

**Minutes**  
**Community Health System 2020 Meeting**  
**April 14, 2008**  
**Finger Lakes Health Systems Agency**

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**Present:** Stephen Ashley (Chair), Leonard Redon (Vice-Chair), Nancy Adams, , Bonnie DeVinney, Robert Dobies, Thomas Flynn, John E. Garvey, Susan Holliday, Augustín Melendez, the Rev. George Nicholas, Edward Pettinella, Thomas Richards, Robert Thompson

**Absent:** Gary Bonadonna, Mark Cronin, H. Taylor Fitch, Michael Nuccitelli, Clayton Osborne,

**Staff:** Fran Weisberg, Sally Trafton, Peggy Clark, Patricia Healey

**Guests:** Marc Voyvodich, Don Horstkotte, Paul Bergeron, Robert Sigmond

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**CALL TO ORDER**

The Chair called the meeting to order at 4:00PM.

**WELCOME & INTRODUCTION**

The Chair welcomed the Commission members and Mr. Marc Voyvodich of Stroudwater Associates. Mr. Voyvodich introduced his colleagues, Mr. Don Horstkotte and Dr. Paul Bergeron. Mr. Robert Sigmond was also introduced. The Chair noted that the Commission would go into Executive Session when the Stroudwater presentation concluded.

**REVIEW & APPROVAL OF MINTUES FROM APRIL 11, 2008**

A motion was requested and seconded to defer reviewing and approving the April 11, 2008, minutes until the April 22, 2008, meeting.

**PUBLIC COMMENT PERIOD (1)**

Six members of the public attended the April 14, 2008, meeting. One individual addressed the commissioners and gave appreciation for the appointment of the Rev. George Nicholas to the Commission.

**2020 COMMISION TIMELINE**

A timeline delineating the major actions of the 2020 Commission and the NYSDOH was presented to the Commission. The Executive Director of the FLHSA, Ms. Fran Weisberg, stated the NYSDOH would be holding hearings in August, October, and December. She and Mr. Voyvodich would be traveling to Albany the following day to vet the timeline with state staff and discuss with them the possibility of holding the hearings in October. The Chair underscored the Commission's deadline of June 30, 2008, to give its final recommendations and the importance of holding to that date. He noted a lot of work lies

ahead for the Commission and for Stroudwater to accomplish its charge.

Mr. Voyvodich remarked his understanding was that the recommendations would be prepared by June 30, which would initiate a process of getting input to the recommendations during the summer. The Chair asserted the Commission would turn in its final recommendations by June 30. One commissioner questioned whether the process of seeking input to the recommendations could potentially change them. The Chair reiterated that additional input would not be sought with an eye towards changing the Commission's recommendations. It was suggested the Commission build in a public hearing and education session into its schedule before June 30. When questioned about the inclusion of these and other presentations, such as the upcoming presentation from the Rochester Business Alliance, FLHSA staff responded that the timeline would be revised as new events were scheduled. A motion was made and seconded to approve the timeline in its current form.

At this time, the Chair yielded the floor to Mr. Voyvodich and his colleagues. Mr. Voyvodich outlined the two main components of the presentation, reviewing the characteristics of high performing health systems nationwide and presenting forward-looking scenarios for the Commission.

### **CHARACTERISTICS OF HIGH PERFORMING HEALTH SYSTEMS**

Mr. Voyvodich introduced the topic of high performing health systems by defining two types of health systems, 1) systems defined primarily by regional geographic focus (i.e., natural systems) and 2) systems defined primarily by corporate structure [Slides 4-5]. He then identified distinguishing features of high performing health systems, as cited in the literature: 1) robust information technology; 2) medical staff alignment; 3) chronic disease management (outpatient); 4) centralized governance; and 5) large scale [Slides 6-12]. Mr. Voyvodich gave the floor to Dr. Bergeron to lead the piece on information technology.

The question was raised whether a strong information technology component held true for a region with multiple systems, not just one [Slide 7]. The question was whether there an opportunity for such an issue locally. Mr. Voyvodich responded the local Regional Health Information Organization (RHIO) was working on achieving an integrated network. He noted that in some communities, more progress had been made with the RHIO.

A question regarding inpatient versus outpatient integration of health information was raised in reference to Slide 8. Dr. Bergeron noted so far, few communities have linked inpatient and outpatient information systems.

Dr. Bergeron noted aligning physicians around performance priorities was key in developing a high performing health system [Slide 9]. There were two factors particularly important in this process: 1) involving physicians in organizational control; and 2) employing physicians in a provider network. The question was raised about differentiating between provider-employed and private physicians and whether the

emphasis in medical staff alignment was on provider-employed physicians. Locally, there is a mixed population of physicians. Mr. Voyvodich remarked that a mixed system is the most common configuration. It was questioned whether this applied to specialists as well as to hospital-based physicians, and Mr. Voyvodich replied that it included the continuum of specialties.

A member of the public addressed Dr. Bergeron and asked which entity was willing to pay for performance. Dr. Bergeron responded different entities – insurers, hospitals – currently pay for performance measures. The Chair asked that members of the public restrict their questions to the public comment period.

Some questions were raised in reference to Slide 12. Stroudwater estimates the FLHSA region's health care market at \$4 billion. This figure was questioned. Also, the estimated value of the Ascension Health market of \$13 billion was also questioned. It was noted that there was a lot of variation of scale within that market, likely characterized by a disproportionate number of small hospitals. There are 12 hospitals in the FLHSA region. It was questioned what proportion of the \$4 billion figure was based in Monroe County.

Mr. Horstkotte introduced the Dartmouth Atlas Project (Atlas), a benchmarking project that uses Medicare data to document and analyze national, regional, and local health market trends, as well as on individual hospitals and their affiliated physicians, was introduced to the Commission [Slides 13-16]. Mr. Horstkotte noted a few limitations with the Atlas data: 1) the latest available comparative data is dated 2005; 2) the data are not discrete enough to adjust for out of area admissions, although this is a universal issue; 3) the data are for Medicare enrollees only; 4) the data come from claims files; and 5) it excludes risk bearing Medicare HMO data [Slide 16]. It was asked how relevant the Atlas was to Rochester since 65% of the Medicare population in Rochester is in risk-bearing HMOs. Mr. Horstkotte acknowledged this fact and noted that the Atlas data are more suggestive of trends than definitive. In its analysis, Stroudwater selected 58 of the 306 hospital referral regions (HRRs) in the Atlas based on the size of the regions' Medicare populations (80,000 to 135,000) vis a vis the Rochester Medicare population (98,000). The latest comparative data available are from 2005. Stroudwater ranked HRR inpatient hospitalization use rates to identify the highest performing HRR for multiple utilization categories [Slides 17-32]. Overall, in terms of total discharges per 1,000 Medicare Enrollees in 2005, the Rochester HRR had 316.2/1,000 total discharges. It ranked 93<sup>rd</sup> out of all 306 HRRs in the Atlas, in the 30<sup>th</sup> percentile. It was questioned whether the data for the Rochester HRR were comparable to all other HRRs, and this was reaffirmed.

There were some questions on Slide 21 regarding the characteristics of a "good" outlier. Mr. Voyvodich responded a hypothetical number of sites that rank highly – Sarasota, Ashville, San Jose – tend to have more organization around the system, have a natural market, have high integration with physicians, and look at system performance in an organized way. On the other end, less efficient HRRs tend to be made up of smaller, independent community hospitals with independent medical practices who work as small entrepreneurs. It was questioned whether fewer discharges were better than more. Mr. Voyvodich responded this was a difficult question that required more work. Mr.

Horstkotte asserted the main takeaway is the data are indicators of hospital utilization. There is an assumption that there is a basic level of quality or standard. It was noted that it was difficult to tell from the data what factors were at play in the lower range of HRRs. These are what the Commission wishes to identify. Mr. Voyvodich responded many of the characteristics of a high performing health system referred to earlier influenced the data – strong IT, alignment among hospitals and physicians – and that a common goal among all entities was key. It was questioned whether Rochester was the best performer of the 58 HRRs from New York State, particularly Buffalo and Syracuse. It was noted that the Commission can recommend incremental change, not systemic. Mr. Voyvodich noted that since Rochester was not benchmark in some aspects, there was room for improvement that might be addressed by the Commission. He noted the Atlas data identify potential opportunities for change.

At the conclusion of the presentation, it was debated whether the presentation could have been organized in terms of short- and long-term goals. If the Rochester HRR is in the 30-40% percentile, it seems that it is doing well. The Commission has to form recommendations that will have some influence on the deltas in the near term that will have implications within the next 5-10 years. This is where the Commission needs to understand and receive guidance in identifying the factors that stand out. IT could make a difference, but what would that mean in terms of improvement? Mr. Voyvodich responded the presentation was intended to provide a picture of the possibilities and provide context for a variety of different approaches towards creating a high performing health system. The point was raised about needing to identify the “best in class” leverage points that could be applied to the Commission’s work. Mr. Voyvodich noted not many communities nationwide make health system decisions, which in itself is influential. It was stated that the Commission has more leverage than just adding beds. It was noted that with the Acute Bed Need Study, there was great difficulty in identifying a range of beds with the information presented. It was questioned whether the Commission wanted to get into the position of allocating beds according to performance. To that point, it was questioned whether that was not part of the Commission’s charge.

## **SCENARIO PLANNING**

### *Supply-Side Solution Scenario*

Mr. Voyvodich introduced the concept of scenario planning, a hypothetical characterization of possible future outcomes of decisions made in the present. The context for this exercise was to examine a year 2020 perspective on decisions made by the Commission in 2008. Mr. Voyvodich first presented a supply-side solution scenario.

It was questioned whether changes in outpatient procedures and future development of outpatient services developed in 2008 to 2013 might affect future capacity. It seems as though the state wishes to drive care out of hospitals into outpatient facilities. It was questioned whether a comparison could be made of the outpatient work done today in the region and use these data as an indicator of quality. Mr. Voyvodich stated it might be possible to do this analysis with actuarial data.

It was noted that the Community Technology Assessment Advisory Board (CTAAB) had

historically limited outside facilities from taking profitable activities outside of the hospital. It is suspected that Rochester is behind because it has held back on this trend. Another related issue is the migration of physicians from the hospital to outpatient facilities. Mr. Voyvodich noted this trend had a negative impact on hospitals' financial performance. Dr. Bergeron noted one area that also changed was the shift of chronic disease management to outpatient facilities. This had the effect of reducing the number of admissions to hospitals. It was raised that New York had more opportunities to protect its rural hospitals. Mr. Voyvodich stated that changes in the supply side in Monroe County would have a negative effect on the rural hospitals. It was noted that the scenario did not include two significant factors. First, the current thinking in the government encourages competition in health care but it is not uniformly enforced. Second, health care today is consumer-driven – people have been told to make choices for their health care and they will. It was stated that perhaps there are better way to manage consumer demand. The rural hospitals are losing market share. It was noted that there may be difficulty in delivering services, citing the shortage in nursing. It is not possible to discuss adding beds without addressing the staffing needs.

Other issues raised in the discussion included long term acute care hospitals (LTACH). It may be possible with the help of NYS to mitigate the Code Red situation. It was noted that Geneva General Hospital is opening its own nursing school, which would increase the supply of nurses in the rural counties. It was noted that it is not sustainable to build more, have more immigration, and build more in response. In return, it was raised that not all Monroe County hospitals are affected the same by immigration.

#### *Real Options Demand Management Scenario*

Mr. Voyvodich introduced a real options demand management scenario, which deals with high levels of uncertainty. It identifies quantifiable benefits of reducing the inherent uncertainty of future projections by delaying action until better learnings are available.

The scenario's inclusion of specialists going out to rural areas on a part-time basis was and the possibility of this occurring was questioned. Mr. Voyvodich stated an economic price point existed at which things would change. One of the issues before the 2020 Commission was what it would take to accomplish a reduction in demand for services. It was stated that this was related to measuring financial investment. It was noted that if one were to put X number of beds online, one would pay an amount per bed day. If money were to be invested in other services, including primary and specialty, it would likely be less than the cost of incremental beds. It was countered that physicians may not respond to financial incentives. Specialists want to see complex cases and have access to the latest technologies; new physicians want the newest and best resources available. Patient preferences also must be factored into demand-side solutions. Another issue that was raised was that the rural hospitals might need to make significant investments in technology in order to attract and accommodate specialists from outside, which could result in duplication of services. It was also noted that physicians needed more than technology, they also needed specialized teams to practice. Mr. Voyvodich noted the scenario did not assume specialists would be employed full-time in a rural setting. Currently, there are physicians who split their time between Monroe County and the

surrounding counties. He noted that to manage a complex disease patients would have to come to Monroe County. It is possible, however, to bridge the gap with telemetry and other technologies. It was posited that perhaps a solution lies in the middle of the supply-side and demand-side scenarios.

It was stated that the scenarios had many moving variables and it was difficult to assess which ones were more important. It was cautioned that anticipating outcomes of the unknown was difficult. One could argue that a lot of things could happen and it was always a gamble. Mr. Voyvodich noted it could be valuable to take the time and test ideas. It was noted that the scenarios motivated commissioners to think about important issues, such as the Code Red issue, the supply of primary care physicians, and effective chronic disease management techniques and settings. It was concluded that there may be other strategies available than just adding beds.

It was noted that the second scenario [demand management] assumed collaboration as an outcome, and that limiting beds would be a conduit. Mr. Voyvodich stated there were points of leverage and the scenarios were neither for nor against adding new beds. The Stroudwater team was expecting to conduct tests on behalf of the Commission to look at the underlying variables and determine if they are constants or if some variation may be possible.

#### **PUBLIC COMMENT PERIOD (2)**

After discussion of the scenarios, the Chair opened the floor for comments from the audience. One individual addressed the Commission and stated that she had lived in San Jose, CA, and that community had a broad network of urgent care centers, which helped manage patients in a non-hospital setting. Another individual, a former nurse, stated that the hospitals were not looking at the plan as a whole. She cited the closing of The Genesee Hospital and the migration of surgeons. She urged the Commission to look at the factors affecting Code Red and stated the community cannot wait for new beds to remedy the situation.

#### **MOTION FOR EXECUTIVE SESSION**

The Chair thanked the Stroudwater team and noted that the Commission could return to any of the issues raised in the presentation at a later time. A motion was requested to move into Executive Session. The motion was made and seconded. The public was thanked for its attendance and comments and dismissed from the meeting.

#### **OTHER BUSINESS**

The Chair thanked everyone for participating. The meeting concluded at 5:05 PM.

*The next meeting is scheduled for April 22, 2008, at FLHSA.*