



Minutes
Community Health System 2020 Meeting
May 21, 2008
Finger Lakes Health Systems Agency

Present: Leonard Redon (Vice-Chair), Nancy Adams, 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, Robert Thompson

Absent: Stephen Ashley (Chair), Gary Bonadonna, Mark Cronin, Augustín Melendez,

Staff: Fran Weisberg, Sally Trafton, Peggy Clark, Patricia Healey, Kathie Pierce, Tori Toliver

Guests: Marc Voyvodich, Don Horstkotte, Stroudwater Associates

I. CALL TO ORDER

In the absence of Mr. Ashley, Chair, Mr. Redon, the Vice-Chair called the meeting to order at 7:30 AM.

II. WELCOME & INTRODUCTIONS

Mr. Redon welcomed the Commission members, Mr. Marc Voyvodich and Mr. Don Horstkotte of Stroudwater Associates, and representatives of the Central Finger Lakes Region's community hospitals and physician groups, as well as members of the public attending the meeting.

III. PUBLIC COMMENT PERIOD

There were no public comments.

IV. PRESENTATION: COMMUNITY HOSPITAL TASK FORCE

Mr. Voyvodich took the floor and explained that he would introduce the presentation of the Community Hospital Task Force, and that Linda Janczak, President/CEO of Thompson Health would then speak as representative of the Task Force [members were listed on Slide 2] The Task Force was convened to inform the FLHSA 2020 Commission with a white paper presentation that gathers regional community hospital opinions and input related to addressing acute bed supply and demand issues from a regional perspective. The regional Community Hospitals are willing to work

collaboratively to address acute care bed needs in Rochester. Their presentation is aimed to explore the viability of the 2020 Commission tenet that *“some number of low acuity patients [from the service areas of the regional community hospitals] now being served by the Rochester hospitals can be cared for [by the regional community hospitals] in the future”* [Slide 3].

To prepare for its presentation, the Task Force met twice, on April 22 and May 16, 2008, to discuss a number of questions: 1) Can bed availability in the regional community hospitals offer some ready capacity to Monroe County hospitals for mitigating the impact of peak periods of inpatient demand? 2) Can regional investment in clinical and medical information technology contribute to managing more patients in the regional community hospitals, and also improve the transfer process to Rochester when appropriate and necessary? 3) What are the costs of providing financial incentives for caring for patients in the regional community hospitals vs. constructing additional acute inpatient capacity in Monroe County? 4) What are the local economics of maintaining acute care hospital services in the regional communities? [Slide 4]

In setting perspective, Mr. Voyvodich explained that the regional community hospitals support a collaborative approach to planning and service delivery that recognizes the unique capabilities and stewardship roles of each hospital in the region. The hospitals historically have supported the concept of regionally distributed health care resources to improve access to care for communities in the region. They honor the concepts that patients who need to be hospitalized should be cared for as close to their homes as possible, and that those patients needing tertiary and quaternary care should be referred to those facilities best equipped and staffed to provide that care [Slide 5]. The regional hospitals have focused on primary and secondary inpatient care, and have referred more complex cases to Rochester hospitals. They wish to be part of the solution to the issues of high occupancies and the Code Red problem in Rochester, especially since these affect access for patients living in the regional communities who require more specialized care in Rochester. They cited the fact that Strong Memorial Hospital in 2007 had to refuse over 600 transfers/admissions from the Central Finger Lakes (CFL) region because they lacked available beds [Slide 6].

Regarding the relationships of the regional community hospitals with Monroe County Hospitals, 37% of CFL counties' (Livingston, Ontario, Seneca, Wayne and Yates) residents who are hospitalized, are hospitalized in the 4 major Monroe County hospitals. CFL residents represent 15% of total discharges for those hospitals; these CFL resident cases have a weighted case mix index (CMI) of 2.43 [Slide 7]. Using CMI of 1.4 (example: simple pneumonia and pleurisy, patient over 17 years old) as a cut point for cases that can routinely be treated in community hospitals, there were 5,030 cases, representing 44% of the discharges from the 5 CFL counties that might have been appropriate for treatment in the regional community hospitals. The weighted average CMI of these cases was 0.89. If those low acuity patients had been admitted to CFL hospitals, the hospitals' market share would have increased by an aggregate of 16.5% [Slide 8]. Mr. Voyvodich presented a map of cases discharged from Monroe County hospitals mapped according to zip code of residence. In general, most of the cases of CFL residents discharged from Monroe County hospitals lived in zip codes closer to Monroe County [Slide 9].

The cases representing residents of CFL counties were then displayed according to each Monroe County hospital. In 2006, the 2,205 of 5,076 discharges from Strong Memorial Hospital of cases from CFL counties fell below the 1.4 CMI [Slide 10]. Of cases from Rochester General Hospital,

1,395 of 3,718 fell below 1.4 CMI [Slide 11]; 1,263 of 1,157 from Highland Hospital [Slide 12], and 187 of 399 from Unity fell below 1.4 CMI [Slide 13].

Mr. Voyvodich then introduced Linda Janczak, President/CEO of Thompson Health. Ms. Janczak introduced the additional members of the Regional Community Hospitals Task Force who were present at the meeting: James Wissler, President & CEO of Nicholas Noyes Hospital in Dansville; John Galati, President & CEO of Clifton Springs Hospital and Clinic in Clifton Springs; Annette Leahy, President of Via at Wayne Hospital in Newark; James Dooley, President and CEO, and Mary Ann Eldred, COO, of Finger Lakes Health in Geneva, and Kevin Nacy, CEO of Lakeside Health System, and CEO of Lakeside Memorial Hospital, in Brockport. Ms. Janczak said that her presentation represented the combined thinking of the group.

Continuing, Ms. Janczak said that there were a number of barriers to serving low acuity cases from the CFL counties in regional community hospitals [Slide 14]. She stated that the CFL hospitals have continued to be responsive to changes in locus of care, and new technologies and services. Many cases formerly performed in inpatient settings are now routinely done in outpatient settings; the CFL hospitals have transformed formerly inpatient units into facilities where outpatient procedures could be performed. Nonetheless, barriers exist to low acuity cases from the CFL counties remaining in CFL hospitals for care. Patients are often unaware of services available at the CFL regional community hospitals, and may feel that they must go into Monroe County for various types of care. As the population grows, former residents of Monroe County who move to one of the CFL counties may keep the physicians they had when they lived in Monroe County, or seek care at facilities with which they are more familiar.

Similarly, physician preferences can be barriers. Unlike the past when physicians in the community would follow their patients admitted to the hospital, physicians now often seek a practice where they can limit their “after hours” and weekend call schedule. This is particularly the case for specialists, who often are one of very few in their field in practice in the CFL counties; they lack partners with whom they can share evening and weekend call, and they may choose not to settle in the CFL counties, or may refer patients into Monroe County for hospital care. There is variable ability to remotely access consultations supported by integrated electronic medical records and telemedicine. Recruiting physicians to practice in the CFL counties is difficult; to attract physicians, offering salaries and similar incentives must often be higher than CFL physicians already in practice in the CFL. From the perspective of urban hospitals, there are financial disincentives to support managing non-tertiary level patients in the regional community hospitals; reimbursement rates to hospitals make it economically advantageous for urban hospitals to want such patients in their own facilities rather than to consult on such patients who are located in CFL hospitals.

Nonetheless, Ms. Janczak cited a number of situations where CFL hospitals contract with hospitals in Monroe County for various services. Among other services, Thompson Health contracts for radiology services, and Newark Wayne contracts for anesthesiology and general surgery. In response to a question as to who controlled reimbursement rates for physicians and whether New York State had any role, Ms. Janczak stated that reimbursement rates for non-public insurance were in the hands of insurers.

Another barrier to care in CFL community hospitals is Emergency Medical Service (EMS) protocols that stipulate that patients injured in certain situations – a vehicle rollover, for example -- be transported to the regional trauma center, in this region, Strong Memorial Hospital. Sometimes these patients have problems, for example, a simple leg fracture, where appropriate care could be given at regional community hospitals. NYS EMS Council establishes these protocols, and is the governing authority for making changes; currently Ms. Janczak said that, to her knowledge, there are no particular efforts being made to review and change any of the protocols. It was speculated that because the protocols are based in medical evidence and best practices supported by health services research, it would be unlikely the EMS Council would make any changes.

The Regional Community Hospital Task Force recommends several interventions that would address the number of low acuity patients in CFL counties who are hospitalized in Monroe County hospitals [Slide 15]. First would be a concerted campaign to educate patients and physicians about the current relationships between Monroe and CFL hospitals. The Opportunities should be sought for Monroe County and regional community hospitals to collaborate in clinical and technological areas, with the goal to create relationships that improve utilization of clinical resources, including inpatient beds, in the region. Further, information and educational initiatives should be developed that would improve understanding of the clinical capabilities of regional community physicians. Finally, the Task Force suggests that the 2020 Commission support enough incremental beds in Rochester to alleviate the existing shortage, but not a number that will damage the viability of the regional community hospitals [Slide 16].

To address the uneven availability of physician specialists to perform procedures and care for patients around the clock in the regional community hospitals, targets should be set to establish selected relationships between Rochester physicians/groups and regional community hospital for additional specialty coverage as needed. Support should be sought from payers to provide incremental resources to fund these contractual relationships. Further, post-graduate medical training initiatives should include rotations at the regional community hospitals; and support the availability of medical education capacity at URM [Slide 17].

Additionally, the Task Force suggests supporting remote consultation for patients cared for in the non-Rochester Hospitals via integrated electronic records, telemedicine, and eICU technology. To facilitate this, the Greater Rochester Regional Health Information Organization (gRHIO) should be extended as soon as practical to the regional community hospitals. A telemedicine task force should be developed to establish specific clinical applications, technology requirements, business plans and utilization protocols for these technologies, and to assess the viability of eICU support between Monroe County-based tertiary providers and the regional community hospitals [Slide 18].

The Task Force further suggests that a payer demonstrations should be designed that would create financial incentives for urban hospitals to support managing non-tertiary level patients in the regional hospitals [Slide 19]. As an additional initiative, the region should develop a new 911/EMS diversion pilot that would test the viability of diverting emergent patients not requiring tertiary levels of care to the regional community hospitals emergency departments [Slide 20]. In sum, Ms. Janczak acknowledged that Rochester area hospitals are running above capacity, and that patients from outside Monroe County are contributing to this. Because inpatient capacity exists outside

Rochester, a collaborative regional approach might allow cost effective solutions that can generate positive results for Rochester hospitals as well as the regional community hospitals [Slide 21].

It was questioned what were the trends in discharge rates from the regional community hospitals over the past 5 years; Ms. Janczak acknowledged that discharges had been down, though discharges have fluctuated with population growth as well as the trend in procedures that were formerly done in inpatient settings moving to outpatient settings. Length of stay, however, has increased as patients who are hospitalized in the regional community hospitals have tended to be sicker. Mr. Galati stated that hospitals nonetheless remain the nucleus for many services, including mental health services, long-term care, etc. Mr. Dooley also emphasized the effect that the region's geography and the natural barriers posed by the Finger Lakes in affecting timely access to hospital care. MS. Leahy emphasized that the occupancy rates at Newark Wayne have benefitted by telemedicine initiatives in affiliation with Rochester General Hospital. Further robotic technology in the ICU allows real time consultation with physicians at RGH, and high resolution cameras allow consultation with specialist physicians in the city. The question was raised whether telemedicine initiatives at Newark Wayne had any effect on the number of discharges; Ms. Leahy said that while discharges have indeed increased, it is unclear whether the increase is due to telemedicine or a combination of contributing factors.

Mr. Wissler stated that while Nicholas Noyes Hospital's occupancy rates have fluctuated in the last 5 years, it is his sense that for the first time in years, there is a real commitment on the part of CFL hospitals to work cooperatively and collaborate. Patients want to receive care close to home, and that should be a goal.

V. **PRESENTATION: AD HOC PHYSICIANS' COMMITTEE**

Ms. Janczak next introduced Brendan Brady, MD, who presented a prepared statement (attached as appendix to these minutes) on behalf of a steering committee composed of the presidents of the medical staff of the 33 Ontario County hospitals and Newark Wayne Hospital, and the presidents of the local medical societies. This statement pertained to Ontario, Yates, Seneca and Wayne counties.

Among the topics addressed by Dr. Brady were the changes in the demographics and population of the Central Finger Lakes, and ways that delivery of medical care had changed in the region. Growth in the number of CFL county residents seeking care in Monroe County hospitals has had a deleterious effect on CFL hospitals. It is more difficult to find physicians willing to practice in the CFL counties, where there are not the opportunities for coverage of hospitalized patients at night and on weekends. Specialists are reluctant to practice in CFL counties where there is not the critical mass of cases to allow them optimal modern medical care. In addition to physicians, other staff necessary for interventional radiology and managing PICC lines, among other care, are not available on a round-the-clock basis in the CFL hospitals.

Dr. Brady cited four crucial steps the physicians' steering committee see as necessary to assure successful regional planning as well as to address acute care beds and modernization: 1) The CFL regional community hospitals should work together and with physicians to implement a sustainable plan for providing care to the entire region's residents; the physicians are developing

guiding principles they see as necessary to an effective plan; 2) the difficult in implementing such a plan will likely require a “Finger Lakes 2020 Commission”, as well as batching of CON applications; 3) URMC should actively support the creation of a Finger Lakes health system, and the 2020 Commission should make this a condition of approving new acute beds at Strong Memorial Hospital; and 4) The number of new beds determined for Rochester should include increased use of CFL hospital beds. The physicians believe that in the absence of local and regional health planning and cooperation, decisions on acute care beds are doomed to failure.

In questions for Dr. Brady, he clarified that the support from URMC meant that URMC should encourage, discuss and even provide financial support for a Finger Lakes Health system. The Finger Lakes 2020 Commission called for by the physicians would be a regional planning process for the CFL counties. Dr. Brady reiterated a desire on the part of the physicians to work together with the regional community hospitals. Mr. Dooley from Finger Lakes Health said that in the last 30 years in the CFL, the region has been consolidating hospitals, including ones in Waterloo, Seneca, and Penn Yan. From his perspective, what is necessary to do this successfully is that governance and management must both be consolidated.

VI. REVISITING LONG TERM BED NEED ISSUES FROM May 16, 2008, MEETING

Mr. Redon gave Mr. Voyvodich the floor. Mr. Voyvodich began the presentation by reviewing the bed need analysis to 2017 results he had presented May 16, 2008 [Slide 4]. At this meeting, it was determined that in order for a bed to be available in the community 95% of the time, with no changes in length of stay (LOS), discharge rate, or urban-rural shift, 156 beds were needed, and at 99% of the time 244 were needed. If these three variables all experienced change the totals fell to 19 and 96 beds, respectively.

A. Extending Projections to 2027

Mr. Voyvodich stated based on feedback from the May 16, 2008, meeting the Stroudwater team had extended the bed need analysis to 2027 to address concerns that the 2017 endpoint did not address the baby boomer (BB) effect. Mr. Voyvodich described the method the team employed: 1) the 2017 population projections were kept constant, which at 2017 were already 17 years past the most recent 2000 census; 2) the age band counts and associated use rates were shifted up to the next higher band for each five year period; and 3) county-specific mortality rate estimates were applied to each age band 65 and over [Slide 5]. Mr. Voyvodich drew attention to an important assumption the Stroudwater team made, which was to hold the population projections constant for the age cohorts 0-17 and 18-44, assuming no change from 2017 to 2027 [Slide 7]. Each age cohort in the 65 and over population increased by age band shift, with the exception of the 85 and over group, which declined [Slide 7]. Mr. Voyvodich explained this was an artifact of the baby bust that occurred during the Great Depression [Slide 6]. Regarding the population estimates, it was recalled that Stroudwater is using the Solucient® estimates, which assume an increase at the margins. It was commented that this is a more conservative approach because it assumes there will be a larger population needing treatment. It was noted that keeping the age groups from 0 to 44 years constant was a significant assumption, but that since these age groups have lower utilization rates it should not greatly affect results.

The results of the bed need analysis to 2027, assuming no change in the 2017 assumptions, culminated in a total of 92 beds in order for a bed to be available in the community 95% of the time and 170 beds 99% of the time [Slide 8].

B. Sensitivity of 20-year Discharge Rate and LOS Assumptions

Mr. Voyvodich cautioned that this method applies the LOS and use rate assumptions for the 2017 analysis and holds them constant over ten more years. Mr. Voyvodich asked the Commission to deliberate the validity of this approach, given the likelihood of changes in LOS and use rates due over the next two decades (e.g., medical technology). It was questioned why declining discharge rates resulted in fewer beds. Mr. Voyvodich responded there were two main reasons for this phenomenon. First, inpatient rates are expected to decrease because of the continuing shift from inpatient to outpatient care. It was assumed that the discharge rate from 2017 to 2027 would decline an additional 0-3 discharges/1,000 population [Slide 9]. The upper bound of no change remained the same. Mr. Voyvodich cautioned that this was unlikely to be achieved if there are no changes in the region's health care delivery system. Second, LOS was assumed to fall an additional 0.1 day in terms of the "most likely" LOS [Slide 10]. Mr. Voyvodich stated the judgments made in the analysis will determine the incremental bed need as well as indicate the Commission's ambitions to make changes in a regional health delivery system. Mr. Voyvodich encouraged the Commission to feel optimistic about this because it has some control over the outcome of the process.

The validity of extending the bed need analysis to 2027 was questioned, in light of the many assumptions that had to be incorporated into the calculations. The impact of the urban-rural shift was questioned as it appeared to result in an 18-bed decline in needed beds to achieve the 99% availability target [Slide 8]. Mr. Voyvodich stated the range of values for the urban-rural shift variable was 6,073 to 2,429 (currently 5,030) and the midpoint is relatively no change. Mr. Voyvodich noted adoption of some of the initiatives the Commission has discussed could decrease the number of low-acuity patients from the five Central Finger Lakes counties seeking care in the three major Rochester hospitals. It was stated the Commission should embrace the urban-rural shift and set the expectation that this will occur. Mr. Voyvodich stated there are serious implications if this does not occur, such as the Rochester hospitals reaching a tipping point in which too many low acuity cases from the Central Finger Lakes region go into Monroe County. It could close one or more of the regional hospitals, which could lead to crisis in the delivery system.

VII. OPINION

Mr. Voyvodich presented the Stroudwater team point of view regarding the 2017 bed need. Mr. Voyvodich stated the region can shape its health care delivery system based on its ambitions. Mr. Voyvodich maintained the projected bed need for 2017 of 19 to 96 inpatient beds is based on conservative, achievable assumptions if treatment and payment system changes are targeted and implemented in the region [Slide 4]. Mr. Voyvodich stated the Stroudwater perspective lies nearly halfway between an aggressive approach, which would require significant change to be achievable, and an ultra-conservative approach that risks overbuilding [Slide 12]. The Stroudwater position would still require significant investment and achievement in the region to be accomplished. Mr. Voyvodich warned there are serious implications of building too few or too many beds. Building

too few beds, among other consequences, compromises patient access and safety, patient and staff satisfaction, operational efficiency, and physician/staff recruitment and retention; it reduces surge capacity; it leads to longer queues for elective admissions; and it potentially decreases the opportunity to provide tertiary/quaternary care to patients from beyond the region, resulting in a loss of economic, research, and economic advantages [Slide 13]. On the other hand, building too many beds is likely to result in creating hospital facility capacity for providing care on an inpatient basis that might more efficiently and less expensively be provided in another setting [Slide 14]. Furthermore, building too many beds results in significant sunk capital costs for capacity that exceeds future need; assumes avoidable incremental operating costs; it could lead to the likely failure of community hospitals outside of Monroe County, resulting in additional future facility costs and higher operating costs within Monroe County to replicate this capacity; and, it would destabilize Rochester-based hospitals [Slide 15].

Mr. Voyvodich proposed the Commission narrow its field of analysis from 75 to 125 needed beds as it explores options [Slide 16]. Mr. Voyvodich stated the Commission may choose to be more conservative in its decisions, or it may decide to take the University of Rochester's economic opportunities more weight. In any case, Mr. Voyvodich underscored the Commission's need to have serious, thoughtful deliberations to arrive at a decision.

VIII. OPTIONS AND NEXT STEPS

It was stated that information presented up to this point helped set up the next steps for Stroudwater and the Commission [Slide 17]. It was questioned whether the Commission was comfortable with having Stroudwater look at options working within the 75 to 125 bed range.

It was raised that some members are not comfortable with settling on the 75 to 125 range and are concerned with this focus because there are a series of factors that influence bed need that are not incorporated into the calculations. For example, the rural hospitals referred to physician recruitment and retention and management as their key issues. Simply deciding the number of beds will not resolve these other, important factors and will not mitigate the rural hospitals' problems. Additionally, the hospital systems need the beds to accomplish other things. It was emphasized that there are more issues at play than just adding acute care beds. Mr. Voyvodich agreed and responded it was rate limiting to simply focus on hospital beds. Mr. Voyvodich stated there is also a need to evaluate changes to the delivery and payment systems. Mr. Voyvodich stated the options the Commission would decide upon over the remaining meetings represent different scenarios of the future, which comprise the different factors that need to change or be created in order to make them possible.

It was affirmed that the Commission is not the Acute Bed Task Force – it looks at the system as a whole, while deciding on the number of hospital beds is a way of putting a stake in the ground. Affirming the earlier point, it was noted that the Commission needs to consider the hospitals' concerns and put the acute care beds into perspective with respect to the other needs of the community. It was stated there has to be change in reimbursement to encourage rural care. It was questioned whether the Commission has given enough weight to technology issues. Mr. Voyvodich responded the Commission hasn't because of the lack of definitive data – the only thing the Commission can do is evaluate the directionality of this issue and make a judgment on

the likely effect of technological and clinical advances. Mr. Voyvodich stated given the trend, these will likely decrease LOS at the margins. The results of the table defining the 2017 bed need were revisited [Slide 4]. It was recalled if there were no changes in the system, 244 beds were needed to have an available bed in the community 99% of the time. It was noted that if 5,000 low acuity patients from outside Monroe County continued to come to Rochester hospitals, as the no change stance assumes, the Commission will have gotten it wrong. If the Commission does not take a firm stance it will propose to build 18 beds in Rochester for out-of-area (beyond the 6 FLHSA county region) patients without considering the merit of such a decision. It was stated the Commission needs to make two key decisions: 1) whether to support out-of-area admissions or not; and 2) how to allocate the beds among the hospital systems. Concern was expressed about the 'gravitational pull' from the rural areas into the city. It was raised that if the Commission decides on adding 75 to 125 beds to the system and the trend continues untouched by measures taken by the rural and Rochester hospitals, Rochester could still be underbedded and the rural hospitals will still be in peril. It was stated the Commission needs to factor in choice and use this as leverage for collaboration among the rural and Rochester hospitals. Concern was again expressed with deciding upon the 75 to 125 bed range. It was stated the Commission should evaluate the higher numbers as alternatives to explain the differences among the options. It was felt 75 to 125 was too narrow a range. It was also stated the Commission should explore the governance issues at length and promote more formal relations among the rural and Rochester hospitals such as the ViaHealth arrangement. It was also noted that the ViaHealth model took a lot of work to establish and sustain, which needs to be considered.

It was questioned what kinds of levers the Commission might employ to make its recommendations stick and the degree of influence it has. It was questioned whether one option might be to put contingencies on its recommendations. It was questioned whether the Commission could expect changes after its recommendations are made. It was responded the Commission's mission was to make recommendations and to follow up to make sure they are respected. It was stated the Commission is tied up with beds because it needs to put a stake in the ground before it considers wider systemic issues.

It was reemphasized the Commission is not the Acute Bed Task Force. That body recommended a range of 83 to 147 beds and determined the system needed 89 beds to satisfy today's need [note: the recommendation was 93 beds]. The recommendations will be critical. Getting them implemented will be difficult, but the Commission first needs to zero in on the number of beds.

It was stated the Commission has not considered the economic side of the bed need. If the Commission errs on the side of building too many beds, it will commit a very costly mistake. The Commission must operate within the context of the affordability of its decisions. It was stated the reimbursement to the rural hospitals needs to be addressed.

The discussion was summarized. It was stated the Commission will look at a 75 to 150 bed range, but with options to affect and accomplish the lower end of the range.

Ms. Linda Janczak, CEO and President of FF Thompson Hospital, invited the Commission members to visit the hospital and see the resources the rural hospitals offer.

IX. OTHER BUSINESS

The Commission did not address any other business.

X. EXECUTIVE SESSION

No motion was made to move into executive session.

XI. ADJOURN

The Chair thanked everyone for attending. The meeting was adjourned at 9:35 AM.

The next scheduled meeting is June 5, 2008, from 4:00 PM to 8:00 PM.

Remarks to Health System 2020 Commission
Brendan Brady, MD
May 21, 2008

Good morning. My name is Brendan Brady. The paper I am presenting is a collaborative effort of a steering committee composed of the presidents of the medical staff of 3 Ontario Co hospitals and Newark Wayne, and the presidents of the local medical societies. We have shared this ahead of time with the CEOs of the 3 Ontario County hospitals. When read from the perspective of an individual hospital, it may seem slightly inaccurate or critical. From a broader perspective it is quite accurate and is not in any way intended to criticize. We are also the unofficial representatives of 130,000 residents of Ontario, Wayne, Seneca and Yates Counties whose access to local, high quality, comprehensive health care is at risk.

We would like to thank the 2020 Commission for their work, and especially for considering the issues outside of Monroe County. We are acutely aware of the current perverse imbalance: we have empty beds here, and our sickest patients cannot be transferred due to lack of capacity in Rochester. We physicians strongly support regional planning. As we emerge from the last decade of regional and local competition, you are our best ally in ensuring that high quality care remains available in our community.

My comments will focus on Ontario, Yates, Seneca and Wayne counties. I came here to practice 25 years ago; at that time each community had full service and well staffed hospitals. Moreover, the residents of these communities were loath to leave town for care elsewhere. The care was both high quality, and comprehensive. With the exception of Thoracic and Cardiac surgery, and sub-specialty Pediatrics, referrals to Rochester were few and far between. At that same time, may I add, we also had locally owned hardware and grocery stores – things have changed indeed.

In the 1990s, demographics and the tight sense of community began to change. Rochester was suddenly closer. The 4 Ontario and Yates County hospitals recognized this and over the next decade at least 3 separate efforts to cooperate or consolidate were attempted, but ultimately failed – though Soldiers and Sailors did eventually merge with Geneva General. For the last decade, we have seen competition resume, both locally and regionally. In Ontario County, we now have 2 cancer centers, 3 stroke centers, and 2 soon to be 3 joint centers. And yet, out-migration continues to accelerate, even for routine care. Why?

Recent issues are complex and multiple. They include demographics: we are now more suburban than rural. There has been an explosion of technology driven care. But more importantly, new volume and quality standards have demanded that hospitals have a critical mass of patients to measure up – if not in the eyes of the regulators, then in the perception of the public. The health care quality bar has been raised, and 60 bed community hospitals will struggle to reach that bar.

An even larger issue is physician manpower. None of the hospitals has the critical patient mass to attract or support the specialists necessary for modern care. I am not speaking of esoteric specialties either. We have no intensivists to care for our ICU patients. Specialists in Nephrology, Infectious Disease, and Pulmonology are not routinely available at each hospital. Most heart attack patients are transferred. We no longer do any major urologic surgery. We do little vascular surgery. And the most fundamental

Finger Lakes Health Systems Agency
1150 University Avenue • Rochester, New York • 14607-1647
585.461.3520 • www.FLHSA.org

specialists – general surgery and obstetrics – are at risk. While each hospital has the responsibility to provide services in these critical specialties 24/7, they do not have the patient volumes to financially support the manpower necessary to provide this coverage. Geneva General spent two years trying to recruit a second general surgeon, and eventually decided to employ two new surgeons themselves (more than required to serve the patient population but necessary to have adequate call coverage.) This will only get worse as the new generation of physicians – who refuse to work every 2nd or 3rd night – replace the current staff. We have too few doctors to staff 3 or 4 hospitals as currently configured.

This problem is primarily physician staffing, but other staffing is of concern – Interventional Radiology, PICC lines, and other routine services cannot be staffed on a 24 hour schedule at all hospitals. Available services currently shrink measurably on weekends. As patient volumes dwindle, the imbalance between call needs and economic reality widens. Collapse of a system may seem to happen suddenly, but is predictable. I won't go into details, but the current situation at Soldiers and Sailors hospital is a very pertinent case in point.

What to do? As impressive as you are individually and collectively, the 2020 Commission cannot solve our problems. But you can either exacerbate or ameliorate them. And we have much to do ourselves. For our local role, let me quote the Berger Commission's Regional Advisory Committee's conclusion on what should happen:

FF Thompson, Clifton Springs Hospital, Geneva General Hospital (Ontario County) and Newark-Wayne Community Hospital (Wayne County) should undertake activities to rationalize service in the region.

Rationalization will reduce the duplication of services across the facilities, and reduce administrative inefficiencies. A successful plan could include all four facilities or any smaller combination of these facilities.

In terms of the greater region, physicians feel strongly that a vibrant, full service health system-however that is configured- that can provide the majority of routine and moderately complex care for this area is in the best interest of all – particularly the University. URMC can only benefit in the pursuit of their core mission if routine care is delivered in the communities outside of Monroe County. The current code red issues emphasize this point. It is in the accomplishment of this goal that the 2020 Commission can help.

We believe 4 crucial steps are necessary to assure successful regional planning as well as addressing acute care beds and modernization:

- Our community hospitals must work together and with physicians to implement a sustainable plan for providing care to the entire region's patients. We physicians are developing guiding principals to ensure an effective plan.
- The difficulty of implementing this sea change will likely require a Finger Lakes 2020 Commission, as well as batching of CONs.
- URMC should actively support the creation of a Finger Lakes health system, and nurture it. This ought to be a condition of creating new beds at URMC. All have much to gain from a mutually supportive relationship.
- The number of new beds in Rochester should consider an increasing, rather than decreasing, utilization of Finger Lakes beds.

In the absence of comprehensive local and regional planning and cooperation, any decision on acute care bed additions is doomed to ultimate failure. As the predictable shrinkage or collapse of one or more Finger Lake hospitals occurs, the cost of shifting much of the health care of 130,000 central Finger Lakes residents to Rochester is too staggering to contemplate.