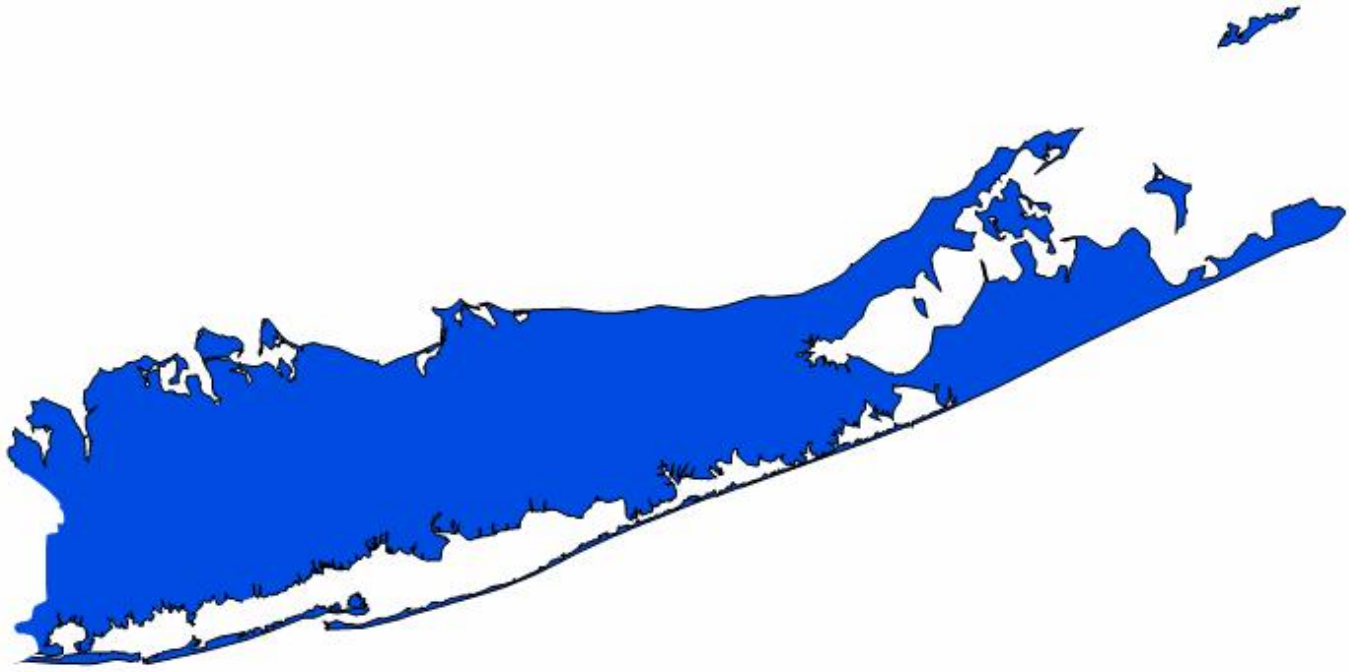
# *Findings of the Long Island Regional Advisory Committee*

***October 2006***



## Commission on Health Care Facilities In The 21st Century

**Long Island Regional Advisory Committee**
**2488 Montauk Highway**
**P.O. Box 1980**
**Bridgehampton, New York 11932**

October 31, 2006

Stephen Berger, Chairman
Commission on Health Care Facilities
in the 21st Century
90 Church Street, 13th Floor
New York, NY 10007

Dear Mr. Berger:

On behalf of the Long Island Regional Advisory Committee I am pleased to submit the final report of its deliberations and findings. This report is based on the comments the RAC received through public meetings, discussions with healthcare providers and pertinent information from the Commission's healthcare database.

The RAC was diligent in discharging its responsibilities and carefully considered the impact of the recommendations contained in this report. The RAC strongly encouraged providers to voluntarily come together and respond to health care needs of Long Island through the development of strong regional networks of care. To this end, the RAC suggests the Commission's final recommendations should include incentives for providers to work together under a unified governance and management structure.

I am particularly grateful for the support that I, and the other RAC members, received from the Commission staff. Janette Simms, Lisa Silver and Shirley Chen were extremely helpful in providing information, organizing our meetings and keeping us focused. They are to be commended for a job well done.

We hope our efforts assist the Commission in making recommendations which result in a more viable health care delivery system. I and other members of Long Island RAC are available to discuss the contents of this report with the members of the Commission.

Sincerely,

George J. Farrell, Jr.

# REGIONAL ADVISORY COMMITTEE MEMBERS

**George Farrell, Jr., Committee Chair**
Partner, Farrell Fritz

**Reverend Calvin O. Butts, III**
Pastor, Abyssinian Baptist Church, New York
President, State University of New York
College at Old Westbury.

**Joseph Carillo**
Administrator, Carillon Nursing and Rehabilitation Center

**Ronald Gaudreault**
Former President and CEO, Huntington Hospital

**Jack Howlett**
Co-Chair of the Board, New Island Hospital

**Jeffrey Kraut**
Senior Vice President Strategic Planning & Marketing,
North Shore Long Island Jewish Health System

**Vincent Muscarella**
Legislator, Nassau County Legislature, Eighth Legislative District

**Joseph Quagliata**
President and CEO, South Nassau Communities Hospital

# CONTENTS



List of Figures

# EXECUTIVE SUMMARY
# FACILITY SPECIFIC FINDINGS

## Acute Care

- The hospitals in eastern Suffolk County**, Brookhaven Hospital and Medical Center, Eastern Long Island Hospital, J.T. Mather Hospital, Peconic Medical Center (formerly Central Suffolk), and Southampton Hospital** should be joined under a single unified governance structure with full authority to develop a strategic plan which restructures the hospitals to assure access to emergency services, rationalizes bed capacity, minimizes duplication of services and develops an integrated health care delivery system for the communities they collectively serve. Planning should include **University Hospital at Stony Brook,** a regional tertiary care provider, which should participate in governance once it is free to do so (see discussion below about Stony Brook). The formation of a system will result in bed reductions, the exact number to be determined following a consultant's study now being conducted by four of the five hospitals. Additionally, the hospitals could benefit from the sharing of best practices for patient care, economies of scale, such as joint purchasing, shared administrative services and through relationships with payors of health care.

- As an academic medical center and one that is publicly funded and subsidized, **University Hospital at Stony Brook** should be given the operational and governance freedom to form an integrated health system with community hospitals. Through extensive discussions with the RAC, the trustees of community hospitals have indicated a desire to partner with Stony Brook and share governance to operate a regional health care system. However, University Hospital is unable to do so under its current organizational structure within the State University of New York. The RAC realizes the importance of University Hospital to continue to be aligned with the mission of the State University, but it needs to pursue an equally important role in serving as the tertiary referral center of a regional health system. Thus, University Hospital should be placed in a new corporate entity, separate from the University

but aligned with the teaching and research role of the Medical School, so it has the ability share governance with other community hospitals.

- The RAC finds that an opportunity exists to close **St. Charles Hospital** and relocate its services to other institutions – rehabilitation to another Catholic Health System campus, medical/surgical services to J.T. Mather Hospital, and obstetrics to J.T. Mather Hospital and other facilities. The Committee is concerned that the reversal of years of losses at **St. Charles** is temporary and, although the Catholic Health System of Long Island may have the ability and commitment to continue to invest and support the hospital, an opportunity nevertheless exists to reduce duplication of services, and strengthen community hospitals in Suffolk through closure of St. Charles and relocation of its largely "destination" services. The RAC's discussion centered around the long term view that one stronger hospital will be better able to serve Port Jefferson and the surrounding communities than two. Both hospitals (less than a mile apart) have a significant amount of fixed costs to carry and will need to continually invest in facilities and technology to remain competitive. Additionally, the RAC recommends that as the planning for consolidation with St. Charles is developed, J.T. Mather should enter into joint planning activities with the East End Hospitals, Brookhaven Medical Center and University Hospital at Stony Brook.

- The RAC strongly supports the Nassau Health Care Corporation's efforts to restructure Nassau University Medical Center and the A. Holly Patterson Nursing Home. **Nassau University Medical Center** must focus on being the highest quality community teaching hospital consistent with the health care needs of the communities that are dependent on it for primary, emergent and acute care. It should continue its niche role in tertiary services such as trauma, burn, and neonatal care and continue to pursue relationships for access to other tertiary services that require a substantial commitment of resources. With respect to acute care capacity, the RAC endorses NUMC's strategic plan to reduce its bed capacity. Today, the Medical Center has 631 certified beds and 515 available beds; in 2004 it ran an average daily census of 338 beds. A final bed capacity of approximately 400 beds would appear to be appropriate.

- The RAC would like to see **Long Beach Medical Center** evolve into a smaller facility that closely resembles a federally designated Critical Access Hospital, and suggests that the NYS Department of Health strongly consider creation of a state designation that would allow institutions to offer a more limited menu of services for their communities, while retaining a level of reimbursement that allows them to remain financially viable.

  The large number of long term care facilities and adult homes on the Island, coupled with its geographic isolation, dependence on drawbridges, and recreational waterfront parks reinforces the need to maintain ready access to acute and emergency services in this location, even though fully half of Long Beach residents migrate off the Island for acute care. Successful transformation of LBMC into a Critical Access- type hospital will be dependent upon the development of a relationship with one or more neighboring hospitals, a relationship that may require the DOH to act as a facilitator, and to provide financial incentives.

**Long Term Care**

- The RAC finds that the A. **Holly Patterson Extended Care Facility (part of the Nassau Health Care Corporation)** should be downsized by 589 RHCF beds to 300 beds. It further recommends that A. Holly Patterson's existing sub-acute services be moved to the empty floors of the Nassau University Medical Center (NUMC) and that a smaller, more appropriate facility be rebuilt, either on the NUMC Campus, or at the existing Uniondale campus. Further, the NHCC should create a Medicaid ALP of not more than 150 beds on the same campus as the new A. Holly Patterson.

- The RAC finds that **Cold Spring Hills Center for Nursing and Rehabilitation** (Nassau County) should be downsized by 90 RHCF beds (one building) to 582 beds. The facility should add a 24-bed Ventilator unit, an evening adult day program, and a 12-station hemodialysis center on the existing campus.

- The RAC finds that **Brunswick Hospital Center Skilled Nursing Facility (Suffolk)** (94 beds) should be closed, and that the facility should create a 50-bed Medicaid ALP for Suffolk County.

# I. INTRODUCTION

The Commission on Health Care Facilities in the 21st Century was created as part of the 2005-2006 New York State budget in order to examine the needs and capacities of the health care system and make recommendations to right-size hospitals and nursing homes. The mandate of the Commission is to consider and be sensitive to local needs throughout its deliberations. To ensure that the particular needs of each region will be fully considered, the Commission is comprised of 18 statewide members and 36 regional members (6 from each of six regions).

In addition, the Commission is required to work with six Regional Advisory Committees (RACs). Each RAC is charged with issuing its own, non-binding recommendations for rightsizing the hospital and nursing home systems in its respective region. Individuals serving on the Long Island RAC are listed in the front of this report.

This report contains findings of the Long Island Regional Advisory Committee with regard to acute and long term care and is being submitted to the voting members of the Commision to assist in their deliberations. It was developed after two public hearings that were held in March and April 2006 where hospitals, health providers, and the public were invited to provide comments relevant to the charge of the Commission. This was then followed by numerous meetings with hospital representatives and discussions among RAC members.

Although the RAC discussed many aspects of the health care delivery system on Long Island, it limited its findings to the identification of those opportunities, consistent with its charge, to right size or restructure hospitals and nursing homes. These findings should also be interpreted along with the significant amount of hospital specific data collected by the Commission and appearing on its web site: www.nyhealthcarecommission.org.

# II. DESCRIPTION OF LONG ISLAND REGION

An extensive socio-demographic profile of Long Island was published in 2003 by the Rauch Foundation and the Regional Plan Association specifically to help inform policy discussions such as those of the RAC about the future of Long Island. Much of the information in this section is summarized from this report which can be downloaded through the web site of the Long Island Index at *www.longislandindex.org/index_maps0.0.html*.

From the Hudson River to Montauk, Long Island is the largest island adjoining the continental USA, extending over 118 miles in length and 20 miles in width. It is geographically surrounded by the Long Island Sound to the North and the Atlantic Ocean to the South. Long Island's linear shoreline extends approximately 1,200 miles. On the western part of Long Island are the New York City boroughs of Brooklyn (Kings County) and Queens (Queens County); east of these are Nassau and Suffolk counties. (Figure 1) However, colloquial usage of the term "Long Island" or "the Island" usually refers to Nassau and Suffolk counties only; Brooklyn and Queens are omitted, as they are part of New York City. For the purposes of this report, the region is defined by the "primary metropolitan statistical area" consisting of the 1,198 total square miles in Nassau and Suffolk Counties.

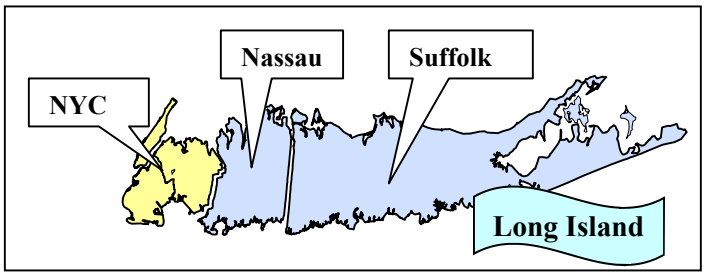



**Figure 1 -Long Island**

## Economy

Long Island has a larger economy than nearly half of U.S. states, and it produces about as much in goods and services as countries such as Israel, Ireland and Venezuela. With an economy currently producing in excess of $100 billion dollars (2003), Long Island's gross metropolitan product (GMP) ranks among the top 20 Metropolitan areas in the U.S. If Nassau and Suffolk were a nation, together they would rank 51st in the world.

Long Island has also been one of the fastest growing parts of the larger New York metropolitan area economy for most of the postwar period. While Long Island's economy remains closely tied to New York City's, a growing proportion of Long Island's workforce works within Nassau and Suffolk. The economies of the city and the island are intertwined in many ways, from

common labor pools to overlapping business networks. Over a quarter-million Long Islanders commute to New York City every day, but 77% of the Island's labor force works on the Island.

The unemployment rate on Long Island is 4.1 % and compares favorably with that of New York City and New York State, see Figure 2. However, when analyzed by race it is only 2.9% for Whites, and twice as high – 6.0% – for Blacks, and three times as high for Hispanics – 8.9%.[1]

**Figure 2 - 2005 Unemployment Rate Population over 16 years of age**
Source: New York State Department of Labor; and U.S. Department of Labor

**Unemployment Rate, 2005**

| | |
|---|---|
| United States | 5.1% |
| New York State | 5.0% |
| New York City | 5.8% |
| Long Island | 4.1% |
| Nassau County | 4.1% |
| Suffolk County | 4.2% |

## Population

Today, Long Island has a population of over 2.7 million people which accounts for 20% of the population of New York State. Nassau County has an estimated 2004 population of 1,339,641 individuals. One of the nation's first suburbs, it is densely settled with 4,655 persons per square mile (2000) and has far less undeveloped land than Suffolk County. Suffolk County, an outer-ring suburb, remains more rural than Nassau with an estimated population of 1,475,488 (2004)—it is a third of the density of Nassau with 1,556 persons per square mile (2000).

As of 2000, Suffolk and Nassau Counties, respectively, are the 3rd and 4th most populous counties in the U.S. In fact, Long Island has a total population greater than that of 19 states and, if it were a city, it would rank as the 4th largest in the nation.

[1] Institute on Race and Poverty, Racism and the Opportunity Divide on Long Island, Prepared for the ERASE Racism Initiative of the Long Island Community Foundation, July 2002

Following several decades of growth Long Island is now mostly developed. Nassau's population grew most rapidly in the 1950s and peaked in 1970. After declining during the 1970s and 1980s, modest growth resumed in the 1990s. Suffolk, on the other hand, grew rapidly through 1980, and has continued to grow at a slightly faster rate than Nassau in the 1980s and 1990s. With homes, buildings and pavement covering most of the Island as far as central Suffolk, the edge of rural, undeveloped land is not found until one travels some 60 miles from Manhattan. Only the East End remains largely undeveloped, and that area is now under severe pressure for development.

**LONG ISLAND AT A GLANCE**

**Population: 2,762,551**
**Households: 923,826**
**Median Household Income: $75,177**
**Property Taxes Per Capita: $2,450**
**Median Home Value: $394,682**
**Under 20 years old: 27%**
**20-34 years old: 17%**
**35-54 years old: 31%**
**55-64 years old: 11%**
**65 years and older: 14%**

Recent and projected population increases are largely the result of immigration and the growth of racial and ethnic minorities. The rapid expansion of the Hispanic and Asian population is a central demographic dynamic on Long Island. Along with African-Americans and other minorities, the non-white population now accounts for 24% of the total population, up from approximately 16% in 1990. (Figure 3) This growth is consistent with patterns throughout the tri-state metropolitan area, as immigrant communities have prospered and followed a migratory pattern from the urban to suburban communities. In the next decade, the white population on Long Island is projected to decline by an additional 78,000, less than 2 per cent, while the non-white population grows by 162,000 or 24 per cent.

**Figure 3- Percent Population by Race and Ethnicity**
Source: Adelphi University, Vital Signs, 2006

| | United States | New York State | Long Island | Nassau County | Suffolk County |
|---|---|---|---|---|---|
| White | 77.1 | 69.0 | 81.8 | 77.9 | 85.6 |
| Black or African American | 12.4 | 16.1 | 9.0 | 10.8 | 7.2 |
| Hispanic* | 14.2 | 16.1 | 11.9 | 11.4 | 12.4 |
| Asian | 4.3 | 6.5 | 4.95 | 6.6 | 3.3 |
| American Indian and Alaskan Native | 0.8 | 0.3 | 0.25 | 0.2 | 0.3 |

*SOURCE: U.S. Census American Community Survey 2004*
**Hispanic can be of any race*

Long Island's population is aging along with the rest of the United States. With the aging of the Baby Boom generation, more Long Islanders are entering their late 40s and 50s. And with longer life expectancies, the elderly

population is also expanding. Nassau has a somewhat older profile than Suffolk, but the gap is narrowing. Eastern Suffolk in particular is attracting many retirees and substantial growth in the number of senior citizens is projected for the region.

As the Baby Boom generation continues to age, we can expect large increases in retirees and older workers. Forecasts of the New York Metropolitan Transportation Council predict a 45% increase in the over 65 population during the next two decades, and a 76% increase in those 55-64. The preschool and school age population is projected to decline[2]. The aging of the population has significant implications for the demand of health services since the Long Island population over 65 years of age utilizes inpatient services between 3 and 4 times greater then those under 65 years.

## Household Income

On the whole, Long Islanders have among the highest incomes in the New York region. In 2000, 29% of Long Island households had annual incomes greater than $100,000, compared with 12% of all Americans. In the New York metropolitan area, only the northern suburbs (Westchester, Fairfield, Rockland and Putnam counties) had a slightly higher share earning over $100,000. However, only 11% of Nassau and Suffolk households had incomes of less than $20,000, substantially less than any other part of the region.

For the purposes of the RAC's charge, a detailed description of Long Island can not be told in terms of averages but rather in the range between the high and low of a measure. In spite of Long Island's relative affluence, it includes include many low-income families and individuals. Additionally, Long Island is among one of the most racially segregated metropolitan areas in the United States and the racial segregation of pockets of communities significantly overlaps with concentrated indicators of poverty. These and other factors significantly contribute to a number of disparities reported for several of Long Island's communities.

About 154,000 persons live below the federal poverty line. At 5.6%, this is low by national standards. However, the federal poverty level for a family of three is only $13,738. Particularly, in a high-cost area like Long Island, that

[2] US Forecast by Urbanomics for the New York Metropolitan Transportation Council appearing in Rauch Foundation and Regional Plan Association, Long Island Profile, April 2003

means that many more people living above the poverty line ought to be considered low-income. According to a 2002 report published by the Institute on Race and Poverty [3], poverty rates in Nassau-Suffolk have increased for both Whites and Blacks over the past decade, but Black households continue to be far more likely than White households to be impoverished see Figure 4 In Nassau County, Blacks are nearly twice as likely as Whites to live in poverty. In Suffolk County, the disparity is almost three-to-one.

**Figure 4 - Estimated Household Poverty by Race, 1999**

Source: 2000 Bureau of Labor Statistics, Geographic Profile of Employment and Unemployment

| | Percent of Households at Poverty | |
|---|---|---|
| **Race** | **Nassau** | **Suffolk** |
| **White/Other** | **6.3%** | **7.4%** |
| **Black** | **11.4%** | **21.0%** |

## Health Disparities and Communities at Risk

At the outset of the discussions, RAC members were concerned about any actions they recommend which could negatively impact the health status of a community which has documented disparities in health measures. To this end, we consulted a recent study sponsored by Adelphi University, entitled *Vital Signs 2006 - Measures of Long Island's Social Health*. The goals of Vital Signs are to "understand existing health and social conditions, help sustain and strengthen community assets, improve regional social health, and reduce social health disparities". The RAC also benefited from having two of its RAC members serving as members of the Vital Signs Advisory Board and thus were very familiar with the contents of the study. A complete copy of the study may be downloaded at the following web site: *www.adelphi.edu/vitalsigns*

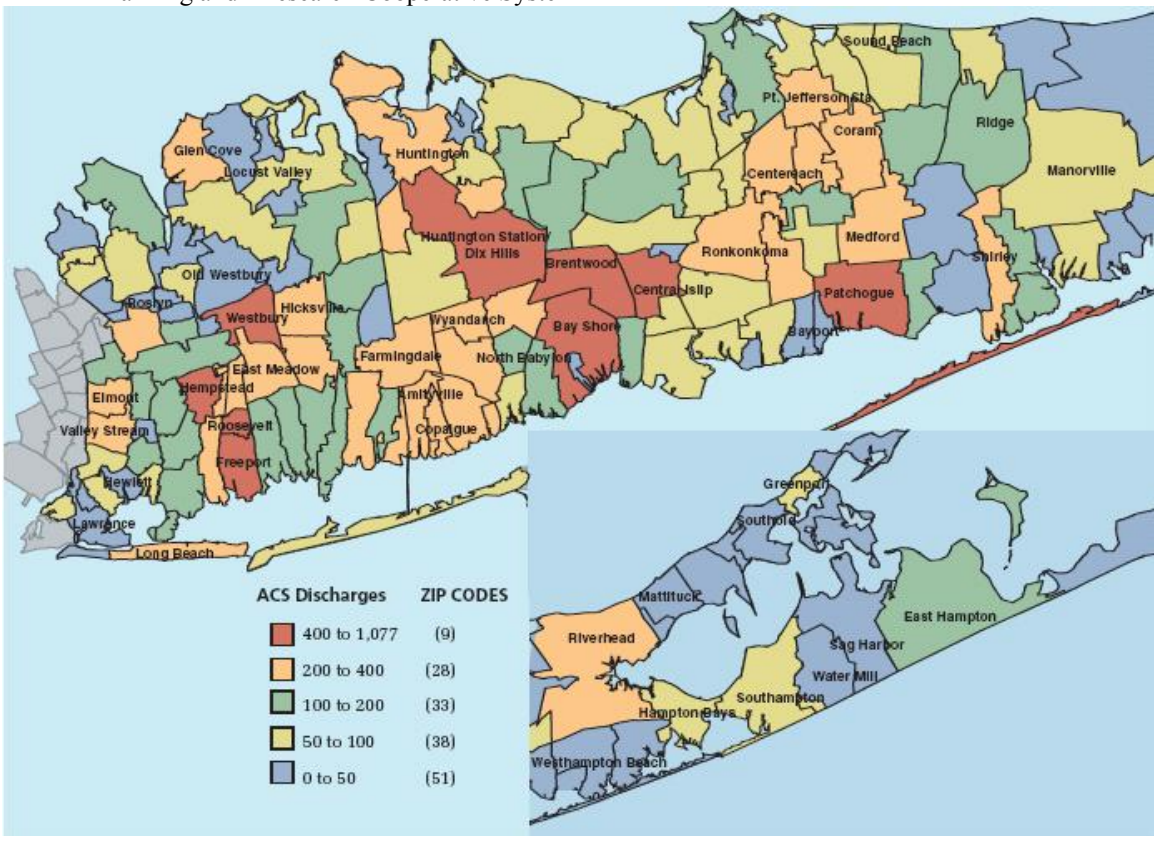
This study is the most recent comprehensive compendium of health and social data available to the RAC and, when combined with community health assessments conducted by the New York State Department of Health, and Nassau and Suffolk County Departments of Health, a detailed picture of Long Island's Health status comes into view. However, what is most important for the purposes of the RAC's charge is that the data also identifies the most

vulnerable communities on Long Island who experience a complex interaction of social, economic, environmental, and biological influences which result in lower health status.

Ambulatory Care Sensitive (ACS) conditions were used to identify communities who may experience difficulty in accessing the health care system. ACS conditions are those which present in hospital emergency departments and because of their severity, result in an inpatient admission. These are conditions like asthma, high blood pressure and diabetes. Access to primary care could prevent the onset of certain illnesses, help control an acute episodic illness or condition, or manage a chronic disease or condition. Figure 5 maps the number of total ACS inpatient admissions by zip code.

**Figure 5 - Total Ambulatory care Sensitive Conditions Inpatient Discharges by Zip Code, 2005**

Source: Long Island Index 2006, New York State Department of Health Office of Statewide Planning and Research Cooperative System




Not surprisingly, when other socio-demographic indicators such as morbidity, mortality, poverty, household income, or the presence and type of insurance

are analyzed these same communities appear time and time again. We have collectively referred to these communities as, "Communities at Risk", and for the purposes of this report they are aggregated into larger contiguous geographic areas. Figure 6 below shows the ACS rates per 1,000 population. (This is not a complete list of every community which may be at risk but it does represent the majority of those on Long Island).

**Figure 6 - Communities at Risk and Ambulatory Sensitive Conditions**

Source: NYS Department of Health, Statewide Planning and Research Cooperative (SPARCS), 2004 and Solucient

| Communities at Risk | ACS Conditions per 1,000 Population |
|---|---|
| Glen Cove | 12.2 |
| Central Nassau | 17.4 |
| Southwest Suffolk | 14.1 |
| Mid Suffolk | 13.6 |
| Eastern LI | 13.0 |
| | |
| Nassau County | 8.9 |
| Suffolk County | 9.1 |
| Long Island | 9.0 |

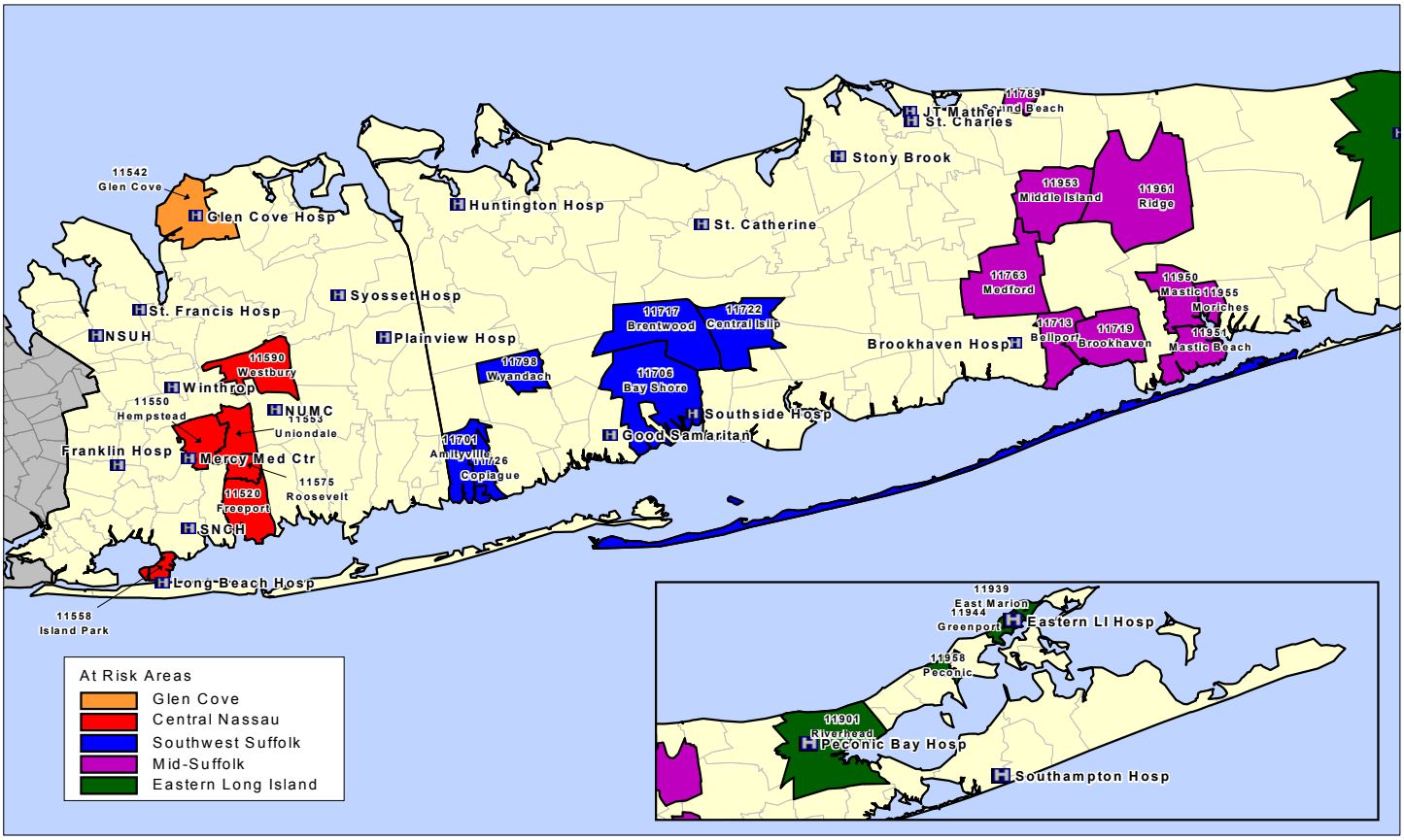
These communities are dependent on nearby hospitals for access to emergency and acute health care services. The top three hospitals that primarily serve the majority of the health care needs of these communities are identified below, see Figure 7. A map of the communities at risk and their neighboring hospitals appear in Figure 8.

**Figure 7 - Top Three Hospitals serving Communities at Risk**

Source: Source: NYS Department of Health, Statewide Planning and Research Cooperative (SPARCS), 2005

| **Communities at Risk** | | **Top Three Hospitals** | |
|---|---|---|---|
| Glen Cove | Glen Cove | North Shore | LIJ |
| Central Nassau | NUMC | Winthrop | Mercy |
| Southwest Suffolk | Southside | Good Samaritan | Stony Brook |
| Mid Suffolk | Brookhaven | Stony Brook | JT Mather |
| Eastern LI | Peconic | ELIH | Stony Brook |

## Figure 8 - Communities at Risk and Neighboring Hospitals




Some of the hospitals which serve these communities are the subject of recommendations appearing in this report. The RAC believes its recommendations will result in the strengthening of several hospitals and thus make them more viable to address some of the health needs and community disparities documented on Long Island.

# III. LONG ISLAND HOSPITALS

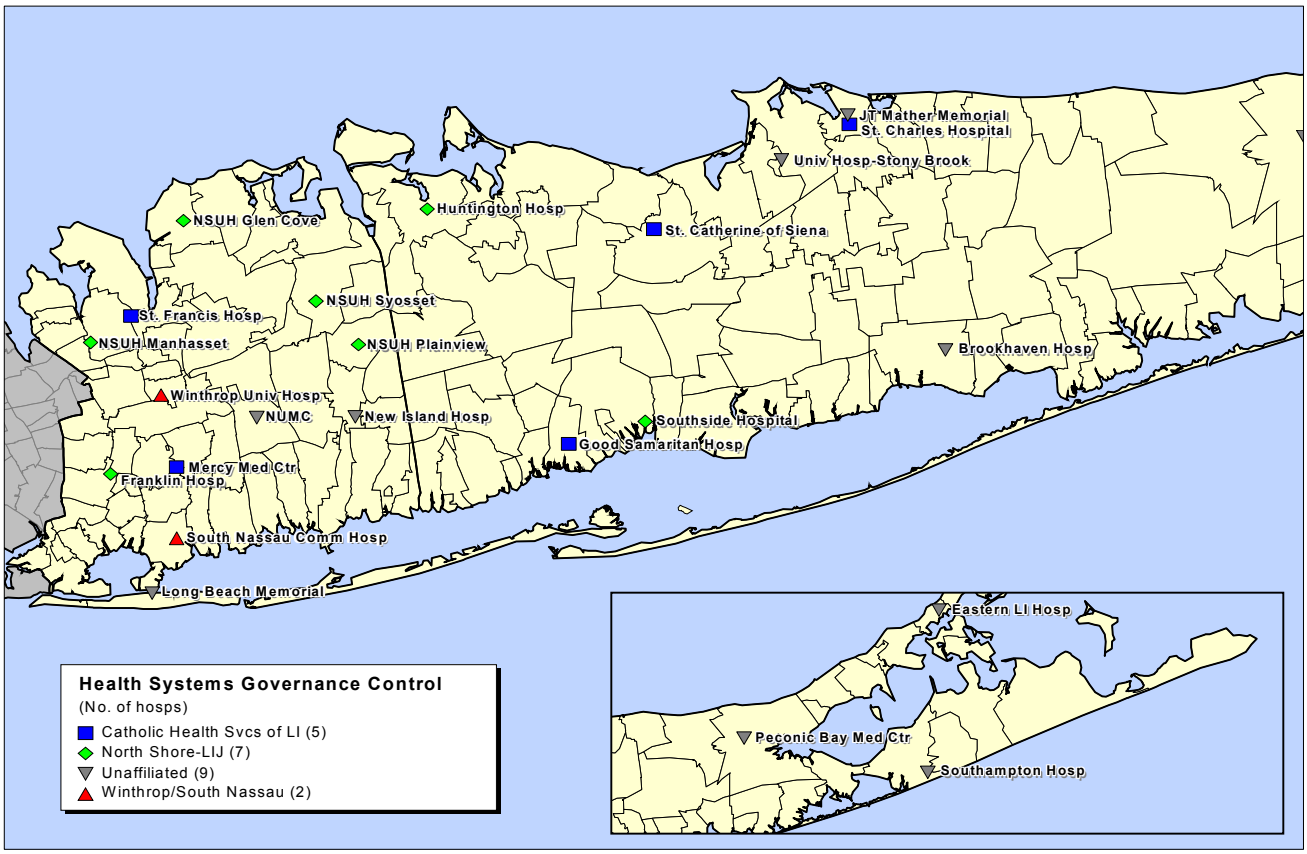
Long Island contains 23 acute care hospitals which in 2004 collectively reported 7,973 beds with an occupancy rate of 73.3 percent, see Figure 9. Of these, 12 hospitals are located in Nassau County and 11 in Suffolk County. There is a wide range in occupancy between service category with medical/surgical generally reporting the highest occupancy rate and pediatrics the lowest. Total occupancy ranges from a low of 41 percent to over 100 per cent. Obviously, there are a number of licensed beds which are not staffed but used on occasion during peak census periods. Over half of the hospitals, 52 per cent, are under 300 beds, 30 per cent are between 300 and 500 beds and 4, or 17 per cent, are over 500 beds. About a third of the beds are located in hospitals under 300 beds, another third in hospitals between 300 and 500 beds and the remaining third in those over 500 beds.

## Figure 9 – Long Island Hospitals, Bed Size and Occupancy, 2005

| HOSPITAL | CERTIFIED BEDS | Discharges | OCCUPANCY |
|---|---|---|---|
| | **2005** | **2005** | **2005** |
| **BROOKHAVEN** | 321 | 21,655 | 75.0% |
| **EASTERN LI** | 80 | 5,257 | 73.0% |
| **FRANKLIN** | 236 | 18,290 | 86.1% |
| **GLEN COVE** | 265 | 17,650 | 74.0% |
| **GOOD SAMARITAN** | 431 | 38,726 | 99.8% |
| **HUNTINGTON** | 408 | 22,653 | 61.7% |
| **LONG BEACH** | 203 | 9,579 | 52.4% |
| **JT MATHER** | 248 | 19,854 | 89.0% |
| **MERCY** | 387 | 23,539 | 67.6% |
| **NUMC** | 631 | 32,374 | 57.0% |
| **NEW ISLAND** | 203 | 11,731 | 64.2% |
| **NORTH SHORE** | 788 | 71,040 | 100.2% |
| **PECONIC BAY** | 154 | 6,522 | 47.1% |
| **PLAINVIEW** | 218 | 19,471 | 99.2% |
| **ST. CATHERINE'S** | 311 | 20,992 | 75.0% |
| **ST. CHARLES** | 289 | 17,594 | 67.6% |
| **ST. FRANCIS** | 279 | 27,334 | 108.9% |
| **SOUTH NASSAU** | 435 | 30,255 | 77.3% |
| **SOUTHAMPTON** | 120 | 5,337 | 49.4% |
| **SOUTHSIDE** | 365 | 23,939 | 72.9% |
| **SYOSSET** | 116 | 6,019 | 57.7% |
| **STONY BROOK** | 504 | 41,600 | 91.7% |
| **WINTHROP** | 591 | 45,230 | 85.0% |
| | | | |
| **TOTAL** | 7,583 | 536,641 | 78.6% |

A majority of the hospitals, 14, are corporate members of regional health systems and operate under a parent governance model. These are the North Shore – Long Island Jewish Health System with 7 hospitals (6 of its other hospitals operate outside of Long Island), Catholic Health Services of Long Island with 5 hospitals and the Winthrop – South Nassau Health System with two hospitals. The three east end hospitals (Peconic, ELIH and Southampton) had formed the Peconic Health System but terminated that relationship in 2006. The remaining 9 hospitals are free-standing although some maintain a variety of academic, clinical or other arrangements between other hospitals or health systems. A map of the hospitals and their health system parent appears in Figure 10.

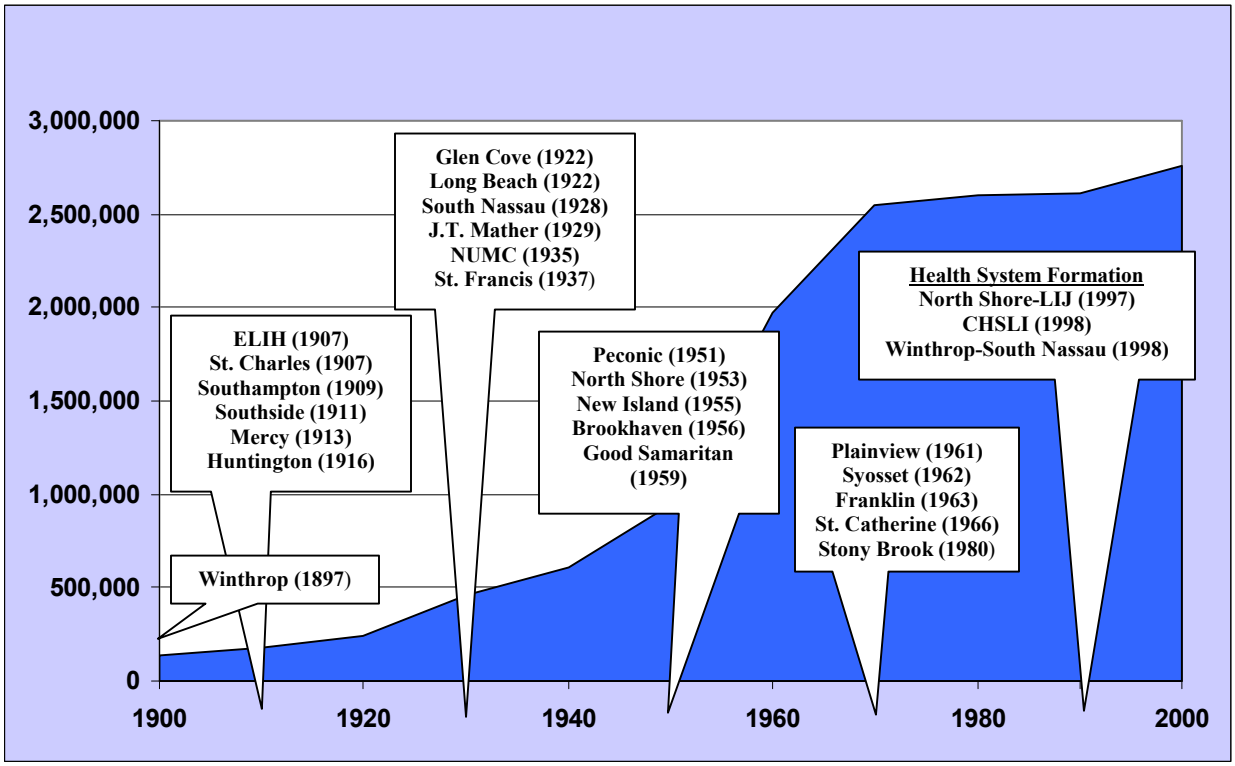
**Figure 10- Map of Long Island Hospitals**




The majority of Long Island hospitals were founded by their communities as not-for profit hospitals in the early part of the 20th century and eleven were established after the population explosion that followed World War II and the development of modern suburbia see Figure 11.

The history of Long Island hospitals is intertwined with that of the communities they serve. Many of the hospitals were founded in response to particular public health need. For example, the oldest hospital in continuous operation on Long Island, Winthrop University Hospital, was founded in response to soldiers returning from the Spanish-American War who were carried off the troopships at Montauk in 1899 suffering from tropical diseases they contracted in Cuba. Handicapped city children were brought to the St. Charles Hospital in Port Jefferson, once known as the Brooklyn Home for Blind, Crippled and Defective Children, founded in 1905 by the Daughters of Wisdom, a French Catholic order. North Shore University Hospital was founded in 1953 because of the injuries sustained in a 1945 auto accident by a Great Neck teenager that galvanized community resolve to raise the funds for construction of a local hospital.

**Figure 11- Hospital Founding and Long Island Population 1900 - 2000**




The hospitals continued to evolve in their current locations as the population swelled and shifted around them. Advances in medical knowledge and availability of health insurance fueled the demand for health care and so did the requirement for capital investment as new technology was acquired,

buildings, floors and wings were added and emergency departments expanded. Only after WWII did Long Island see the development of smaller physician owned, proprietary hospitals. Today, there are no for-profit acute care hospitals operating on Long Island, all have either closed or converted to non-profit sponsorship

Health care is local on Long Island with almost 90 per cent of residents receive their care at Long Island hospitals. Another 5 per cent, particularly those is western Nassau County go to Queens Hospitals such as Long Island Jewish in New Hyde Park, which is actually located on the Queens/Nassau border and another 5 per cent out-migrate to hospitals in New York City. This in contrast to the Westchester County population, where 80 % of the population receives care at Westchester hospitals and 18 per cent migrate out of the county to go to New York City hospitals.[4]

The Commission staff and Department of Health have already assembled an extensive database on operating and statistical information profiling NYS hospitals that has been made available to Commission members. The purpose of this report is not to repeat that information but rather to help interpret the information. It is important to recognize that the health care system on Long Island has undergone significant evolution in the past decade. Any discussion about the future bed supply of Long Island hospitals should also include an understanding of how that bed supply has changed over the past years. Since 1995, four acute care hospitals with a licensed capacity of approximately 800 beds have closed. These hospitals include Brunswick Hospital (192 medical/surgical beds), Amityville (Suffolk); Island Medical Center (213 beds), Hempstead (Nassau); Community Hospital of Western Suffolk (271 beds), Smithtown (Suffolk) and Massapequa General Hospital (122 beds), Massapequa (Nassau).

For the most part, physicians and patients alike have migrated to neighboring hospitals for emergent and acute care. Where issues of access to services exist, and it does exist for communities on Long Island as discussed in Section II of this report, the solution to improved access will not be found in additional hospitals or opening closed ones, but rather to enhance and invest in primary care capacity which is closely linked to the acute care setting. The RAC believes, very strongly, that the hospitals which are closed should remain so.

[4] NYS Department of Health, SPARCS data, excludes newborns, 2005

To do otherwise would undermine a regional objective of operating more beds in fewer facilities.

Another factor to appreciate is that hospitals have not been static but have been changing their bed capacity in response to community health needs and market forces. For example, Long Island hospitals have diversified away from medical/surgical bed capacity and expanded into behavioral health and rehabilitation, and created specialized inpatient programs and services which focus on short-stay minimally invasive surgical procedures. In addition, many hospitals have successfully participated in area-wide health planning by joining regional health care systems which have consolidated obstetrical and pediatric bed capacity or relocated specialized services, such as cardiac catheterization, from tertiary centers to community hospitals.

As noted above over half of the Long Island hospitals have merged or consolidated into health systems that have regionalized care within their systems and made significant investments in the hospitals. For example, Catholic Health Services of Long Island (CHSLI) acquired the St. John's Episcopal Hospital in Smithtown and renamed it St. Catherine's, it has also extended the cardiac programs at St. Francis to Mercy Hospital and created a joint program with Memorial-Sloan Kettering to offer cancer services there as well. Recently, it has reorganized its Nassau and Suffolk hospitals into two regional networks of health care so as to better manage and coordinate program development in each county. North Shore-LIJ had acquired community hospitals and completely rebuilt them from the inside out. It has merged Syosset Hospital with North Shore University Hospital and re-tasked Syosset to become a surgical specialty hospital for short stay minimally invasive procedures. North Shore-LIJ has closed obstetrical services at Glen Cove and Franklin hospitals and relocated those services to its neighboring hospitals.

## Capital Investment

There is already a significant amount of capital invested in Long Island hospitals, with over $2 billion in long term debt, two thirds of which is issued through DASNY. Long Island hospitals continue to invest and evolve their physical plants to meet the needs of the communities they serve. A review of Certificate of Need approvals of Long Island hospitals includes approximately $1 billion in major facility investments over the past few years. Projects completed or underway include:

- Huntington Hospital: Construction of a $45 million addition to the hospital to rebuild 12 operating rooms, new intensive care units and renovated medical/surgical units.

- Mercy Hospital: Recently opened a $41 million, 160-bed acute care pavilion to house orthopedics, oncology, cardiac and medical/surgical care
- North Shore University Hospital: Has recently invested over $60 million to add 80 medical/surgical beds, four additional cardiac catheterization laboratories, three operating rooms and expanded its emergency room. It is also in the process of investing over $100 million for the development of a 400,000 sf Center for Advanced Medicine to house a continuum of specialized ambulatory care activities which include ambulatory surgery, cancer care, imaging etc..

- South Nassau Community Hospital: The Hospital opened a new 170,000 sf $103 million bed replacement project for Maternity, NICU, Psychiatry and Medical/Surgical care. It also expanded the capacity of its emergency room with specialty areas for pediatrics, behavioral health and orthopedics.

- Southside Hospital: A $30 million upgrade project to expand its surgical suite, relocate intensive care units, and rebuild and expand its cardiac catheterization laboratories.

- St. Francis: A major new patient care building that will add 150,000 square feet of clinical space to the Hospital's main campus is under construction. This is part of a $190 million project to add two medical/surgical floors and an intensive care unit, with a total of 184 patient beds as well as an increase in the number of operating rooms and

cardiac catheterization laboratories. The building represents a 40 percent increase in space at the Hospital.

- Stony Brook: University Hospital is in the fourth year of implementation of a $300 million major modernization project. The project includes the development of a Heart Center, Ambulatory Care Pavilion, expanded emergency department, women's and infant's center and a renovated surgical suite.

- Winthrop University Hospital: The Hospital has undergone a series of major modernization projects in excess of $80 million which has rebuilt medical-surgical beds, added cardiac catheterization laboratories, added operating rooms, a new parking structure, renovated and expanded its emergency department, intensive care units, radiation oncology and diagnostic imaging center.

Furthermore, CON's approved and projects about to begin include the conversion of medical/surgical beds at NUMC to adult and child psychiatry beds, the addition of a cardiac catheterization laboratory at Brookhaven Hospital, a $23 million renovation at Peconic Bay for it operating suite, emergency department and medical/surgical patient care units and an additional cardiac catheterization laboratory and expanded emergency department at Good Samaritan Hospital.

Commission members have to recognize the significant amount of capital being invested in several Long Island Hospitals to permit them to continue to meet the health care needs of the region.

# IV. HOSPITALS AND THE LONG ISLAND ECONOMY

Among the six criteria adopted by the Commission in its analytic framework is the consideration of the economic impact of hospitals in the region. Hospitals are valued for providing access to vital health care services 24 hours a day, seven days a week, 365 days a year, however, the economic contribution of Long Island's hospitals to its community in terms of employment, purchasing and the multiplier impact of their employees' spending and tax payments has only recently been recognized.

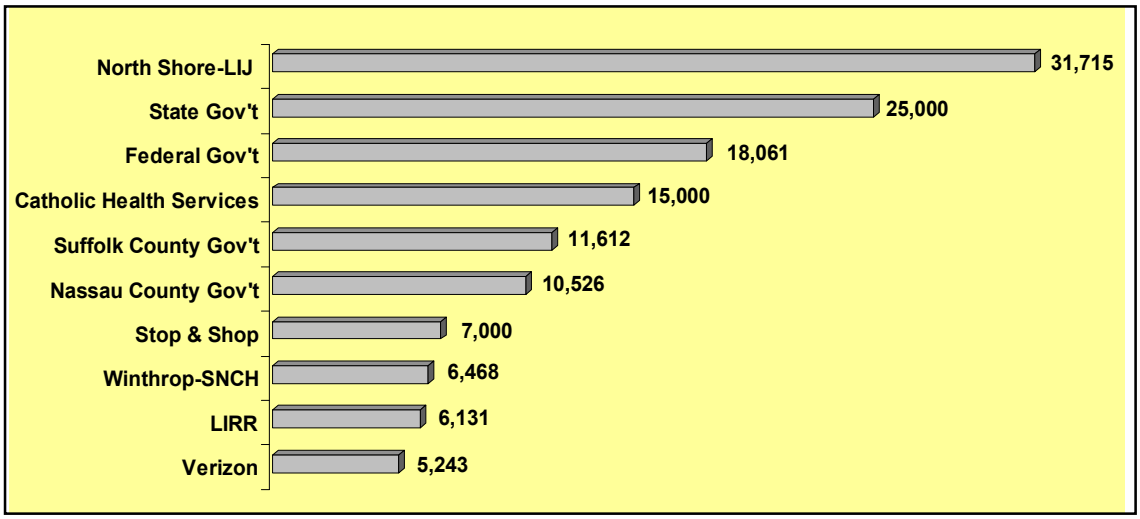
Hospitals on Long Island are among the largest employers in the region. A recent report by *Newsday*, indicates that among the top ten Long Island employers, Long Islands Health Systems are the 1st, 4th and 8th largest employers, see Figure 12.

The economic effect of Long Island Hospitals is well documented. In 2003, the 23 hospitals on Long Island contributed over $9.5 billion to their local economies. This includes direct and indirect spending by hospitals and their employees. These figures were reported in an analysis conducted by the chief economist of the Long Island Association (LIA) for the Nassau Suffolk Hospital Council. The LIA is the regions largest business association representing approximately half of Long Island's workforce. The analysis utilizes data derived from the 2001 Institutional Cost Reports (ICRs) for each hospital (two of the hospitals included in the analysis, Island Medical Center and Brunswick have since closed).

**Figure 12- Long Island's Largest Employers**

Source: *Newsday*, May 15, 2006

Note: NSLIJ Health Employee count includes Queens and Richmond County Employees



According to the study, "Long Island's hospitals employed almost 42,000 full-time equivalent workers in 2001 and accounted for about 3.5 percent of total payroll employment on Long Island. Their aggregate wages, including fringe benefits, exceeded $2.76 billion and their total expenditures exceeded $4.60 billion in 2001. The direct effect of hospital employment is that each Long Island hospital worker supports 2.2076 jobs throughout the Long Island economy. Thus the hospital workforce in 2001 supported another 50,650 jobs throughout the Long Island economy, see Figure 13.

These expenditures generally remain within the Long Island economy and undergo several rounds of "respending" so that their ultimate economic impact is a multiple of the original expenditure. This is the so-called multiplier effect. For example, hospital workers spend their wages in local stores and restaurants thereby creating additional business at these establishments. Retailers, in turn, purchase goods and services from other Long island businesses and the process continues. Hospitals themselves purchase goods and services from local businesses thereby triggering the multiplier process starting with these establishments. The indirect economic impact of Long Island Hospitals was estimated to be $4.9 billion"[5]

The Gross Metropolitan Product of Nassau and Suffolk Counties, its total output of goods and services, is estimated to be about $ 101 Billion. This means that hospital spending on Long Island directly or indirectly accounts for approximately 9.5 percent of Long Island's Gross Metropolitan Product.

The RAC recognizes that as large community employers' hospitals are instrumental in supporting the local economy and investments in Long Island's health care system has important economic implications beyond the health of the regions residents.

[5] Kamer, Pearl, The Vital Role of Hospitals in the Long Island Economy; A Special Research Report to the Nassau-Suffolk Hospital Council, Long Island Association, 2003

## Figure 13- The Direct and Indirect Employment Impact of Long Island's Hospitals, 2001

| Hospital | Direct Jobs | % Distribution | Direct & Indirect Jobs | Indirect Jobs |
|---|---|---|---|---|
| Brookhaven Memorial Hospital Medical Center | 1,353 | 3.2 | 2,986 | 1,634 |
| Brunswick Hospital Center * | 1,132 | 2.7 | 2,499 | 1,367 |
| North Shore University Hospital at Plainview | 887 | 2.1 | 1,957 | 1,071 |
| Central Suffolk Hospital | 613 | 1.5 | 1,353 | 740 |
| Eastern Long Island Hospital | 254 | 0.6 | 560 | 306 |
| Franklin Hospital Medical Center | 1,050 | 2.5 | 2,318 | 1,268 |
| Good Samaritan Hospital Medical Center | 2,399 | 5.7 | 5,295 | 2,897 |
| Island Medical Center * | 310 | 0.7 | 684 | 374 |
| Huntington Hospital | 1,313 | 3.1 | 2,898 | 1,585 |
| John T. Mather Memorial Hospital | 1,352 | 3.2 | 2,985 | 1,633 |
| Long Beach Medical Center | 918 | 2.2 | 2,027 | 1,109 |
| Mercy Medical Center | 1,598 | 3.8 | 3,528 | 1,930 |
| New Island Hospital | 562 | 1.3 | 1,240 | 678 |
| Nassau University Medical Center | 3,171 | 7.6 | 7,000 | 3,829 |
| North Shore University Hospital at Glen Cove | 991 | 2.4 | 2,188 | 1,197 |
| South Nassau Communities Hospital | 1,618 | 3.9 | 3,572 | 1,954 |
| Southampton Hospital | 656 | 1.6 | 1,447 | 792 |
| Southside Hospital | 1,751 | 4.2 | 3,866 | 2,115 |
| St. Charles Hospital & Rehabilitation Center | 1,159 | 2.8 | 2,559 | 1,400 |
| St. Francis Hospital – The Heart Center | 2,042 | 4.9 | 4,507 | 2,465 |
| Episcopal Health Services, Inc. | 1,430 | 3.4 | 3,158 | 1,727 |
| St. Catherine of Siena Medical Center | 1,353 | 3.2 | 2,988 | 1,634 |
| Stony Brook University Hospital | 3,826 | 9.1 | 8,447 | 4,621 |
| Winthrop-University Hospital | 3,667 | 8.7 | 8,096 | 4,429 |
| North Shore University Hospital, Manhasset & Syosset Divisions | 6,538 | 15.6 | 14,434 | 7,896 |
| **Total** | **41,943** | **100.0** | **92,593** | **50,650** |

Source: HANYS, LIA * Acute Care Hospital no longer in operation.

# V . FINDINGS

## Designing a Health System for Long Island

One of the questions the RAC members discussed was that if Long Island was a blank canvas what type of health system would be built – how many hospitals and where would they be located? We never fully answered the question but we did come up with some guiding principles such as;

- There would be fewer hospitals but, with more beds concentrated at each to recognize economic efficiency which accompanies scale;

- Hospitals would not be located next to one another. They would be distributed across Long Island so their locations would be proximate to population centers and acute care access via the east/west and north/south roadways would be maximized.

- Community hospitals would be linked to tertiary centers of specialized care.

- Where population is geographically dispersed and access was of critical concern there would be one full service hospital in a region with remote access locations and a highly developed transport system to respond to urgent and emergent health needs.

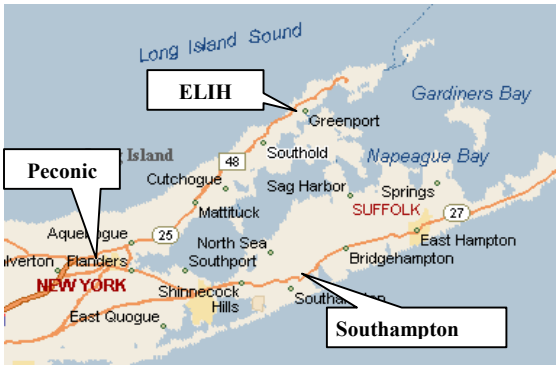
- Hospitals would not be built in parts of Long Island that are susceptible to flooding or to hurricanes.

This is, of course, a partial list and it is beyond the scope of the work of the RAC to thoughtfully evaluate and identify the complex interactions necessary to design a new healthcare system for Long Island. However, these principles, along with the criteria in the Commission's analytic framework guided our deliberations in the development of recommendations. We are also mindful that Long Island is an Island. There is only one way vehicular traffic can evacuate the Island and that is through the west – through the 2.4 million residents of Queens. In the event of a disaster, Long Island Hospitals have to have sufficient capacity to respond to the needs of the population during a crisis. This means the RAC has to carefully assess the opportunities for rightsizing and to recognize the geography in which our hospitals operate in.

The recent experience of hospitals in New Orleans brought home the fact that at least 5 our 23 hospitals are located in a flood zone and their operations could be severely compromised in the event of a Category 3 or 4 Hurricane. In addition, regional planning for a pandemic flu also reinforced the role hospitals are expected to play and it is important for Commission members to bear this in mind when developing its final recommendations.

## Long Island Region - Acute Care Findings

### Peconic Medical Center *(formerly Central Suffolk Hospital)* – Riverhead
### Eastern Long Island Hospital – Greenport
### Southampton Hospital – Southampton




This recommendation is based on a long term view that these three hospitals should be restructured to better serve the interests of the collective communities of the East End of Long Island and not just those surrounding the hospitals which have comprised the historic service area of each. Changes in the practice and delivery of healthcare and in reimbursement have led the Committee to conclude that the future of these hospitals is inextricably linked. Therefore, the Committee finds that the three hospitals should be consolidated into one entity to plan, coordinate, manage and be accountable for the delivery of acute care and related services.

In making this recommendation, the Committee acknowledges that the distribution of population, distance (Eastern Long Island is 23 miles east of Peconic Medical Center and Southampton is 20 miles southeast) and drive times are of real concern and thus, access to emergency and urgent acute inpatient care must be maintained in all three locations. Attempting to maintain three community hospitals which aspire to provide a comprehensive range of health services and compete for the relatively small, but, albeit growing and aging population, will most likely result in two and possibly all three hospitals being chronically weak from both a clinical and financial perspective and thus, unable to effectively fulfill their mission.

**Peconic Medical Center**

**Certified Beds: 154**
**Total Discharges: 5,684**

**ER Visits: 23,809**
**Net Patient Revenue: $63,283,573**

**Debt: $24,771,275 (58.7% DASNY)**

The RAC members have had numerous conversations with the parties and a plan was shared with the RAC which included the development of a new health system structure. However, there is a lot of work which needs to be done between this plan and an executed agreement. Therefore, the RAC has outlined below several generic elements it hopes to see in a newly formed relationship between the four hospitals:

**Restructure Acute Services and Maintain Access to Emergency Care**

A consultant has been retained to develop a plan to restructure clinical services among the hospitals as well as Brookhaven Hospital and Medical Center. The expectation is that this plan will address current and projected community health needs of the north and south forks of the East End as well as the growing population to the west of Riverhead towards Brookhaven Town. In addition, concerns have been voiced with respect to the availability of emergency care and medical/surgical services at all three hospitals and access to urgent care to the communities east of Southampton Hospital.

In this regard it is important that the Department of Health provide these hospitals with maximum flexibility in the programs, services and obligations that define a hospital, particularly those that have committed to work together and serve the greater good of a broad geographic area. Although these hospitals may not meet all the current criteria to be federally designated as a Critical Access Hospital, a more liberal state-designation should be formulated which would achieve the same end. A NYS–designated critical access hospital is one that is necessary to respond to emergent health crises, stabilize a patient and provide access to a full spectrum of care and be reimbursed at a level that supports its continued existence.

**Development of Specialized Services**

The RAC is supportive of plans that strengthen the provision of specialized, destination services for patients whose conditions are not emergent and for which the hospital provides urgent or elective treatment for health services. This is certainly the case with Eastern Long Island Hospital (ELIH) and the specialization it has developed in the provision of behavioral health services. This program provides access to the populations of the north and south forks as well as to other communities in Suffolk County. In this respect, a unique community health need is fulfilled which also contributes to the financial stability of the hospital.

**Southampton Hospital**

**Certified Beds: 168**
**Total Discharges: 5,927**

**ER Visits: 24,886**
**Net Patient Revenue: $69,696,002**

**Debt: $43,095,000 (0.0% DASNY)**

However, there is concern that a hospital such as ELIH may be prevented from pursuing this opportunity because it may tip the inpatient bed distribution too

much towards psychiatric care. This would then disqualify a hospital from receiving Medicaid reimbursement because of the Institute for Mental Disease exclusion that exists in federal law. Similar to what is being proposed for Nassau University Medical Center, the State should seek a waiver under its State Plan amendments to eliminate the Institute for Mental Disease exclusion.

**Eastern Long Island Hospital**

**Certified Beds: 80**
**Total Discharges: 3,062**

**ER Visits: 7,980**
**Net Patient Revenue: $24,181,490**

**Debt: $11,214,579 (0.0% DASNY)**

**Operate Under a Single Governance Structure**

These three hospitals had attempted to develop a collaborative relationship before, having formed the Peconic Health System (PHS) in 1997, but dissolved this relationship in 2006. One of the major factors which contributed to the dissolution of PHS was the nature of its governance structure in that the PHS Board required a supermajority for many decisions and had insufficient delegatory powers from the individual hospital boards which had remained in place. This structure made it difficult for meaningful change to occur and, therefore, the interests of the individual hospitals were often placed above the collective interests of all the communities of the East End.

The RAC members are hopeful that the new governance structure would not only address the interests of the founding members but also include significant representation of other community members who did not serve as a trustee of any of the hospitals, and who share a broad definition of the communities to be served. Therefore, a single unified governance structure should be put in place over all three hospitals which would have the full authority to develop a strategic plan which restructures the hospitals to assure access to emergency services, rationalizes bed capacity, minimizes duplication of services and develops an integrated health care delivery system.

**Encourage the Development of a Regional Health System Which Includes University Hospital at Stony Brook**

In the past year, there were very encouraging discussions between University Hospital at Stony Brook and the four hospitals with regard to forming a larger health network that may also include J.T. Mather Hospital. Ideally, the RAC recommends that a regional network be developed which includes Stony Brook and all five community hospitals in a shared governance arrangement. For a variety of reasons, this effort appears to have lost momentum. However, to better meet the health care needs of eastern Long Island patients must have access to a tertiary continuum of health services that cannot be efficiently

provided at a community hospital. University Hospital, as a regional academic health center, can assume this important role if it fully appreciates how a relationship with the other community hospitals will not only support its operational objectives but is also consistent with its mission. A more detailed discussion about the role of University Hospital at Stony Brook appears in the following section.

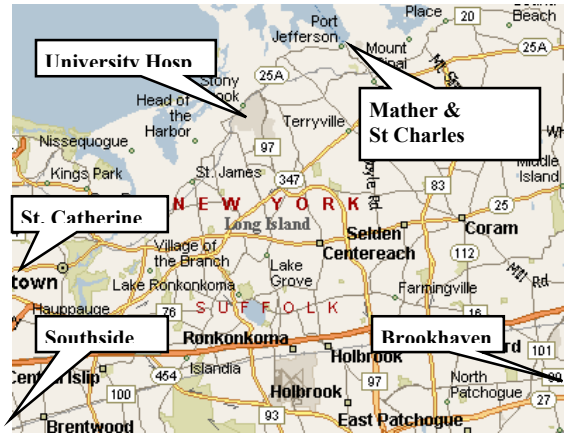
**Provide Support to Realize Goals of Consolidation and Restructuring**

The Department of Health should place a high priority on supporting these efforts by giving consideration to providing resources to plan and implement the restructuring of the four hospitals. The four hospitals, Eastern Long Island, Southampton, Peconic and Brookhaven have requested a HCRA loan to support their joint planning efforts. In addition, the Department of Health should review licensure requirements and reimbursement of Article 28 Hospitals to permit the evolution of community hospitals into a new state-designated definition of a critical access hospital as described above.

**Do Not Support Program Expansion Until Consolidation Occurs**

The RAC is optimistic, based upon its conversations with the leadership of these hospitals, that they will embrace this preliminary recommendation and put forward a realistic plan to accomplish the goals discussed above. Therefore, the RAC recommends that the Commission and Department of Health to be supportive and provide positive incentives to facilitate the restructuring of the four hospitals. However, until a plan to restructure the hospitals has been advanced, the Department of Health should not consider any requests from an individual hospital to expand, reconfigure or rebuild its programs and facilities unless it is in the interest of patient safety or consistent with the spirit of these recommendations. There should be no duplication of destination services (behavioral, obstetrics, etc.) among the three most eastern hospitals, until the hospitals develop a coherent plan for rational distribution of their clinical services.

## University Hospital –Stony Brook




Although the RAC has no specific findings concerning the acute care bed capacity of University Hospital, it wants to use this opportunity to share some of its observations concerning the role of University Hospital in the context of the larger health care delivery system. Clearly, University Hospital is an important regional provider of tertiary health services and a leader in many other dimensions on Long Island. However, in a number of conversations with hospitals, frustration was expressed by the inconsistent policy of University Hospital in its attempts to create stronger relationships with surrounding community hospitals. As an academic medical center and one that is publicly funded and subsidized, University Hospital should consider how its regional role could be further enhanced by entering into a health system partnership with other hospitals.

Two other state-owned university hospitals operate on the health science campuses of Upstate (Syracuse) and Downstate (Brooklyn) where the hospitals and their parent medical schools have enjoyed a long history of relationships (both academic and referral) with neighboring community hospitals. University Hospital Stony Brook is the only state-owned hospital located on one of the university campuses of the State University. Although University Hospital is also partnered with a medical school, it has yet to develop stronger relationships beyond its campus. Those that have tried to advocate for a more regional role for University Hospital have met with either disinterest or bureaucratic barriers from the University.

**University Hospital**

**Certified Beds: 504**
**Total Discharges: 27,489**

**Emergency Visits: 64,727**
**Net Patient Revenue: $492,063,843**

**Debt: $167,889,000 (75.6% DASNY)**

**State University of New York**

The RAC recognizes that the teaching mission of the University has primacy, but it wishes to express support for providing University Hospital with the ability to pursue a somewhat different destiny. University Hospital should continue to be aligned with the State University, but given the operational and governance freedom to enter into meaningful partnerships with other hospitals

so as to create a health care delivery system that will better serve the needs of the region.

The RAC recognizes that there are a variety of health system organizational arrangements that may not require a governance commitment. Certainly, effective patient referral relationships to tertiary centers can be put in place absent any modification of governance. However, the forces of change in the health care marketplace are blurring the line between tertiary and community hospital. Technology and practice is evolving rapidly and traditional tertiary referral relationships are becoming increasingly unstable. This is primarily due to the ability of community hospitals to provide a safe environment and invest in services that heretofore have been the province of the academic health center. Thus, absent the planning, control and distribution of resources that occurs in a shared governance model, society ends up with highly competitive hospitals which must first invest in staff, buildings and equipment and then compete to redirect patients away from the tertiary center. Similarly, the tertiary facility may begin to actively compete with needed community hospitals for their bread and butter secondary discharges. This typically results in one or more hospitals becoming financially weaker.

It became very clear during the RAC discussions that University Hospital must now be permitted to assume a leadership role in forming a network with the four hospitals of eastern Suffolk who themselves are holding discussions to form into a regional network (Brookhaven, Eastern Long Island, Peconic and Southampton hospitals). In the previous section we described past attempts of three of the four community hospitals to coalesce into an east end health care network. The RAC, as well as the hospitals, believe this network must have a shared single governance structure. All four of these hospitals relate to University Hospital in its role as the regional tertiary care center for various clinical services. However, there are still a significant number of patients who require elective procedures that bypass Stony Brook because referring physicians have a variety of relationships with other long island health care providers.

The network discussions are at a critical juncture and the community hospitals have indicated successful conclusion of their negotiations may hinge on whether or not University Hospital can join the network and is willing and able to participate in a shared governance arrangement. The hospitals realize that without the regional tertiary referral hospital at the core of a provider

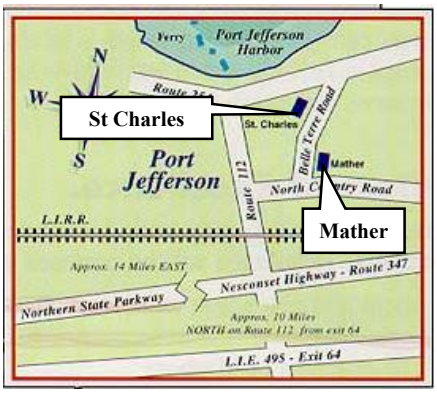
network their individual long term viability and ability to serve the communities of eastern Suffolk is not only limited but weakened.

The RAC's charge is to make recommendations which strengthen the regional health care delivery system. The inclusion of Stony Brook in a regional network is clearly such an opportunity where if the four hospitals come together they will be stronger but, if they come together with University Hospital their strength and, more importantly, their long term viability increases exponentially rather than in an additive manner. There is a greater good to be pursued which much take precedent over the concerns of individual hospitals. It is for this reason the RAC strongly recommends that University Hospital must be given the ability to leave the sponsorship of SUNY Stony Brook and directed to join with the other four community hospitals to create a regional network of health care providers. The founding missions of all the participants can be embraced in a consolidated governance structure if they jointly commit to the pursuit of excellence in patient care, education, research and community service.

The RAC realizes this is not a simple process. However, in order for this opportunity to become a reality it must be accompanied with a sense of urgency and inevitability. This way the focus of activities will be on how to accomplish the objective rather then why it can't happen. Therefore, the RAC requests the Commission to include this objective in its final recommendations in a clear and straightforward manner leaving no question as to the expected outcome.

Given the expertise of its staff, the depth of its clinical programs and the hundreds of millions of dollars already invested in equipment and facilities, the assets of University Hospital can be leveraged for a greater good. Failure to do so may not only result in a lost opportunity to better serve the residents of Long Island. In addition, a failure to create a stronger relationship may also encourage community hospitals to pursue the development of alternatives with other Health Systems which can only diminish University Hospital’s leadership role and increases the financial burden of New York State taxpayers to further subsidize the operations of the hospital.

**John T. Mather Memorial Hospital- Port Jefferson**
**St. Charles Hospital and Rehabilitation Center -Port Jefferson**




These two hospitals are located on adjacent parcels of property in Port Jefferson. Mather is a free-standing community hospital and St. Charles is a part of the Catholic Health System of Long Island and both have independent management. This is an example of how two hospitals, once independent and competitive, created an arrangement to distribute services so that both could survive. The goal of the Mather - St. Charles Health Alliance was to avoid the duplication of many costly services and to permit more resources to be invested in clinical program development rather than competition. It was also structured to accommodate the Ethical and Religious Directives for Catholic Healthcare Organizations. The Alliance hospitals share a common medical staff and virtually all physicians on staff at either hospital also have privileges at both. The hospitals are located less than a mile apart. Their location in Suffolk County is not easily accessible, as Port Jefferson is quite a distance north from the Long Island Expressway, which is the major thoroughfare in Nassau and Suffolk Counties.

**St. Charles**

**Certified Beds: 289**
**Total Discharges: 9,902**

**Emergency Visits: 21,760**
**Net Patient Revenue:**
**$119,782,645**

**Debt: $72,234,000**
**(95.8% DASNY)**

**Catholic Health Services of Long Island**

Their model was initially based upon achieving a balance of services in which there was coordinated program development around licensed inpatient services and acquisition of technology. Mather focused on acute medical/surgical services and St. Charles pursued a specialty rehabilitation hospital strategy in addition to operating Orthopedic and Obstetrical services. In addition to general medical/surgical beds, a duplicated service of note is the emergency department that is operated at both hospitals. In 2004, Mather reported 42,562 emergency visits and 21,760 emergency visits occurred at the St. Charles site.

Mather Hospital has generated a modest surplus from operations for the past several years. St Charles did not fare as well and reported several years of significant operating losses that were further compounded by the

implementation of the 75 % rule for rehabilitation providers. Continued eroding levels of reimbursement, movement of the locus of patient care from inpatient to ambulatory settings and competitive pressures by other hospitals and niche providers have now begun to create an imbalance in the Alliance which makes it difficult to maintain and build on the relationship. Recently, both hospitals launched competitive Bariatric Surgery and Sleep Medicine programs.

When the RAC first reviewed the opportunities on Long Island, the history of the Alliance, physical proximity and overlapping medical staff placed Mather/ St. Charles on the agenda for discussion. The RAC's discussion centered around the long term view that one stronger hospital will be better able to serve Port Jefferson and the surrounding communities than two. Although the financial status of St. Charles has improved as of late, its years of accumulated operating losses raise questions as to whether or not it can return to profitability. The latter profitability would probably occur only through competition for profitable lines of business among the two hospitals. Both hospitals have a significant amount of fixed costs to carry and will need to continually invest in facilities and technology to remain competitive.

**J. T. Mather**

**Certified Beds: 248**
**Total Discharges: 11,414**

**Emergency Visits: 42,562**
**Net Patient Revenue: $142,126,014**

**Debt: $32,221,944 (87.8% DASNY)**

Most recently, responsibility for the management of St. Charles and that of St. Catherine's in Smithtown has been consolidated with that of Good Samaritan in Islip, with the three forming the Suffolk County network of the Catholic Health System of Long Island. If it were not for the support St. Charles received from CHSLI, the continued existence of St. Charles would have been questionable. Of further concern is the fact that the CHSLI itself will be increasingly challenged in the years ahead due to the new CMS re-weighting which will have disproportionate impact on revenues at St. Francis, which has long been the economic engine of the entire system.

## Finding

### Close St. Charles Hospital

The RAC is concerned that the reversal of years of losses at St. Charles is temporary and, although CHSLI may certainly have the ability and commitment to continue to invest and support the hospital, an opportunity nevertheless exists to close St. Charles and relocate acute medical surgical and

obstetrics services to Mather, and other elective destination services such as rehabilitation to one of the two CHSLI hospital campuses in Suffolk County.

The issue the RAC debated is, do we wait for a crisis to occur that may endanger and undermine the operations of both hospitals or should we explore the possibility that a hospital closure will produce a larger financially stronger hospital which can better serve its communities? The RAC concluded that the history of cooperation, availability of buildings, land and highly desirable property, and a common medical staff provide the essential ingredients which can be combined, monetized and redeployed to create one hospital whose long term future will be better assured.

The RAC recognizes the myriad of issues that need to be addressed. On the surface, the closure of St. Charles and the consolidation of services at Mather and the other CHSLI campuses appears to be an opportunity which merits further exploration, and a determination of the overall cost/benefit to the health care system and the community of this course of action. To this end, the leadership of Mather hospital has provided the RAC with an assessment of what it would take from a financial and facilities perspective to absorb services now being provided at St. Charles.

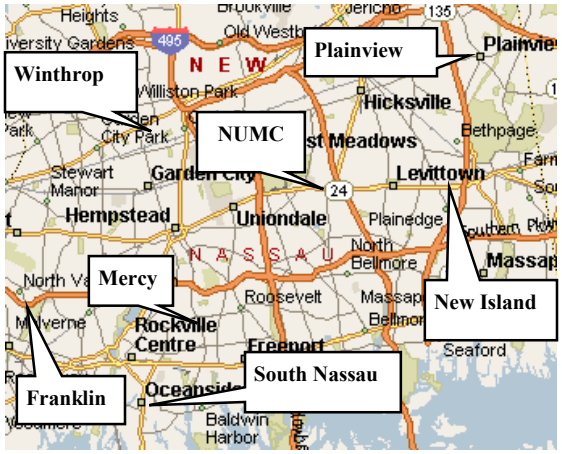
**Support the Planning Activities and Provide Transitional Support**

In order to facilitate a complex discussion, the Commission and Department of Health should be an active party in these talks and provide a menu of incentives and financial support which makes some of the most vexing issues with respect to debt, capital investment and transitional support less so. The probability of a successful outcome is dependent upon it.

**Do Not Support Program Expansion Until Consolidation Occurs**

The RAC believes that until the parties have had an opportunity to study this recommendation and determine the feasibility and cost to close St. Charles and redeploy its clinical services, the Department of Health should not consider any requests from either hospital to expand, reconfigure or rebuild its programs and facilities unless it is in the interest of patient safety or consistent with the spirit of these recommendations.

## Nassau University Medical Center- East Meadow




The Nassau Health Care Corporation (NHCC) includes Nassau University Medical Center (NUMC), a 515-bed community teaching hospital, A. Holly Patterson Extended Care Facility (AHP), an 889 bed skilled nursing facility, and six community health centers providing 57,000 primary care visits per year. NHCC also receives a substantial operating subsidy from Nassau County in recognition of the unique role it assumes in providing acute care access to many Nassau County communities with documented health disparities and large proportions of low income or underinsured residents. Over 50 % of all Medicaid inpatient discharges from Nassau County hospitals occur at NUMC.

NHCC was created to assist Nassau County in addressing a budget shortfall by "purchasing" the assets from the county and placing them into a newly formed public benefit corporation. NHCC financed the "purchase" with additional debt that was guaranteed by Nassau County. Another objective was to provide increased flexibility to operate the constituent facilities free of government-owned restrictions to more effectively operate in an increasingly competitive environment.

**Nassau University Medical Center**

**Certified Beds: 631**
**Total Discharges: 20,608**

**ER Visits: 75,022**
**Net Patient Revenue: $292,167,639**

**Debt: $267,667,000 (0.0% DASNY)**

NUMC has experienced significant challenges and obstacles in achieving financial stability since 1999 when it was transferred from county-ownership and placed into NHCC. Revolving door leadership and shifting strategic focus have punctuated its precarious operating history. NUMC operates in the same competitive marketplace as do other Long Island hospitals but it is operationally burdened by legacies of its county-owned past. The increased debt guaranteed by Nassau County coupled with disproportionate dependence on Medicaid reimbursement (which does not fully reimburse hospitals for reasonable costs incurred in the care of this population) has intensified government oversight and involvement. Accordingly, Nassau County has retained its own

consultants to help NHCC navigate it way back to firmer financial footing and has recently appointed new management and governance.

The continued existence of NUMC as an acute care hospital is critical to the residents of Nassau County—it is the safety net provider for the county. Other providers in Nassau County also play an important role in providing access to Medicaid, uninsured and underserved populations but many of these hospitals operate their staffed beds at relatively high occupancy rates and often have patients waiting in their emergency departments for an inpatient bed. If NUMC were to close, neighboring hospitals could not absorb NUMC's 75,000 emergency visits and approximately 21,000 inpatient admissions.

The leadership of NHCC clearly understands the necessity to redefine its mission and refocus its strategy in light of the fiscal, operating and competitive realities of its marketplace. A new strategic plan is being developed to redefine and strengthen the core clinical services needed by the communities dependent on NHCC for their care and to continue the pursuit of financial stability.

**Finding**

The RAC wants to strongly support efforts by NHCC to restructure NUMC, AHP and its community health centers and believes the Commission and Department of Health should place a high priority in assisting NHCC in accomplishing its goals. Although many of the requests for assistance NHCC identified in its discussions with the RAC were similarly expressed by other hospitals, there are some recommendations that would be of particular benefit to NHCC and merit further consideration:

- NUMC must focus on being the highest quality community teaching hospital consistent with the health care needs of the communities that are dependent on it for primary, emergent and acute care. It should continue to assume a niche role in certain tertiary services such as trauma, burn, and neonatal care and stop trying to become a tertiary care provider in areas that require a significant investment of resources to develop. It should continue to seek out relationships that facilitate access to tertiary services NUMC does not provide.

- With respect to its acute care capacity the Commission and DOH will need to review NUMC's plan to refocus its clinical services and redeploy it beds. We have assumed that this plan will also be accompanied with a substantial reduction in bed capacity consistent with its redefined role and community health needs.

- In addition to any proposed reduction in bed capacity, NUMC has three vacant floors of raw space which have never been occupied, and could be used for program expansion or consolidation of other health care activities. NUMC should utilize, subject to a cost/benefit analysis, its current space assets in a productive fashion before proposing new additional construction. This is particularly important with respect to the rebuilding of A Holly Patterson Nursing Home.

- The RAC has been informed that discussions are currently underway with the Department of Health regarding the reduction of nursing home beds at AHP and the possible private development of a Continuing Care Retirement Community ("CCRC") along with beds being designated as part of a Medicaid Assisted Living Program. Also under consideration is the possible replacement and relocation of the current AHP facility into two divisions: one located on the current site in Uniondale in support of the CCRC, and the other on the NUMC East Meadow campus. NHCC has projected that the restructuring and downsizing of AHP will require approximately $15 million in financial support.

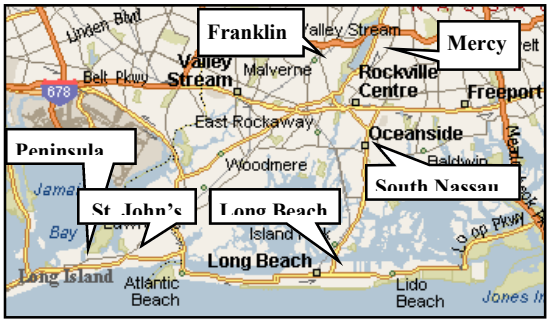
  The recommendation of the RAC with respect to AHP and its bed capacity is addressed in the Long Term Care Section of our report. However, in light of potential available capacity at NUMC, the RAC believes certain long term care bed designations for medically compromised patients such as ventilator and dialysis would be best located proximate to the acute care programs and a range of medical and surgical specialists. The RAC also suggests that NHCC strongly consider whether selling the Uniondale property and relocating a downsized A Holly Patterson and an additional continuum of care service portfolio to the hospital campus, would provide long term savings from operational efficiencies and shared services.

- NUMC also plays an important role in behavioral health and has a unique community health need it can fulfill which also would contribute to its financial stability. However, there is concern that NUMC may be

prevented from pursuing this opportunity because it may tip the inpatient bed distribution too much towards psychiatric care and disqualify NUMC from receiving Medicaid reimbursement because of the Institute For Mental Disease exclusion which exists in federal Law. Similar to what is being proposed for Eastern Long Island Hospital the State should seek a waiver for NUMC under its State Plan amendments to eliminate the Institute for Mental Disease exclusion.

As indicated above, NHCC's specific strategy for AHP, the restructuring of NUMC and its community health centers will be detailed in a revised strategic plan that was made available after the RAC's preliminary recommendations were forwarded to the Commission.

**Long Beach Medical Center - Long Beach**




Long Beach Medical Center (LBMC) consists of a 203-bed community teaching hospital and a 200-bed sub-acute and skilled nursing facility known as the Komanoff Center for Geriatric and Rehabilitative Medicine). LBMC treats a high percentage of Medicare patients, has a limited amount of elective surgery and has reported losses from operations the past several years. It is independent hospital and is not a member of a larger health system.

LBMC is located in the city of Long Beach, which is a south shore barrier island accessible to the mainland of Nassau and Queens Counties via three drawbridges. These bridges are located at the east and west ends of Long Beach Island and in the central portion as well. LBMC is located adjacent to the central drawbridge that connects to Nassau County.

Long Beach and its adjacent island communities contain approximately 40,000 persons. There are also a relatively large concentration of nursing homes, adult homes and assisted living facilities located in Long Beach and 16 % of the population is over 65 years of age. The RAC assumes that the hospital receives a substantial number of non-emergency admissions from its own nursing home as well as from neighboring nursing homes, adult homes and assisted living facilities.

The closest hospital to Long Beach is South Nassau Communities Hospital which is located 5.25 miles to the north over the adjacent drawbridge. Seven miles to the west is St. John's Episcopal Hospital and nine miles to the west is Peninsula Hospital. Both of these hospitals are located in Far Rockaway Queens and are accessible from the western drawbridge.

**Long Beach**

**Certified Beds: 203**
**Total Discharges: 5,587**

**Emergency Visits: 14,743**
**Net Patient Revenue: $86,438,344**

**Total Debt: $27,879,490 (78.0% DASNY)**

According to the 2005 SPARCS database, residents of Long Beach accounted for approximately 6,000 discharges from all hospitals in New York State. Of these, 3,000 or 50 % were discharged from LBMC and the other 50 % traveled off of Long Beach for acute inpatient care. South Nassau Communities Hospital, St. Francis Hospital, North Shore University Hospital and Mercy Medical Center were the top four destination hospitals. These hospitals collectively account for another 30 % of all Long Beach resident discharges. The overwhelming majority of Long Beach patients treated at LBMC, 88 %, were admitted under an emergent classification whereas, 68 % of those residents admitted to other hospitals were categorized as emergent.

## Evolve LBMC into a Critical Access Hospital

The large number of facilities and housing focused on an elderly population coupled with the geographic isolation of Long Beach and its dependency on drawbridges (which are frequently up in the summer, and which have been known to malfunction at times) reinforces the need to maintain access to emergency services and operate a limited number of acute care beds to care for the Long Beach residents. It is for these reasons that the RAC had initially identified LBMC as an ideal candidate to evolve into a state-defined Critical Access Hospital. This is further supported by the fact that half of the residents already travel off of Long Beach to receive acute care.

LBMC indicated that it had made several attempts to join other health systems but because of its operating losses and the dynamics of its market place was unable to secure a partner. It is clear that the successful transformation of LBMC into a Critical Access Hospital will be dependent upon the development of a relationship with one or more neighboring hospitals. Long Beach residents must have access to a continuum of acute care services in the

event further treatment is needed after emergency treatment and stabilization at LBMC.

As with ELIH described above, it is important that the Department of Health provide maximum flexibility in the programs, services and obligations that define LBMC as a Critical Access Hospital. In addition, the Department of Health has to provide a mechanism to insure that if LBMC evolves into a different treatment model it must be reimbursed at a level that supports its continued existence and does not dilute the balance sheet of potential partners.

The RAC recognizes that there is a lot of analysis that has to occur in order to assess the feasibility of the implementation of this recommendation. Therefore, the RAC additionally recommends that the Commission and Department of Health assume a proactive role is securing a partner to work with LBMC and community representatives in planning for a successful transformation of the hospital.

**Brunswick Hospital - Amityville**

The acute medical /surgical capacity of Brunswick Hospital has been closed and this is not a major focus of the RAC's activities. The RAC, however, questions the advisability of maintaining the Rehabilitation and Psychiatric services as an Article 28 Hospital provider, when the hospital is no longer operational. It appears that, if these beds are needed (the RAC makes no determination on this point), then they could be closed at this site and reallocated to other hospitals with excess capacity as part of an objective to have more beds located at fewer hospitals. Any financial benefit which would accrue the operator of these services would be helpful in supporting community safety net services such as an emergency room and access to acute medical/surgical services to the medically indigent - an obligation Brunswick no longer is burdened by.

## Long Island Region Long-Term Care Findings

### Holly Patterson Extended Care Facility (Nassau County)

*Recommended Action*: Downsize facility by 589 RHCF beds to 300 beds. Move sub-acute services to the empty floors of the Nassau University Medical Center (NUMC) and re-build a smaller, appropriate facility. Create a Medicaid ALP of not more than 150 beds on the same campus as the new A Holly Patterson.

[X] RAC Recommendation
[X] Staff Recommendation
[X] Voluntary/Provider-Initiated (This is consistent with Provider's "ultimate" goals)

*Facility Description*: A Holly Patterson is an 889-bed residential health care facility owned and operated by the public benefit corporation Nassau County Health Care Corporation. Not only does it provide baseline services, but also it operates an 80-bed subacute service, a 20-bed AIDS unit, and provides ventilator care.

A. Holly Patterson (AHP) is operating at one of the lowest occupancy levels in the State (60%), significantly lower than the troubled 84% of 2002. Even within that occupancy, about 30% of its beds are filled with "low-acuity" residents, a good number of whom can be served in a less-intensive setting, if such were available. AHP's quality-of care is of concern as well. The number of deficiencies cited by State surveyors ranged from 7 to 16 over the last three years, whereas the regional median is 3. Some of AHP's quality indicators are far below the regional average, including: percent of residents losing bowel and bladder control; percent of residents experiencing pain, and percent of short-stay residents obtaining pressure sores.

*Situational Factors*: Nassau County definitely has excess nursing home capacity. Despite a paper need for more than 1,200 nursing home beds, the county operates at only a 90% occupancy rate. Even taking out all of AHP's unused beds, the remaining providers ran at about a 6% vacancy rate in 2004. Such excess capacity is hurting the providers financially in terms of lost bed-hold payments; acceptance of lower-acuity individuals than they might otherwise admit, thereby reducing total Medicaid revenue through a lower

CMI; and significant funds spent on marketing efforts to "chase" the available admissions.

Another factor for consideration is that the NUMC building has 3 empty shell floors that have never been built-out, and so could be built to nursing home regulations to accommodate AHP's sub-acute services.

*Implementation and Investment*: Capital would be required to renovate the "shell" floors in the NUMC building; an architect and a cost-estimator would be needed to determine this amount. However, we do not recommend moving the remaining long-term AHP program off the Uniondale campus unless the new services could be moved with it. The idea of developing ALP and perhaps independent-living on the campus with the SNF has tremendous value to the community.

As an estimate, we can assume that 240 beds will remain on that campus, meaning a capital cost of approximately $48M. Given the tremendous downsizing involved here, the equity contribution should be 10%; half of this contribution should come from State re-structuring funds, for an estimated investment of $2.4M. A Certificate of Need application would need to be submitted, but a rough estimate of annual Medicaid capital costs is $5M, based on an 8.5% interest rate and 30-year depreciation.

In the meantime, the downsizing can be accomplished by reducing the number of buildings and floors in use; there may be some incremental costs during the "transition" phase, and we recommend that AHP discuss those with the Department of Health upon documentation. Transition costs anticipated would be costs of maintaining appropriate staffing (eg, at least one RN per shift) even as the unit's occupancy is declining.

We recommend that 309 of AHP's licensed beds be de-certified immediately, as these are currently not in use. We recommend that simultaneously, the Corporation execute a contract and a plan of action for a developer to create a 150-bed Medicaid ALP on the campus within 24 months. We then recommend that AHP close and de-certify 120 beds over the first 12-month period, and the remaining 160 when the ALP is operational. (Note that this is <u>ONLY</u> a Medicaid ALP we are recommending: no additional private pay assisted living is needed on Long Island, while the need for Medicaid assisted living is tremendous.)

**Cold Spring Hills Center For Nursing And Rehabilitation (Nassau County)**

*Recommended Action*: Downsize by 90 RHCF beds (one building) to 582 beds. Add a 24-bed Ventilator unit, an evening adult day program, and a 12-station hemodialysis center on the existing campus.

*Facility Description*: Cold Spring Hills is a large (672-bed) proprietary residential health care facility housed in several buildings. It has a good CMI (1.18) and a good sub-acute program, as well as a 50-slot geriatric psych adult day program and a long-term home health care program. The facility was placed in receivership in 1996, and purchased in October 2004. Since the purchase, Cold Spring Hills has seen some quality and occupancy improvements, and thanks to an experienced management team, ran at 94.5% occupancy in 2005, up from the lower 90s in the preceding years.

The facility has been making improvements, but quality-of-care continues to be at issue. Cold Spring Hills has had between 6 and 12 deficiencies over the last three years, while the regional median is 3; in addition, it was cited with a "level 3" deficiency in its last survey, falling in the bottom quintile for the region. Community reputation, as described by RAC members and the CEO, continues to be poor, and much work is needed to change it. The facility's recent affiliation with the North Shore-LIJ system will put in place additional improvements to hopefully improve surveys and MDS indicators.

*Situational Factors*: As above, Nassau County seems to have a significant number of excess beds, judging by the 2004 county occupancy of 90% and nearly 900 PA/PB level residents occupying skilled nursing beds. A number of Nassau County nursing homes—Cold Spring Hills included—have commented that it is quite difficult to keep beds filled, particularly with the recent new facilities established in the area. In addition, Cold Spring Hills borders Suffolk County, which has a stronger occupancy level (96%), but also a small number of calculated excess beds (48). A downsizing at Cold Spring Hills could strengthen providers in both counties.

Cold Spring Hills was the seventh largest nursing home in the State, and with recent Rightsizing demonstrations and other Commission recommendations, it will be the fourth. The recommendation to downsize will maintain Cold Spring Hills well above the 300+ peer group, and will ease surplus capacity in

the region. Moreover, closing an entire building should maximize efficiencies to be gained from downsizing.

At the same time, Cold Spring Hills with its clinical affiliation with North Shore-LIJ, should be bolstered in its ability to serve a post-acute role. We recommend approving its existing CON application for 24 ventilator beds, and for the creation of an on-site, 12-station hemodialysis center. To provide additional non-institutional resources for the community, we further recommend that Cold Spring Hills' CON for a 50-slot shift of evening adult day care be approved as well.

*Implementation and Investment*: The investment required for the Vent unit creation is articulated in the CON application, and does not require State capital re-structuring support; nor does the hemodialysis or second shift of ADHC require State investment.

The closure of the 90-bed Brookville building would require a transition period, although with the other Cold Spring beds on the same campus, the transition costs may not be as great as might otherwise be the case.

**Brunswick Hospital Center Skilled Nursing Facility (Suffolk)**

*Recommended Action*: Closure of RHCF (94 beds). Create 50-bed Medicaid ALP for Suffolk County.

*Facility Description*: Brunswick Hospital Skilled Nursing Facility is 94-bed facility. It is part of a 4-part proprietary health care corporation, comprising a 124-bed psychiatric facility (article 31), a 50-bed physical medicine and rehabilitation facility, and the recently-closed Brunswick Hospital acute care facility. All these components share a campus in Amityville, which neighbors Broadlawn Manor, a 320-bed residential health care facility.

Brunswick Hospital SNF had been in receivership from 2001-05, during which time a legal battle over ownership occurred. During that time, the facility saw admissions decline, although they are now operating at 95% occupancy and making a profit. Even though the acute care sister facility ceased operations, Brunswick Hospital SNF maintains its hospital-based Medicaid rate.

Brunswick Hospital SNF has raised some quality concerns (15 deficiencies compared to a regional median of 3), and poorer performance on pressure sores, weight gain, and continence. Some of its survey deficiencies stem from its physical environment, which is housed in two cottages dating from 1938 and the early 1950's. The facility has plans to move the SNF operation into the general hospital building, and while that would provide in-wall gases for ventilator-dependent residents, the 120-year-old hospital building is antithetical to state-of-the-art (and future) long-term care.

*Situational Factors*: As in Nassau County, new facilities have been opened or are being opened, and this has created excess competition in the county. With nearly 1,000 low-acuity residents in Suffolk nursing homes, the opportunity exists to create non-institutional alternatives in place of nursing home beds.

In addition, Brunswick Hospital SNF does not appear to have a strong referral base from local hospitals. Other than its own facilities, the next most significant referrers are Good Samaritan and North Shore. Good Samaritan has told the RAC that it will be working more closely to refer to Catholic Health System facilities, and North Shore recently entered into an affiliation with Cold Spring Hills, which is not too distant from Brunswick Hospital SNF. It is the feeling of the RAC and the staff that these admissions can be accommodated elsewhere, as had occurred when Brunswick Hospital SNF was in its ownership battle.

*Implementation and Investment*: The Brunswick Hospital Center and all its programs are currently in Chapter 11 bankruptcy proceedings. Closure of the SNF will require payment of debts, but these are not known, nor is it known what may be appropriate for State restructuring fund support.

As with other recommendations, the creation of the ALP for Suffolk County should proceed through an RFP process. Given the population size of the county, the capital costs for the development can be passed-through for Medicaid reimbursement.

**Bed Need And Pipeline Beds (Nassau and Suffolk Counties)**

*Recommended Action*: Revise the bed need to existing beds or fewer.

A good number of existing nursing home providers in Nassau and Suffolk counties are struggling to fill their beds with appropriate nursing home

residents, and the RAC believes this stems in large part from the Department of Health's bed need methodology which maintains a need for over 1,200 additional beds in Nassau County and 48 in Suffolk County. Because of this, there are pending nursing home expansion and establishment CON applications, which will only perpetuate excess capacity on Long Island.

Therefore, we recommend that the Nassau and Suffolk county nursing home bed need methodology be revised to cap current "need" as follows:

- Nassau County would be existing approved beds less the 589 de-certified by AHP and the 90 de-certified at Cold Spring Hills, for a total of 7,100
- Suffolk County would be existing plus the Coram Manor approved CON, for a total of 8,865
- Ensure no NEW beds are allowed to be built on Long Island for 5-10 years
- Shift any further documented long-term care resource need to the home- and community-based services and supportive housing need categories, for the next 5-10 years.