Minutes
Community Health System 2020 Meeting
May 16, 2008
Finger Lakes Health Systems Agency

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

Absent: Leonard Redon (Vice-Chair), Gary Bonadonna, Mark Cronin, Robert Dobies, Thomas Flynn, Augustín Melendez, Clayton Osborne,

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

Guests: Marc Voyvodich, Don Horstkotte, Stroudwater Associates; Robert Sigmond (tel.)

CALL TO ORDER

The Chair called the meeting to order at 7:30 AM.

WELCOME & INTRODUCTIONS

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

APPROVAL OF MINUTES

There were no corrections to the May 6, 2008, minutes, and they were approved as submitted.

PUBLIC COMMENT PERIOD

There were no public comments.

REMAINING TIMETABLE & PROCESS

The Chair gave the floor to Mr. Voyvodich, who reviewed the timetable and agenda for the remaining 2020 Commission meetings [Slide 3]. It was noted that a Public Forum has been scheduled for May 29, 2008. The Forum will be held in the 8th Floor Conference Room of the Powers Building (16 West Main Street). The purpose of the Forum is to hear from the community regarding plans for expansion and modernization of existing health care facilities. Notice of the meeting will go out the week of May 19, 2008.

The Chair noted as the Commission moves into June, more process will be built into the meetings. He stated the week after Memorial Day weekend, he and Mr. Redon will convene with the Stroudwater team and FLHSA staff to work on a communications plan presenting the Commission's position.

OVERVIEW OF PROCESS

Mr. Voyvodich reviewed the tenets for setting the bed need that had been approved by the Commission [Slide 5]: 1) hospital utilization can trend downward in the future, but the Commission will not base 2017 projections on existing national best practices; and 2) some number of low acuity patients now served by the Rochester hospitals can be cared for by the Central Finger Lakes hospitals in the future. A third tenet was presented to the Commission for discussion and direction: 3) whether bed need related to patients living outside the six county FLHSA region should be assessed separately from the population-based analysis for the region.

Regarding the first tenet, it was questioned why the Commission's recommendations will not project further than 2017. Mr. Voyvodich responded while demographic projections beyond 2017 are available, they are not very reliable. Ms. Nancy Adams noted that the Acute Bed Need Task Force had struggled with this issue. There is also some debate over which data source for regional demographic data and projections is more valid. The Acute Bed Need Task Force used the Cornell Institute for Social and Economic Research (CISER) population data for its projections. This source is somewhat controversial because it projects a 40,000 population decrease by 2020. The Stroudwater team instead used data from Solucient® in its calculations because it estimates a population increase at the margins. Mr. Voyvodich confirmed that the demographic changes fell within the margin of error and that the Commission will make its recommendations for 2017.

Regarding the second tenet, it was praised that the Commission would consider the resources of the Central Finger Lakes hospitals in its deliberations, as decisions made in Monroe County would affect the residents of the surrounding counties. The point was raised that there is not a single rural view – instead, there are three different rural-urban perspectives and the Commission may need to consider specific aspects of each.

Mr. Voyvodich brought the third tenet to the attention of the Commission and highlighted its importance. Considering whether to treat the bed need for economic development separately from the community need is a material issue. It was questioned whether this is possible or if the components were so intertwined that it would be difficult to differentiate the two populations. Mr. Voyvodich stated the Commission was charged with reviewing the Certificate of Need Applications (CONAs) from a regional, not a hospital, perspective. Mr. Horstkotte stated the Stroudwater team looked at the bed need from short and long term perspectives. While it was not possible to assess the local and incoming bed need in the short term, it was possible to segregate the need for the long term. Mr. Voyvodich stated the team began its work with the end in mind [Slide 7]. He noted assessing the short term need was not about making projections, it is about arithmetic. Some policy judgments need to be made, but the real issue is looking out across a decade and designing a health care delivery system for the future.

Mr.Voyvodich stated the Acute Bed Need Task Force had done a good job in identifying variables ("force fields") that could shift and influence bed need over the next decade [Slide 8]. Ms. Adams stated a lot of thought went into identifying these issues and analyzing their impact on bed need. She noted that it was difficult to predict the influence of certain variables and that it was not an exact science. It was questioned whether the factors identified as having an impact on acute bed need were included in the model. Mr. Voyvodich responded the four most influential

variables were included: use rates, length of stay (LOS), the urban-rural mix, and out of area patients. Mr. Voyvodich noted the Acute Bed Needs Task Force findings were consistent with the national trend in declining inpatient admissions and increasing outpatient admissions [Slide 9].

In reviewing the variables considered in calculating the bed need for 2017, Mr. Voyvodich highlighted the differences and similarities between the methods his team employed and those used by the Acute Bed Need Task Force [Slide 11]. The formula used for calculating the bed need remained essentially the same, and the variables and analysis was similar. This provides consistency between the studies. The major change is that the Stroudwater team addressed peak demand in the system by solving to a specific percentage of time (i.e., 95% or 99%) that an incremental bed will be available in the community rather than to a target occupancy rate.

Mr. Voyvodich explained the approach and assumptions his team made [Slides 12-17]. First, Mr. Voyvodich clarified that the calculations include only medical/surgical (M/S) (including observation), pediatric, ICU, and rehabilitation beds, because these are the bulk of the beds and the types that make the most impact [Slide 12]. Mr. Voyvodich affirmed that any other type of bed was excluded even if it were in the CONA. Second, the team identified the expected occupancy by using the projected range of patient days for the year 2017 (i.e., highest number, lowest number, and mean value) by month, for each individual hospital, for each bed type within each hospital. Afterward, the team ran the resulting values interactively through 10,000 times in a Monte Carlo simulation, a statistical method that relies on repeated random sampling to compute results and is useful for modeling phenomena with significant uncertainty in inputs, such as the calculation of risk. Third, the team applied probability distributions to range assumptions regarding inpatient discharge rates, lengths of stay, and rural shift [Slides 13-15]. Fourth, the team stratified discharge rates to specific age cohorts [Slide 16]. Mr. Voyvodich explained that rather than aggregating the 65 and older population, the team broke the category into five age cohorts: 65-69, 70-74, 75-79, 80-84, 85 and older. The rationale for this method is that there are significant differences among discharge rates for the elderly, and one risks overestimating the impact of aging if the discharge rate is averaged for the entire 65 and older population. This was one source of dissention in the Acute Bed Need Task Force study.

The Stroudwater team emphasized it is imperative the Commission decide on the percentage of time Monroe County hospitals should have an additional bed available, as this affects the calculations. The Stroudwater team feels this is a better method of solving for bed need: it deals with the peak demand issue because demand is not constant. Mr. Voyvodich stated each percent change represents 22 beds and $20 million. The maximum number of beds in the peak demand season was questioned. Mr. Horstkotte responded this approach assumed an 88% to 89% occupancy rate. Mr. Voyvodich stated one reason for solving to available beds was that the more beds that are available in the community, the incentive for the hospitals is to run at a higher occupancy rate. It was stated the different method did not necessarily calculate a higher number of needed beds, but was a different way of posing the question. It was questioned how the Stroudwater team had considered individual hospitals' needs for additional beds, i.e., how they had dealt with variation among the hospitals. Mr. Voyvodich responded the team's method began solving to the individual hospitals needs before aggregating the results to calculate the ideal rate for the community. The Commission strongly endorsed this approach, in light of

criticism with the methods employed in the Acute Bed Need Task Force study. It was noted beds are not fungible and whether one solution might be managing elective procedures. It was stated on September 11, 2001, all elective procedures were cancelled and they represented approximately 20% to 30% of all hospital admissions. Mr. Horstkotte confirmed in a typical hospital, approximately two-thirds of admissions stem from the Emergency Department (ED).

FINALIZING THE BED NEED

Mr. Voyvodich presented the findings of the bed need analysis for 2017 [Slide 19]. In June 2007, there were 1,442 set up beds in the six-county region, while the mean expected average daily census was 1,382. This suggests on an average basis, the community is pushing capacity. Mr. Voyvodich stated normally one would expect to see a higher delta between the two numbers. Mr. Voyvodich stated that the end result of the calculations, assuming no change in current levels of LOS, discharge rate, or urban-rural shift, the bed need delta set up to 95% of time was 156 beds and 99% of the time was 244. Mr. Voyvodich noted this number was not far off from the aggregate number of incremental beds requested in the three CONAs. This is noteworthy since the hospitals made their calculations individually assuming no change in current trends. Mr. Voyvodich stated the Commission's responsibility was to determine whether it would also assume no change in current levels. Continuing with Slide 19, Mr. Voyvodich demonstrated the change in number of beds needed assuming change in LOS (+0.2 days to -0.6 days), a change in discharge rate (decline from 0 to 6 discharges per 1,000 population), and a change in the number of low-acuity patients from the five Central Finger Lakes counties seeking care in Rochester (currently 5,030) (6,073 to 2,429). If changes in all three variables are assumed, 19 incremental beds were needed to have an available bed 95% of the time, and 96 beds 99% of the time.

It was questioned why the number of needed beds increased from having a bed available 95% to 99% of the time. Mr. Voyvodich stated that for a higher probability that a bed is available, more beds would be required in the community. The Commission asked the Stroudwater team to clarify aging and population effects on LOS. Mr. Voyvodich referred to the discharge rates stratified to specific age cohorts and stated the change in population by age range and growth in population were incorporated into the calculations [Slide 16]. Mr. Horstkotte added the calculations assumed a 0.5% increase in population instead of the 0.4% increase used in the Acute Bed Need Task Force study. It was questioned if LOS increased across the base why did it result in a decrease of needed beds. Mr. Voyvodich responded this occurred because the number represented the culmination of 10,000 scenarios of LOS changing between +0.2 to -0.6 days. Mr. Voyvodich stated the Commission could decide to apply a flat distribution to LOS and determine +0.2 as the midpoint, which would result in a different number. The Commission noted Stroudwater had applied the triangular distribution by each bed category, thus the result did not represent a blending of these. Mr. Horstkotte stated that because of data limitations, the team used community numbers for LOS and discharge rate. Mr. Horstkotte stated acuity was indirectly applied via an average value. There is a correlation between LOS and acuity but the team did not use acuity to modify LOS. It was cautioned that there is a lot of uncertainty over LOS and a more conservative approach may be to assume a 0.2 day increase.

Mr. Voyvodich presented the current bed analysis [Slides 21-26]. Mr. Voyvodich reported differences in methodologies employed by the Acute Bed Need Task Force vs. the Stroudwater team [Slide 21]. The approach and assumptions used in the calculation of the current bed need

mirrored those used to calculate the need for 2017 [Slides 22-23]. The calculations included beds and need at Strong Memorial (SMH), Rochester General (RGH), Unity, Highland, and Lakeside Memorial (Lakeside). Ultimately, the bed need delta set up to 95% of time was 42 beds and 99% of the time was 115 [Slide 24]. Mr. Voyvodich posed a policy question to the Commission, whether the 14 to 29 available beds at Highland and Lakeside should be included in the current bed need analysis [Slide 25]. Mr. Voyvodich cautioned that within two years only 51 incremental beds can be made available based upon the current CONAs and that available regional data used in the analysis is current only through May 2007 [Slide 26].

Mr. Voyvodich presented the assumptions used in the bed need calculations. Regarding discharge rates, he noted reducing discharge rates requires a Toyota 'lean' process of ongoing identification and removal of waste and inefficiencies to improve performance within the hospitals and at the community level [Slide 28]. The hospitals are already working to apply Lean-six Sigma principles to reducing LOS. Mr. Voyvodich stated improving access to primary care is the consensus single biggest opportunity to reduce local demand for hospital emergency and inpatient care based upon stakeholder interviews, but that this also increases the demand for primary care physicians (PCPs) [Slide 29-30]. Currently, Monroe County has a shortage of over 100 PCPs. It was noted that in addition to have a shortage of PCPs, approximately 40% of them are not accepting new patients. Mr. Voyvodich stated the hospitals don't have a short term solution to this issue. In the absence of the ability to access a PCP, patients present at the ED. Mr. Voyvodich referred to data from the Monroe Plan indicating approximately 50% of patients presenting to the ED go for care that does not require ED or hospital attention. Mr. Voyvodich stated to the extent this problem can be mitigated it will have a significant impact on hospitals and the health of the community. The shortage in primary care resources is not limited to Rochester – it is a national phenomenon. Another issue is that once patients access the hospital, options for diverting them to other facilities narrow since the federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligates hospitals to provide or arrange treatment for a patient with an emergent condition until he/she stabilizes [Slide 29].

Mr. Voyvodich posed another policy question to the Commission, whether discharge rates can be reasonably expected to decline by up to 6 discharges/1,000 population (currently 111) if certain initiatives, such as increasing the number of Federally Qualified Health Centers (FQHCs), increasing electronic linkage of hospitals and community agencies, and resolving transportation issues, were implemented [Slide 30-31]. Mr. Voyvodich noted all of these initiatives have the potential of reducing use rates at the margins. It was noted, however, that none increased the numbers of PCPs, and in fact would increase the demand for primary care. It was questioned whether this issue related to the Commission's charge and the amount of control the Commission might have in changing the current allocation and delivery of primary care resources.

Upon its conclusion, the Commission discussed issues raised in the presentation. Regarding re-directing demand to rural hospitals, it was raised that Monroe County hospitals would appear to have an interest in supporting the financial health of the rural hospitals, since a reduction in the rural hospitals' ability to provide health care increases the pressure on Monroe County. It was questioned whether the rural hospitals had thought of strategies for better interface with the Rochester hospitals. It is known that there are partnerships, but it was questioned whether

anything else could be done. Mr. Voyvodich noted there would be a presentation from the rural hospitals to the Commission May 21, 2008, which might answer these questions.

The bed need analysis to 2017 was revisited [Slide 19]. It was suggested the Commission discuss each issue (e.g., shifts in LOS) and assess its comfort level with a range of possible change in order to give the Stroudwater team direction. Mr. Voyvodich recommended the Commission use the 99% availability threshold as its target. It was noted there are still backups in the system at 99%, and it was questioned whether the Commission should aim for having a bed available in the community 100% of the time. If the number of proposed beds is too low the hospitals will not be able to access money and resources fast enough to rectify the situation. If the Commission were to overshoot its recommendations it would not put the hospitals out of business. Mr. Voyvodich responded 100% was not an achievable target.

The table of use rates was re-examined [Slide 16]. The Baby Boomers (BB) are on track to max out in the 65+ cohort. It was stated this table could be construed in terms of risk of being admitted. It was stated one aspect of the Commission's deliberations should be assessing the risk and cost of being over-bedded. The BB effect will not be felt in 2017. The graph showing the historical impact of factors on inpatient vs. outpatient hospital use rates was also discussed [Slide 9]. It was noted that the use rates appeared to be flat after 2004. It was wondered if demographic trends were overlaid onto the use rates, the extent to which this would cause admissions to increase. Mr. Voyvodich responded there were no more recent data, but that the graph suggested the directionality of the trends. Mr. Voyvodich stated the team would devise a method to move the BB cohorts ten years forward to 2027. He cautioned, however, that this will necessitate making many assumptions.

The utility of the Monte Carlo approach was questioned. To the extent to which the method substitutes a point in time for a range of values, it was stated the Commission ought to make a judgment on a range instead in order to judge the consequences of the range, including the costs. For example, if the cost of being at one end was $3 million, it would be worth buying off the risk. It was stated when the Commission checks the factors that might change, it should exercise judgment in targeting the variables that can influence the factors. For example, PCPs are unlikely to be affected by a change in inpatient beds, but this will affect the rural hospitals. In response, it was stated a lot of primary care was controlled by the three health systems, so the Commission might ask them to use their influence to restructure primary care delivery. It was added that primary care is a large problem in New York State, especially in rural areas.

It was stated there seemed to be general consensus on approving the 99% threshold. There was some discomfort about decreasing LOS. Mr. Voyvodich restated the range (+0.2 to -0.6 days) and noted the most frequent value in the analysis was -0.2. There is significant discomfort with the discharge rate. This variable appears to have the most impact on the bed need analysis. Some are not convinced that over the next 15 years there will be a decrease in discharges. Mr. Horstkotte stated the team looked at current discharge rates in Rochester and compared them to national best practices, which is a lower discharge rate. It then assumed the most likely outcome would be a 15% move towards best practices, which resulted in a roughly three day decline.

Regarding pushing out the analysis to 2027, it was cautioned that trying to predict future trends in less tangible variables (e.g., chronic health, medical technology, etc.) required making large assumptions. It was recommended the Commission resist on erring on the side of caution and evaluate the implications of recommending more beds than were needed. It was stated one of the most important issues to consider is the demographic trends and projections. In Western New York State, young people are expected increasingly to leave the area. There is concern that this trend could accelerate and while the population does not dramatically decrease, there is greater concentration of the cohorts with greater utilization and increased LOS. It was conjectured if this thesis were accepted and the percentage of elderly in the community were to increase, could we still expect to see a reduction in LOS because there are better places than hospitals to care for elderly patients. Mr. Voyvodich responded there were communities with a higher percentage of elderly with a lower LOS, but that this requires high integration of community resources.

It was raised that the CON proposals have parts that are not connected to adding new beds. For example, RGH requires more private rooms. It was important for the Commission to determine whether the hospitals can implement their plans in the absence of new beds. Mr. Voyvodich responded this question would in part be answered by the ConfigureHealth presentation on June 5, 2008, in two ways: 1) it will advise whether the approach to the renovations makes sense; and 2) it will do a sensitivity analysis to assess the effect on the project if the incremental revenue related to incremental capital is not there.

It was raised whether Excellus might change its revenue and reimbursement formulas. Mr. Voyvodich stated Excellus was doing its own analysis of the aggregate impact of the CONAs on premiums. Mr. Voyvodich stated Medicare payments represent a disproportionate percent of total payments. NYS does not have the authority to dictate Excellus's rates.

The Commission's stance on key variables was reassessed. There is a bias to accepting the 99% bed availability threshold. There is some agreement that a modest decrease in LOS may be realistic. Questions still remain on the feasibility of decreasing discharge rates and the Stroudwater team will continue to analyze this issue. The urban-rural shift issue would be tabled until the rural hospitals' presentation on May 21, 2008.

It was recommended that Stroudwater look beyond the four bed categories it identified in its analyses [Slide 12]. It was also restated that some are not prepared to accept the Monte Carlo approach and that the Commission needs to consider the range of costs and the impact of operating within the parameters. Ultimately, however, there was consensus that Stroudwater was authorized to continue with its analytic plans.

OTHER BUSINESS
The Commission did not address any other business.

EXECUTIVE SESSION
No motion was made to move into executive session.

ADJOURN
The Chair thanked everyone for attending. The meeting was adjourned at 9:30 AM.

The next scheduled meeting is May 21, 2008, from 7:30 AM to 9:30 AM.