern about preserving local ownership/governance, medical staff issues and union issues.

- **Required investment**

To support the creation of an integrated organization, funds should be made available to support the following activities: facility investments to repurpose the current facilities and better coordinate care, consulting investment to support the consolidation of organizations, working capital required during the transition, retraining and placement cost for staff and debt reduction.

Recommendation 2:
Van Duyn Home and Hospital should convert to ownership by Community-General Hospital.

- **Background**

Van Duyn is a 526-bed residential health care facility located in Syracuse, owned and operated by Onondaga County. Van Duyn provides baseline services[*] and short-term care, and serves a very key role in moving patients out the hospital, including those who are not attractive to private facilities, due to a "Medicaid-pending" status, which puts months of payment at risk for a provider.

While Van Duyn has experienced fairly high occupancy (ranging from 97 to 95% over the 2002-04 period), the facility operates at a considerable operating loss. The 2006-07 projected Van Duyn deficit is $8M, and this is a significant burden on Onondaga tax-payers.

Van Duyn has a very low CMI (1.02 in 2003 compared to an adjusted statewide average of 1.19) and 22% of its residents fall in the PA/PB category of lowest clinical need over the 2001-03 period, with 25% in 2003. This suggests that Van Duyn may be filling some its beds with individuals who may be better-served in less-restrictive settings.

Van Duyn is on the same campus as Community General Hospital, which, in addition to providing acute care services, also houses a 50-bed skilled nursing facility. The Community General SNF also has a fairly high occupancy (ranging from 94% to 96%

[*] Baseline services is an operating certificate designation, meaning the facility provides all services required by the Federal and State regulations, including: nursing, medical care, physical and occupational therapy, social services, recreational activities, dietician services, nutritional support, and personal care. In addition, residents are provided access to podiatry, ophthalmology, and other health services.

over the 2002-04 period) and receives a hospital-based SNF Medicaid rate. The CGH SNF also has a relatively low CMI (also 1.02) and 19% of its residents fall in the PA/PB category. At the same time, CGH has increasing need for space for its acute care plans, and could create more evidence-based design opportunities such as private rooms if it had the space.

- **Rationale**

Neither the Van Duyn or the CGH SNF are adequately meeting the needs of Onondaga county residents because of the constraints of their physical plants. Van Duyn is built on the long, double-loaded corridor model, which greatly impairs staff line-of-sight and which restricts social interactions and on-floor therapeutic activities. At the same time, some of these existing beds may not be necessary in a county with a PACE program and other growth of home- and community-based services that should delay or avoid nursing home placement.

An integrated organization will reduce the duplication of services across the two facilities, reduce operating costs at Van Duyn, allow Van Duyn to rebase, and create an integrated continuum of care on the campus.

- **Required investment**

To support the creation of an integrated organization, funds should be made available to support the following activities: facility investments to repurpose the current facilities and better coordinate care, consulting investment to support the consolidation of organizations, and debt reduction.

Recommendation 3:
St. Joseph's Hospital and Arnot Ogden Medical Center (Chemung County) should undertake regional planning efforts to rationalize and maintain services in the Elmira community.

- **Background**

Arnot Ogden Medical Center is a 216-bed acute care facility which includes the Finger Lakes Heart Institute, Falck Cancer Center, Joslin Diabetes Center, Health Center for Women, Maternal and Child Health Center, and the HIV Primary Care Clinic.

The Center also provides Level III Neonatal Care and Level II Trauma Care. The next closest location for these services is approximately 70 miles away. The facility has had capital investments with up to date facilities including an expanded ED in 2005.

St. Joseph's is a 224-bed acute care facility which provides medical surgical and physical medicine and rehabilitation services. The facility also provides inpatient and outpatient mental health, drug and alcohol services. The ED is an OMH 9:39 evaluation site. St. Joseph's provides safety net acute care services to vulnerable populations. St. Joseph's is an aging facility and will need to make investments in facility upgrades; specifically an upgraded emergency department is needed in the immediate future.

The average daily census at Arnot Ogden and St Joseph's are almost exactly the same in 2004 (137 at Arnot Ogden versus 136 at St Joseph's in 2004). This translates into occupancy figures of 63.3% at Arnot Ogden and 60.6% at St Joseph's based on certified beds. However, St Joseph's was operating only 183 of their 224 certified beds while Arnot was staffing all 216 of their certified beds. This boosts St Joseph's occupancy to 74.5% in 2004 based on available beds.

Financially, St. Joseph's is barely breaking even with minor positive and negative shifts from year to year. Annually, they invest between $1.5 and $1.8 million on technology and facility upgrades. Their bad debt is increasing year over year. Margins at Arnot Ogden are somewhat stronger than St. Joseph's and long term debt is significantly lower.

Competition for medical services has been particularly fierce within the community. Arnot Ogden has traditionally provided the full scope of cardiac services including cardiac catheterizations. St. Joseph's submitted a CON for cardiac catheterization services. The CON was denied.

Arnot Ogden provides dialysis services. With capacity functioning at approximately 70%, St. Joseph's submitted a CON for similar dialysis services. That CON was approved. Finger Lakes HSA did not support that CON.

There were merger between attempts between Arnot Ogden and St. Joseph's approximately 15 years ago. Religious issues were addressed during those merger proceedings. The merger was unsuccessful in the final stages due to an inability to resolve existing debt structure under a new entity.

Three years ago, St. Joseph's contacted Guthrie Health about forming a partnership. Guthrie is firmly established in the Southern Tier of NY State. The system includes an established hospital site at Corning Hospital, just to the West of Elmira, and a base of Guthrie Clinic physicians in practices in sites throughout the Southern Tier.

This outreach has impacted physician referral patterns in Elmira. Historically, the position of the physicians in the community has been to try to maintain some level of balance between the two hospitals. Recently, Guthrie Clinic based physicians are admitting to St. Joseph's and referring specialty care to Robert Packer Hospital, the tertiary care Guthrie facility in Sayre, Pa. Admissions at Arnot Ogden have declined approximately 800 per year. Referral patterns out of NY impact the economy and physician specialty base and access to other levels of health care services in the community.

On June 23, 2006 St. Joseph's announced their intention to form a "collaborative partnership" with Guthrie. The results of these negotiations are expected to be announced within 180 days.

- **Rationale**

Regional planning efforts will reduce the duplication of services across the two facilities in Elmira (e.g., emergency departments, medical surgical beds, operating rooms), reduce administrative inefficiencies, limit the medical arms race between the facilities and ensure the future of health care availability in the area.

The recent announcement of further collaboration between Guthrie and St. Joseph's is not expected to address the community need for a single hospital with common government and management.

Potential barriers to successful integration include sectarian/non-sectarian issues, debt retirement and the future role of Guthrie in the Elmira community.

- **Required investment**

To support regional planning efforts, funds should be made available to support the following activities: facility investments to repurpose the current facilities and better coordinate care, consulting investment to support the consolidation of organizations, and debt reduction.

Recommendation 4:
Albert Lindley Lee Hospital should be converted to an outpatient/urgent care center.

- **Background**

A.L. Lee Memorial Hospital, a 67 bed acute care facility, and Oswego Hospital, a 164-bed acute care facility, are located approximately 12 miles apart in Oswego County. A.L. Lee is approximately 28 miles Northwest of Syracuse.

In 2004 occupancy at A.L. Lee was 55.7% while occupancy at Oswego was 42.0%. The average operating margin at A.L. Lee has been -2.0% for 2000 through 2003 while Oswego has had an average margin of 4.6%.

Both facilities have recently undertaken renovations. Oswego Hospital recently completed $35 million worth of renovations and will feature a new ambulatory surgery entrance, operating rooms, intensive care/critical care unit, maternity department, cafeteria and main front entrance. A.L. Lee Memorial's Emergency Department Renovation and Outpatient Services Consolidation began in mid-2004 and concluded in late 2005, resulting in an expanded E.R. with separate entrances for walk-in and ambulance patients.

- **Rationale**

There is not a demonstrated need for two hospitals in the Oswego County area. The population in Fulton, where A.L. Lee is located, is declining. Recent capital investment at Oswego Hospital makes it the more modern of the two facilities. Service to vulnerable populations is low and the financial viability of A.L. Lee is questionable.

Other hospitals in AL Lee's service area could accommodate the capacity from the closure of AL Lee. Based on 2004 SPARCs data, Oswego hospital and SUNY each serve about 30% of AL Lee's coverage area, St Joseph's and Crouse each serve 20% and 14% respectively. Among these coverage partners, sufficient capacity exists to absorb A.L. Lee's patients as measured by both average daily census (40 patients) and peak daily census (52 patients).

The impact of closure on the local physician population would likely be negligible because A.L. Lee shares a physician base with nearby Oswego.

However, the average travel time of patients currently served by AL Lee would increase from 7 minutes to 41 minutes if service at A.L. Lee was eliminated entirely. Therefore, an outpatient/urgent care facility should remain at the site to meet these immediate needs of the population.

- **Required investment**

Facility investments to convert the current facility to an outpatient/urgent care clinic.

Recommendation 5:
FF Thompson, Clifton Springs Hospital, Geneva General Hospital (Ontario County) and Newark-Wayne Community Hospital (Wayne County) should undertake activities to rationalize service in the region.

- **Background**

The four hospitals all operate within a small geographic area and are all suffering from reduced occupancy. The distance between the two farthest hospitals (Newark-Wayne to FF Thompson) is no more than 20 miles.

Clifton Springs has 154 certified beds, Geneva General has 132, FF Thompson has 113 and Newark-Wayne has 132. The occupancy in each facility hovers in the low 40s (Clifton Springs 42.4%, Geneva General 43.4%, FF Thompson 43.0%, Newark-Wayne 43.3%).

All three Ontario county hospitals have an average positive margin for the 2000-2003 period. Newark-Wayne has an average operating margin of 2.2% over the same period.

Clifton Springs is currently exploring conversion to a Long Term Acute Care (LTAC) Hospital to serve overflow capacity from Monroe area.

- **Rationale**

Rationalization will reduce the duplication of services across the facilities, and reduce administrative inefficiencies. A successful plan could include all four facilities or any smaller combination of these facilities.

Preliminary discussions with medical staffs suggest that they would be amenable to the consolidation into a single entity right-sized to meet the future needs of the community.

This consolidation would include closure of all three Ontario County facilities and construction of a new, centrally located facility.

- **Required investment**

Dependent on the form of consolidation.

Recommendation 6:
Auburn Hospital (Cayuga County) should reduce its inpatient capacity from 226 beds down to approximately 100 beds.

- **Background**

Auburn Hospital has struggled financially for a number of years. It currently holds substantial debt ($20 million plus) that has been secured by Cayuga County.

Occupancy has been in the low 40's in recent years with occupancy of 41.0% in 2004.

Movement to outpatient services and loss of key staff have been particular problems for this facility.

Auburn Hospital has taken proactive steps to turnaround and has contracted with Wellspring for turnaround assistance. The RAC is awaiting further details from Wellspring before making a specific recommendation regarding the facility.

- **Rationale**

RAC is awaiting further information on plans.

- **Required investment**

Support to retire debt, restructure facilities, new program development and refinement of programs no longer supported by population or medical staff.

Recommendation 7:
Close Lakeside Nursing Home (Tompkins County) contingent on the development of an 80-bed Medicaid ALP and 20 to 30-slot adult day health care program in Tompkins county.

- **Background**

Lakeside Nursing Home is a 260-bed propriety residential health care facility in Tompkins County, providing baseline services. Due to severe quality issues several years ago, the Department of Health arranged a receivership, and Peregrine Health Management Company has been the receiver since 2000. The facility operates in Chapter 11 and maintains sizable debts, including monies owed to the Department of Health and others since the bankruptcy filing.

Quality of care has improved under Peregrine's receivership, although the facility appears on the Consumer Reports "watchlist" for the last four years under Peregrine, with a higher than average number of deficiencies, although none at the "actual harm" level in the last survey. In addition to quality issues, the facility continues to experience

significant problems. The facility runs at less than 85% occupancy (and perhaps as low as 65%). It has operated at a sizable operating loss for a number of years, and perhaps as a result of that has not maintained the facility as well as might be expected. Lakeside does not offer any spectrum of services to meet specific needs such as post-acute care or specialty beds, and so does not seem to be a "modern" provider. Its CMI was 1.05 in 2003. Comments have been made by DOH officials that the Lakeside beds are not needed.

- **Rationale**

Tompkins County is a "county of opportunity." There is a documented excess supply of nursing home beds in the DOH bed need methodology, and the county's nursing facilities as a whole operate at only 92.7% occupancy. Tompkins County has only 28 non-institutional slots per 1,000 seniors (compared to a statewide average of 33) and has NO ALP beds or adult day health care slots at all within its borders.

- **Required investment**

The Department of Health should issue an RFP for the development of an 80-bed ALP and 20-30-slot ADHC. (Upon selection of a developer/operator, Lakeside should proceed to close.

Recommendation 8:
Willow Point should downsize by 83 RHCF beds to 300 beds. Construct replacement nursing home. Add 30-slot ADHC

- **Background**

Willow Point is a 383-bed residential health care facility owned and operated by Broome County, and providing baseline services. While the facility enjoys fairly high occupancy (97-96% in the 2002-04 period), it is plagued by several problems. First, Willow Point is financially precarious and a financial burden on the County; over the 2000-02 period, it lost over $6.4M.

Additionally, the facility has presented quality concerns, with 14 survey deficiencies (which is significantly above the regional average of 5) and a few "immediate jeopardy" citations (meaning the surveyor believed that it was a life-threatening situation.) Some of Willow Points' Medicare quality indicators fall well below Statewide averages, including percentage of residents in pain and percentage who lose continence. This is perhaps due to the size and age of the Willow Point facility, which Department of Health officials have commented is no longer appropriate for skilled nursing care. Willow Point provides only long, double-loaded corridors which inhibit interactions and do not provide today's therapeutic milieu.

Other facility factors of note are a relatively high number of low-scoring individuals in the facility (about 18% of all residents over the 2001-03 period), and a relatively limited availability of services, although the facility does operate a short-stay program.

- **Rationale**

Broome County is a "borderline" opportunity for resource shifts. While the bed need methodology shows few surplus beds, the 2004 occupancy across the county was only 92.8%. With Willow Point at a high occupancy, that implies that some of the beds in higher-quality facilities are going unused. In addition, the county still needs over 650 "slots" for non-institutional services, especially for adult day health care, for which only 20 slots exists for the entire county.

There are pros and cons to the final size of Willow Point. The current reimbursement methodology gives facilities with over 300 beds a higher "ceiling" on indirect costs, and so 300 makes some financial sense. However, given the size and population of Broome County, the 300 beds may not be necessary to serve the community in the future.

- **Required investment**

Because of the age, size, and physical layout of the facility, we recommend replacement. A Certificate of Need application would need to be submitted. The new facility should accommodate the ADHC on the first floor, perhaps with additional space to expand if future needs warrant. We would anticipate a new facility to come on line in approximately two-and-a-half to three years.

Recommendation 9:
Mercy of Northern New York (Jefferson County) should downsize by 76 RHCF beds to 224 beds. Create a 60-bed Medicaid Assisted Living Program (ALP) and a 16-slot adult day health care program (ADHCP) in the vacated Madonna building, as well as a Long Term Home Health Care Program (LTHHCP) of approximately 20 slots to reduce or delay demand for residential care.

- **Background**

Mercy of Northern New York is a voluntary, 300-bed residential health care facility in Jefferson County. The facility provides baseline services. In addition, Mercy of Northern New York provides a broader spectrum of services, including certified home care, renal dialysis, and ambulatory physical and behavioral health services. The facility has recently emerged from bankruptcy (January 2006) and is developing plans to put itself on solid financial footing. One issue which jeopardizes this is Mercy's relatively low occupancy (ranging from 94% to 92% over the period 2002-04) combined with a 90% Medicaid payor mix, which has reduced bed-hold revenue by a couple of hundred thousand dollars each year.

At the same time, Mercy of Northern New York has a low CMI (1.09) with about 24% "low-acuity residents in the 2001-03 period. In fact, in 2003, 36% of its residents were in the PA/PB categories. Despite these low clinical demands, Mercy of Northern New York has been at the top of the Consumer Reports nursing home "watch list" for the last four years. The combination of low occupancy and low revenue resulted in the facility providing nursing hours per resident per day significantly below statewide averages which could in turn adversely affect quality of care and reputation.

- **Rationale**

Jefferson County is one of the counties in the Central Region which presents a compelling opportunity to shift long-term care resources. There is a small surplus of beds according to the need methodology, the county as a whole had an occupancy rate of less than 88% in 2004, and the county has a shortage of non-institutional alternatives. In fact, Jefferson has only 20 "slots" of non-institutional services per 1,000 seniors, which is significantly below the statewide average of 33. In particular, Jefferson County has NO Medicaid assisted living (ALP) beds, which may explain why so many low-acuity residents are in the nursing home.

Mercy has a viable plan for converting the Madonna Home building into a consumer-friendly ALP, with 15 units per floor, built on the Greenhouse Model, which can be renovated at a reasonable cost.

- **Required investment**

By reducing its bed-complement by 76, Mercy of Northern New York is able to vacate one existing building on its campus; this building can be renovated to house the ALP and the ADHC program for approximately $1M, for which the provider will arrange financing. Mercy is already "warehousing" its empty beds for this purpose, and it should take fewer than six months to vacate the building to begin renovations.

Note that this recommendation will require the establishment of an adult home for the purposes of creating an ALP. We recommend that the Department expedite this unless quality and competence standards are not met.

Recommendation 10:
United Helpers, Canton (St. Lawrence County) should downsize by 64 RHCF beds to 96 beds. Construct replacement nursing home, and create Medicaid ALP program of 48 slots on the new campus.

- **Background**

United Helpers Canton is a 160-bed voluntary residential health care facility in St. Lawrence County. United Helpers Canton has a strong sub-acute care program and also provides a good continuum of care through its outpatient physical therapy. United Helpers is part of a broader system that provides a full continuum of services, including independent living, adult home, and other SNFs. The facility enjoys a relatively high occupancy (95%) but it is important to note that nearly 30% of those beds were occupied with low-acuity individuals (in the 2001-03 period), some of whom could likely be served in an ALP if that were available.

In the past, the facility has presented some quality concerns (including a recent "immediate jeopardy") but it is our understanding that the facility has submitted an effective corrective action plan to the Department of Health. On top of these concerns, the facility is in tenuous financial condition, with some significant operating losses (about half-million annually), at least through 2002.

United Helpers Canton proposed downsizing by 16 beds in its plans for a replacement facility, to build the state-of-the-art "pods" of 12 and neighborhoods of 48. In speaking with the Department of Health officials, as well as considering the situational factors described below, the Staff recommends that United Helpers Canton further downsize its RHCF beds and convert them to lower-levels of care, which is a significant unmet need in that community.

- **Rationale**

United Helpers is working with a number of local organizations as it plans its replacement facility in Canton. This may include co-locating a child day care center on-site and possibly a Hospice residence on-site.

In terms of St. Lawrence County, the county is significantly "over-bedded" with a bed need methodology surplus of 158 beds. Like many other counties in the Central Region, St. Lawrence has a dearth of non-institutional alternatives, and NO ALP beds or ADHC slots. In particular, with a good number of potential ALP residents already residing at United Helpers, an ALP as part of its replacement plans will fill an unmet need.

- **Required investment**

United Helpers Canton should submit a Certificate of Need application for a replacement facility. We recommend that this CON include a 48-bed ALP. We anticipate no quality and competence issues as the United Helpers "system" already owns and operates adult homes in New York.

Structural/Policy Considerations

Throughout our process of investigating the health care needs across the Central Region, a number of common themes have emerged in provider meetings, public hearings and among RAC and Regional members.

- **Rural community health needs are different than urban/suburban health needs.**

Hospitals are the locus of care in rural communities. In many cases hospitals are the only infrastructure to support health care and are the primary resource for economic development in the community. Closure of a hospital in rural communities affects access to many non-acute services by influencing the presence of physicians in a community.

Rural hospitals face significant difficulty recruiting and retaining physicians in their community. Hospitals are faced with guaranteeing physician salaries and paying a premium to guarantee on call access to physicians. Hospital CEOs frequently describe the situation as being "held hostage" by physician access issues that can add anywhere from hundreds of thousands to millions of dollars of to a hospital's operating costs.

A lack of community based alternatives is particularly dramatic in rural areas. Community based alternative services are fragmented, there are gaps in services and the gaps and fragmentation drive hospital costs and create an artificial need for hospital beds. The most significant areas of need for services include: inpatient and outpatient services for child and adolescent psych; alcohol and drug inpatient and outpatient, alternative eldercare services, and dental care. Not only is a continuum of services lacking, but even where services are established other issues limit the usefulness of these resources. For example, some county run CHHAs close for two weeks of the month due to a lack of staffing.

Geography, weather and transportation are three key factors that must be considered when addressing rural health needs.

- **Regulation and reimbursement methodologies are obstructing our communities' abilities to create new and innovative community based healthcare services.**

The continuum of assisted living, adult home and a full range of services allowing people to live independently outside of an institutional setting are constrained by regulation. The resulting inefficiencies and a lack of coordination has a monumental cost, quality and efficiency implications throughout the state.

Examples include:

- Hospice requiring nursing homes to readmit from assisted living to the nursing home to allow the patient to become eligible to be paid for hospice services;
- The lowest acuity patients (PA's and PB's) do not have alternative funding streams to pay for services outside of a nursing home forcing their placement and retention in nursing homes;

- Group homes are required to adopt a medical model instead of a social model for their clients driving up costs.

Consequently, a continuum of community based alternative services is not readily available, resourced, nor reimbursed to replace beds or capacity within either the nursing home or hospital.

- **The CON process creates an uneven playing field for hospitals**

CON laws requiring hospitals but no one else to apply and be approved for resources, has created, not only an uneven playing field, but also an entrepreneurial window of opportunity for those who are unregulated and a disadvantage to the safety net community hospital.

- **Reimbursement issues in Nursing Homes**
  - Payor mix has changed, with little self pay to off-set Medicaid
  - Upstate providers feel that they receive only 60 to 70% of Medicaid costs vs. downstate receiving 90% plus
  - No incentives to create the types nor number of alternatives to nursing home beds an example is the continued cap on using assisted living for Medicaid patients

- **IT investment is essential.**

Everyone recognizes the potential of informational and communication technologies to increase quality, accessibility and reduce costs caused by duplication of tests and services. With the exception of a minority of the large academic and community hospitals and large group practices few have made the investment in people, software and hardware. Capital and expertise is lacking to make this a reality. Hospital and Physician groups do not believe they are generating adequate cash flow to replace plant or invest in IT infrastructure

- **Physician and Nursing Workforce Issues**

Physician and Nursing shortages are expanding throughout the Central NY region.

Hospitals have always been the employer of nurses but now they are also becoming the creator of groups to recruit and retain physicians. Physicians are working less hours and this is placing a continued strain on the supply as it is now taking 1.5 to 2 FTE's to replace one FTE physician. Changing lifestyle requirements, physician educational debt and malpractice insurance costs are adding costs and risk to physician practice. Hospitals as the community health resource are being required to take on the business risk to assure an adequate supply of physician, nursing and technical staff in their community.