



Minutes
Community Health System 2020 Meeting
May 6, 2008
Finger Lakes Health Systems Agency

Present: Stephen Ashley (Chair), Leonard Redon (Vice-Chair), Nancy Adams, Gary Bonadonna, Mark Cronin, Bonnie DeVinney, Robert Dobies, Thomas Flynn, John E. Garvey, Susan Holliday, the Rev. George Nicholas, Michael Nuccitelli, Edward Pettinella, Thomas Richards, Robert Thompson

Absent: H. Taylor Fitch, Augustín Melendez, Clayton Osborne,

Staff: Fran Weisberg, Sally Trafton, Peggy Clark, Lynn Varricchio

Guests: Marc Voyvodich, Don Horstkotte, Stroudwater Associates; Robert Sigmond

CALL TO ORDER

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

WELCOME & INTRODUCTIONS

The Chair welcomed the Commission members, Mr. Marc Voyvodich and Mr. Don Horstkotte of Stroudwater Associates, and Mr. Robert Sigmond.

APPROVAL OF MINUTES

Ms. Nancy Adams requested a change to the April 23, 2008, minutes. The revision will be reflected on page 5, second paragraph, third sentence. There were no further corrections to the minutes to the April 23, 2008, minutes. The April 28, 2008, minutes were approved as written.

PUBLIC COMMENT PERIOD

Dr. Brendan Brady from Canandaigua addressed the Commission. He stated decisions regarding the Rochester hospitals have a major effect on the Finger Lakes hospitals. He urged the Commission that the decisions on Monroe and the Finger Lakes counties be tied. There were no other public comments.

The Chair noted the Commission would have the opportunity to hear from the Finger Lakes hospital representatives at the May 21, 2008, meeting in Canandaigua.

CLINICIAN PERSPECTIVE

The May 6, 2008, meeting, featured two panel discussions from nurses and physicians. The nurses' panel presented first.

Ms. Deb Zimmermann, MS, RN, CNA, BC, Senior Vice President and Chief Nursing Officer, Rochester General Hospital, addressed the Commission and stated there are 200,000 practicing nurses in New York State. Ms. Zimmermann cited national nursing statistics on the future of nursing nationwide, which indicate some improvement in the supply of nurses. Ms. Zimmermann cited a local study, which indicated that the changes in Rochester parallel national trends. Strong Memorial Hospital (SMH), Rochester General Hospital (RGH), and FF Thompson Hospital have magnet designations and have all adopted common practices, including mandatory overtime and increased use of electronics at bedside. Ms. Zimmermann identified several challenges in acute care, including: the increasing elderly population; increasing longevity; the effect of technology on length of stay (LOS); the rising case mix index (CMI) and acuity level of the inpatient population; local hospitals are at full occupancy; the average age of hospitals, specifically RGH, is higher than the national average; and long waits in the emergency department (ED). Ms. Zimmermann asked the Commission to consider these challenges and consider solutions to help nurses efficiently deliver care.

Ms. Mary Comerford, RN, MSN, FNP, CNA-BC, Associate Director, Medical Surgical Emergency Nursing, Strong Memorial Hospital, also presented the nursing acute care perspective. Ms. Comerford reported that at SMH there is currently a 4% vacancy rate for nurses, but that by summer there would be no vacancies. In March 2008, SMH was at 100% occupancy. Ms. Comerford stated according to a daily survey of the top 180 diagnoses, SMH's LOS was better than the national average in all but 13. Ms. Comerford stated SMH has wonderful recruitment and retention of nurses and does not experience great turnover. Ms. Comerford stated SMH has enough staff but has insufficient beds, and that private rooms are key to accommodating patient needs. Ms. Comerford noted SMH is a Level 1 trauma center and transplant center. Last year, of the 4,200 transfer requests SMH received from other hospitals, it was unable to take 600. Ms. Comerford also stated SMH treats approximately 65% of the local Medicaid population.

Ms. Mary Nicholson, BSN, COS-C, Director of Corporate Compliance and Quality and Director of Patient Services, Visiting Nurse Service of Rochester (VNS), presented the nursing home care perspective. Ms. Nicholson reported VNS admits 30-40 patients per day, it has an average daily census of 2,000, and makes 10,000 visits per month. VNS is one of three certified home health agencies (CHHAs) in Monroe County. It oversees two long term home health care programs, two hospice programs, and a Program of All-inclusive Care for the Elderly federal demonstration project (PACE). VNS provides 24-hour home care seven days a week. Ms. Nicholson stated the average age of a VNS home care nurse is 47 years. Ms. Nicholson identified several challenges to home care nurses, including security for staff; deeply discounted reimbursement rates; regulatory and quality initiatives are not waived; home care struggles to compete with hospitals for funds and benefits; training is ongoing; and fragmentation of services. Ms. Nicholson maintained a community call to action was needed to resolve the region's nursing shortage. Ms. Nicholson identified several areas needing attention, including: increasing the availability and size of scholarships to encourage career advancement; changes in health plans' reimbursement for care of complex patients and increased technology demand; and, changes in state and federal policies across the continuum of nursing. Ms. Nicholson stated the hospital bed stress affects home care when patients who need to be hospitalized can't be admitted.

Diane Cooney Miner, PhD, RN, CNS, Dean, Wegmans School of Nursing, St. John Fisher College, presented the academic perspective. Dr. Cooney Miner stated Rochester has remarkable health resources, including five bachelors and three associate nursing programs. A fourth associate program is being planned at Geneva General Hospital. There is also a nursing program at SUNY Syracuse and nine overall in New York State. Dr. Cooney Miner reported four years ago graduated 30 nurses a year. Now the Wegmans School of Nursing graduates 100 nurses per year, and 97% stay in Rochester. The three magnet hospitals also help retain nursing graduates. Dr. Cooney Miner stated notwithstanding these positive trends, there are problems in the academic nursing field. These include: an average age of nursing faculty of 57 years; close to 90% of nursing faculty will be eligible for retirement in four to six years; and, economic deterrents for doctorally prepared nurses to enter academe.

The Commission posed questions to the nurses panel. It was questioned whether there are home care nurses in counties outside of Monroe. Ms. Nicholson responded there is a large scarcity of registered nurses (RNs) for home care. Ms. Nicholson gave the example of Orleans County, which has three RNs for the CHHA. Ms. Nicholson stated telemedicine is used more outside Monroe County, and that other resources help offset some RN resource issues.

After the nurses had concluded their presentation, the physician panel was introduced by Ms. Nancy Adams of the Monroe County Medical Society. Ms. Adams asked the physicians to identify key issues, including: LOS, patient boarding, and rural issues. Leslie Algase, MD, Internist/Geriatrician (Independent), stated hospital inefficiency detracts from the delivery of timely care. Dr. Algase stated longer LOS begins in the ED with patients who do not need to be admitted to the hospital being admitted due to miscommunication between private physicians and hospital staff. Dr. Algase maintains a good percentage of patients could be treated and turned around in the ED without being admitted.

Michael Nazar, MD, Family Physician (Employed, Unity), stated historically many people were admitted to the hospital. Dr. Nazar stated as patients increasingly were diverted to outpatient facilities, the patient population admitted in hospitals grew increasingly older, sicker, and frailer. These patients are generally cared for by older and sicker children. Dr. Nazar stated while LOS over the last five years has trended downward, the inpatient population has changed. Dr. Nazar maintained while technological and surgical advances, and control of nosocomial infections has reduced LOS, the inpatient population, with its higher burden of chronic disease, is driving higher LOS. Dr. Nazar stated the immediate opportunities to reduce LOS had already been taken. Dr. Nazar stated the inefficiencies of the system Dr. Algase identified will require national as well as regional changes beyond the scope of the 2020 Commission. Dr. Nazar stated he is pessimistic about more reductions in LOS and said the best scenario is a flat LOS.

Joseph Vasile, MD, Psychiatrist (Employed ViaHealth), stated any increase in efficiency may be offset by the older and sicker inpatient population. Dr. Vasile also stated the best guess at LOS is that it will remain neutral.

Louis Papa, MD, Internist (Employed, URMC), stated there are two types of hospitalized patients: short and long term stays. Dr. Papa stated hospitals spend a great deal of time to discharge a long term stay patient.

The Commission posed questions to the physician panel. It was questioned whether increasing the supply of acute care beds would simply delay needed increases in efficiencies. Dr. Nazar responded efficiencies are driven at the top, such as through reimbursement policies. Dr. Vasile responded efficiencies would keep occurring and that there is not a linear relationship between the number of beds and efficiencies. Dr. Vasile stated the actual shortage of inpatient beds magnifies systemic inefficiencies. It was stated that the changing demographic trends, e.g., the aging of the population, would appear to increase LOS rather than decrease it. Dr. Nazar responded hospitals are interested in improving their efficiency via strategies such as Lean-6 Sigma or reducing nosocomial infections. Dr. Papa responded keeping LOS flat is an optimistic view.

It was questioned how Rochester compares with national standards of best practices, such as for chronic disease management. Dr. Papa responded physicians are trying to fly the plane without a map – physicians are told the desired endpoint but not given guidance on how to implement best practices into their practices. It was questioned what the consequences of overcrowding were to patient care. Andrew Doniger, MD, MPH, Director, Monroe County Department of Public Health, responded the last ten years have seen increasing Code Reds from multiple facilities. New York uses soft diversion (i.e., if a patient or physician insist on taking a patient to a specific institution, the ambulance must recognize the request) rather than hard diversion (the ambulance takes patients to the nearest hospital). Dr. Doniger maintained Code Red is essentially a problem with inflow and outflow issues – a symptom of a mismatch of supply and demand. Generally, hospitals can see patients for care and discharge them in the ED, but the problem is with patients who require admission. Dr. Doniger stated the biggest issue now is Code Red and will continue to be for three to five years until new beds are brought on line. Dr. Doniger reported FLHSA and the Monroe County Department of Public Health (MCDOH) have conducted meetings examining how to improve throughput. The community needs to address issues such as: barriers to discharge, especially Medicaid eligibility; protocols for infection treatment in nursing homes; and, guardianship issues. Dr. Doniger stated there is currently no surge capacity in the hospitals. It was questioned whether inflow from adjoining counties could be diverted to those counties. Dr. Doniger responded with soft diversion the community has less control on manipulating ambulances. Dr. Doniger stated emergency transports could probably be manipulated, but that these are complicated by patient and family preferences, as well as continuity of care issues. It was asked that Dr. Doniger elaborate on insurance issues as a discharge barrier. Dr. Doniger responded typically social work staff are the experts on this subject. Dr. Doniger stated Medicaid eligibility is complicated by bureaucracy. Nursing homes currently have excess capacity but reimbursement to nursing homes and patient safety requirements may delay or prohibit admissions. Dr. Doniger added that while Medicare Part D has helped with the cost of prescription drugs, it does not cover all of them and nursing homes must absorb these costs. Dr. Nazar stated reimbursement issues are very difficult.

It was questioned whether long-term acute care hospitals (LTACHs) or collaboration with rural hospitals could be part of the solution to the Code Red situation. Dr. Algase stated outlying hospitals send critically ill patients to Rochester hospitals, while Rochester hospitals can't send less sick Monroe patients to non-Monroe hospitals. Dr. Vasile stated the Rochester hospitals could do a better job working with the rural hospitals and use them more efficiently. Dr. Vasile

stated there is a need to keep the rural hospitals healthy because their status will affect that of Monroe County hospitals. Dr. Doniger stated NYS does not recognize LTACHs, although many other states do. Dr. Doniger stated NYSDOH is nervous about adding new costs without additional revenue to the system. Dr. Doniger stated there was no question that LTACHs would improve the quality of care, but that an LTACH bed is still a bed. Clifton Springs Hospital & Clinic had submitted a Certificate of Need Application (CONA) to start an LTACH but the state has not taken action on it. Dr. Doniger stated there needs to be a concerted effort at the state level to introduce these facilities into the system.

It was questioned how behavioral health co-morbidities affected hospital discharges. Dr. Vasile stated some things were being tried locally to deal with this issue, but reimbursement was also a barrier. Dr. Vasile stated there is not adequate reimbursement to nursing homes for mental health, and that there is also a shortage of providers for nursing homes. It was questioned whether there was community coordination to reduce the inflow of patients with behavioral health co-morbidities to the ED. Dr. Vasile responded there were greater social issues at play, such as poverty or homelessness, which require a broader community effort to address. Dr. Vasile stated increased social support would take some of the pressure off of hospitals.

Given the rising acuity level of inpatients, it was questioned what percent of the burden would subacute provide. It was stated this would require funding mechanisms to change – for example, Medicare will not reimburse for a hospital stay shorter than three days. Dr. Doniger cited the Votava study (Acute Bed Need Task Force Final Report, Appendix F) as a comprehensive answer to the question.

Ms. Zimmermann made a final comment in response to the discussion. Ms. Zimmermann stated Rochester has fewer admissions than the national average. Ms. Zimmermann stated while Hospitalists have helped reduce LOS, the acuity of the average inpatient is so high that they are not comfortable treating patients. Ms. Zimmermann stated the ED only takes care of ED patients, and that it is Medicine that decides whether to admit a patient.

The Chair thanked the panelists for their contributions and closed discussion.

FRAMEWORK FOR 2020 COMMISSION DECISION MAKING

The Chair gave the floor to Mr. Marc Voyvodich of Stroudwater Associates. Mr. Voyvodich stated there were two objectives for the remainder of the meeting: 1) to establish a framework for decision making; 2) to set the policies that will enable decisions.

Mr. Voyvodich stated the team needed the Commission's advice on setting the policy and approach for decision making. Mr. Voyvodich stated the Commission could provide a unique regional approach on the best investment strategy. Mr. Voyvodich emphasized the CONAs on a stand alone basis were elegant solutions for each hospital's problems. The problem was that since the state was batching the CONAs, they had to be considered together. In this context, Mr. Voyvodich stated, the net result is twice as many beds as were deemed necessary by the Acute Bed Need Task Force. Mr. Voyvodich emphasized the Commission was the only local voice other than those of the individual hospitals that would address the state and give its

recommendations. As a result, Mr. Voyvodich stated the Commission must consider the collective needs of the region and look at the region's assets to make the best decision.

It was stated there was a disconnect between the CONAs, which did not have a regional perspective, and what the Commission was preparing to do. It was stated the hospitals looked at their own needs, but that the state is asking for a regional solution. Consequently, the Commission must consider all of the systems as though they were one. It was questioned whether the DOH had communicated its intent to the hospitals. Ms. Fran Weisberg stated the state has verbally communicated to the hospitals its intention to batch the CONAs, and it is in the process of drafting letter to that effect. The state had communicated its intention to stress the need for a regional approach to the CONAs and its intention to partner with the FLHSA 2020 Commission. It was stated the hospitals had justified their requests for new beds as solutions to the region's problems.

It was questioned whether the hospital CFOs could provide clarity to ensure that the Commission interpreted the CONAs correctly. Mr. Voyvodich responded his team was assembling a data resource book for the Commission. Mr. Voyvodich stated it was imperative to understand where the data are consistent. This data book will be supplemented over time. It was requested that the data book include information about the aging of the population and stratification by age cohort.

Mr. Voyvodich set forth a framework for decision making [Slide 4]. The framework calls for setting key tenets for setting bed need, finalizing bed need (short and long-term), defining investment options, evaluating options through the application of criteria, and recommending an option, including requirements for success. The framework also sets out target dates for accomplishing each of these steps.

Getting final agreement on bed need is a lynchpin to the 2020 process [Slide 5]. Four elements to this decision are (1) demographics, including population growth and age; (2) utilization of hospital beds, affected by inpatient admission rates and length of stay; (3) market share distribution across the facilities applying for new beds as well as other available resources for acute care, and (4) establishing optimal rates for inpatient occupancy. All of these are inputs for defining regional bed need both in the short term as well as the long term. Of these four, 2020 Commission direction is needed for (2) and (3).

It was suggested that the Acute Bed Need Task Force included length of stay assumptions. Two assumptions contributed to the high estimate and the low estimate that determined the range of needed beds were: 1) for the high estimate, length of stay would be changed from the current average LOS only due to the affects of aging, or 2) for the low estimate, LOS would trend downwards at the rate of its historic trend. The Acute Bed Need Task Force left it to the 2020 Commission to consider other things that might affect length of stay [Acute Bed Need Task Force Report, Appendix C-3].

Several key tenets for setting bed need were proposed. These addressed the setting of benchmarks for best practices in inpatient bed use [Slide 6], and for basing need on use of rural bed capacity as a resource for Rochester inpatient demand [Slide 7].

Discussion about the proposed tenets included questions as to whether benchmarks for best practices should be a point estimate versus a range estimate, and whether different benchmarks for different hospitals should be considered. There were requests for additional information, including a projection of the effects of different lengths of stay assumptions, and what would be included in specific best practice approaches. It was also stated that each of the rural hospitals offered different resources for the Rochester region, and that the economics effects on their use should be considered. It was suggested that unless there was an explicit decision to such effect, the Commission ought not to recommend the building of new beds in Monroe County if the result would be to increase the flow of low acuity patients from outside Monroe into Monroe County hospitals.

Commission members were asked to consider these proposed tenets as principles, rather than the details behind their requirements and effects. Additional discussion of these topics was deferred to a future meeting due to time constraints.

NEXT MEETING

The possibility of setting an additional meeting in May was raised. One date under consideration was May 12, 2008. The attendance for this meeting was not confirmed, so FLHSA staff was asked to check the availability of Commission members to attend a meeting the week of May 12 and alert Commissioners of a future meeting.

OTHER BUSINESS

Mr. Ashley reviewed the calendar for the upcoming meeting on May 21, 2008. He reaffirmed this meeting would be held in Canandaigua and would feature a presentation by the Finger Lakes hospital CEOs. FLHSA staff was finalizing the location of that meeting and would report to the Commission shortly.

EXECUTIVE SESSION

No motion was made to move into executive session.

ADJOURN

The Chair thanked everyone for attending. The meeting was adjourned at 6:30 PM.

The next scheduled meeting is May 16, 2008, from 7:30 AM to 9:30 AM.