Report of the Western New York Regional Advisory Committee to the Health Care Commission on Facilities in the 21st Century

November 15, 2006

Overview

Health care in the eight western counties of the State of New York is in or is rapidly approaching a crisis. The causes of this situation are manifold, but are primarily related to the pervasive presence of a depressed economy in many business sectors, a dwindling, yet aging population, and a fractionalized, competitive health care environment with considerable excess capacity and duplication of services.

Because of the magnitude of the work effort with which the *Western New York Regional Advisory Committee* (WRAC) was charged by the *Health Care Commission on Facilities in the 21st Century* (Commission), either the entire group, subgroups, or individual RAC members sought and obtained data, input and advice from a wide variety of sources. These included but were not exclusively limited to: 1) Data and analyses provided by the Commission, 2) Voluntary testimony by individuals representing all areas of the population effected by health care (prior and potential care recipients, business, local and regional government officials, health care facilities and systems, and providers) in three public sessions (previously reported), 3) Chief Executive Officers and Board of Director Chairs of health care facilities and health systems, 4) Chief Executive Officers and Chief Medical Officers of the three major health plans, and 5) Regional and State representatives on the Commission as well as Commission staff. In some cases, discussion occurred in closed session with the RAC, and in other cases RAC and/or Regional members and their colleagues sought input from the principals of certain facilities on site.

Summary of Findings

Our findings can be summarized as follows:

- There is considerable excess capacity in both urban and rural acute care facilities;
- There is considerable excess capacity in long term care facilities, both free standing and those associated with acute care facilities;
- Virtually all existing urban and rural acute care and long term care facilities are aging and deteriorating;
- Many if not most costly tertiary care services are distributed and duplicated at too many sites, leading facilities and providers to compete, adding significantly to overall health care costs;
- A significant dearth of health care providers is predicted in the near future.

Impact of Plan Implementation

The following plan deals with each of the aforementioned issues. Enacted *in toto,* our group assessed the impact as follows:

- Approximately 900-1100 acute care beds would be decertified, equally distributed across the urban and rural regions;
- Approximately 650-700 long term care beds would be decertified;
- Certain facilities would close or be reconfigured to other uses including providing health care in a different fashion;
- Many, albeit not all, tertiary care services would be consolidated at a limited number of sites including a new state-of-the-art 21st century tertiary care facility leading to enhanced quality and

decreased health care costs, that would provide a significant revenue engine for Western New York while concurrently allowing the region to train, retain, and recruit the next generation of health care providers;

- The remaining, reconfigured health care systems would become financially stable;
- The depressed economy would improve, and the population would begin to grown as additional jobs are created.
- Through a consortium of health systems, health plans, and providers, health care in Western New York would be driven to be high quality, readily accessed, affordable, and substantial effort and resources would accrue to medical informatics, population based analyses, and preventive medicine, gradually diminishing the need for many tertiary care services.

The underpinnings of this plan reside in the potential synergy that should be achieved by realigning several strengths extant in the region: 1) biomedical research and education, and 2) health care (plans, systems/facilities, and providers). All members of the WRAC agreed that enacting only a portion of this comprehensive plan either for lack or resolve or funding was highly likely to be more detrimental than maintaining the *status quo*, due to the financially tenuous yet highly competitive nature of the health care environment. The plan purposely is ambitious because the WRAC strongly believes that the ailing and fragile health care system in Western New York will not be healed by applying a "band-aid."

Thus, the RAC offers the following plan in tabular form with subsequent accompanying textual detail for the study of the regional and state Commission members. It is divided into three sections: 1) *Acute care within Erie and Niagara counties,* 2) *Rural acute care,* and 3) *Long term care*. Footnotes are present in certain areas of the table to provide additional detail or commentary.

Erie/Niagara Acute Care

Facility/Health System	Action	Effective Date	Statutory Factors							Necessary Investment
			Vulnerable Populations	Availability	Quality of Care	Utilization	Viability	Economic Impact	Total	
University Hospital Erie County Medical Center (ECMC) Buffalo General Hospital	Eliminate duplication of services amongst three facilities, part of which would entail a full asset merger: * Create NYS owned SUNY Hospital on Buffalo Niagara Medical Campus (BNMC) with a separate governance structure that is aligned with the SUNY/UB Medical School; Consolidate Level I trauma, solid organ transplant, open heart surgery, other medical/surgical tertiary health care as service lines; * Consolidate inpatient behavioral health and medical rehabilitation services. * All other adult medical and surgical inpatient services not performed at University Hospital or ECMC.	12-31-09	1	1	1	1	1	1	6	$505
Kaleida Health * Millard Fillmore Gates Circle Hospital * DeGraff Hospital	* Decertify acute care beds and close * Decertify acute care beds at, converting to alternative community based services.	06-30-07	1	1	0	1	1	0	4	$85M
Catholic Health System	Decertify acute care beds at St. Joseph's Hospital, converting to alternative community based services.	06-30-07	1	1	1	1	1	1	6	$20
Sheehan Memorial Hospital	Close all inpatient beds. Provide outpatient behavioral health and primary care services via new and/or renovated facilities.	06-30-07	1	1	1	1	1	1	6	$8M
Niagara Falls Memorial Hospital Mount St. Mary's Hospital Lewiston	Full asset merger, decertifying acute care beds and converting to alternative community based services.	06-30-07	1	0	0	1	1	1	5	$20M
Subtotal										**$638**

Rural Acute Care										
Northern Service Cluster Intercommunity Hospital Lockport Memorial Hospital Medina Memorial Hospital[1] *Southwest Service Cluster* Brooks Memorial Hospital TLC Lakeshore Hospital[2] Westfield Memorial Hospital *Southeast Service Cluster* Bertrand Chaffee Hospital TLC Tri-County Hospital	Create 3 regional service clusters via acquisitions or full asset mergers, decertifying acute care beds and converting to alternative community based services as dictated by specific site alignments. The goal is to ensure access to quality care with remaining facilities functioning at higher capacity levels.[3]	06-30-07	1	1	1	1	1	1	6	$30M
Bry Lyn Hospital[4]	Decertify acute care beds and close.		1	1	1	1	1	1	6	---
Subtotal										**$30M**

Long Term Care										
Mount View Nursing Facility	Close and reallocate 172 beds for regional assisted living program.	06-30-07	1	1	1	1	1	1	6	$1M
Williamsville Suburban Skilled Nursing Facility (SNF)	Close and reallocate 220 beds for regional assisted living program,	06-30-07	1	1	1	1	1	1	6	$1.2M
The Waters of Allegany	Accept Medicaid patients.	06-30-07	1	1	1	1	1	1	6	0
Lake Shore Health Care Center	Decertify 40 beds and reallocate for regional assisted living program.	06-30-07	1	1	1	1	1	1	6	$0.4M
Millard Fillmore Gates Circle SNF	Close and reallocate 75 beds for regional assisted living program.	06-30-07	1	1	1	1	1	1	6	$1M
Episcopal Residential Health Care Facility	Close and reallocate 172 beds for regional assisted living program.	06-30-07	1	1	1	1	1	1	6	$1M
Subtotal										$4.6M

TOTAL		***$672.6M***

[1] This entity initially expressed interest in collaborating with Lakeside Hospital in the Central Region. However, more recently, interest in being part of a service cluster in the Western region has been indicated.

[2] Further deliberation and discussion needs to occur to determine if TLC Lakeshore fits better in the southeastern or southwestern service cluster.

[3] A new model for rural acute care services should be instituted in which acute ambulatory care services are provided in new facilities that also comprise 3-4 acute care beds for 1-2 day hospital stays. Extant facilities readily could be retrofitted.

[4] The WRAC fully recognized that this facility does not fall under its purview under Article 28, but nonetheless decided to make this recommendation.

Erie/Niagara Acute Care

The health care environment in the urban areas of Erie and Niagara counties can be characterized succinctly as follows: 1) excess capacity, 2) deteriorating facilities, 3) inability of facilities to voluntarily close or right size due to either substantial debt service, labor costs, or both, 4) significant competition between health systems and providers, 5) costly tertiary care services that are distributed and duplicated at far too many practice sites, 6) an aging, progressively diminishing and often under reimbursed health care work force, and 7) a depressed economy in which businesses are unwilling or unable to sustain increased health care costs.

The WRAC deliberated for nearly six months and decided to recommend a multifaceted, broad plan in order to rectify all of these issues, the components of which are as follows:

1) Eliminate Duplication of Tertiary Care Services via Consolidation in a New Facility

In order to consolidate and eliminate duplication of tertiary care services, while concurrently creating a vehicle to train, recruit, and retain the next generation of health care providers in Western New York a New York State owned SUNY hospital should be constructed as part of the Buffalo Niagara Medical Campus (BNMC). The governance of this facility should be separate from that of the other health systems, and it should be closely aligned with the five SUNY/UB Health Science schools. Linked to several significant drivers of the economy in Western New York (education, biotechnology, and health care), this facility should become a significant economic engine for the region.

Medical and surgical tertiary care services will be consolidated using a formal service line structure, A new model for provision of tertiary care services will be developed through collaborative discussions with all area providers and the community. The facility would entail limited inpatient facilities (100-150 beds) in conjunction with privately financed UBMD outpatient facilities and the Jacobs Institute (outpatient vascular and neurological care). Concurrently, a detailed survey, population-based needs assessment, and creation of quality indicators and measurements should be undertaken for tertiary care services. The Certificate of Need (CON) process used to initiate tertiary care services should be revamped. A new care model employing state of the art imaging and minimal interventions in which the delivery of such services is provided largely in the ambulatory care setting is envisioned, limiting the need for costly lengthy hospital stays.

Concurrent with this process, consolidation of inpatient behavioral health and medical rehabilitation services should occur at Erie County Medical Center, while the Buffalo General Hospital and the Catholic Health System should continue to provide all other adult medical and surgical inpatient services not performed at University Hospital or ECMC. Consideration should be given to a full asset merger between these remaining entities.

2) Remove Excess Capacity

The WRAC recommends that:

- Decertify all acute care beds at Millard Fillmore Gates Circle Hospital be decertified and close the facility;
- Decertify all acute care beds at DeGraff Hospital be decertified and convert the use of the facility to alternative community based services that are unique and not duplicated at other nearby sites;
- Decertify acute care beds at St. Joseph's Hospital, converting to alternative community based services;
- Close all inpatient beds at Sheehan Memorial Hospital Provide outpatient behavioral health and primary care services via new and/or renovated facilities to this underserved portion of the urban community.

- Niagara Falls Memorial Hospital and Mount St. Mary's Hospital Lewiston should enter into a full asset merger, decertifying acute care beds and converting to alternative community based services.

Rural Acute Care

The rural delivery system in the western region of New York is comprised of a variety of "homegrown" solutions developed to meet the health care needs of small and sometimes isolated communities. Early on in its deliberations, the WRAC determined that the unique characteristics of the rural delivery system dictated a separate and distinct review from the urban centers. Resource allocations in the rural setting are far more sensitive to adjustment then the urban centers, where resources are greater, and sometimes duplicative. Additionally, issues related to time and distance required to access health care are exaggerated in the rural setting and require a unique perspective. In acknowledgment of these variations, a straightforward methodology was adopted to identify opportunities for efficiency and improvement in the quality of rural health care.

An initial analysis would suggest that each rural hospital, on an average, has a service area radius of approximately 10-12 miles. Once the service areas were delineated, it became obvious that in certain areas there was an overlap of coverage. Where ever this "eclipsing" of service areas occurred, it was determined that a "service cluster" could be established. Each "service cluster" was viewed as an opportunity for collaboration and efficiency. Within the boundaries of the Western region, there appeared to be three obvious "service clusters". One north of the Greater Buffalo Metropolitan Area (GBMA) and two located south of the GBMA.

Any rural hospital found not to "cluster", was preliminarily determined to be an essential community provider with limited opportunity for efficiency. "Un-clustered" facilities were excused from further review at this time.

1) **Northern Cluster:** Lockport Memorial Hospital in Lockport, New York, Medina Memorial Hospital in Medina, New York and Intercommunity Hospital in Newfane, New York are the three hospitals representing the northern cluster. Lockport Memorial and Intercommunity Hospital share some management elements and some hints of common governance. Medina Memorial is a freestanding facility with no obvious affiliations. The WRAC interviewed the principals of each of these facilities, and initially strong arguments were made to suggest that the "clustering" theory lacked validity in their particular situation. Representatives of Medina Memorial and Lockport Hospital presented their views that there was no natural relationship between their patient populations, medical staff or other support elements that would suggest that there was an opportunity for meaningful collaboration. In fact, leadership from Medina Memorial Hospital expressed interest in pursuing a relationship with Lakeside Hospital in the Central region. Subsequently, the principals of Lockport and Intercommunity Hospitals have indicated their interest in participating in a full asset merger. The principals of Medina Memorial Hospital are interested in pursuing discussions with Lockport and Intercommunity Hospitals or with Lakeside Hospital.

Proposed Provider Plan: Lockport Memorial Hospital and Intercommunity Hospital propose to proceed with a full asset merger. Currently, discussions will occur with Medina Memorial Hospital which potentially could be included in the merger, concurrent with discussions between Medina Memorial and Lakeside Hospitals...

Recommendation: Lockport and Intercommunity Hospitals are well-positioned for full asset merger and the establishment of a single, obvious, governing body. It is expected that consolidated oversight would quickly recognize the opportunity to remove any duplication of service and thus become more efficient. This plan should proceed, and discussions should continue to determine if Medina Memorial Hospital should be included as well.

2) **Southwest Cluster:** Brooks Memorial Hospital in Dunkirk, New York and Westfield Memorial Hospital in Westfield, New York are the principal elements in the cluster southwest of the GBMA. There has been considerable thought and dialogue, pointing to the potential of including the TLC/Lakeshore Hospital located in Irving, New York, operated by the TLC Health System. TLC Health System has advanced a different consolidation plan which will be discussed in the Southeast Cluster segment of this document. Currently, Westfield Memorial enjoys linkages with St. Vincent's Hospital in Erie, Pennsylvania. Representatives from St. Vincent's have been involved in all discussions surrounding the realignment and rightsizing of Westfield and Brooks. A preliminary plan has been advanced to the Commission detailing a reduction of services and Westfield and a clear and distinct alliance with Brooks Memorial. The leadership of Brooks/Westfield feels strongly that the TLC Health System Hospital located slightly north and connected by the I-90 would be well suited to join in their discussions. It was pointed out that there is an intrinsic connection with the medical staff and the referral of patients between TLC and Brooks. That natural connection could minimize the potential social trauma associated with this rightsizing initiative. It was also suggested that the TLC proposed alliance in the southeast cluster was unworkable due to geographical and medical migration patterns.

Proposed Provider Plan:

1. The Westfield community must have an appropriate level of medical care that would include emergency care, and ambulatory surgery, diagnostic services, and other outpatient programs that are appropriate and needed in the community.
2. The Brooks facility will house the appropriate number of medical/surgical, ICU, CCU and obstetrical beds indicative of the secondary level hospital with an appropriate level of outpatient services.
3. The overall quality of the health care delivery system for the communities we serve must be maintained and/or improved.
4. Any plan developed must be financially viable. We anticipate and integral component of this plan will be access to the Heal New York Fund for debt relief and necessary capital improvements.

Recommendation: Accept and develop further the plan advanced by Brooks/Westfield. In greater detail, examine the utility of maintaining ambulatory surgery at Westfield Memorial. Facilitate an open and meaningful dialogue between Brooks Memorial and the TLC Health System. Explore and reconcile the issues associated with realigning the TLC hospitals with Brooks Memorial instead of accepting the affiliation plan advanced by TLC and outlined in the Southeast Cluster recommendation. Promote the establishment of sole community provider (SCP) status for Brooks Memorial.

3) **Southeast Cluster:** TLC Lakeshore Hospital in Irving, New York, TLC Tri-County Hospital in Gowanda, New York and Bertrand Chaffee Hospital in Springville New York represent an apparent service cluster located south east of the GBMA. A plan, as outlined below, has been approved by each board of directors and advanced to the Commission for approval. The sponsors have worked directly with Mark Ustin of the Commission and Neil Benjamin of the New York State Department of Health in the formulation of their plan. Proponents argue that the plan will strengthen their system(s) and provide improved quality to the residents of their community. Opponents argue that this is an unnatural configuration that is impaired by geography, and the natural flow of medical staff and patients.

Proposed Provider Plan:

1. Eliminate all medical /surgical beds at TLC Tri-County Hospital.

2. Reduce the license capacity at Bertrand Chaffee Hospital so that the facility functions with less than 25 licensed beds. This bed reduction, along with the closure of the medical/surgical beds at Tri-County Hospital qualifies Bertrand Chaffee Hospital for either or SCP status or critical access hospital (CAH) status. Bertrand Chaffee Hospital would then organize BCH under the regulatory status that provides the most appropriate menu of services for the community while optimizing revenues for the new system.
3. Eliminate the 40 bed Residential Health care Facility (RHCF) license at TLC Lake Shore Hospital. There are two separate licenses at Lake Shore Hospital for RHCF beds. One is for 40 beds and the other is for 120 beds. The WRAC proposes to sell the 40 bed license to the operators of Fredonia Place, who would relocate them to a brand new existing license dementia unit. They have agreed on a price of $10,000 per bed for the 40 bed license, and we are working out the details of a formal purchase agreement at this moment. This would provide the funds to retire the debt on that portion of the campus that is currently occupied by these 40 beds and provide Lakeshore with much-needed space to expand their growing outpatient business.
4. Submit a CON for the approval of 10 detoxification beds under the Office of Alcohol and Substance Abuse Services (OASAS) for Tri-County Hospital. Detoxification services are currently being provided at Tri-County Hospital under a scattered bed methodology of medically supervised withdrawal using the existing medical beds on campus. This service needs to be continued for the community since it provides the continuum of chemical dependency (CD) services along with the 25 bed women's intensive rehabilitation unit as well as the 24 bed CD unit. Both units have occupancy rates in excess of 92% at all times. This, along with the outpatient CD services would solidify the Tri-County Hospital as the center for CD services for the southern tier of Western New York.
5. Consolidate laboratory services at Tri-County Hospital. Tri-County is exactly halfway between the two other facilities. This consolidation would eliminate redundancy, reduce costs and allow for more testing to be performed system wide, instead of sending these tests to expensive outside reference laboratories.
6. Emergency and outpatient primary care will continue to be provided at the Tri-County Hospital.

Recommendation: The Commission and its representatives have fostered an environment that encourages providers to propagate their own rightsizing plan. In this case, the provider has advanced a plan that may not be optimum for the region as a whole. As outlined in the southwest cluster discussion, potentially greater rewards could be reaped through an affiliation with Brooks Memorial and TLC Lakeshore Hospitals. If those discussions proved to be systemically more valuable, then a detailed analysis would be required to examine the viability of the residual components (Bertrand Chaffee and Tri-County Hospitals). There certainly seems to be merit in the establishment of a detoxification unit at Tri-County. The reallocation of long-term care beds needs to be explored consistent with the long-term care planning of the commission for this region. Finally, an understanding needs to be reached with regard to the ongoing viability of Bertrand Chaffee Hospital. At this point in time it is inconclusive as to whether or not Bertrand Chaffee Hospital sought an alliance with any of the other providers in the southern rim the GBMA. Although implied, attention to the Seneca Nation of Indians and its health care needs should be included in any analysis of services in the southern tier. In view of their newfound wealth, the Seneca Nations may be interested in contracting for services .To date there has been no mention of the needs of the Seneca Nation among the various potential providers. Since the Brooks and TLC Lakeshore Hospitals are the cornerstones of each southern cluster, it is imperative that discussion and exploration be initiated as soon as possible to determine the optimal configuration of each cluster.

Long Term Care

The Western Region is comprised of eight counties that comprise both urban and rural areas. According to the Census bureau data, the population in the Western region is projected to decrease by more than 10% by the year 2030. Presently, the Western Region has a higher proportion of elderly residents at 15.5% when compared to the statewide average of 12.9%. Moreover, it is expected to experience a higher rate of increase in its population that will be aged 65 or older to more than 20% by the year 2030.

The region has 85 nursing homes with 12,009 beds. Average occupancy is at 94.5% with individual facilities varying from 100% to 52.4%. There are 1,642 low acuity residents (Physical A or B), of whom, some can be cared for in less restrictive settings.

Recommendations:

1) Previously licensed SNF Beds not currently in service should be removed from the bed count.

The RAC further recommends that any beds not currently operating, are not to be returned to active service and the bed need methodology be recalculated to reflect the decreased number of beds in the counties of the Western Region. Presently, the following beds should be removed from the bed need methodology: **Episcopal Home** 172, **St. Clare's** 21, and **Manor Oak** 362.

2) CON Applications should not be processed.

The RAC recommends that current and future CONs that request expansion and/or construction of new SNF beds not be approved and not further considered until June 30, 2008.

3) Close **Mount View Nursing Facility**, which consists of 172 beds and reallocate those beds for an Assisted Living Program.

Mount View is a 172 bed county facility, which has had a low occupancy rate for the past several years. Most recently, the occupancy rate was 80.3% in 2004 with the statewide average being 94.2%. In 2003, the facility had 83% of their days paid for by Medicaid. The most recent case mix is 1.07. Twelve percent of its residents fall in the PA/PB category of lowest clinical need over the 2001-2003 periods. The facility provides Adult Day Health Care.

The combination of a high percentage of Medicaid patients, the low utilization rate and high cost of benefits has resulted in the facility operating at a significant loss. During discussions with the Niagara County Manager and the administrator of the facility, it was discovered that employee benefits are an exorbitant 52% of wages and that county provides ~$2M per annum to subsidize the facility. The county has decided to sell the facility to a private buyer.

4) Close **Williamsville Suburban Skilled Nursing Facility** (SNF) and reallocate the 220 beds for the Assisted Living Program (ALP).

Williamsville Suburban is a for-profit nursing home operated by Williamsville Suburban, LLC. Their operating certificate states that they provide baseline services as well as outpatient physical and occupational therapy.

The facility is currently in Chapter 11 bankruptcy proceedings. Certified financial and occupancy data for the previous 4 years are unavailable. For the previous 3 years, the facility has experienced quality and survey problems as evidenced by an extremely high number of deficiencies when compared to the other facilities within the Western Region and statewide. The survey of 2005 resulted in 27 deficiencies, the survey of 2004 resulted in 36 deficiencies and the survey of 2003 resulted in 11 deficiencies while the

statewide average is five deficiencies. Moreover, the facility complaint substantiation rate for 2001-2003 was 38.1% while the statewide average was 5.9%.

Per the Administrator, the most recent occupancy rate is 93%. The most recent case mix index was 1.13 in April. At that time, they had 29 PAs and 9 PBs which means that 17% of its residents are in the PA/PB category of lowest clinical need. They also have a 40 bed sub-acute unit with approximately 60-70% occupancy.

5) The Waters of Allegany must seek approval for Medicaid patients.

The Waters of Allegany has 37 skilled nursing beds and is a for-profit facility that only accepts private pay and Medicare patients. This has resulted in an extremely low occupancy rate of 71.4% in 2004 and no access for economically disadvantaged patients. The facility is located in Cattaraugus County, which has limited skilled nursing facilities and non-institutional long-term care resources. Seeking and receiving the ability to accept Medicaid patients in the facility will provide better access to patients and provide needed services in the area.

6) Lake Shore Health Care Center should take 40 beds out of service.

Lake Shore Health Care Center has requested permission to eliminate 40 beds from their facility and to sell them to Fredonia Place. The money would be used to renovate the area vacated by the 40 beds to convert to another use. The WRAC rejected the proposal to sell the beds, and recommends that the beds be taken out of service and that this same number of beds to be applied to the overall ALP in the region (*vide infra).*

7) When a Hospital closes, the WRAC recommends closure of the attached SNF.

The WRAC believed that retaining SNF beds will not allow for economies of scale and therefore the facility will not be financially viable without the affiliated hospital. The difficulty and expense of converting older facilities to meet the present nursing home code requirements and regulation was explored. On this basis, the WRAC recommended closure of **Millard Fillmore Gates Circle** SNF with (75 beds).

8) Expanding the Assisted Living Program

Based on information obtained by the New York Department of Health, there is a significant unmet need for non-institutional long term care which would include the ALP. In order to attempt to meet this need the WRAC has determined that the number of SNF beds removed from the health care delivery system should be returned to the overall system by increasing the number of available ALP beds. The beds would then be allocated to a specific county based on the proportion of bed need attributed to each county. Presently, the total number is 679. The breakdown is described below:

Millard Fillmore Gates Circle	**75**
Episcopal Residential Health Care Facility	**172**
Lake Shore Health Care Center	**40**
Mount View	**172**
Williamsville Suburban	**220**
Total	**679**