

Minutes
Community Health System 2020 Meeting
April 23, 2008
Finger Lakes Health Systems Agency

Present: Stephen Ashley (Chair), Nancy Adams, Mark Cronin, Bonnie DeVinney, Robert Dobies, H. Taylor Fitch, Thomas Flynn, John E. Garvey, Susan Holliday, the Rev. George Nicholas, Michael Nuccitelli, Clayton Osborne, Edward Pettinella, Thomas Richards,

Absent: Len Redon (Vice-Chair), Gary Bonadonna, Augustín Melendez, Robert Thompson

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

Guests: Marc Voyvodich, Stroudwater Associates

CALL TO ORDER

The Chair called the meeting to order at 1:00PM.

WELCOME & INTRODUCTIONS

The Chair welcomed the Commission members and Mr. Marc Voyvodich of Stroudwater Associates.

APPROVAL OF MINUTES

The April 11, 2008, minutes were approved. There was a motion to correct the April 22, 2008, agenda item specifying the review and approval of the April 14, 2008, minutes. Those minutes will be presented at the meeting on April 28, 2008, along with the minutes from the April 22 and April 23 meetings.

PUBLIC COMMENT PERIOD

No members of the public were present to address the Commission.

REGROUNDING THE WORK OF THE COMMISSION

Ms. Weisberg

Ms. Fran Weisberg introduced the presentation prepared by Stroudwater Associates, and directed the commissioners' attention to Slide 3, 'Regrounding the work of the Commission.' She highlighted the Commission's charge and reminded the Commission that it will make its recommendations by June 30, 2008, and issue its final report September 1, 2008. Ms. Weisberg emphasized that the Commission's recommendations could determine the number and configuration of inpatient beds among the three Rochester health systems based on a regional view, including a recommendation for each of the current Certificate of Need Applications (CONAs) [Slide 4]. Furthermore, the recommendations will include a framework for future policy and structural initiatives in the region. Ms. Weisberg highlighted the dynamic nature of the Commission's charge.

OPTIONS ANALYSIS & EVALUATION CRITERIA**Mr. Voyvodich**

[Slides 5-7]

Mr. Voyvodich described the process of the Commission's arriving to its recommendations as a distillation of facts, assumptions, and opinions [Slide 5]. He identified April and May as a time to hear stakeholder presentations and to complete an analysis of options, including the submitted CONAs.

Mr. Voyvodich reaffirmed the Commission will be looking at the CONAs in aggregate.

It was questioned what type of facility analysis was underway. Mr. Voyvodich stated Mr. Domenic S. Pesce of ConfigureHealth was conducting a high level assessment of the region's hospitals evaluating whether the facility plans met the test of sequencing, modern standards, and other related issues.

Mr. Voyvodich emphasized it was important for the Commission to agree on a framework for achieving the charge. June is slated for a series of Commission working sessions.

[Slide 6]

A question was raised regarding the issues listed under 'Future.' Mr. Voyvodich stated they represented ideas that were elicited so far by the Commission, including how to think about a regional information technology system, a payment/reimbursement model, and disease management.

[Slide 7]

Mr. Voyvodich suggested the Commission develop a set of evaluation criteria in which to compare different options (e.g., status quo, accepting all CONAs as they stand, etc.). This would enable the Commission to consider different options with a common point of view. It would also help the Commission decide on the options it wishes to consider. Mr. Voyvodich stated the evaluation criteria he had listed emerged from prior discussions, but were not exhaustive, and should be formulated decided on by the Commission.

It is part of the Commission's responsibility to consider its charge to create a more effective health delivery system. The possibility of combining one or more of the existing Monroe County health systems is not a new one. Approximately 5-6 years ago, ViaHealth and Strong Health had conversations about some sort of affiliation, and ViaHealth and Unity more recently, as well as Unity and Lakeside Memorial Hospital (Lakeside) had also done so. It was posited it might make sense to pursue this line of reasoning when considering the rural hospitals. It was questioned whether these issues had surfaced in discussions with the NYSDOH. The Commission had to make recommendations on the CONAs, but it was questioned if other recommendations paralleling those of the Berger Commission would be entertained by the DOH. Ms. Weisberg stated NYS wants a locally informed process with input from stakeholders, including the hospitals. It was noted that the state is poised to listen to the Commission's recommendations.

Returning to Slide 7, it was questioned whether the Commission should evaluate each option by itself or all at once. It was also debated whether a weight should be ascribed to each criterion. The question was raised whether or how the Commission would compare the utility of a bed at one institution instead of another in terms of cost, financial impact, or benefit to the community. For example, SMH's cases had greater acuity, but arguably higher financial return, plus the benefits of being a research institution. It was questioned whether the Commission should consider all beds as equal or whether there were reasons to allocate beds differently among the hospitals. It was also questioned whether some beds were flexible versus fixed in their ability to be used for different functions. Mr. Voyvodich stated that some beds have the capacity to be used for differing functions. The Commission needs to understand the difference among beds (e.g., pediatric vs. med/surg vs. OB).

[Slide 9]

It was questioned whether the Commission should factor in the 56 pediatric beds in the SMH CONA. It was clarified that these beds in SMH's application do not represent a contemporary addition of new beds, just modernized space for improved patient care. SMH has dedicated pediatric beds, while the other two hospitals do not. Rochester General Hospital (RGH) has a pediatric unit that can be swung back and forth as needed. Unity does not have special pediatric beds but children can be placed in a general med/surg bed. The Acute Bed Need Task Force spent a great deal of effort on this issue. All of the incremental beds are med/surg beds. These could conceivably become ICU, or occupational rehabilitation beds, but by all intents and purposes they are med/surg beds. The question was raised whether the Commission needed to estimate first what the overall need was for new beds before deciding where they needed to be allocated. This was answered by calling attention to the Acute Bed Need Task Force report's findings. In response to the issue of flexibility, fungibility of beds was proffered as an evaluation criterion.

[Slide 10-13]

Mr. Voyvodich drew attention to the CONAs and the component of incremental beds from a regional perspective [Slide 10]. For each of the facilities, there are incremental med/surg beds and beds returned to service. The applications call for increases in ICU and CCU beds, as well as for the decertification of rehabilitation and psychiatric beds. The total changes net to 278 incremental beds in the community. Currently, there are 1,596 licensed beds in the community – this total would rise to 1,807 if all three CONAs were approved [Slide 11]. Mr. Voyvodich noted while the difference in incremental beds is 278 beds, the CONAs call for 231 new beds and for 309 renovated beds. This amounts to 574 total incremental and renovated beds, or the modernization of 32% of the total resulting capacity in Monroe County. The question was raised if the Commission was looking at regional capacity, should it consider the beds at Lakeside. Mr. Voyvodich responded this issue might be parsed out, as the existing capacity at Lakeside and the hospitals in the perimeter counties were perhaps more similar. Returning to Slide 7, Mr. Voyvodich listed community economic and political acceptance as potential criteria for

evaluating the CONAs. He emphasized that the criteria on this slide represented a straw man to initiate discussion.

It was noted that commissioners felt economic viability was two-pronged [Slide 7]. The first question was could the community afford it, and the second was whether the plan was viable for a specific institution. It was posited whether quality issues might influence the decision regarding the number of new beds. The question was also raised that the criterion 'Aligned with future health care delivery trends and standards' might be separated into two different criteria. Mr. Voyvodich responded that it might be worth differentiating between the two. A relevant question for the Commission is whether adopting best practices help move the community towards a more effective system of care. One way of measuring differences in relative quality is through patient satisfaction. It was questioned whether cost could be used as a measure of quality and best practices. For example, does an appendectomy cost more at one institution than another, and could this be construed as a quality issue? Mr. Voyvodich stated it was an excellent question, but it would be difficult to access these data.

Mr. Voyvodich questioned how the Commission felt about some claims that there would be no cost to the community where new costs represented incremental Medicare dollars from the federal government. He questioned how commissioners felt about relying on Medicare to fund the community's modernization plans and its effects on premiums. It was stated that arguments stating there would be no levy on the taxpayer did not ring true. It was also noted that the philanthropy claims in the CONAs were not insignificant and that there is a cost to the community in terms of available philanthropic dollars. It was raised that Medicare costs have some local effect on affordability. It was questioned how the difference would be paid for if Medicare and Medicaid did not cover all of the costs. Mr. Voyvodich responded his team was working on assessing the costs of the different beds.

Regarding the options listed on Slide 7, the point was raised that if the Commission is planning to evaluate the CONAs and develop a framework that describes the next generation of health care delivery in the northern Finger Lakes region by the deadline, it cannot recommend a new model. Removing this option would be one way of disciplining and consolidating the process. It was stated the Commission may need to first decide on the CONAs and then go onto the second step of the process. One thing to consider is to avoid recommending things in Step 1 that prevent recommendations in Step 2.

Another option on Slide 7 that was discussed was 'Availability of human resources,' as that was one of the principles raised by the CONAs relative to physician recruitment and retention. Graduate medical education is important to the region's economy. Mr. Voyvodich pointed out that one of the 2020 Commission's meetings will be devoted to clinician perspectives and issues. The term 'availability' was meant to be more specific, embracing recruitment and retention and addressing graduate medical education as these related to the delivery and quality of health care.

At this point, there was debate on a potential decision making framework [See attached Decision Cascade]. It was affirmed that the Commission needs some way to identify commonalities among the CONAs. Mr. Voyvodich stated the process needs to be disciplined. It would be constructive to develop a series of statements to capture the range of discussion and the ideas expressed in the meeting. It was noted that these were different suggestions, the first a process of analyzing the CONAs and the second creating a matrix of criteria against which to judge options.

It was questioned how the findings of the Acute Bed Needs Task Force report will be considered in the Commission's work. Mr. Voyvodich noted that the Task Force had deferred some key issues for the consideration of the Commission, which had been acknowledged could change the number of new beds ultimately decided upon. The question was raised that there was a significant difference between the Task Force's recommended range of beds and the number of beds requested in the CONAs. The Acute Bed Study Task Force recommended the addition of up to 147 beds. The group also referred several factors to the 2020 Commission for more extensive consideration, recognizing that the outcome of those discussions may alter the final recommendation. Mr. Voyvodich stated that the Commission would need to assess the number of needed beds within the region.

Mr. Voyvodich turned the Commission's attention to Slide 12, noting that while a major focus in the CONAs was the number of new beds to be allocated, the applications also include plans for the renovation and modernization of various clinical services and public areas [Slide 12]. The three submitted CONAs project an aggregate investment of \$538 million, with 30% in the form of equity and 70% from incremental debt [Slide 13]. Furthermore, once the projects are completed, the hospitals anticipate adding a combined 590 new FTEs to their payrolls. The hospitals expect a combined total of \$6.6 million in incremental net income from the projects, but the operating margin on the projects ranges from approximately 49.1% to +12.5%.

[Slide 14]

Regarding modernization, Mr. Voyvodich stated the hospitals in the FLHSA region have not been maintained to contemporary standards, given the average of plant in the region is 13.6 years versus the national average of 9.7.

Returning to the issues on Slide 13, the issue was raised that in assessing the criteria, the Commission will have to examine whether the applications meet a legitimate community need and are affordable. It was suggested that the Commission look at each CONA individually, and then weigh them together. First, it should assess the feasibility of the proposals in terms of financial viability, capital, and implementation. Second, the Commission needs to weigh the proposals in terms of community impact and other advantages gained from approval. Third, it should see whether the proposals address specific issues such as supporting a regional trauma center or meeting the needs of the west side of the city. In response, it was stated that the Commission needs to differentiate between an evaluation process and criteria. Once the process is determined, then the criteria can be developed and applied. It was stated that it is critical for the Commission

to arrive at the number of needed beds in order to clarify its goal. The Acute Bed Needs Task Force report was referred to. The methodology was described, including the inclusion of different factors and assumptions made to arrive at the range of 83 to 147 needed beds. Length of stay (LOS) was the biggest source of conflict for the Task Force because the hospitals did not include LOS changes into their calculations. Another source of contention was whether to increase capacity in the Rochester hospitals while hospitals in the outlying areas had excess capacity. An issue that the Task Force did not consider and turned over to the Commission was economic benefit to the community. Despite these issues, there is confidence in the Task Force's conclusions.

[Slide 16]

In a review of market share, the three CONAs project an additional 8,523 discharges in total from their current service areas. Only 2,284 incremental discharges are anticipated in those service areas due to population and demographic changes, including aging, leaving 6,239 discharges needing to be gained from market share increases at other organizations' expense. These data suggest that in order to achieve their targets, the three hospitals combined need to grow their market share in the six-county region by 5.2% to 57% to achieve their discharge projections. An estimated 56,000 of the projected discharges come from outside Monroe County. These market share projections are projected out to 2017. The issue of technological advances and their potential impact on admissions and discharges was raised. This was noted, although it was also pointed out that technology could either increase or decrease LOS. It was stated that the hospitals' market share projections appeared to depend on taking patients away from the rural hospitals, which made their statements of financial viability questionable. It was noted that this might be an argument for a super-regional facility in Ontario County.

ANALYTIC MODELS

This topic was deferred to a later date due to lack of time.

KEY INSIGHTS: WHAT HAVE WE LEARNED SO FAR?

This topic was deferred to a later date due to lack of time.

OTHER BUSINESS

Mr. Ashley reviewed the calendar for the upcoming meeting on April 28, 2008.

EXECUTIVE SESSION

No motion was made to move into executive session.

ADJOURN

The Chair thanked everyone for coming and for staying a little later than planned. The meeting was adjourned at 2:42 PM.

The next scheduled meeting is April 28, 2008, from 1 PM to 2:30 PM. The meeting will be held in Executive Session due to the confidentiality of the Rochester General Hospital presentation.