Commission on Health Care Facilities in the 21st Century
90 Church Street, 13th Floor, New York, NY 10007 • Phone (212) 417-5544 • Fax (212) 417-4893
Stephen Berger, Chairman • David Sandman, Ph.D., Executive Director

New York City Regional Advisory Committee

COMMISSION ON HEALTH CARE FACILITIES IN THE 21ST CENTURY

NEW YORK CITY REGIONAL ADVISORY COMMITTEE

RECOMMENDATIONS

November 10, 2006

Contact Information: Arthur Webb, Chair • (212) 337-5763 • arthurw@vcny.org
Fax: (212) 366-7197 • Mailing Address: 154 Christopher St., New York, NY 10014

Opening statement

We, the New York City Regional Advisory Committee, strongly endorse the work of the Commission and encourage the state legislature, and the Governor to continue its support for a systematic examination of the New York State health care delivery system.

We support the assumption that the hospital and nursing home system of care in New York State can be made to be more efficient. We learned, though, that access varies across the City and no single generalization can capture these variations. Each community needs to be examined individually. However, having large academic medical centers also influences the flow of patients across county and borough borders, and in some cases state borders making the assessment of access even more difficult. But as a whole, we found that close to 75% of all hospital admissions are within distinct geographic and surrounding communities.

We see our work as the first chapter in a longer term planning effort to more systematically assess the accessibility, effectiveness and efficiency of the health care delivery system for all New Yorkers. We also see our work as creating a more efficient system in the future to meet the needs of populations that may, in fact, entail rebuilding.

Our recommendations take into account the demands of population growth and the increases in diversity. We also recognize the need to have modernistic facilities so we do call for hospital re-building where appropriate. We do want to emphasize that there is value in having excellent networks that support primary care and long-term care.

We believe there is great value in having an organized and official government function to conduct a statewide assessment of costs, quality and access issues facing New York's citizens. Indeed, all three of these points of this classic triangle must be examined together. Only looking at one factor would be too narrow a focus and any action taken on one factor only might negatively affect other critical factors. There have been many official government activities like health planning and the current Commission examining these issues over the years. We are not taking a position on any specific proposal but a new governor might benefit by strengthening the planning capacity of the state department of health.

While overall bed need in relationship to capacity is critical from the access to inpatient care point of view, much of the re-alignment of health care need to capacity can not be effectuated without assessing the payment systems for <u>all</u> levels of care and incentives to improve quality. In the course of its public hearings and deliberations, the RAC became aware of a multitude of efforts already underway by hospitals to realign, etc. In its recommendations, the RAC has attempted to note and in some instances, build on and optimize some of the more productive activities.

It must be pointed out at the outset that there has been and is now a considerable amount of voluntary effort by hospitals to re-align them to meet community and clinical needs. Indeed, several hospitals have closed and HHC has downsized over 2,000 beds in the past few years.

In looking at New York City, one is immediately faced with issues of poverty, diversity and health care disparity in the midst of one of the most sophisticated collection of centers of excellence in research, service and education in the world. These dynamics must inform and influence public policy.

While health epidemics like AIDS, TB, and crime-related trauma, which had impacted hospital utilization for the past twenty years have abated to some degree due to population-based preventive services aggressive efforts to provide care and reduce crime--all good things, there is another reality that is facing New York City and that is the health status of its citizens. According to the New York City Department of Health and Mental Hygiene, the City is faced with an increase in demands for access to diagnosis and care for diabetes, cardiovascular disease, childhood asthma, hypertension, substance abuse and mental health, renal failure and the list goes on. These health status issues will directly impact access to hospital inpatient, outpatient and emergency rooms and must be taken into account in looking to reduce beds and hospitals and skilled nursing facilities. It should also be highlighted that an aggressive prevention can reduce the prevalence and incidence of major diseases like obesity.

To put all of this in perspective, many of the issues we face today are not new to this generation or this current Commission. From an historical point of view, many issues the current health care system is facing are not new. Please see the footnote below for a historical reference.[1]

For a more contemporary set of recommendations see the Governor Pataki's Health Care Reform Working Group, chaired by Steven Berger, which frames the issues that are of major concern of the Commission and this RAC.[2]

The Working Group's recommendations include:

- **Restructuring and Rightsizing the Hospital System** -- The competitive pressures and loss of revenues in the acute care system associated with out-migration of services to alternative providers have meant excess inpatient capacity and a struggle to maintain quality core services. We recommend the state develop measures to reduce excess hospital capacity, and adopt alternative models for hospitals to ensure access to quality

[1] For instance, here are some key recommendations that were made in the mid-Twentieth Century:

- Subsidize the expansion of services to ambulatory patients by making limited grants to hospitals.
- Seek to raise the level of care currently being provided for individuals with mental illnesses or disorders by expanding State facilities.
- Develop a comprehensive program for the expansion of mental hygiene clinics now being operated by the State and voluntary groups. (hospitals)
- Secure through voluntary efforts some of the requisite funds to experiment in better ways to providing, at the lowest possible cost, a high level of hospital care.
- Establish rates of payment to private (voluntary) nursing homes which would enable them to provide a higher level of service in general and medical care in particular.

Source: A Pattern for Hospital Care: Final Report of the New York State Hospital Study, Eli Ginzberg, Columbia University Press, 1949.

[2] The Health Care Reform Working Group--Final Report, November 17, 2004

care in all communities is maintained. Revenues generated by this restructuring should be reinvested in the healthcare system.

- **Maintaining the "Public Good" Functions of Hospitals** -- Dramatic advances in technology, and shifting practice patterns will continue to have significant financial impact on hospitals, affecting their ability to continue to serve the public good. To address this, we recommend a reallocation of HCRA funds -- specifically, changing the dispersal methodology of the Indigent Care Pool and the Public Indigent Care Pool, and creating a new Essential Services Pool. This reallocation is, in effect, a reinvestment of funds generated by more cost-effective practices to support critical services provided by the hospital system.
- **Addressing the Rate Paradigm** -- Current Medicaid reimbursement rates for "high-end" services, such as cardiac and vascular surgery, are disproportionately generous when compared to the reimbursement rates for "safety net" services such as emergency services, births, and trauma services. This unevenness naturally prompts hospitals to acquire and over-utilize high technology specialty services to offset the low reimbursement rate of services that enhance the public welfare. We recommend revising the rate paradigm to help hospitals that provide the majority of safety net services. This fiscal alignment will not only restore fairness, but will help to ameliorate these negative trends.
- **Improving Hospital Quality** -- There is a move on the national level to improve the quality of care in hospitals by rewarding good results. We recommend establishing a State Quality Improvement Council and the creation of mechanisms for the State to use its leverage and authority as both a regulator and major purchaser of health care to drive improvements in hospital quality.
- **Improve Health Information Technology (HIT)** -- To ensure that health care providers develop the essential technology required to operate high quality, efficient facilities in the 21st-century, we recommend the State create information system standards consistent with Federal regulation for recording and transmitting data. We also recommend the state explore and develop alternatives for financing HIT projects with all relevant providers including risk models that permit financing against future saving.
- **Seeking Federal Waivers to Support the Reinvestment Strategy** — The federal government will realize significant savings as a result of the reform and restructuring program we recommend. It is critical to our success that the federal Medicaid and Medicare programs participate in the State's reinvestment strategy. We recommend that the State use the recently approved F-SHRP waiver to use federal and state savings for reinvestment. A similar approach was used when the State initiated its Medicaid Managed Care Program in the mid 1990's. The Federal government advanced anticipated savings into a nearly $1.25 billion multi-year reinvestment strategy that supported ambulatory care expansion and worker retraining to enable the development of managed care. That waiver has proven to be highly successful, providing improved care while generating significant savings for our local, State and Federal governments.

We believe that our recommendations are in line with the intent and direction of the Working Group's recommendations and timing may be right to realize the hopes of this and other historical policy proposals.

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I.A Recommendations on Hospitals

One of the main working assumptions underlining the RAC's recommendations is the importance of improving the efficiency of the health care system in New York City—rightsizing the hospital sector, expanding the availability of community based primary care, creating an appropriately sized institutional long term care sector and enhancing community based options for long term care. Then, assuring that there are effective connections among each level of care to assure appropriate, cost effective care for the patient in different stages of health and illness. While the major focus of the Commission's charge is to address acute and long term care bed need vs. supply, such decisions must be made in the context of a community and its heath needs and resources. We have tried to adhere to these principles in conducting the analysis that has led to our recommendations.

Shrinking the hospital sector will press the remaining facilities to improve efficiency and increase the throughput of admissions over fewer beds and reduce the high length of stay that exists in NYC. The NYC HHC system has been pursuing this goal for the past several years. Several voluntary hospitals also indicated that, by reducing their LOS, they have been able to accommodate increases in their admissions. Another value of reducing beds, is to shift certain clinical procedures (where practicable and safe) to the outpatient/ ambulatory sector. Of course, there needs to be a major payment reform to further incentivize hospitals and physician practices to change their over-reliance on institutional care.

l. The State should reduce unnecessary acute care beds by removing certified, but unstaffed beds, from the operating certificates of hospitals that are no longer using such beds and have no plans for their future use. While this may be merely symbolic, it signals the direction by the State to reduce the overall size of the hospital sector. This also will force the hospitals to address their overall configuration and make efficiency improvements.

NYC's HHC, the largest public hospital system in the U.S. has reduced its overall bed complement by close to 3,000 beds and its acute care length of stay from 6.6 to 5.4 days in the last several years. This should be recognized. The importance of having a first class public health system can not be more important for New York City as it address the issues of access and quality. In his presentation to the RAC, HHC's President identified that future re-configurations of the system are anticipated after the full implementation of their Capital Plan which includes the rebuilding of Harlem Hospital, Jacobi Medical Center, Coney Island Hospital and Kings County Hospital Center.

The recent closings of voluntary hospitals like St. Mary's and St. Joseph's point out several things: the financial fragility of community hospitals; the impact of a hospital closure on community access; the disruption in relationships between patients and their physicians; the lack of overall state planning to manage the demise of community hospitals; and the dramatic economic impact on the lives of workers and their families and to the surrounding communities.

2. We recommend serious attention to development of a new model of an urban *community hospital* (see below) We have seen examples of institutions fitting this model, though they are difficult to maintain in the current financing environment. They are characterized by size (less than 200 beds), service provision directly related to community need with minimal "boutique" specialty services merely to generate revenue; linkage to larger networks or health systems that are committed to retaining low cost, community based care provision, not merely using network members to feed the specialty services of the tertiary care parent; and they generally have effective and , often, long standing relationships with physician groups or organized primary care providers. They tend to be low cost providers, and appear to provide acceptable quality of services. They are, however, fiscally fragile within the current reimbursement system which drives development towards high cost specialty care. The State should address this problem. We see the value of community hospitals and they should not be abandoned or unnecessarily targeted for closure. Included in our thinking is the need for safer to sustain net and critical access hospitals.

The specific recommendations that follow are based on a logic that the Commission staff supported.

We used a three-part analysis that included the following concepts:

1. Absorptive capacity
    - Simulated closing each hospital, one at a time
    - Redistributed patients in same proportion as where other people living in the same Zip code go for the same service
        - Emergency admissions treated as a single service
        - Scheduled admissions distributed in 35 clinical service lines
    - Identified principal *coverage partners*
    - Determined whether coverage partners were proximate and had sufficient capacity to absorb most patients
    - Answered the question: Can the hospital close?

2. Essentiality
    - Degree to which hospital provides essential services
        - Services to vulnerable populations
        - Special services, e.g., psychiatry, obstetrics
        - Employment
        - Answered the question: Must the hospital stay open?

3. Sustainability
    - Whether management can sustain operations
        - Financial and other considerations
    - Answered the question: Is the hospital failing?

The RAC used multiple sources for its quantitative analysis supplied to us by the Commission staff. We have included maps of all of the "coverage" partners to assess the first part of our analysis. See #1 above. The maps are in Appendix A.

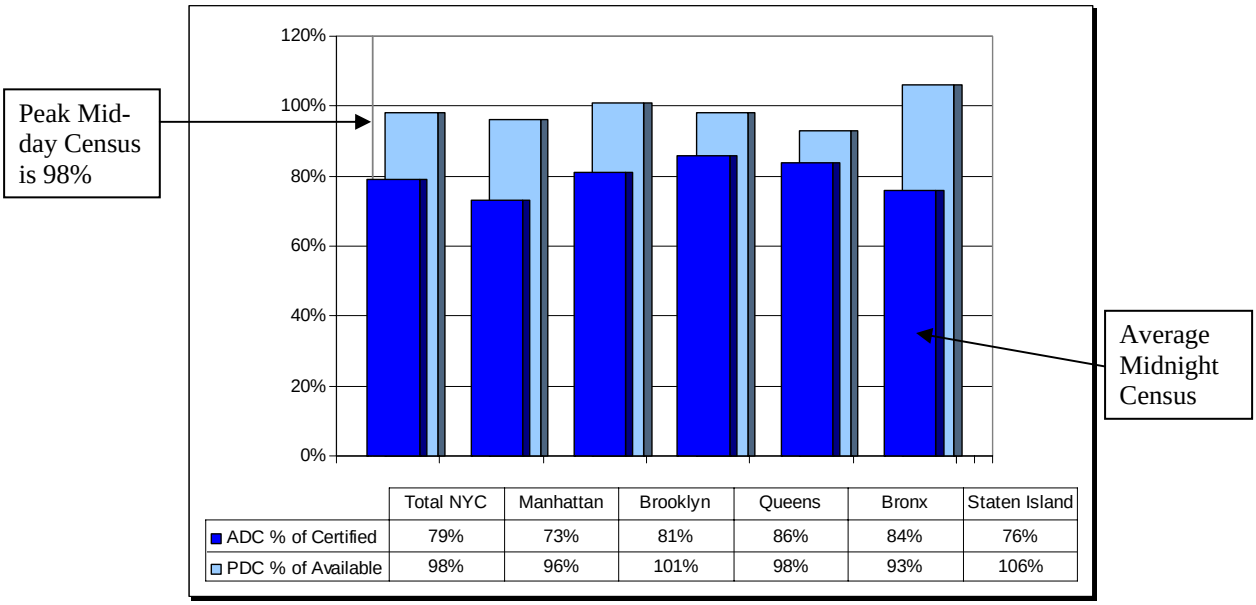
A major piece of our analysis relating to hospital restructuring in relationship to the availability of primary care can be seen in a table on page 35, 36 and 37

The individual hospital quantitative analysis was complemented by a qualitative assessment drawn from the individual provider meetings and from testimony given at public hearings. In addition, we used a community planning model to link capacity with need by looking at local need (including analysis by neighborhood of health status provided by NYC DOHMH and an analysis of primary care capacity and need conducted by the Primary Care Development Corporation and the New York City Health and Hospitals Corporation – see Appendix D). Ultimately, the RAC members used its collective judgment, experience and wisdom to arrive at our conclusions, which are unanimous. There were specific discussions and development of recommendations from which certain RAC members were required to recuse themselves, and these same members were not physically present when the recommendations were finalized. These recusals are identified below.

We hope that the essence of our recommendations communicates the importance of the relationship of a particular hospital to its community and to its surrounding providers. We were sensitive to how these communities would be adversely affected. The RAC included recommendations on primary care because the current lack of access to primary care for some communities is dramatic and the potential impact of a hospital's closure/restructuring closure in these communities would exacerbate this problem.

A starting point for the NYC RAC was to ask the question: Are there too many beds or hospitals in the City of New York?

Bed Capacity is About Right for Current Utilization in New York Citv



	Total NYC	Manhattan	Brooklyn	Queens	Bronx	Staten Island
ADC % of Certified	79%	73%	81%	86%	84%	76%
PDC % of Available	98%	96%	101%	98%	93%	106%

PDC = peak daily census, which represents the average of the busiest four hours of the day on the average of the 30 busiest days of the year (i.e., influenza season).
Source: 2004 New York State Institutional Cost Reports (ICRs) and Statewide Planning and Research Cooperative System (SPARCS).

However, this does not mean that there are not possibilities of hospital bed closure and configuration especially in Manhattan, which is significant outlier in LOS and admissions per 1000. We do recommend that the *paper* beds be reduced and, as you will see in our recommendations below, we are recommending closing approximately **3,000 certified beds** in NYC. See Table 1 in the appendix.

Another major concern of the RAC is the high concentration of acute care beds in Manhattan with close to 8 beds per thousand population, which far exceeds the national average. In addition, we observed that there is a concomitant high LOS. We certainly respect and support the importance of the large academic medical centers throughout New York City. They are world class leaders in research, service and education that produce many breakthrough treatments. They are also major supporters of a network of hospital services. On the other hand, we do believe that greater attention to clinical practices that shifts more cases to outpatient settings is good for the whole system of care. This would result in more efficient uses of hospital beds,

reduction in LOS, Medicaid savings that could be re-invested in new models of care, and may help in responding to demands from population growth.

The most important perspective for the Commission to consider and one that guided our recommendations is that for most hospitals in NYC access is generally a local phenomenon. Yes there are very large regional centers like North Shore- LIJ, New York Presbyterian, Mt. Sinai and Montefiore but, in general, most of the utilization of hospitals comes from nearby communities. In fact, we examined inpatient utilization and found that more than 75% of impatient use comes from the surrounding ZIP codes of each hospital and these formed the "small market" areas, which was discussed above and demonstrate that hospitals often serve very distinct communities with distinct needs. This is, perhaps, a potential breakthrough for re-examining public need.

These facts lead us to see the value of small community hospitals in meeting certain community needs. We heard many opinions about the sustainability of small community hospitals at the 200 bed or less range and there are two distinct opinions: One-they cannot survive and the second, opposite to the first, they are essential to meet community needs.

We are also calling for a major new model of a *community hospital* as we state under our general comments. The shape, size, the linkages with networks, governance structure, quality care and fiscal viability are critical issues that need to be addressed by the state including new payment methods that support such entities. We do see the value of community hospitals and they should not be abandoned or unnecessarily targeted for closure. Included in our thinking is the need for safety net and critical access hospitals. These terms are used loosely and may need greater specification.

Perhaps a new " urban community hospital" model might be considered using some of the following criteria:

- Is it a low cost provider?
- Is it serving a significant Medicaid population?
- Is it a preferred provider in its community?
- Is it tied to a network?
- Is it providing a continuum of ambulatory care (in the communities it serves)?
- Is its quality on par?
- Is its LOS being reduced?
- Are there unique services?
- Can it be sustained?

The State Department of Health may have to develop special Medicaid payment methods to sustain these centers. We are aware that of the existence of state regulatory provisions for "community access hospitals," but we understand that these may be targeted for rural areas.

The RAC supports and recognizes the value of "networks" of care but we strongly recommend that there is a mutual obligation that must be part of any equation for restructuring. Large

systems who have networks like New York Presbyterian Health System. North Shore-LIJ, Montefiore, Mt. Sinai, Continuum Health Partners and others must make a commitment to help their community network hospitals appropriately serve their respective communities including offering ambulatory care, improving the efficiency of their operations with IT investments, improving the quality of care, finding ways to make them financially viable, and helping rebuild their facilities where needed. We realize that the community hospitals often times appropriately refer the high-tech tertiary and quaternary care cases to the main academic medical centers. These patterns need constant review but in terms of reducing the unnecessary "arms race," these high-tech centers may well be the appropriate places for concentration of these services.

All of the above have informed and shaped our recommendations.

We also caution the readers that we did everything possible to not fall into what reporters and other critics of the Commission believe is a "hit" list mentality that some people suspected that existed from the beginning and where the RAC process was seen to legitimize such a list. While the following recommendations do have some overlap with various publications listing "vulnerable" hospitals, some of this is simply obvious because of past financial and operating troubles of certain hospitals. The real essence of our recommendations gets to the relationship of a particular hospital to its community and to its surrounding hospitals. We were sensitive to how these communities would be adversely affected. One of the reasons the RAC included recommendations on primary care is for the very reason of the current lack of access to primary care for some communities and the potential impact of a hospital's closure/restructuring closure in certain communities.

After all of the above is considered, our thinking devolved to answering one simple question: Could hospitals services be absorbed by the "coverage" partner hospitals and, therefore, close?

Our recommendations should be seen as priorities for use of HEAL NY funds and FSHRP funds, when they become available. A separate priority list of HEAL NY funding follows the recommendations. We also recommend that any new workforce funding be targeted to respond to the impact of these recommendations.

Staten Island

St.Vincent's CMC Staten Island hospital is an "essential" hospital.

It is part of the bankruptcy proceedings of St. Vincent's CMC, which is in negotiations with a major provider from New Jersey to assume the operations of takeover St. Vincent's SI. There are discussions about significant service reconfigurations within the campus of St. Vincent's, Staten Island. However, these plans are not firm and are subject to negotiations. Large areas of Staten Island are currently serious shortage areas for primary care (see Map 1 under Primary Care), especially for Medicaid and other vulnerable populations, and the needs for these services must be considered in hospital service configurations, sizing and capital investment decisions.

Bronx

Restructure: Westchester Square Medical Center (WSMC)

WSMC appears to fit into the "community hospital" model that is discussed in our narrative, which means that it may have continuing value in serving its community. Of particular note, is the linkage with New York Presbyterian Hospital (NYPH) and its commitment of financial support. While WSMC's acute care services can be absorbed by the surrounding hospitals, it is critical to consider the following points before a final decision is reached or there is a rush to close this hospital. Westchester Square Medical Center is part of the NY Presbyterian Health System (NYPH), which has been extremely responsive to the challenge the Commission faces in supporting appropriate community hospital services:

It is the lowest cost hospital in the Bronx with a Medicaid case discharge rate of $4,460

- The hospital's case mix index is 1.42 (high case mix)
- It appears to be the number one choice of Throgs Neck/Pelham community residents.
- Has over 23,000 emergency room patients
- It is financially sound. It generates a small surplus each year
- A high quality provider. Each year it meets or exceeds JCAHO standards. However, other indicators of quality should be assessed.
- Its primary service area includes parts of Northeast Bronx and Pelham/Throggs Neck neighborhoods which are "stressed" and "serious shortage areas" for primary care (see Map 1).
- There are strong bonds between the patients and the physicians who practice in this area. Closure could significantly disrupt access.

We heard from Wayne Osten about NYPH's commitments to WSMC. (see the attached letter from NYPH. It will:

- Establish closer linkages and keep WSMC a low cost hospital
- Make additional investments in an IT system, the infrastructure and physical plant of the hospital;
- Reduce the LOS to downsize the beds by reducing its certified beds from 205 to 150 - a 25% reduction

Please see Appendix B for additional details.

Brooklyn

Restructuring: New York Methodist Hospital and Community Hospital

We are recommending that Methodist Hospital and Community Hospital be merged and fully integrated into a single entity with two campuses. **Close to 100 medical-surgical beds should be eliminated with this merger.**

This relationship fits with the "community hospital" model that is discussed above.

New York Methodist Hospital's primary service area also includes neighborhoods facing serious shortage of primary care provision (Map 1). Therefore, the need for sustained and additional primary care capacity must be considered in final consolidation plans and capital investment decisions

See the attached plans in Appendix C, which were submitted to the RAC by Methodist and Community Hospital. The NYPH system helped facilitate these discussions. The RAC supports their specific request for use of HEAL NY Funds as noted in their presentation.

Restructuring: Victory Memorial Hospital
(Dr. Vincent Calamia and Frank Serbaroli Esq. recused themselves from the RAC discussions and recommendations.)

The RAC recommends that VMH and Maimonides Medical Center be supported in their plans to reconfigure this service area. While the RAC is not in a position to evaluate the impact of Chapter 11 re-organization might have on the ultimate configuration, the plans and financial material submitted to the RAC clearly indicate substantial progress in their mutual planning since we first met with both facilities early in our deliberations.

The plans that they have put forth encompasses all of the needs that the changing community of Bay Ridge, Dyker Heights and the rest of South West Brooklyn have. Public transportation is major concern that needs to be addressed.

We would support the reconfiguration of this institution to serve as a community hospital with a smaller compliment of acute medical-surgical beds and ambulatory care services which are aligned with the healthcare needs of the residents of the southwest Brooklyn community. We would support the use of state funding to facilitate this institution's reconfiguration and further coordination with Maimonides Hospital to develop an integrated continuum of health care for southwest Brooklyn residents.

Based on public testimony, Victory Memorial has certain key services that need to be taken into account: culturally responsive OB/GYN services for the Muslim community; a sister nursing home; and services /programs designed to address linguistic and cultural needs of Chinese patients. The hospital is also one of the major providers in the Bensonhurst-Bay Ridge community, serving close to 50% of all hospital admissions from this specific community. The Bensonhurst – Bay Ridge community also faces serious shortages in primary care.

We would only support the use of HEAL NY funds for the reconfiguration of this institution within the larger health care network based on the joint plans put forth. These plans are included in the attachments.

Restructuring: <u>The Brooklyn Hospital Center (TBHC)</u>

TBHC, one of oldest hospitals in New York City, is an "essential" hospital. It is in the midst of bankruptcy proceedings. However, hospital leadership came forth voluntarily with the support of NYPH system executives and presented a coherent and well constructed plan for recovery and turnaround, and for the hospital's future configuration.

Please see Appendix D for a description of their plans. To summarize, they are planning to add a 28-bed new psychiatry inpatient service by closing 39 Med/Surg beds and 18 ICU/CCU beds. In addition, they will continue to support their extensive outpatient programs. They have plans to reconfigure some of these outpatient services. However, it is premature to lay out these options.

We would recommend the use of HEAL NY funds to support their reconfiguration plan which includes the development of IT infrastructure, ED expansion, new psychiatry beds, and ambulatory care transition this hospital serves the Williamsburg/ Bushwick, Bedford-Stuyvesant/ Crown Heights and Flatbush/ E. Flatbush communities that have serious shortages of available primary care for Medicaid eligible or low-income populations.

No other hospitals are recommended for restructuring or closure in this borough.

The RAC met with Interfaith Hospital leadership. It is an essential hospital and they seem to be on their way to a stable operation, though access to primary care services for this community is a significant challenge in any future planning. Kings' Highway, which is part of the Continuum Health System is also considered an "essential" hospital because of the unique geographic market this facility serves and the inability of surrounding facilities to absorb its inpatient capacity. It is also located in and serves community that is "stressed" for lack of primary care capacity (see Map 1 Under Primary Care).

<u>Queens</u>

In examining Queens we identified six market areas in which certain hospitals play a distinct role in meeting the needs of the borough's diverse communities. Overall, Queens is

an under-bedded borough, especially in the face of a significantly growing population. (See coverage maps in Appendix A).

Market Area: Rockaways

Restructuring: <u>Peninsula Hospital Center and St. Johns Episcopal Hospital</u>

We are recommending that Peninsula Hospital Center and St. Johns Episcopal Hospital be merged into a single entity and a new hospital be built with an inpatient capacity of 350 – 400 beds. While this will entail significant capital investment, we cannot support the continuation of two separate, inefficient and outmoded facilities as this area of Queens, which is experiencing major development and population growth.

While eastern Rockaways is very poor, the western part of the peninsula is experiencing growth of a new middle class. Blending services for these communities must be part of the planning agenda. Each entity has unique service strengths but the exact configuration of services and beds should be the result of comprehensive planning process. This process should also focus on strategies to ensure continued improvements in quality. We posed the question about the need for a single hospital to both administrators and the response was supportive of a course of action. Of course, each one indicated that they should be selected to lead the effort. We are not indicating any preference.

We strongly support the use of HEAL NY or other funds to start and support a planning process toward restructuring.

Market Area: South Queens

Restructuring: <u>Mary Immaculate Hospital (MIH)</u>
(LaRay Brown recused herself from the discussions and recommendations.)

MIH is an "essential" hospital serving a distinct market. MIH is part of the bankruptcy proceedings of St. Vincent's CMC. MIH is also on the same operating certificate of St. John's Hospital, which is also part of the bankruptcy proceedings. On June 22, the bankruptcy judge approved the plans of Wyckoff Heights Medical Center and its new nonprofit entity, Caritas Health Planning, Inc., to assume responsibility for the MIH and St' John's operations. In a presentation by Wyckoff HMC to the RAC, the topic of the future configuration of MIH was discussed. The administration at Wyckoff HMC recognize the challenge at MIH and indicated that while it is premature to determine the ultimate size of the inpatient facility and configuration of services, they recognized that its overall size might be reduced in Med/Surg capacity. They also recognized that MIH's future is directly affected by the future plans of Jamaica Hospital and Queens Hospital (HHC).

We recognize that MIH's financial future may be more certain as it emerges from bankruptcy, the RAC recommends that planning for the future configuration of MIH is done in conjunction with Jamaica Hospital and Queens Hospital (HHC) and that the final configuration be decided by

a joint planning process that includes analyses of the health needs of the catchment area served by MIH, Jamaica Hospital and Queens Hospital.

See Appendix E for more information.

Expansion: Queens Hospital Center (HHC)--additional 40 - 45 beds
(LaRay Brown recused herself from this discussion and recommendations.)

In the face of the growing population in Queens, the impact of St. Joseph's recent closing and the need for additional inpatient capacity, we recommend the expansion of 40 - 45 beds. We were told that the QHC could accommodate this expansion by modifying its current ambulatory pavilion construction project.

See Appendix F for more information.

This expansion cannot be done without access to HEAL NY funds. Therefore, we strongly support the use of these funds for this expansion project.

Market Area: West Queens

Restructuring: Mt. Sinai Hospital of Queens

This facility is an essential facility but needs to be reconfigured and renovated to meet the present and future needs of this community, which is anomaly because of the lack of access to any other hospital within five miles. MSHQ is a division of The Mt. Sinai Hospital under the same operating certificate and Medicare provider number.

Leadership at Mt. Sinai submitted their concept of a new approach to community hospital development. The highlights include:

- Expand capacity from 192 available beds (certified capacity is 235 beds) to 250 or 300 with most of this expansion being in the med/surg capacity.
- Build a new tower adjacent to existing hospital and renovate existing hospital by eliminating all three-bedded rooms
- Expand ED space
- Increase numbers of community physicians who would be affiliated with hospital (particularly in primary care disciplines) by providing space in the new tower, providing access to state-of-the-art IT and including these physicians in MHSP's quality improvement activities.

The expected outcomes of this initiative would be to:

- Increase the availability of physicians who provide primary care. (MSHQ's primary service area is Long Island City/ Astoria which includes two zip codes for which there is a shortage of primary care capacity.)
- Reduce Queens' residents' out migration to Manhattan by expanding access to needed services such as oncology, non-invasive cardiology, gastroenterology, pulmonary medicine, and neurology. In addition, expand access to surgical capacity.

(There were 5,600 cases from the above catchment areas that out migrated with much of this, over 60%, going to Manhattan)

- Improve health status (this area has relatively poor outcomes of health).

See Appendix G for more information.

Market Area: North Queens

Potential Review: <u>Flushing Hospital Medical Center</u>

In using the analysis that the Commission staff provided, Flushing Hospital is considered an "essential" hospital. Flushing Hospital serves a large Medicaid and uninsured population**.** This area is facing serious shortages in primary care.

The North Queens area could benefit from a review of the potential coordination of future services in this area between NY Hospital Queens is planning and Flushing Hospital.

Market Area: Central Queens

Potential Closure: <u>Parkway Hospital</u>

This hospital is a potential target for closure because it is not an essential hospital and the surrounding hospitals can absorb the acute care demand.

Using the need criteria developed by the Commission's staff, and particularly considering this hospital's past problems with financial and administrative mismanagement, and more importantly, quality of care, Parkway is a prime candidate for closure. However, the new operators of the hospital have presented a credible plan for emerging from bankruptcy, reconfiguring it into a physician-model hospital, and improving the quality and cost-effectiveness of inpatient care. **This leads us to the recommendation that closure be postponed for a period of two years, during which its owners will have the opportunity to reconfigure services and downsize beds and to demonstrate the viability of the physician-model hospital that they have presented to the RAC.**

It does, however, meet our criteria for a community hospital: it is a low cost hospital and only has a small percentage of Medicaid days. The shift of these Medicaid days/ admissions to higher cost hospitals will increase costs to the State's Medicaid program. Parkway is the primary hospital for several physician group practices some of which are owned by the owners of the hospital. The physicians in these practices serve over 100 self-insured union health plans. By

closing this hospital, there may be a significant disruption to services for these union members, a crisis among these plans, dislocation of workers and a loss of physicians providing care in this area. Parkway admits patients from throughout Queens and parts of Brooklyn. These patients get their outpatient care at the above-mentioned group practices located throughout Queens and parts of Brooklyn.

Parkway is a for-profit hospital and is in bankruptcy. Its owners report that it is planning to emerge from bankruptcy in the near future with a financially viable plan. The hospital recently achieved JCAHO accreditation and its chiefs of service are board certified. If the facility could be made financially viable and provide quality care, there may be an interesting model of doctor-controlled facilities to support.

It may be worthwhile to delay immediate decisions; and to follow the outcomes of the bankruptcy process and the ability to sustain and improve on current quality and cost.

Restructuring: St. Johns Queens and North Shore Forest Hills

St. Johns is an essential hospital serving a market that is dependent on its services. Forest Hills is not as essential but is controlled by North Shore-LIJ. On June 22, 2006 the bankruptcy judge approved the plans of Wyckoff Heights Medical Center and its new nonprofit entity, Caritas Health Planning, Inc., to assume responsibility for its operations.

We were told by the Mike Dowling that North Shore was prepared to assume responsibility for St. Johns, expand that facility's inpatient capacity upwards to 500 beds and subsequently close Forest Hills Hospital, if this arrangement was approved by the State. He also believes that St. John's needs to expand upwards to 500 beds to make it an efficient facility serving this market.

In Wyckoff HMC's presentation they addressed the specific synergies that would benefit St. John's. Wyckoff indicates that they serve the same market area of St. John's and operations (and therefore, expenses) would be rationalized with their assumption of responsibility for the hospital.

See Appendix E for more information.

Market Area: East Queens

North Shore-LIJ is the dominant provider serving this market and we are not recommending any restructuring.

New York County

This borough has the greatest concentration of hospital beds in the City. The number of beds far exceeds the national average of beds per 1000 population; and lengths of stay are significantly over the national average and the averages for the other boroughs in the City. Our

recommendations focus on specific hospitals. The larger issue of bed concentration in high cost academic health centers and the need for greater efficiency in bed use were not specifically addressed but are key to achieving meaningful health care cost savings in New York County.

Restructuring: St. Vincent's Hospital Midtown

The RAC is supporting the plans for clinical integration of services between St. Vincent's Midtown and the 12th Street Campuses and would support the continuation of acute care services in the midtown location in order to stabilize and sustain the 12th St campus which the RAC sees as an essential facility. (Please see Appendix H)

St. Vincent's CMC is in discussion with various potential partners for the restructuring and rebuilding of its 12th Street Campus. Although the various partnership discussions ensue, St. Vincent's CMC has submitted a proposed plan for clinical integration and rationalization of services between the Midtown campus and 12th Street that can be implemented with or without partners. Absent a clear linkage of Midtown services to support of the viability of St Vincent's downtown, it would appear that its acute care services and ER and outpatient services could be absorbed by surrounding facilities. The outcome of these plans should be considered carefully in determining the future for this facility (St. Vincent's Midtown).

Closure: NY Downtown

There is no need for this facility under present demand or configuration. The surrounding hospitals can absorb the hospital's utilization. The hospital and NYPH leadership did not present a compelling case for the continued need for this hospital nor did they present reconfiguration options to remain a viable health care resource for the hospital's current patient population.

There is a concern that access to OB/GYN services to the Chinese communities of Lower Manhattan and the burgeoning "Chinatowns" of Queens and Brooklyn, would be compromised without the development of a formal transition plan and assumption of inpatient and ambulatory service responsibility by other hospitals (coverage partners) in both Manhattan and Brooklyn and that is a major concern of the RAC. However, we were told that St. Vincent's CMC at 12th Street is also preferred provider for OB/GYN services for the Chinese communities. In addition, Gouverneur, Beth Israel and Bellevue Hospital also serve the Chinese communities of Manhattan, Queens and Brooklyn. Bellevue and Gouverneur combined could absorb OB/GYN services workload (both inpatient and outpatient).

As Lower Manhattan increases its residential population and nearby commercial property is expanded, the longer term planning for this area should include consideration of need for health care facilities to be located nearer to new housing concentrations and business development.

Closure (Inpatient Only): Cabrini Medical Center
(Arthur Webb recused himself from the discussion and recommendation.)

There is no continuing need for an inpatient medical/ surgical capacity at this facility. While the administration and the board have been very aggressive in attempting to preserve Cabrini as a hospital, and have been creative in developing different configurations including reducing medical/ surgical beds, it appears to us that the surrounding hospitals can easily absorb inpatient admissions from this market area.

We therefore recommend that Cabrini's inpatient beds be closed, that its current inpatient behavioral health capacity be transitioned to other facilities, and that the facility continue its service to the community by expanding its primary care and specialty care capabilities into a Diagnostic and Treatment Center. The institution should be supported in restructuring to become a D&TC and possibly a federally-qualified health center (FQHC) with assistance and funding by the State.

Cabrini is a critical provider of ambulatory care. Its primary service area includes communities that face serious primary care shortages for Medicaid and low-income residents (Chelsea/ Clinton and Union Square/ Lower East Side); as well as high incidence of mental illness, substance abuse, HIV/AIDS and chronic diseases.

We are aware that Cabrini is in discussions with other providers and these discussions will go beyond the RAC's deadlines.

Restructuring: <u>Continuum Health Partners: St. Luke's – Roosevelt Hospital Center & St. Luke's Hospital</u>

Stanley Brezenoff submitted a very broad, future plan for Continuum Health Partners. Please see Appendix I for more details. The plan is highly confidential and the release of these contents to the public should first be discussed with Mr. Brezenoff.

Highlights for Manhattan:

- St. Luke's Hospital: Consolidate hospital to North Block with only one location. The hospital has 541 certified beds and operates 444 beds. The leadership is recommending operating 470 beds with the consolidation and in its plan for the future.
- Roosevelt Hospital: it has 505 certified beds and operates 426 beds and plans to operate 490 beds.
- Overall reduction is 86 beds.
- Achieve efficiencies by reconfiguring certain services (e.g. maternity and psychiatry services).
- Beth Israel Medical Center: Long range plans include the possibility of rebuilding the Petri Division. They are increasing the ED department to handle over 90,000 visits per year, a 40% increase.
- New York Eye and Ear Infirmary: consideration of fully integrating all of CHP's Ophthalmology and Otolaryngology under the leadership of NYEEI. Also consideration of a disbursed model of the outpatient services depending on need and location. The future plans for the Petrie Division might include the needs of NYEEI into this re-building plan.

The RAC is concerned about those aspects of the proposal that would increase acute care beds; and therefore, these plans should be reviewed in the context of the health care system's plans and the outcome of ST. Vincent's renewal process.

Closure: <u>Manhattan Eye and Ear (MEETH) and New York Eye and Ear</u>

There would appear to be no need for either of these facilities to continue as free-standing institutions, though the high quality outpatient services provided by these facilities are critically important for the City of New York.

We strongly encourage the State to engage both facilities and their sponsors in a joint planning effort to transition the inpatient services to other hospitals in Manhattan; and to determine the ongoing sponsorship of the outpatient services operations. It was also pointed out that these facilities have very valuable real estate that could be used to help resource the restructuring of their operations.

Lenox Hill made a presentation and informed the RAC that it has initiated a RFP process in a search of a partner to operate MEETH. Please see Lenox Hill's presentation. See Appendix J.

Please refer to the discussion of the NYEEI in the above plans for the Continuum Health Partners. There is a concern about the possible loss of federal funding for medical education. The RAC also received a letter from the President & CEO on July 3, 2006 describing his justification for the need for inpatient beds at NYEEI. See Appendix J.

Restructuring: <u>North General Hospital</u>

We support North General's restructuring plans. We had extensive discussions with North General Hospital leadership and Mount Sinai Hospital leadership in separate meetings. North General has a plan for the future viability of the hospital and the maintenance of its commitment to its community through increasing interdependence with the Mt. Sinai system and its system. The model that was reported on in a recent Wall Street Journal article describes what was addressed in their presentations to the RAC.

Priorities for HEAL NY Funds to facilitate Restructuring (not listed in order of need)

<u>Hospitals and complimentary ambulatory care/primary care facilities as noted:</u>

- New York Methodist Hospital and Community Hospital (Restructuring)
- The Brooklyn Hospital Center (Restructuring)
- Peninsula Hospital Center and St. Johns Episcopal Hospital (Planning)
- Queens Hospital Center (HHC) (Expansion)

- Cabrini (Closure of inpatient beds and Restructuring as a Diagnostic and Treatment Center)

Pending acceptable completion of planning processes for reconfiguration as discussed in report above:

- St. Vincent's Hospital Midtown and St. Vincent's Downtown to support the long term viability of the latter institution(Restructuring)
- Continuum Health Partners: St. Luke's – Roosevelt Hospital Center & St. Luke's Hospital (Restructuring)
- Victory Memorial Hospital (Restructuring, but not as a freestanding facility)

I.B Nursing Home Recommendations

The RAC heard testimony on the status of nursing homes and long-term care reform. While the RAC is very concerned with the need for LTC reform, we have no community specific or facility specific recommendations at this time. There are several "rightsizing" and other voluntary restructuring already underway and we would encourage the State Department of Health and the Commission to support these initiatives.

Using the State's need methodology there are virtually no excess beds in NYC.

In fulfilling our task, we do not see excess capacity in any large measure in any of the boroughs that offer a prime opportunity to shift resources to non-institutional settings. Only the Bronx has surplus beds, but also has the highest occupancy (97%) and meets almost all of its non-institutional need according to the State DOH. All other boroughs are above 94% occupancy, and similarly offer a good spectrum of home- and community based services.

It should also be pointed out that we did not spend any time with the for-profit sector, which represents close to 50% of all beds, 22,000, in New York City. We believe that in the context of the larger long-term care reform agenda, we recommend the issue of the for-profits should be addressed.

Rightsizing-Related Initiatives

The following not-for-profit (NFP) providers are undertaking initiatives approved by the State Department of Health under the "rightsizing" legislation. It is important to reinforce the work of these providers because they are pointing the way to restructuring the long-term care sector.

Most of these providers will be seeking access to HEAL NY Funds.

Beth Abraham/CNR
(Frank Serbaroli recused himself)

Elimination of 72 beds in its Bronx nursing home:
Using the resulting space to accommodate information services, financial, and other back-office activities to support the growth and expansion of the existing PACE program. In exchange for eliminating the beds, it establishes new (LTHHCP) slots.

Metropolitan Jewish Geriatric Center
(Frank Serbaroli recused himself)

Permanent decertification of 156 inpatient beds:
Expansion of an existing Long Term Home Health Care Program in Kings County by 156 slots.

Rutland Nursing Home

Permanent decertification of 10 inpatient nursing home beds:
Establishing of new ADHC program slots.

Menorah Home and Hospital
(Frank Serbaroli recused himself)

Decertifying 21 beds to create new LTHHCP slots

Cobble Hill

Decertification of 156 beds:
Undertaking a full renovation of the existing inpatient facility and eliminating all 3 & 4 bedded rooms. The physical restructuring will be undertaken in parallel with a staff training initiative and organizational restructuring effort that will support a more resident-centered approach to care – with one building, serving longer term residents, operated on a neighborhood model, and another building delivering more medically-oriented care for sub-acute, rehabilitation, and dialysis patients.

Adding 30 slots to an existing Medical day health program.

Terence Cardinal Cooke
(Frank Serbaroli recused himself)

Converting 156 nursing home beds to 100 ADHC slots. Also seeking approval to establish 100 new LTHHCP slots.

New Demonstration Initiatives

New York City Not-for-profit Demonstration
(Frank Serbaroli, Arthur Webb, and Jo Ivey Boufford recused themselves)

Village Care of New York is authorized under a state demonstration initiative to take its 200-bed nursing home, Village Nursing Home, and build a new state-of-the-art 100-bed nursing home. In

exchange for reducing 100 beds, Village Care is being authorized to open 80 Assisted Living Program beds, 125 slots of LTHHCP and open a MMLTC program. The 1199SEIU union is partner in this initiative.

Other Initiatives:

The following are examples of what many nonprofit providers are considering in anticipation of the second round of "rightsizing" applications.

Staten Island

Sea View Hospital Rehabilitation Center and Home (Sea View)
(LaRay Brown recused herself)

Sea View, part of the NYC HHC, is licensed to operate 304 RHCF beds and an ADHCP. The Robitzek Building, which houses all resident-related services, including the RHCF beds (that operate at 98.7% to 100% occupancy) and the ADHCP (which also has a full census) was built in 1972, is fully utilized and requires modernization. NYCHHC is working with the City to develop a financing plan for the construction of a new $141 million facility. In addition, as part of its strategic direction to expand the long term care services continuum for its patients and NYC residents, NYCHHC has entered into a long term sublease with an independent developer for the use of the Nurse's Residence (a building on the Sea View campus no longer used by the facility) and approximately four acres of land to develop and operate as housing for seniors. In addition, NYCHHC/Sea View will seek SDOH approval for a 30-slot expansion of its current ADHCP and HEAL NY funding to support this program expansion.

Manhattan Not-for-Profit

Cabrini Center for Nursing Rehabilitation

CCNR on the lower eastside of Manhattan will be building a new nursing to replace its antiquated facility in the same neighborhood. As part of the future planning, CCNR is considering reducing its overall size and replacing nursing home beds with the state's Medicaid ALP program. It will need support from HEAL NY funds for its equity contribution.

<u>Other Initiatives Being Explored or Underway</u>

Many not-for-profits throughout New York City are evaluating potential conversions of SNF to ALP and/or Home Care slots. Others are undertaking rebuilding projects which will reduce the size and service configurations of the institutions.

HEAL NY FUND Priorities

- All the centers proposing “rightsizing (See above)
- Sea View Hospital Rehabilitation Center
- Village Care of New York--Village Nursing Home
- Cabrini Center for Nursing Rehabilitation

I.C PRIMARY CARE RECOMMENDATIONS

Without an initiative to assure alternative capacity, hospital closures could eliminate a major source of primary care and exacerbate existing shortages, particularly those experienced by low-income New Yorkers. This would have the effect of worsening community health status, heightening disparities and increasing costly but avoidable Emergency Department and inpatient use.

See Appendix K for full report and additional Maps

1. ***New York City has a Shortage of Primary Care Providers Serving Low-Income New Yorkers and Disparities Exist in Primary Care Availability Across the City.*** *Medicaid-enrolled residents are used here as a proxy for all low income residents, though the figures undercount the number of low-income New Yorkers since they exclude those who are uninsured or underinsured.*

   - Medicaid-enrolled residents comprise 39% of New York City's population, but have access to only 25% of the primary care physicians based in the City. (See Table I of Primary Care report, Appendix K).

   - Between 38% and 62% of the City's zip codes have an inadequate supply of primary care physicians, according to the federal Health Resources and Services Administrations (HRSA) standards.
     - Map 1 shows the areas, comprising 62% of the City's zip codes where the primary care physician supply available to low-income New Yorkers is either "Stressed" or experiencing a "Serious Shortage". As defined by HRSA, Bureau of Primary Health Care and used nationwide in designating Health Professional Shortage Areas, an area is deemed Over utilized – herein identified as "Stressed" – if it has a rate of 2,000 to 2,999 Medicaid-enrolled residents per primary care physician full-time equivalent (FTE), or deemed Underserved – herein identified as "Serious Shortage" – if it has a rate of 3,000+ Medicaid-enrolled residents per primary care physician FTE.

   - In total, more than 1.1 million low-income New Yorkers currently live in areas with an inadequate primary care physician supply. That is, more than one-third of the residents of the neighborhoods in Brooklyn, Queens and Staten Island, among them:
     - Bushwick,
     - Bedford Stuyvesant,
     - Flatbush,
     - East New York,
     - Jamaica,
     - Southeast and Southwest Queens,

- Port Richmond,
- Stapleton, and
- Willowbrook.

2. To Meet Community Residents' Needs Today, Particularly Those of Low-Income New Yorkers, Additional Primary Care Capacity is Essential in the City's Stressed Neighborhoods

- To achieve the same per capita supply of primary care physicians for Medicaid-enrolled residents of shortage/stressed areas, as currently exists for the residents of these areas overall, an additional 259 FTE primary care physicians, willing to serve low-income residents, would be needed (as shown in Table 2, Appendix K). There continues to be significant difficulty recruiting physicians to serve low income, Medicaid patients.

3. Avoidable Hospitalizations are High in New York City – Indicative of an Inadequate and Poorly Performing Primary Care System

- The rate of Ambulatory Care Sensitive (ACS) admissions – admissions for conditions that could have been prevented if ambulatory care treatment had been obtained sooner – is an indicator of shortcomings in the primary care system.
  - In more than one-third of the City's zip codes[3], the ACS rates exceed the citywide average
    (17 discharges per 1,000 population), as shown in Maps 3 and 4 – ACS rates tend to be higher in low-income areas. The analysis focuses on the 173 residential zip codes and the 21 point zip codes that they encompass (these are zip codes that may have physicians but have no residents), and excludes the 2 airport zip codes.
  - The ACS rates are highest in the City's designated Health Professional Shortage Areas, notably:
    - Southern Bronx,
    - Northern Manhattan,
    - Central and Northeast Brooklyn,
    - Northern Staten Island,
    - Long Island City, and
    - Jamaica.

4. Low-Income New Yorkers are Highly Reliant on Hospital-Based Physicians for Their Primary Care, Making Their Access to Care Highly Vulnerable to Hospital Downsizing Decisions

- Overall, 16% of the City's primary care physician supply is hospital-based.

[3] The analysis focuses on the 173 residential zip codes and the 21 point zip codes that they encompass (these are zip codes that may have physicians but have no residents), and excludes the 2 airport zip codes.

- For low-income New Yorkers, the stock of available hospital-based primary care physicians is twice the citywide average at 32%.
- If hospital-based supplies were unavailable to low-income New Yorkers, and Medicaid-enrolled residents had access only to the existing community-based primary care physicians, then 95% of the City's zip codes would have a woefully inadequate supply of primary care physicians. In other words, most of the City would be designated as a serious shortage or stressed area, as shown in Map 5.

- Three quarters of the outpatient care (including both primary and specialty care) that is provided in Article 28-licensed settings in New York City is provided by hospitals, as shown in Table 3, Appendix K.

- Two out of every five Emergency Department (ED) visits – over 1 million visits citywide – are for conditions that can or should have been treated in primary care settings, as shown in Table 4, Appendix K.

5. Hospital Restructuring/Closure Would Increase the Stress on an Already Stretched Primary Care System if the Existing Primary Care Capacity were not Preserved Within Each Community

- Hospitals are a key access point to New York City's health care system.
  - As noted above, hospitals are a main source of primary care, especially for low-income New Yorkers, delivered in both the hospitals' EDs and outpatient settings.
  - Moreover, New Yorkers' dependence on Emergency Departments has grown in recent years (As shown in Table 5, Appendix D). The ED has become the chief portal for patients requiring hospitalization: between 1999 and 2002 the percentage of inpatients admitted through the ED grew by more than 60%, increasing from 39% of all discharges to 65% of all discharges. This poses concerns for communities where hospital closure – and, as a result, ED closure – may occur.
- Loss of Emergency Department or hospital outpatient capacity could be expected to reduce residents' access to primary care, worsen health status, and increase ACS admissions rates, putting added strain on the remaining hospital infrastructure, and increasing Medicaid spending.
- Policymakers must plan hospital closures carefully and systematically, and ensure that existing ambulatory care resources are not only preserved but strengthened to improve residents' access to primary care. This ambulatory care redevelopment cannot be left to the affected hospitals and markets, since the incentives, notably financial, are neither inherent nor aligned to achieve this outcome.

6. ***While preserving and enhancing primary care capacity requires up-front investment, research shows it produces health systems savings over the mid- and long term.***

- New York City's health care system is overly reliant on inpatient, hospital-based care, and under-invested in outpatient care.
- Research shows that effective primary care invariably results in overall cost savings.
  - In New York State, Medicaid patients treated by Federally Qualified Health Centers (FQHCs), a nationally recognized primary care model, and cost taxpayers 23% less in outpatient spending and 41% less in inpatient spending than Medicaid patients treated in other settings.
  - Chronically ill patients, such as diabetics, account for 70% of health care expenditures. New York State taxpayers save 36% in outpatient costs and 41% in inpatient costs if a diabetic patient is treated by an FQHC.
  - A five-state study showed that Medicaid patients treated in community-based primary care centers were significantly less likely to use Emergency Departments or to be hospitalized for ACS conditions.
  - Medicare costs are found to be inversely related to the supply of primary care physicians – the greater the supply of primary care, the lower the Medicare spending rate.
  - Detailed accounts of the above-mentioned research on cost savings are found in the two reports identified below:
    - Barbara Starfield, Leiyu Shi & James Macinko, *Contributions of Primary Care to Health Systems and Health*, The Millbank Quarterly, Vol. 83, No.3, 2005 (pp. 457-502); and
    - Sara Rosenbaum, JD, Peter Shin, PhD, & Ramona Perez Trevine Whittington, *Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative*, Feb. 2006.

CONCLUSIONS/RECOMMENDATIONS

Decisions about hospital closure or restructuring must take into account the existing unmet need as well as the capacity of other area primary care providers to take up the slack and ensure the City's public health.

The existing primary care capacity must be preserved – hospital closures or restructurings should not undo the expansion of the primary care delivery system achieved over the last decade.

To be most effective, resource availability and distribution decisions must be analyzed and addressed at the community level.

- Large area analyses suppress underlying variations, e.g., as is apparent from Maps 4A and 4B, an essential level of precision, available at the zip code level, is lost at the borough level.

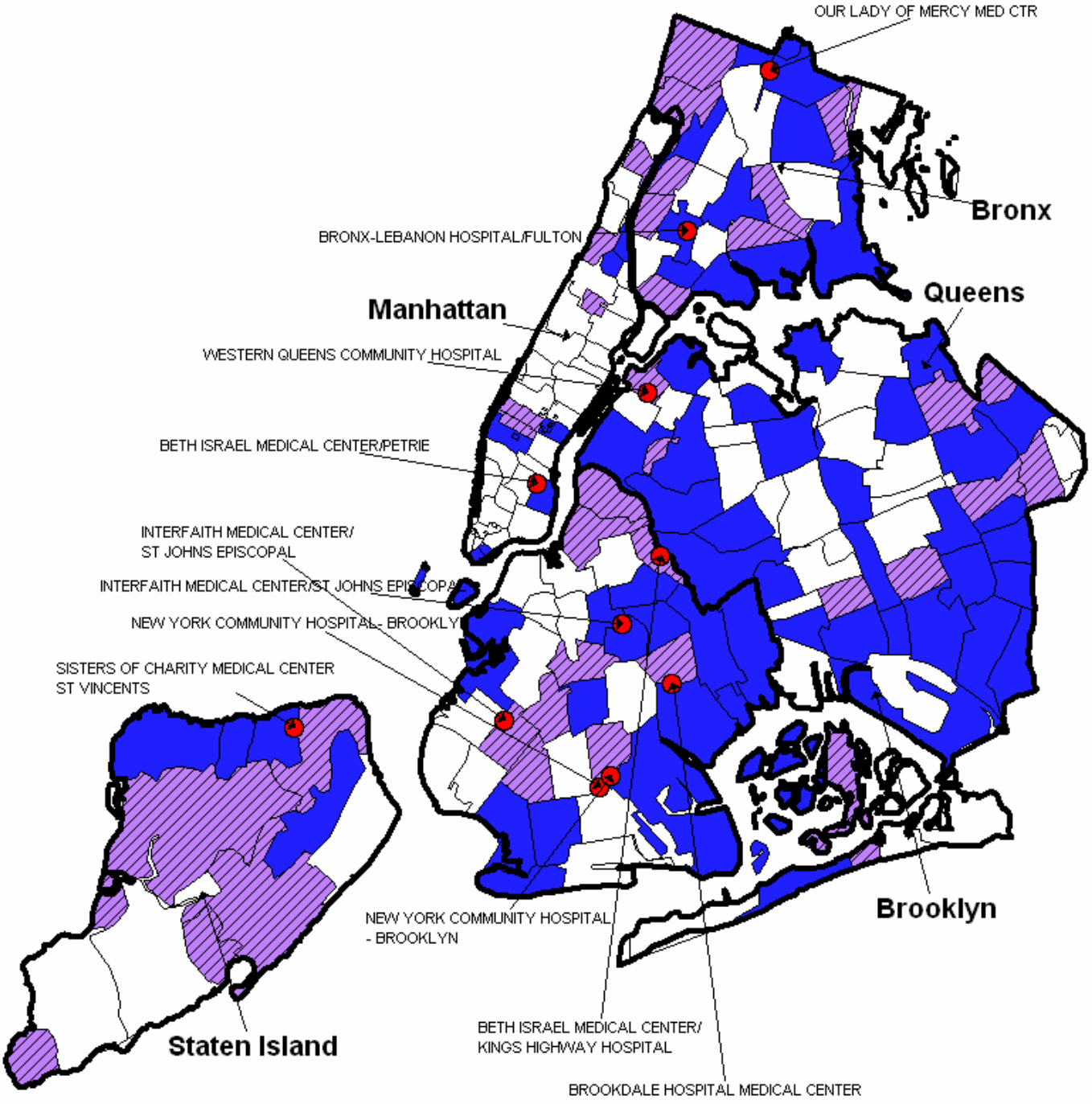
- Consequently, resource distribution decisions must be made at the level of "community" most affected – based not only on a circumscribed geography, but also or alternatively based on socioeconomic considerations, including special cultural/linguistic requirements.

The RAC believes it is incumbent on the State to invest in preserving ambulatory care resources within each community where hospital-based resources are to be downsized. Such investments should be offset over time by reductions in Medicaid spending for more expensive (and often preventable) emergency and inpatient care. Therefore, HEAL NY funds should be considered to enhance primary care capacity in "Stressed/Serious Shortage" areas served by hospitals for which the RAC has recommended closing.

MAP 1

Medicaid-Eligible Population-to-Primary Care Provider Ratio

Serious Shortage (>3,000 Population-to-Provider Ratio) (71)
Stressed (2,000-2,999 Population-to-Provider Ratio) (36)
Total number of zip codes =173



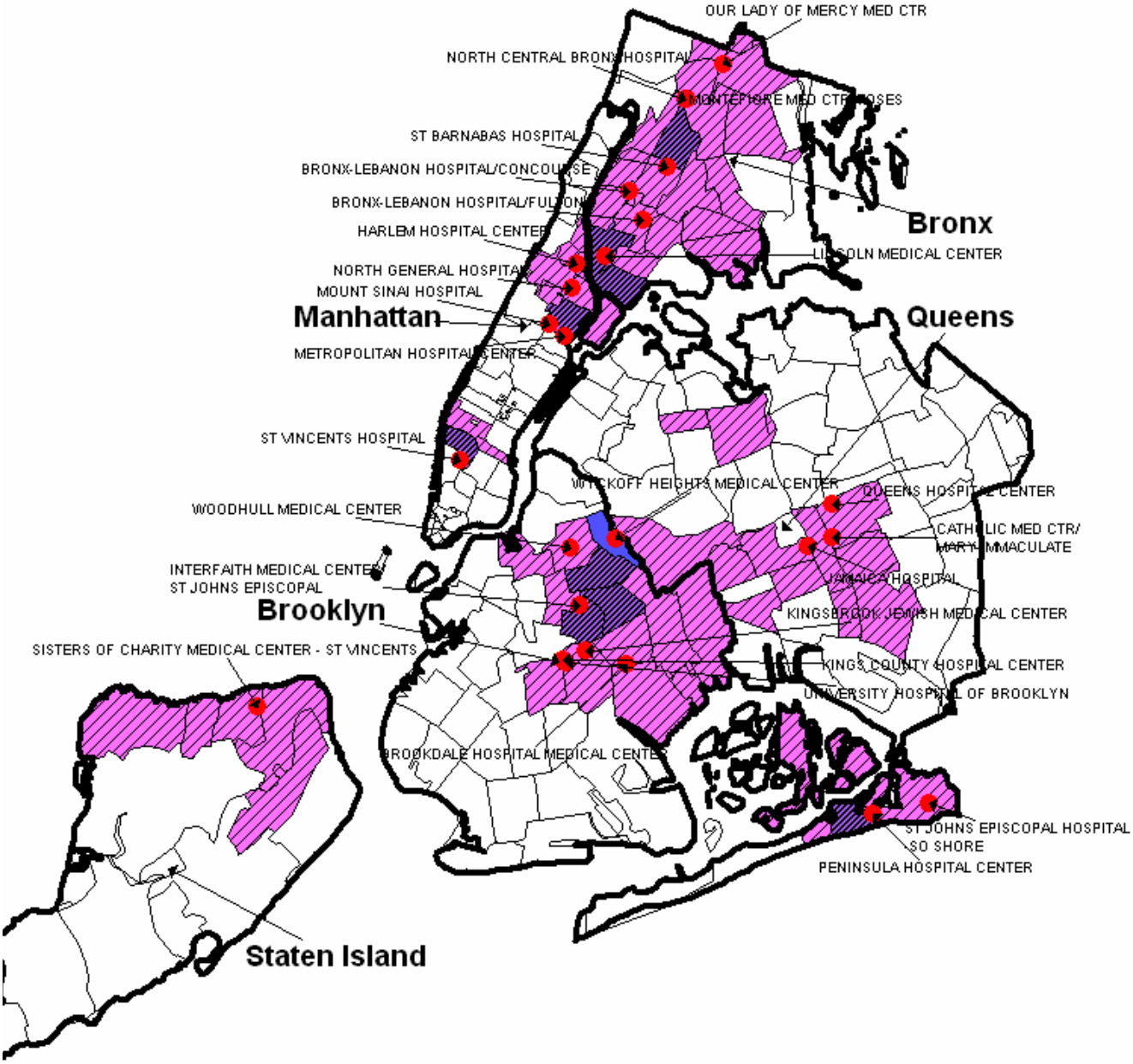
Source: Center for Health Workforce Studies, SUNY, Albany,
NYS Physician Re-registration Survey 2004-2006

MAP 2

Ambulatory Care Sensitive Condition Admission Rates, 0 to17
(Discharges per 1,000 Population)

> 200% of NYC ACS Rate	(>34)	(1)
150-200% of NYC ACS Rate	(25.5 to 33.9)	(9)
100-150% of NYC ACS Rate	(17 to 25.4)	(52)

Total Number of Zip Codes =173



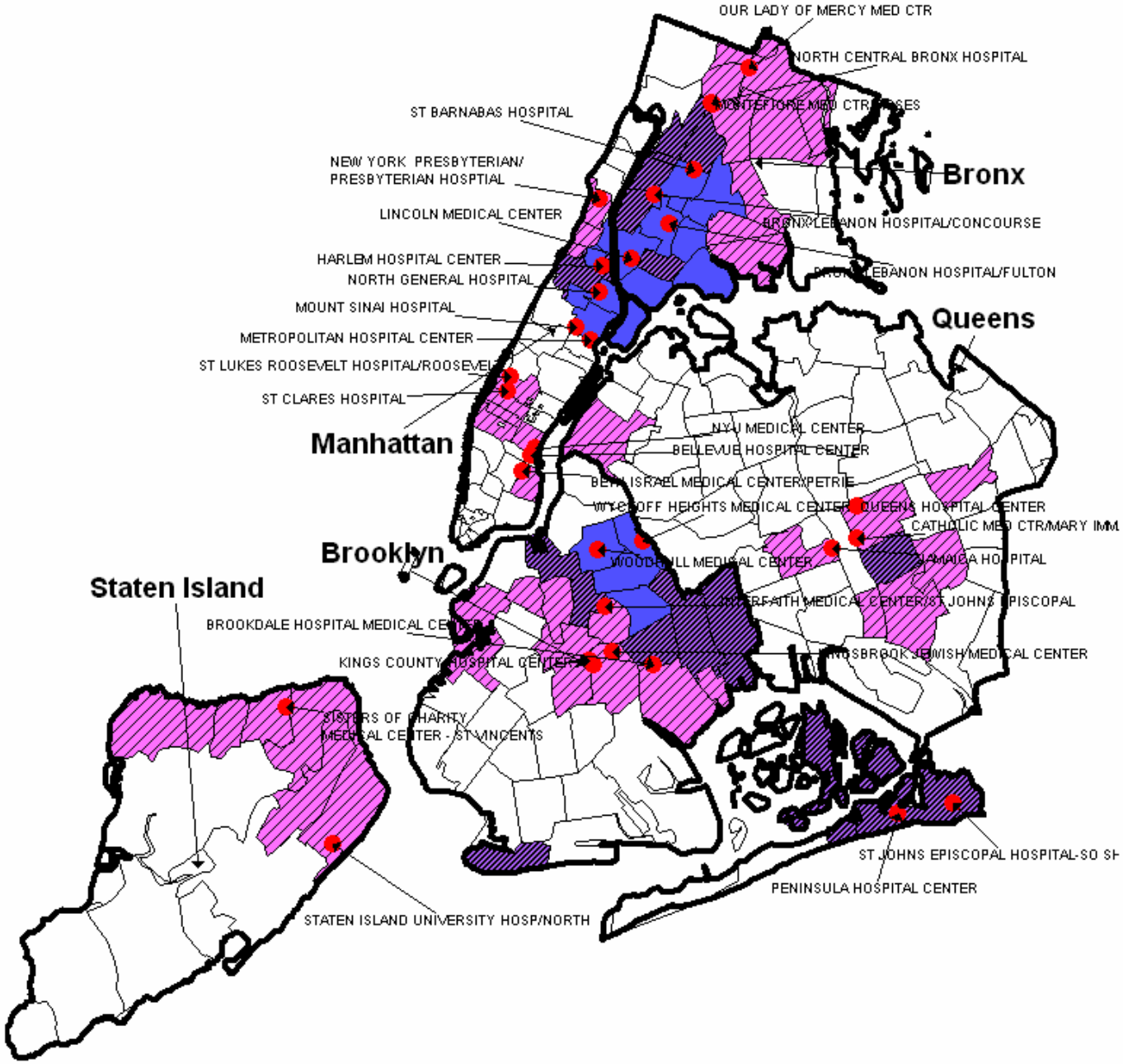
Source: Center for Health Workforce Studies, SUNY, Albany,
NYU Center for Health and Public Service Research

MAP 3

Ambulatory Care Sensitive Condition Admission Rates, 18-64
(Discharges per 1,000 Population)

> 200% of the NYC ACS Rate	(>34)	(17)
150-200% of the NYC ACS Rate	(25.5 to 33.9)	(17)
100-150% of the NYC ACS Rate	(17 to 25.4)	(40)

Total Number of Zip Codes =173



Source: Center for Health Workforce Studies, SUNY, Albany,
NYU Center for Health and Public Service Research

Hospital	PSA Zip Code	Neighborhood	Serious Shortage Area	Stressed Area
NY WESTCHESTER SQUARE MED	10461	Pelham/Throgs Neck		
	10462	Pelham/Throgs Neck		X
	10469	Northeast Bronx	X	
	10465	Pelham/Throgs Neck	X	
ST VINCENT'S MIDTOWN HOSP	10019	Chelsea/Clinton		
	10036	Chelsea/Clinton		X
	10029	East Harlem		
	10025	Upper West Side		
	10001	Chelsea/Clinton	X	
	10034	Washington Hgts/Inwood		
	10031	Washington Hgts/Inwood		X
	10456	Highbridge/Morrisania	X	
	11221	Williamsburg/Bushwick	X	
	10018	Chelsea/Clinton		X
	10032	Washington Hgts/Inwood		
	10026	Central Harlem/Morningside Hgt		X
	11355	Flushing/Clearview		
	11354	Flushing/Clearview		
FLUSHING HOSPITAL MEDICAL	11368	West Queens	X	
	11357	Flushing/Clearview		
	11356	Flushing/Clearview	X	
	11358	Flushing/Clearview	X	
	11102	Long Island City/Astoria		X
	11106	Long Island City/Astoria		
	11105	Long Island City/Astoria	X	
	11103	Long Island City/Astoria		
PARKWAY HOSPITAL	11375	Ridgewood/Forest Hills		
	11374	Ridgewood/Forest Hills		
	11368	West Queens	X	
	11372	West Queens		
	11385	Ridgewood/Forest Hills	X	
	11415	Southwest Queens		
	11373	West Queens		
	10001	Chelsea/Clinton	X	

	11379	Ridgewood/Forest Hills	X	
	11435	Jamaica	X	
	11377	West Queens	X	
	11418	Southwest Queens		
	11369	West Queens	X	
	11419	Southwest Queens		X
VICTORY MEMORIAL HOSPITAL	11214	Bensonhurst/Bay Ridge	X	
	11209	Bensonhurst/Bay Ridge		
	11228	Bensonhurst/Bay Ridge		
	11204	Borough Park		X
NEW YORK METHODIST HOSPIT	11215	Downtown/Heights/Slope		
	11218	Borough Park		X
	11226	Flatbush/E. Flatbush	X	
	11238	Bedford/Stuy/Crown Heights		
	11235	Coney Island/Sheepshead Bay		
	11225	Flatbush/E. Flatbush		X
	11217	Downtown/Heights/Slope		
	11236	Canarsie/Flatlands	X	
	11230	Borough Park		
	11234	Canarsie/Flatlands	X	
	11231	Downtown/Heights/Slope	X	
	11214	Bensonhurst/Bay Ridge	X	
NY COMM HOSP BRKLYN INC	11235	Coney Island/Sheepshead Bay		
	11229	Coney Island/Sheepshead Bay		
	11230	Borough Park		
BROOKLYN HOSP CTR @ DWNTN	11205	Downtown/Heights/Slope		
	11221	Williamsburg/Bushwick	X	
	11238	Bedford/Stuy/Crown Heights		
	11216	Bedford/Stuy/Crown Heights	X	
	11206	Williamsburg/Bushwick		
	11201	Downtown/Heights/Slope		
	11226	Flatbush/E. Flatbush	X	
MOUNT SINAI QUEENS MEDICA	11102	Long Island City/Astoria		X
	11106	Long Island City/Astoria		

	11105	Long Island City/Astoria	X	
	11103	Long Island City/Astoria		
CABRINI MEDICAL CENTER	10001	Chelsea/Clinton	X	
	10002	Union Sq./Lower Eastside		
	10003	Union Sq./Lower Eastside		
	10009	Union Sq./Lower Eastside	X	
	10010	Gramercy Park/Murray Hill		
	10011	Chelsea/Clinton		
	10012	Greenwich Village/Soho		
	10013	Greenwich Village/Soho		
	10016	Gramercy Park/Murray Hill		
	10029	East Harlem		
	10038	Lower Manhattan		

II. Context

Through the public hearings, testimony and individual meetings, we have seen how vibrant and dynamic New York City is; how immigrants or those frequently called the "newest" New Yorkers are creating community pressures on all social services including health care to be more responsive; how the population growth of over eight percent in New York City is causing pressures on human services and will continue to impact on issues of access to health care. This dynamic among others make the alignment of current and future need with hospital capacity a critical issue for the Commission and our public officials. The population in NYC is growing faster than the state particularly in the boroughs of Queens, the Bronx and S.I. This growth is causing great pressure on existing providers and is an emerging issue that directly impacts the state's need methodology. The NYC RAC has not attempted to offer suggestions to revise the state need methodology at this point.

One of the most pressing issues for public officials is the cost of the health care system, yet there is another crisis, a deeper crisis of access and coverage for many poor, uninsured New Yorkers and, for primary care services, those with Medicaid. The Institute of Medicine's Report was referred to many times: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* The uninsured is close to 24% of the City's population according to the United Hospital Fund Report, 2005. These issues are major issues facing the State and City of New York and will create pressure on he current system of care.

These crises coupled with the serious disparities in public health status among different populations of New Yorkers, especially those in poor areas was presented to us by the NYCDOH and requires a high level of attention and action by government officials. By not addressing these fundamental issues, there will only be additional burdens on hospitals and other health care facilities which are strained under current conditions.

The current financial status of many hospitals and other providers were identified as "fragile" or constantly teetering on financial crisis. The recent bankruptcies illustrate this point. The history of hospital closures over the years has disproportionately affected communities of color and the poor. We heard consistently the concerns expressed about exacerbating already serious disparities in access and quality of care. Most of the hospitals closed over the past 40 years have been in poor and medically underserved areas of the City where many of the city's most vulnerable populations reside. In the past 10 years 14 NYC hospitals have closed or converted. While most of the admissions were absorbed, there is qualitative evidence that critical services were disrupted directly impacting poorer communities.

The specific care needs of vulnerable populations including persons with AIDS, mental illness and substance abuse have not adequately been addressed by the Commission and the NYC RAC. However, we heard from many hospital providers how mental health issues are impacting all of their services. We were told by many experts and hospital executives that the issues of behavioral health including mental illness, substance abuse and detoxification services are at a

critical level. These issues directly impact on high utilization of emergency room services, high utilization and LOS in inpatient services and over-tax outpatient services. In addition, these patients are frequent and multiple users of all services. Individuals with combined chronic medical illnesses and mental illness are some of the highest cost cases in the Medicaid insurance system according to Professor John Billings from the Wagner School at New York University.

Chronic illness and disease including congestive heart failure, asthma, diabetes, arthritis, etc. cut across the whole health care sector. Looking at Medicaid spending, chronic illness represents over 75% of all expenditures. When combined with Medicare, chronic illness can explain many reasons why the health care system is so expensive with high LOS in hospitals, high occupancy in nursing homes and high utilization of home care.

It also can help explain why there is so much hospital spending in the last two years of a Medicare person's life. A recent report by Dr. Jack Wennberg attempted to demonstrate the extent of Medicare expenditures in the last two years.

More than 1.1 million low-income New Yorkers live in areas with an inadequate primary care physician supply. Hospital closings and restructuring will increase the stress on an already stretched primary care sector if the existing primary care capacity is not only preserved within communities but expanded where it has been identified that under-capacity exists. Financial incentives for service provision and capital investment are badly needed and will pay off in long term cost savings and avoided hospitalizations.

Long term care, especially non-institutional long term care needs additional investment and regulatory flexibility to achieve more effective linkages with acute and primary care providers to better serve the patient and their families.

Without significant restructuring of the health care financing system to re-balance investments in hospital based acute care, primary care and long term care, the problems that have lead to the current expensive system of care and one that is not as efficient as it could be and one that is plagued with significant access problems, the hospital financial fragility will continue. Any savings that might be achieved from facility downsizing or closure will only be short term and not sustainable because the fundamental problems will not have been addressed.

Over the past several years there has been considerable impact on workers in the hospital, nursing home and health center sectors. The recent closings of St. Mary's and St. Joseph's are but the latest examples. There are many other closures that sometimes do not hit the press but, nonetheless, have negatively impacted workers and their surrounding communities.

The state legislature and the Governor over the past five years have responded to the needs of worker recruitment, retention and retraining with millions of dollars of public funding. We see a need for another round of workforce supports.

III. Fulfilling The Legislative Mandate

The enabling legislation creating the Commission establishes regional advisory committees who shall recommend the reconfiguration of region's hospitals and nursing home bed supply to align bed supply with regional and local needs. In developing these recommendations, each RAC shall as far as practicable estimate the efficiencies that may be derived from reconfiguration. The RACs will provide specific recommendations for facilities to be resized, consolidated, converted, or restructured. These recommendations shall include: (i) dates such actions shall occur; (ii) necessary investments including workforce, training and other investments to ensure that remaining facilities are able to adequately provide services within the context of a restructured institutional provider health care system in such region; and (iii) provide justification for its recommendations, including use of factors like need, economic impact, amount of capital debt, impact on Medicaid, uninsured and underinsured, and potential for improved quality. (See section 5 of the enabling legislation)

Our task is targeted to the alignment of need with capacity. Over the past 30 years, the state has pursued many government actions to improve the cost, quality and access while attempting to attain an efficient hospital system of care. The range of actions includes health planning and certificate of need, payment methodologies, quality incentives and report cards, Medicaid cost containment has been a constant factor in virtually every year since Medicaid was enacted in the state in 1967. Another factor in influencing bed supply is the increasing reliance on "market" forces to drive the system, but the way it has evolved has not provided an adequate safety net for the uninsured or adequate funding for basic hospital and primary care services that are not "high end" and well financed, even though there has been a very significant increase in various insurance products for citizens including Family Health Plus and Child Health Plus.

For this Commission, in this era, the focus is on bed supply. The working assumption is that with fewer hospital beds, the hospital system will be more efficient. The interpretation of efficiency is open to many opinions and measures. One perspective is that with fewer beds the "through put" of patients will improve by reducing LOS while increasing admissions. This is particularly relevant in light of the demographic and population changes, which will cause an increasing demand on services. Another viewpoint is that with fewer beds clinical practices will change, thereby shifting inpatient cases that can more appropriately be served in outpatient settings. This pattern in already underway with the increase in ambulatory surgery visits.

More cases that are sensitive to outpatient will increase. Another perspective is that public dollars can more efficiently be used to support fewer beds, thereby reducing the cost of debt service, overhead costs and other indirect expenses while preserving direct care dollars for needed services.

Whatever the perspective, the NYC RAC argues in favor of improving the efficiency of the health system, with a focus on hospitals, but a need for a broader look at the provision to meet the legislative mandate to "promote the stability of the infrastructure."

The NYC RAC Planning process

The NYC RAC approached our legislative task from a small market area analysis by combining this with a community health perspective. We strongly think that we could not consider "rightsizing/closure" based only on the financial viability of the facility, we must look at small area analysis of health statistics, socioeconomic and demographic data as well as alternative capacity in the area to look for solutions that avoid negative impacts on a population's health.

We are very appreciative of the support we have received from the Commission staff in preparing some very sophisticated analysis to support a "community health planning" approach. We also are indebted to the Greater New York Hospital Fund for their contributions to the Commission and the NYC DOHMH for its assistance. The NYC RAC reached as far and as wide as time and process permitted to gain insight and information on the relationship of need and capacity.

The Hospital World in 2006

Major Observations

Here are some further specifics or policy issues that have influenced our thinking about the alignment of hospital capacity with need. For most of these issues, the NYC RAC will not offer any further insights or recommendations but we want to press the point that simple closer or restructuring of beds and/or hospitals must be done in conjunction with policy changes in most of these major areas.

1. **Many** h**ospitals appear to be in dire financial straits.**

The lack of universal insurance coverage and the current reimbursement system drive (and constrain) the NYS/NYC health care system. The current payment methodologies, public and private, are creating a very fragile financial world for hospitals. In the past year, seven NYC hospitals have declared bankruptcy with one system, St. Vincent's Catholic Medical Centers accounting for five of these (St. Mary's, St. Joseph's, Mary Immaculate, St. John's, St. Vincent's Staten Island and Manhattan), Brooklyn Hospital Center--NYPH, and Parkway.

We have learned that there are other significant factors contributing to these problems include administrative and financial mismanagement, obsolete and unattractive physical plants and facilities, poor quality of care, staff insensitivity to patients, lack of strategic planning, and issues of overall compensation.

It was also pointed out that Medicaid alone can't solve the financial situation but that all payors must be part of the solution. It might be totally unrealistic to think that the State of New York or its Medicaid program can be solely responsible for realigning health care services. Nevertheless, the federal government and private insurers must play a role. Leadership from the State of New York is crucial.

Many hospitals are not credit worthy and/or do not have access to capital to make requisite investments in technology and physical plants. Indeed, according to the United Hospital Fund, the 35 voluntary hospitals operating declined again in 2004 to a negative 1.3 percent.

2. **We have exactly the system we pay for**.

Without significant restructuring of the health care financing system to re-balance investments in hospital based acute care, primary care and long term care, both institutional and community based, the problems that have lead to the current expensive non-system of care that is plagued with significant access problems, inconsistent levels of quality and high dependence on hospitals will continue. Any savings that might be achieved from facility downsizing or closure will only be short term and not sustainable because the fundamental problems will not have been addressed.

We are convinced that if public officials and private payers don't pay for the changes that are clearly required to meet community health needs or create incentives for providers to try innovative approaches, the health care system in general and hospitals specifically will not change in their ways or on a timetable needed to achieve efficiencies and sustainability of critical institutions.

Most providers who testified indicated the ways in which they are restructuring their services in response to community need, changes in clinical practices, government mandates and payor pressure for quality and efficiency. Many indicated, including most notably the NYC public hospital system, that restructuring and "rightsizing" has been a constant strategic goal for many years. Several also indicated how they have shifted their services to meet the changing demographics in the communities they serve. Examples indicate how, without additional reimbursement, they have added language access services (including trained interpreters, telephonic services and translation of written materials), hired community outreach workers, located clinics in targeted communities, etc., but the very institutions acting in these responsible ways are often the most financially fragile.

3. **The economic importance of institutions to their communities (providing jobs for individuals usually as the largest employer in the community) and surrounding businesses is a central concern.**

We are very cognizant and sensitive to the economic impact that closer or rightsizing have on the surrounding neighborhoods and this is an issue that needs attention by the Commission in making its recommendations.

This raises the importance of workforce re-deployment and potential need for workforce plans to address the impact on the workforce. The NYC RAC is sensitive to these issues

but has not directly estimated the direct impact on the workforce. In addition many "displaced" workers would be disproportionately people of color.

4. Hospitals' role in their communities

When considering hospital closings, the Commission must not only assess the access to ER and inpatient services a hospital has afforded a community but also myriad non-inpatient diagnostic, specialty treatment; enabling and support services; health education; disease prevention services, etc., and culturally and linguistically competent support services on which residents of that community and other health and human services providers and organizations rely. In addition, these institutions are often the largest employer in the community, especially the poorest communities, who provide many jobs and opportunities for economic improvement to entry level workers and support local business, housing and social and economic service development. We have heard testimony about how hospitals act as a facilitator or catalyst for change.

5. The need for significant capital investment.

Effective restructuring of the acute care system needs a plan for significant and sustained capital investment in hospitals and free-standing primary care facilities. The NYC RAC was constantly asked about access to HEAL NY funds. We have not calculated estimates of the amount of HEAL NY funding or any other funding that might be necessary to foster and complete any restructuring as many planned changes are not yet that specific and we did not have the means to develop these estimates. Where we have recommended new building, it is to replace, merge or consolidate services in areas of high need now served by inadequate infrastructure.

6. The workforce implications of recent closures and, with new closures on the horizon, needs another round of support for workforce retraining and dislocation support.

Over the past several years there has been considerable impact of health system changes on workers in the hospital, nursing home and health centers. The recent closings of St. Mary's and St. Joseph's are but the latest examples. There are many other closures that sometimes do not hit the press but, nonetheless, have negatively affected workers and their surrounding communities.

The state legislature and the Governor over the past five years have responded to the needs of worker recruitment, retention and retraining with millions of dollars of public funding.

The Department of Health (DOH) has announced a Request for Applications (RFA) under the Health Workforce Retraining Initiative. The announcement notes that up to $56 million will be available for projects to train or retrain health industry workers to obtain positions in occupations where documented shortages exist and also provide employment for health care workers who need new skills due to changes in the health care system.

DOH points out that, to the extent possible, the program will be coordinated with and will compliment the efforts of the Commission on Health Care Facilities in the Twenty-First Century to rightsize the health care delivery system in New York state. Grantees that are successful under this application request should ensure that their projects are consistent with Commission goals and recommendations.

7. The demographic and population changes play a major role in assessing the relationship between need and hospital and primary care capacity for the future.

Population of New York City: 8,086,000 in 2003 and a 9.2% increase since 1998

- Bronx: 1,363,000 a plus 14.4% increase
- Kings: 2,473,000 a plus 9.1% increase
- New York: 1,565,000 a plus 1.2% increase
- Queens: 2.225,000 a plus 11.7% increase
- Richmond: 460,000 a plus 13.0% increase

Source: Greater New York Hospital Association. Health Care Statistics, 2005.

These population changes have resulted in significant increases in utilization of services in NYC and one must assume that some of these patterns will increase, especially in boroughs outside Manhattan.

The concern the RAC has, if the population continues to grow, will there be enough hospital services to meet these growing needs? The Commission prepared a report on these trends.

In terms of the size of the hospital world, here are some statistics that show its size. The RAC attempted to get its hands around this mammoth system of care and make sense of the relationship between need and capacity.

- Average daily census including outpatient services in 2003: 33, 861 down from 37,763 in 1990*
- Average daily census per 1,000 persons in 2003: 4.2 compared the U.S of 3.1*
- Total admissions in 2003: 1,204,000 an increase of 8.6% since 1998*
- Total admissions per 1,000 population: 148.9 compared to the U.S. 119.6*
- Average LOS: 7.2 compared to the U.S. of 5.7 days*

- Beds per 1,000 population (SPARCS 2004):
  - **NYC:** 3.71
  - Bronx: 3.14
  - Kings: 3.02
  - New York: 7.88
  - Queens: 2.11
  - Richmond: 3.71
- Emergency room visits: 3,590,000 in 2004 an increase of over 12% since 1999˚

- Ambulatory surgery: 583,000 in 2004 an increase of over 33% since 1999
- Total FTEs: 163,073 including professional and Residents, and other salaried personnel
- Total Revenue all payors: $18,255,000,000˚

*Greater New York Hospital Association. Health Care Statistics, 2005.
˚ United Hospital Fund, Hospital Watch, June, 2005

The statistics above reveal the significant outlier status of Manhattan hospitals in both LOS and hospitalizations per thousand. There is significant bed concentration in academic teaching hospitals in the borough and there is a clear need for greater efficiencies in the use of these beds. The incentives needed to promote such redesign must be identified and implemented to address the significant expenses of these high cost providers.

The high concentration of acute care beds in Manhattan with close to 8 beds per thousand population far exceeds the national average. In addition, we observed that there is a concomitant high LOS. We certainly respect and support the importance of the large academic medical centers throughout New York City. They are world class leaders in research, service and education that produce many breakthrough treatments. They are also major supporters of a network of hospital services. On the other hand, we do believe that greater attention to clinical practices that shifts more cases to outpatient settings is good for the whole system of care. This would result in more efficient uses of hospital beds, reduction in LOS, Medicaid savings that could be re-invested in new models of care, and may help in responding to demands from population growth.

Two more recent phenomena require special attention because they affect hospital utilization and financial viability. These are the changes in case mix and the dramatic increase of admissions from emergency room visits.

We were told that hospitals are suffering from exploding ER utilization due to many factors: the lack of investment in an effective and available non-hospital based primary care system; patients who are uninsured; and , perhaps the physicians without admitting privileges or close connections to hospitals using the ER as an access door for their patients to hospital inpatient care. This pattern shows up in data that close to 65% of all inpatient admissions come from the ED and this is up from only 35% in year 2000. This is at a time when ER rates have been frozen for years, though now may be increased, a factor which can help hospitals financially, but may undermine investments in adequate primary and preventive services. And lead to discontinuity of care and higher costs long term.

The second phenomenon is the dramatic drop in the overall CMI especially in fiscally troubled and “safety new facilities” further aggravating already troubled situations. In a newly released report by the United Hospital Fund, Hospital Watch called *Drop in Severity of Illness Further Strains Hospital Finances*, June, 2006. The report indicates that the CMI declined at 70 percent of the hospitals studied between 1995 and 2002. Several factors influenced this decline: increase in ambulatory surgery; more case management in outpatient settings, aging; and drop in epidemic cases (AIDS, TB, substance abuse, and crime-related trauma).

In addition, the financing system encourages networks to maximize referrals of specialty services with higher CMIs from community hospitals to the tertiary care "mother ships" which are all high cost providers. The extent and appropriateness of these transfers needs to be a factor in determining bed need in local facilities, but financial incentives must also be addressed if this pattern is to be reversed. The CMI varied significantly by payer class and between medicine and surgery admissions. The CMI may have changed since 2002 but we did not have the latest information.

By starting with the question, Can a hospital close?, we immediately were confronted by the impact of bed closure on these distinct communities. When you overlay (as we did) communities with poor health status, high Medicaid and low-income residents, as well as communities with limited primary care capacity and high incidence of ACS admissions, we saw very serious limitations of simple closing and, therefore, some serious losses of access.

The Nursing Home World and the State of Long-Term Care Reform

The Regional Advisory Committee (RAC) heard testimony about the need for long term care realignment and innovation in the 21st century to prepare for a region that will see increased numbers of frail elderly and disabled individuals, demands from consumers for a more responsive and less confusing system, pressure from the Supreme Court's Olmstead decision to allow older people to be cared for in the least restrictive setting and increased financial pressure on all purchasers, governmental and individuals.

The current long-term care system is characterized by over reliance on institutional care and disjointed financing. There is still too prevalent a tendency to admit people to institutions who could be cared for in a less costly and clinically preferable home and community-based setting. Findings indicate, in fact, that 10-15% of those admitted to nursing homes could be cared for by home and community-based services. The RAC believes it is important to focus on how to facilitate the needed system transition, and to ensure that an adequate infrastructure of home and community services exists in each local community. Some steps toward a transition are already underway with the "Rightsizing" initiative, which seeks to increase flexibility in regulations, and change financial incentives. It has already produced a number of conversions (need #) from institutional beds to Long Term Home Health Care program slots in the community in the New York City Region.

There are several other nonprofit nursing homes that are actively pursuing "rightsizing" but are not ready to identify themselves but the range of "rightsizing" includes actively evaluating conversion of one or two floors from inpatient SNF beds (40 to 80 beds) to ALP and Home Care slots; establishing a 50 registrant LTHHCP to serve predominantly residents of two sponsored senior housing sites and seeking to develop a senior center to be co-located at one of the sites; actively evaluating establishing a new ALP program; actively evaluating decertifying 16 beds and renovating and upgrading common living areas.

If there is one over-arching observation we could make, that would be on the general lack of linkages between nursing homes, hospitals and home care. The phenomenon of "silos" remains a barrier to integration and continuity of care. On the other hand, we find that a very high percentage of all hospital admissions come from nursing homes. The State could dramatically reduce unnecessary hospital admissions and reduce transfer trauma if it invested in linkage agreements and development of special services. In one instance, one hospital actually provides a nurse practitioner to nursing homes to improve quality care and reduce hospital transfers.

After discussions with several experts and the Commission staff, and a review of the Commission reports on nursing homes and LTC reform, the following are among the key issues that need to be considered by the Commission and the State Department of Health.

- The average age of the capital plant in New York City has not been determined but experts indicate the plants are old.
- The financial status of the City's nursing homes is very fragile, with approximately half of all facilities operating in the red and losing collectively well over $100 million on operations each year.
- It is likely that certain nursing homes will close on their own because of financial weakness, loss of market share, loss of owner's interest, value of their real estate, and other factors.
- The dynamic of the flow of hospital admissions and discharges to and from nursing homes can be better managed.
- The evolution of nursing homes as significant providers of post-hospital care for patients with sub-acute, rehabilitation, and other short-stay needs, as reflected in the dramatic increase in nursing home through-put and the related dramatic decline in average length of stay, which has dropped by approximately 250 days (or more than 50%) over the past ten years.
- The lack of investment in home and community-based services. Even though NYS ranks very high in terms of dollars and people served in HCBS relative to other states, there are glaring inadequacies in the availability of needed HCBS options in the State.
- There is a particular deficit in the availability of low and moderate income assisted living capacity and affordable housing options for older and disabled New Yorkers in need of supportive services. This contributes to unnecessary nursing home admissions and prevents or delays discharges for certain residents who could be effectively served in the community with appropriate shelter and supports. Home care in general should be expanded.
- Highly prescriptive regulations pertaining to nursing home construction and design, and restrictive limits on total capital expenditures per nursing home bed, present substantial barriers to the implementation of flexible and innovative facility reconfigurations that are responsive to person-centered care initiatives, new care delivery models, and changing consumer needs and expectations.

In addition the recommendations contained in the section under **Recommendations**, the RAC recommends the following:

Enhancing the home and community based system to strengthen the infrastructure of both services and housing. Investment needs to be directed to the workforce who comprise the

capacity of the system and whose training, stability and commitment are key to quality services as well as to the securing of affordable housing options.

- We strongly support the F-SHRP Waiver and urge that New York State use resources generated through the waiver flexibly so that funding can be channeled as needed to vital long term care reform priorities, including innovative restructuring initiatives, HCBS services expansions, information technology initiatives, and other important long term care investments.

Supporting "aging in place" initiatives that reinforce informal caregivers. A viable home and community centered system needs to allow people to "age in place" and maximize their independence and connection to a network of family, friends and community. Another essential element should be incentives and support for "informal caregivers" who remain the backbone of the system and currently provide 75-80% of care.

Current home and community based providers and those nursing homes seeking to reconfigure and adapt to the changing marketplace, should be allowed to build on and expand currently successful models like NORC's, Long-Term Managed Care Plans, PACE, adult day care and respite arrangements. Long-term care providers should also be able to join with consumers to take advantage of and adapt emerging assistive technology in homes.

- A set of recommendations should be developed to reduce the legislative and regulatory burdens that currently limit the growth of these programs in New York.

Continuing to encourage creation of new nursing home models that are more person-centered, home-like and can accommodate diverse populations. Needed construction and renovations of institutions should incorporate these features to the fullest extent possible.

- In light of the high percentage of nursing homes with aging and antiquated physical facilities, DOH should review the capital needs of nursing homes and identify regulatory and reimbursement changes that would enable essential providers to upgrade and reconfigure their physical plants to meet changing patient needs and expectations.

Strengthening the transitions process in which individuals often shift back and forth between acute and long-term care settings. These are particularly difficult experiences for patients and families, and gaps in communication and safety can occur. Also, as nursing home stays get shorter and are targeted to a subacute population, transfers to home are more likely to occur. Experimentation needs to take place to test "partnerships" between primary, acute and long-term care entities that better integrate care and prevent unnecessary emergency room visits and hospitalizations. This type of restructuring will require investment funding from HEAL and other sources as well as that current incentives be realigned. In building a more seamless system that enables providers of care, whether in facilities, home settings, physician offices, or emergency rooms to share information and communicate in real time, long-term care organizations should be encouraged to maximize their use of information technology. Emerging RHIO's and other collaborations supported by HEAL grants should include long term care providers as an

important partner since they often serve the most chronically ill, impaired and costly patients, and those most likely to require care in multiple settings.

Reimbursement reform is a must. While the recent legislative and governor approval of new methodology to overcome the disastrous effects of the historic base-year rate based on 1983 costs is encouraging, we think that attention needs to be paid to the effects of this reimbursement on the larger efforts to develop home and community-based services. Creative reimbursement incentives are also needed to encourage institutional providers to expand more aggressively into the delivery of home and community based services.

New initiatives and thinking about housing and assisted living programs need to be high priorities. There is a particular deficit in the availability of low and moderate income assisted living capacity and affordable housing options for older and disabled New Yorkers in need of supportive services. This contributes to unnecessary nursing home admissions and prevents or delays discharges for certain residents who could be effectively served in the community with appropriate shelter and supports.

IV. Open Issues for Future Consideration

There were many issues we identified as we moved through our planning process which we did not have the time to adequately address or the data to analyze. Some were outside our charge but do directly impact on the issues of access.

End of Life

The exorbitant spending on inpatient and specialist care in the last two years of person's life has long been known as serious public policy issue. Dr Jack Wennberg from Dartmouth recently demonstrated the EOL practice patterns in NYC, which is a significant national outlier in providing high cost care in this period with heavier reliance on inpatient stays. Even though there has been major strides in developing access to hospice and palliative care options outside of the inpatient setting, we see the end of life as a very complex issue involving moral and individual choices, larger investments making hospice and palliative care options more available, support for caregivers, the need for changes in medical and public education and options other than hospital care as part of any future health policy along with many other dimensions beyond our charge.

Behavioral Health

We made every attempt to maintain existing capacity and did identify key recommendations for service improvements for the Commission. Adequate mental health services in appropriate setting can have potentially huge impact on access and quality for children, adolescents, and especially adults with diagnosis of chronic mental and medical illness are sources of very high cost of care to Medicaid adults and seniors that we strongly recommend the Commission and the state to take a broader and more comprehensive look at this issue.

Use of the Emergency Room as the "front door"

This issue emerged for us as we met with many hospitals and looked at the recent data on utilization. As we say in the narrative, the reasons for this phenomenon are complex but are certainly linked to the availability of adequate primary care services in the community and the pressure to fill hospital beds. This issue must be understood immediately to avoid an "arms race" in emergency care that gains access hospital specialty services. This is especially important as the ED rates go up. Virtually every hospital presented restructuring plans for an expansion of the ED departments.

Long-Term Care Reform

This is such a major issue facing this state and this country that felt it was beyond our reach. We did make several major recommendations based on our experience and understanding of the current state of affairs and strongly believe that the any new federal Medicaid waivers be targeted to pushing the agenda for more flexible, community based solutions to long-term care reform.

Community Hospital Model

We came to a realization (see narrative above) that there is a role for community hospitals in the City. While many who testified saw the demise of community hospitals because of the reimbursement system and others lamented their loss. But in our review, we find that community hospitals are a must to ensure access to high quality, low cost care. While we did not have sufficient time to develop such a model, we did highlight in our report and noted that successful models seem to be well connected to significant physician practices in the community and supported by larger health care networks that see the value of retaining effective community-based services rather than mainly using community affiliates to generate referrals to specialty care.

The Role of Teaching Hospitals and Resident Teaching Programs

We did not address the value and impact that these programs have on the utilization, quality and cost of care in New York City. This was beyond our scope. With such a major national role these programs have, there needs to be greater attention to their role in shaping the delivery system in the City. Again, New York is a dramatic outlier in the size and cost of its graduate medical education programs. We do address these programs in the context of "networks" of care, which is addressed in the Context section.

Public Health and Prevention

There is no doubt that an aggressive prevention program can reduce the incidence and prevalence of major diseases. Prevention programs have demonstrated the value of such programs from the early years of this nation to today. We did not address the impact of these programs on access or the cost of care. The recent revitalization of the NYC Department of Health as an aggressive promoter of population-based prevention programs for tobacco related illness, asthma, and diabetes to name a few are important responses to the City's public health challenges and to the significant health disparities exist. Financial support and policy attention to preventive programs will have a significant long-term payoff for our citizen's quality of life and a savings to our expensive health care system.

Regulatory, Payment and Certificate of Need Reforms

Throughout our report there are references to regulatory and payment reforms but there needs to be more attention paid to what a comprehensive agenda might include. If there is a desire to change the current delivery system to make it more

efficient and effective in terms of cost , quality and access, the current framework needs a radical change. The 2004 Governor's Working Group addressed many of these issues and that might be a good starting point as it is enriched by our recommendations.

We believe our report speaks for itself.

The End

Attachment A

Fulfilling the Legislative Mandate--The Process

The process of the NYC RAC was implemented to respond to the questions and considerations articulated in section 5 of the Commission's enabling legislation. More specifically, questions of capacity, economic impact, health status and essentiality, have all been brought to bear as the NYC RAC has held public hearings, met with providers, and generally engaged the spectrum of experts and consumers that comprise the health care system in New York City.

Section 7 of the Commission's enabling legislation, which outlines the duties and expectations for the RACs further served as a guide for the RAC's work. In particular, the RAC has modeled its process in accordance to the legislative language that stipulates that RACs "shall foster discussions among, and conduct formal public hearings with requisite public notice to solicit input from, local stakeholder interests, including but not limited to community-based organizations, health care providers, labor unions, payers, businesses and consumers."

Since the beginning of the year, the NYC RAC has been engaged in the process of collecting data, holding public hearings, and meeting with experts and providers with the goal of honing on in on a comprehensive picture of health care in the city of New York today, while identifying needs and challenges for the future. Throughout this process, the RAC has attempted to move beyond the picture provided simply by occupancy rates and financial indicators, to employ a multi-variable analysis that includes consideration of facility essentiality and community health indicators.

Calendar of Activities
(For names and titles of individuals, see "synopsis" section below)

The RAC's work began in December. At the RAC's first meeting, held 12/22/2005, David Sandman presented the statutory authority, organizational structure and timetable for the Commission's work. In addition, RAC members reviewed the Analytic Framework Criteria prepared by the Commission Staff, and discussed potential conflict of interest and financial disclosure issues.

At the next meeting, held 1/19/2006, RAC members reviewed the Commission's Legislative Mandate, Work Plan, and Bylaws. In addition, the RAC discussed the structure and schedule for its public hearings, as well as stakeholder meetings.

At the 1/26, the Bylaws specifically for the NYC RAC were revised and approved. RAC members began compiling the stakeholder list, delegated responsibility for the planning of upcoming public hearings, and discussed the creation of an overarching framework to help assess the issues of access, need and facility specific viability. Identified data needed to move forward with analysis.

At the 2/9, RAC members reviewed, amended and approved a draft letter to be sent to providers and stakeholders. The Staten Island and Queens Public Hearings were confirmed, and a plan was created for hearings yet to be scheduled. Finally, the RAC reviewed the 6 Analytic Criteria provided by the Commission for the purpose of analysis.

The 2/23 of the NYC RAC was held at the Greater New York Hospital Association. Karen Heller, Senior Vice President and Executive Director of THEORI, presented a multi-variate analysis of health care services in New York City and fielded questions from RAC members. After Karen Heller's presentation, RAC members amended/augmented the list of facilities and stakeholders to meet with. We understood that the Commission staff would be adapting this methodology for use by the RAC.

At the 3/9 meeting, RAC members, confirmed Bronx and Manhattan Hearing dates. Allison Silvers of the Commission Staff presented LTC information relevant to the NYC marketplace. The later part of the meeting was devoted to a discussion with Robert V. Levine, President and CEO, Peninsula Hospital Center Peninsula Hospital. Mr. Levine presented on future plans and current activities underway designed to strengthen Peninsula's operations and respond to the population growth in the Rockaways.

At the 3/23, RAC members discussed the need to reach large hospital systems like North Shore-LIJ. The majority of the meeting was spent on examining South Brooklyn by first meeting with Victory Memorial Hospital, who presented on the history and current status of the hospital, highlighting special services and demographic trends seen in its patient population.

After Victory's presentation, Maimonides Medical Center separately presented an overview of its official approach to partnering with Victory Memorial Hospital, focusing on financial variables and future plans. At the end of the meeting, RAC members were requested to write-up five broad themes and compelling issues heard at the public hearings to include in the interim report, as well as issues from the three provider meetings.

At the 3/30 meeting Robert S. Chaloner, President and CEO, Cabrini Medical Center presented Cabrini's plan for restructuring the medical center emphasizing the adherence to Cabrini's charter and mission, which the Sisters reinforced. Mr. Chaloner presented this information in the context of the current health care environment, as well as its partnership with Mt. Sinai Medical Center. Mt. Sinai representatives who were there reported to be in full support of Cabrini's plan.

At the 4/13 meeting, RAC members met with the Health and Hospitals Corporation to discuss the scope of services they offer in NYC, as well as addressing the complexities and challenges presented by specific service areas.

Karen Heller and Ismail Sirtalan of The Health Economics and Outcomes Research Institute in conjunction with Commission staff presented a multi-variate analysis of the hospital landscape in NYC, employing a model based on "focal hospitals" and their "coverage partners" as a means of understanding the effects of potential changes in the City's health care system.

Lastly, the RAC reviewed, edited and expanded the draft of May 11th presentation. The discussion focused on Queens, and how to reform the health care system in the borough by looking at different service areas, as a model for the NYC RAC's recommendations.

At the 4/20 meeting, Parkway Hospital presented an overview of its history as an institution since changes in management and ownership, as well as its vision for the future as a vital community hospital serving the largely elderly population of Forest Hills. Also explained the current bankruptcy proceedings, which they indicated might end this summer.

At the 4/27 St. John's Episcopal Hospital South Shore gave a presentation the demographics of its patient population, as well as its availability of services, financial situation, and vision for the future. Louise Cohen, Acting Deputy Commissioner, NYC DOHMH, discussed the health status of New York City, using a variety of indicators, in order to provide a picture of health-need today, as well as identify opportunities for change in the future.

At the 5/4 meeting, John Billings, associate professor at the Robert F. Wagner Graduate School of Public Service at New York University presented the latest report by Dr. John Wennberg with RAC members about different health trends in New York City. Dr. Wennberg's report was released two weeks later.

At the 5/11 meeting Interfaith Medical Center joined the RAC to discuss the essential services it provides to the population of central Brooklyn as a low-cost, community hospital. The remainder of the meeting was spent reviewing the materials to be presented at the RAC's presentation before the Commission that afternoon.

At the 5/25 meeting, Cabrini Center for Nursing and Rehabilitation presented an overview of its history and the population it serves. In addition, it outlined the resources required to relocate and restructure its facility in the future.

Following Cabrini Center, City Council Speaker Christine Quinn introduced the preliminary recommendations of "The New York City's Council's Hospital Closing Task Force," as well as engaged the RAC regarding how these recommendations respond to, and may have an effect on, the work of the RAC and the Commission.

Lenox Hill Hospital and Manhattan Eye and Ear Hospitals were the next group to join the RAC. LHH and MEETH's meeting with the RAC consisted of an explanation of the history two hospitals' partnership, as well as a discussion of its future and economic viability. They emphasized the importance of their mission and discussed the inpatient program and how it might have to be closed or reconfigured. They have issued a RFP seeking a partnership with them to address this issue.

Michael Dowling, President/CEO, North Shore-LIJ shared his perspectives on healthcare in Queens and on Long Island, particularly as it relates to North Shore LIJ's network of hospitals and health care facilities in this region. In particular, Mr. Dowling indicated his commitment to work to build a regionalized plan for central Queens. He said that this level of commitment has to involve the State.

At the 6/1 meeting, Stanley Brezenoff, President/CEO of Continuum discussed the future of NY Eye and Ear Infirmary as a specialty hospital in the context of the changing health care environment in which another eye and ear hospital exists.

Ken Davis presented his vision for Mt. Sinai Queens while addressing issues presented by the physical plant, the realities of health care delivery in Queens, and challenges of maintaining physician buy-in. Lastly, he discussed the status and future of other partnerships Mt. Sinai shares with NYC region hospitals.

Jim Tallon highlighted the uniqueness of the New York City and State health care markets, and its implication for the quality, organization, and economic viability of the health care delivery system. He also offered his perspectives on the nature and importance of the Commission's work.

At the 6/8 meeting
Wayne Osten, Vice President, System Development, New York Presbyterian Healthcare System
David Hoffman, Council, Wyckoff Heights Medical Center

At the 6/15 meeting (to be developed after 6/15):

Dr. Samuel Daniel, President and CEO, North General Hospital

Possible meeting with NYC Mental Health Commissioner

Discussions with providers –synopsis:

3/9:

Peninsula Hospital: Robert V. Levine, President/CEO

3/23:

Victory Memorial Hospital: Donald DiCunto, President/CEO, William J. Recevuto, Associate Administrator

Maimonides Medical Center: Pamela S. Brier, President and CEO, and Robert Naldi, Executive Vice President, Finance & Chief Financial Officer.

3/30:

Cabrini Medical Center: Robert S. Chaloner, President/ CEO, as well as other members of Cabrini's executive staff and representatives from Mt. Sinai Medical Center.

4/13:

Health and Hospitals Corporation: Alan D. Aviles, President, Marlene Zurack Director of Finance and Donna Green,

4/20:

Parkway Hospital: Robert J. Aquino, Present and CEO, Jeanine A. Aquino, COO, Katherine Ferrarri, Senior VP, Operations and Regulatory Affairs, and Jeffrey R. Ruggiero, Council.

4/27:

Episcopal Health Services: Luis A. Hernandez, Chief Executive Officer, St. John's Episcopal Hospital South Shore, and John J. Morahan, Director of Finance.

5/11:

Interfaith Medical Center: Edward Glicksman, CEO, David Weinraub.

5/25:

Cabrini Center for Nursing and Rehabilitation: Patricia Krasnausky, President/CEO.

New York City Council: Speaker, Hon. Christine C. Quinn, Chairperson, Hon. Helen Sears,

Lenox Hill Hospital & Manhattan Eye Ear and Throat Hospital: Gladys George Gladys George, President/CEO, Terence O'Brien, Executive Vice President/COO and Michael Breslin, Senior Vice President/CFO, In addition, Philip Rosenthal, Vice President, Operations; Executive Director, and Scot Glasberg, M.D., Attending Plastic Surgeon-MEETH

North Shore-LIJ: Michael J. Dowling, President /CEO.

6/1:

Continuum Health Partners: Stanley Brezenoff, President/CEO.

The Mount Sinai Medical Center: Dr. Kenneth Davis, President/CEO and Dean, Mount Sinai School of Medicine.

United Hospital Fund of New York: Jim Tallon, President,

6/8:

NewYork Presbyterian Healthcare System: Wayne Osten, Vice President, System Development, Elliot Lazar, CMO, Lin Mo, President/CEO, Community Hospital Brooklyn, Mark J. Mundy, President/CEO, NY Methodist Hospital

Wyckoff Heights Medical Center: Dominick Gio, President/CEO, David Hoffman, General Council.

6/15:

Lloyd Sederer, Executive Deputy Commissioner, NYC Department of Health and Mental Hygiene Services

North General Hospital: Dr. Samuel Daniel, President/CEO.

NY Presbyterian Healthcare System: Wayne Osten, Vice President, System Development, Bob Hunter, Chairman of the Board, NY Downtown**,** Jane Connaughton, COO, NY Downtown**,** Dr. David Alge**,** Scott Cooper, President/CEO, St. Barnabas Hospital, Allan Kopman, President/CEO, Westchester Square, Randy Nisi, Chairman of Board, Westchester Square.

6/22:

NYPH and The Brooklyn Medical Center

6/29:

St. Vincent's CMC

Expert presentations –synopsis:

4/13:

The Health Economics and Outcomes Research Institute: Karen Heller, Senior Vice President and Executive Director and Ismail Sirtalan,

4/27:

New York City Department of Health: Louise Cohen, Chief of Staff, and Edward K. Kim, Assistant Director, Bureau of Intergovernmental Affairs.

5/4:

John Billings, associate professor at the Robert F. Wagner Graduate School of Public Service at New York University.

Public Hearings Held:

Public hearings were held in each of New York City's five boroughs, with 180 individuals testifying cumulatively.

Staten Island: Friday, February 17, 2006, 6-9PM
Number of people giving testimony: 14

Brooklyn: Friday, February 24, 2006, 9-1PM
Number of people giving testimony: 44

Queens: Tuesday, March 7, 2006, 5:30-10PM
Number of people giving testimony: 44

The Bronx: Tuesday, March 28, 2006, 4-7PM.
Number of people giving testimony: 38

Manhattan: Thursday, March 30, 2006, 3-7PM.
Number of people giving testimony: 41

Appendices

Table 1: Overall Bed Capacity in the City of New York

A. Coverage Partner's Map
B. Westchester Square Medical Center
C. Methodist Hospital and Community Hospital
D. The Brooklyn Hospital Center
E. Caritas--Wychoff Heights Medical Center
F. Queens Hospital Center
G. Mt. Sinai Hospital Queens
H. St. Vincent's CMC and Midtown
I. Continuum Health Partners
J. Lenox Hill Hospital
K. **Potential Impact of Hospital Restructuring on NYC's Primary Care Capacity**

Handouts

Commission on Health Care Facilities in the 21st Century
Observations by the New York City Regional Advisory Committee
May 11, 2006

Background Material

Save of Safety Net-Campaign

North General Hospital

St. John's Episcopal Hospital

Peninsula Hospital Center

Parkway Hospital

Interfaith Medical Center

New York Downtown Hospital

Children's Mental Health Needs Assessment in the Bronx
NYC Department of Health and Mental Hygiene, August, 2003

New York City Council's Hospital Closing Task Force