



Community Health System 2020 Meeting
June 17, 2008
Finger Lakes Health Systems Agency
Minutes

- Present:** Stephen Ashley (Chair), Leonard Redon (Vice-Chair), Nancy Adams, Mark Cronin, Bonnie DeVinney, Robert Dobies, H. Taylor Fitch, John Garvey, Susan Holliday, Thomas Richards, the Reverend George Nicholas, Michael Nuccitelli, Clayton Osborn, Edward Pettinella, Robert Thompson
- Absent:** Gary Bonadonna, Thomas Flynn
- Staff:** Fran Weisberg, Sally Trafton, Peggy Clark, Patricia Healey, Wade Norwood, Melinda Whitbeck
- Guests:** Marc Voyvodich, Don Horstkotte, Stroudwater Associates; James Clyne (Deputy Commissioner, Office Health Systems Management), Neil Benjamin (Director, Division of Health Facility Planning), Richard Cook (Deputy Director, Office of Health Systems Management), Karen Lipson (Director, Policy and Planning), NYSDOH
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CALL TO ORDER

Mr. Ashley called the meeting to order at 4:00 PM.

WELCOME & INTRODUCTIONS

Mr. Ashley welcomed Mr. Marc Voyvodich and Mr. Don Horstkotte, Stroudwater Associates, Mr. Jim Clyne, Mr. Neil Benjamin, Mr. Rick Cook, and Ms. Karen Lipson, NYSDOH; Commission members, and members of the public attending the meeting.

REVIEW & APPROVAL OF MINUTES FROM THE MEETING OF JUNE 5, 2008

The minutes for the meeting of June 5, 2008, were approved without revisions.

PUBLIC COMMENT PERIOD

No public comments were made.

PERSPECTIVES FROM FLHSA'S AFRICAN AMERICAN AND LATINO HEALTH COALITIONS

Mr. Ashley gave the floor to Mr. Wade Norwood, FLHSA Director Community Engagement. Mr. Norwood thanked the Chair and commissioners for granting him the opportunity to address the Commission on behalf of the FLHSA's African American and Latino Health Coalitions. These coalitions are led by the Reverend George Nicholas and Hilda Rosario-Escher. The health coalitions comprise nearly 100 leaders in the African American and Latino communities, including clergy, social agency staff and

administrators, small businesspeople, health professionals, and community activists. The coalitions have been meeting since March 2007 to explore the nature of the Rochester community's health care disparities; to build collaborative efforts to mobilize community leaders and resources in the effort to expand access to health services and to eliminate racial/ethnic health disparities; and to advocate for the policy changes that will support these efforts at a community-wide level. Mr. Norwood laid out four main goals for the presentation:

1. Present key demographic information about the region's African American and Latino populations
2. Clarify how demographic and socioeconomic disparities impact health and contribute to preventable hospitalizations
3. Highlight the prevalence and consequences of diabetes and demonstrate how these preventable hospitalizations affect the hospital systems
4. Share the coalitions' belief that investments in primary care and community-based programs and services, which can reduce the need for in-hospital care, with a higher return on investment, and shift the local health care system towards one that provides the "right care at the right time at the right place."

Regarding demographics, Mr. Norwood stated the region's population is largely non-Latino and white. The region's African Americans and Latinos predominantly live in the City of Rochester [Slide 4]. Furthermore, in addition to being an overwhelmingly urban population, the majority of African Americans and Latinos live in poverty [Slide 5]. Mr. Norwood drew attention to the intersection and interaction of race and ethnicity, poverty, and geography in the region [Slide 6]. Poverty in the region is concentrated in the City of Rochester and the Southern Tier. Mr. Norwood stated this concentration of race-related poverty has a meaningful impact on health.

Mr. Norwood presented statistics on health status. Mr. Norwood presented data from the Monroe County Adult Health Survey indicating African Americans are significantly more likely than whites to report they are in fair or poor health, and Latinos are significantly more likely than non-Latinos to report they are in fair or poor health [Slides 8-9]. Mr. Norwood noted these data are supported by an analysis of Years of Potential Life Lost (YPLL), which calculates the total number of years a group of individuals would have additionally lived had they not died of a particular disease [Slide 10]. Mr. Norwood stated YPLL analyzes the relative impact of disease and other lethal causes of death on and in a population. Mr. Norwood emphasized YPLL highlights the human and societal costs of chronic disease in the community and suggests these costs are not evenly distributed among racial and ethnic groups.

Mr. Norwood stated the coalitions' position that the work of the Commission must reflect that building a system that delivers the "right care at the right place right time" requires an understanding of how class and color affect the quality and kind of care people receive. Mr. Norwood introduced diabetes and noted it was selected to demonstrate health care delivery because of the recent media attention given to the disease. Mr. Norwood demonstrated prevalence of diabetes and hospitalization for diabetes varies significantly between African Americans and whites, and between Latinos and non-Latinos [Slides 12-13]. Mr. Norwood showed the map of Prevention Quality Indicators (PQIs), which are a set of measures that can be used with hospital in-patient discharges to identify hospitalizations that could have been avoided with quality primary care and prevention [Slide 14]. Mr. Norwood noted preventable hospitalizations for diabetes in the six-county region under study come disproportionately from the same zip codes that indicated socioeconomic disparities. Mr. Norwood stated emergency department (ED) treated and released visits with primary diagnosis of diabetes

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also come from neighborhoods that are predominantly poor and populated by people of color [Slide 15]. Mr. Norwood presented indicators of quality of diabetes care for the Dartmouth Atlas Rochester Health Referral Region (HRR) and the relative standing of the Rochester HRR in diabetes care compared to other communities [Slides 16-18]. Mr. Norwood quantified the costs in terms of charges and beds used by diabetes PQI hospitalizations in Monroe County hospitals, which totaled \$15.9 million in charges and 21 beds [Slide 19].

Mr. Norwood presented disparities in access to health care, starting with insurance coverage in Monroe County [Slide 21]. Mr. Norwood stated having health insurance significantly differs among racial and ethnic groups, with African American adults more likely to lack health insurance than whites, and Latino adults more likely than non-Latinos to lack health insurance. Mr. Norwood noted these differences repeat in terms of having a health care provider and being able to afford medical care in the past year [Slide 22]. Mr. Norwood stated language also poses a barrier to access, as many residents of Monroe County and the City of Rochester report speaking English poorly or not at all [Slide 23]. Mr. Norwood demonstrated ambulance run volume is rising for basic life support calls and not for advance life support calls [Slide 24]. Mr. Norwood noted these transports reflect an increase in preventable encounters with hospitalizations and the ED. Mr. Norwood demonstrated overall PQI hospitalizations come from zip codes that are home to poor people of color [Slide 25]. Mr. Norwood stated PQI discharges totaled 10% of total discharges, preventable hospitalizations filled 172 beds and totaled \$133.5 million in charges [Slide 26]. Mr. Norwood emphasized there is a role for prevention in reducing PQI hospitalizations.

Mr. Norwood indicated there are evidence-based models of how high-performing health care systems may be achieved. Mr. Norwood emphasized the Commission should embrace the elimination of disparities in access, treatment, and utilization by adopting best practices on the provider and patient side [Slide 28]. Mr. Norwood presented an example of a program in Corpus Christi, TX, using *promotoroes* to implement strategies of prevention, early diagnosis, and treatment of diabetes [Slide 29]. Mr. Norwood stated the ED is not the appropriate place for care. Mr. Norwood presented the number of potential low-acuity ambulance diversions to urgent care, health centers, and clinics per week, weekdays 8 AM to 8 PM identified by the FLHSA Ambulance Alternate Destination for Non Emergency Patients project [Slide 30]. Approximately 80 patients could be diverted from the ED to community services.

Mr. Ashley thanked Mr. Norwood and FLHSA staff for giving and preparing the presentation, and the Rev. Nicholas for his leadership in bringing these issues to the Commission's attention. In reference to Slide 30 and the potential ambulance diversions, it was asked what barriers prevented people from going to the community health centers, and why there was extra capacity in the centers. Mr. Norwood responded knowledge and behavior are one: people believe they have to go to the ED for care and are not trained as effective consumers. Mr. Norwood stated transportation also contributes to this trend – many people maintain making a 911 call that sends an ambulance is easier or preferable to having to find their own way to a health center. Mr. Norwood stated the ambulance diversion project is attempting to overcome this mindset. Mr. Norwood stated access may be compromised by how centers operate. Mr. Norwood cited some clinical redesign efforts in some centers to enable people to be seen at the drop off place. Mr. Norwood stated ultimately the largest barrier is the attitude and mindset of the person making the 911 call. It was asked if the issue was people were making a judgment between getting care at the ED vs. the Anthony L. Jordan Health Center. Mr. Norwood replied this was the case in the context of an emergency. It was questioned whether clinics' hours of operation were an issue. Mr. Norwood responded this did not

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seem to be a factor. It was asked whether first responders were able to drop off people to health centers. Mr. Norwood responded first responders were required to respect people's choices. It was asked whether the lack of health insurance influenced people's ability to be dropped off at health centers. Ms. Trafton responded insurance status and the location of the health center influenced whether an urgent case was taken to a center instead of the ED. Ms. Trafton stated often someone who does not have insurance who tries to go to a health center may be asked to fill out paperwork, enroll in Medicaid, and comply with other steps that might delay care. Ms. Trafton stated one of the initiatives of the Ambulance Alternate Destination for Non Emergency Patients project was to facilitate Medicaid enrollment, or permit patients to be seen first and then deal with insurance issues. Ms. Trafton stated some clinics already see patients without insurance. Ms. Trafton stated in a lot of ways, education and information could mitigate some of the resistance to using the community health centers, as well as efforts to reduce the "hassle factor." It was questioned if the barriers discussed were overcome whether there would be sufficient capacity to accommodate the 12,200 per year low-acuity calls, if this number was indeed accurate. Mr. Norwood responded the centers had stated they could accommodate 80 calls per week during their normal hours of operation without having to increase hours or capacity. Mr. Norwood stated if the community tried to divert all 12,200 low-acuity calls to the health centers, these would need to increase their capacity. The African American and Latino Health Coalitions are trying to get at the needs beyond 8 AM and 8 PM. It was commented 80 patients per week, or 4,100 cases a year equaled approximately one-third of the total volume and would make a significant impact on Code Red. Mr. Norwood relayed there was a feeling that people go to Jordan for a check up but go to Strong when they're sick.

Mr. Norwood was asked to clarify his use of the word "preventable" hospitalizations. Mr. Norwood explained "preventable" referred to cases that were they managed in an appropriate primary care setting with better self management, the hospitalizations might not have occurred. It was noted that there needed to be more hemoglobin A1c testing as well as lifestyle changes. Mr. Norwood added preventable hospitalizations should not deny appropriate hospitalizations occurred, but that inpatient hospitalization should have been avoided with more appropriate treatment. Mr. Norwood referred the Commission to the Agency for Healthcare Research and Quality (AHRQ) website for more information about health care quality measures.

It was asked that the graph on Slide 13 be explained, as there appeared to be a dip in hospitalizations in the early 1990's that later reversed and trended upward. Ms. Whitbeck stated some of the dip could be explained by changes in coding and better coding of conditions. Ms. Whitbeck stated there was better identification of Latinos. It was asked whether in 1994, a condition would have coded as "diabetes" and later not coded as "diabetes" under the new system. Ms. Whitbeck stated there was a difference in the way hospitals were reimbursed, which might have influenced the coding. The figures in the graph were based on the primary diagnosis recorded in the insurance claims. It was questioned whether the trends indicating an increase in diabetes hospitalizations was purely due to demographics, better diagnosing, or frequency of occurrence and increased incidence. Mr. Norwood responded the self-report data on diabetes prevalence suggest diabetes is on the rise in Monroe County as it is nationally. Mr. Norwood stated the FLHSA is eagerly awaiting the Greater Rochester Health Foundation's report on obesity. Mr. Norwood emphasized the most troubling aspect of the graph is that the gap between African Americans, Latinos, and whites persists. Mr. Norwood stated there were two ways of reducing that gap: 1) worsening whites' outcomes; or 2) improving minority populations'. Currently, minority populations' situation is worsening and widening the gap. Regarding the difference in coding, it was stated there was a push to code to the greatest specificity in the early 1990's,

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which changed the way things were reported. It was added a lot of care was not compensated because of certain regulations limiting what could be paid for. It was noted this correlated with a time the hospitals were under significant financial constraints.

It was noted that diabetes was used as a case study, which should be a *non sequitor* – there should not be many or any diabetes hospitalizations. It was stated the fact that the most recent data indicate 400 to 250 per 1,000 population diabetic admissions suggests the room for improvement is zero. It was noted the same case could be made for asthma, as most asthma can be cared for in an ambulatory setting. It was stated the context for the case study is that right now, there are a lot of hospitalizations that were probably preventable if the community implemented its disease management and ambulatory care resources properly.

It was asked whether Mr. Norwood could give three to four specific recommendations to address the problems discussed in the presentation. Mr. Norwood stated implementing best practices and getting to the issue of giving the right care. Mr. Norwood stated standardized measures of quality and monitoring among different entities, as well as language competence, need to be developed. It was asked whether Mr. Norwood referred to setting these standards in cooperation with health centers and the hospitals. Mr. Norwood stated empowering lay educators and funding a cadre of people to do the street-level work would strengthen the system. Mr. Norwood cited his own positive experience quitting smoking with his sister, and how it was easier to quit with a group, to illustrate the benefits of peer educators. Mr. Norwood also urged the Commission look at a reimbursement scheme that looks at prevention as a lucrative area. Mr. Norwood indicated one change would be to increase reimbursement for chronic disease management and consultations. Mr. Norwood stressed community measures be developed to understand the system inputs and outputs. If the community is aware of the rate of amputations then it is galvanized to take action. Mr. Norwood stated there must be standardization with regard to language competency. Mr. Norwood relayed his own misunderstanding when his doctor spoke of reducing salt in his diet instead of sodium. It was noted that increasing language competence and health literacy was needed across the board because lay people and providers do not speak the same language.

It was noted that while community health centers are major providers of primary care, the bulk of provided services are by large practices operated by the hospital systems. It was stated the Commission's responsibility was to think through what was needed to stimulate activity not just at the community health centers but also a major practices.

DISCUSSION WITH NEW YORK STATE DEPT OF HEALTH (DOH)

It was asked whether the DOH representatives could provide some opening comments and then respond to questions from the Commission. Mr. Clyne responded DOH is doing a lot of what the FLHSA and the Commission are doing. Mr. Clyne noted the past decade was not kind to health planning and DOH is trying to reinvigorate that process. DOH is not looking to create health systems agencies (HSAs) across New York State, but believes something must be done about health planning. Mr. Clyne stated competing our way out of costs has not been successful. Mr. Clyne stated DOH wants to plan around community need. Mr. Clyne stated DOH sees a role for competition but it should be focused on quality and outcomes – the most impact occurs when consumers understand quality and outcome differences among providers. Mr. Clyne noted DOH is working on a request for proposal (RFP) system that will allocate \$6 million for planning to enable a number of community groups to have access to funds that will allow them to do the kind of work FLHSA is doing and that Mr. Norwood referenced. Mr. Clyne stated the idea is to disseminate information

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and seed money to do more planning at the local level and away from the DOH. Mr. Clyne stated the DOH is also working on mapping PQIs to assess variations across the state. Mr. Clyne maintained this would be useful for groups trying to apply for the \$6 million and also to do planning on their own.

Mr. Clyne stated PQI is only the beginning of making data available, with the goal of avoiding another Berger Commission process. Mr. Clyne emphasized Rochester was relatively unscathed by the Berger Commission, but this was a traumatic experience for communities that didn't conduct planning at the beginning. Mr. Clyne stated it is better to begin now to have impact at the local level. The Commission and Acute Bed Needs Task Force Study will be very useful to the DOH as they review the CONAs. Mr. Clyne maintained they could not look at the CONAs individually in a vacuum as that would lead to over-bedding. Mr. Clyne stated it was important to make a decision that recommended everyone can't have everything and outlined a cost-effective plan. Mr. Clyne stated the DOH looked forward to working with the Commission in the future. Mr. Clyne noted it will be interesting to see what comes out of the Commission. Mr. Clyne stated the DOH will take that information, apply it to the systems they have to review the CONAs, and come out with something that is a wise investment for the community.

The letter the DOH sent to the three hospital systems (dated 5/22/08) was referenced, in particular the statement "Projects that propose initiatives and programs of care targeted at reducing preventable hospitalizations over time, by redirecting a portion of capital into the delivery and management of appropriate outpatient and hospital based services, will be viewed most favorably." It was asked that the DOH expand on this statement and articulate what it will be looking for. Mr. Benjamin responded the DOH is really hoping to move on this and is structuring something to move CON and the planning process away from institution-based planning to population-based or community-based planning. Mr. Benjamin stated Mr. Norwood's presentation was very consistent with some of the approaches the DOH will be taking. Mr. Benjamin cited earlier conversations attempting to parallel some of the reimbursement initiatives that are moving some dollars into community-based and primary care and move the planning process in alignment with that. Mr. Benjamin stated the DOH is looking at community based health indicators, AHRQ, and the PQI model – which is a very powerful tool – which will be key in helping the state identify some of these issues. Mr. Benjamin noted for so many years, individual institution projects came in that were focused on that institution's view of its market and services and argued "if we build it, they will come." Mr. Benjamin stated they often presented their case as desiring to expand a certain project and therefore needed new beds to support this initiative. Mr. Benjamin stressed he was talking in generalizations, not commenting on any one application. Mr. Benjamin stated one thing the DOH learned in assessing beds is that just because an institution is adding or expanding services doesn't mean there isn't room to develop capacity by moving in the direction that Mr. Norwood's presentation illustrated – in other words, identify the prevalence of hospitalizations that could be avoided or reduced by redirecting resources into better managed, more appropriate primary care. Mr. Benjamin noted this was very hard to do, but in order to justify moving resources into a project, tough questions need to be asked. Mr. Benjamin recalled that in the past, applicants used to have to show the DOH all the reasons and data justifying the need for new beds. Mr. Benjamin stated the questions the DOH would now ask questions like "how much of this capital outlay is being directed to the development of initiatives that in the future will begin to reduce the incidence of inappropriate and expensive hospitalizations?", with a secondary, primary care goal of improving everyone's health at an earlier stage.

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It was asked when the DOH looks at the capital investment for a project, whether it will determine what would be a reasonable percentage that would be invested in primary care. Mr. Benjamin responded the new emphasis represented a change in mindset, not necessarily a prescribed dollar amount. Mr. Benjamin stated that with some degree of certainty, it is possible to assess overlap in markets and services and whether a request for new beds is an attempt to grab market share from a competitor. Mr. Benjamin noted this line of thinking led to the arms race. As for the amount of capital investment that should be diverted towards primary care, Mr. Benjamin stated that this will be done on a case by case basis. Mr. Clyne stated there may be new ways of processing patients that might have good outcomes, such as improving the transition from hospital discharge to primary care. Mr. Clyne stated future applicants will have flexibility in how they make their case, but the important issue is how they intend to positively impact community health outcomes.

It was asked if the DOH is heading back toward a system of collaboration rather than competition. Mr. Clyne responded it is encouraging collaboration in local health planning. Mr. Clyne stated there should be competition around outcomes. Mr. Clyne stated it was not a case of a facility getting an MRI and attracting more patients. Instead, Mr. Clyne described the competition as facility X demonstrating it had better cardiac outcomes than facility Y as the reason for attracting more patients and investing in another cath lab. Mr. Clyne stated it was not the state's intention to penalize facilities because they're doing a good job. Mr. Clyne reflected perhaps those facilities who cannot compete on outcomes should be shut down, not the best. Mr. Clyne stated it would be great if the systems can work together, but otherwise, the state will decide.

It was stated one of the issues before the Commission was the status of independent hospitals other than the three applicants and their roles regarding the bed need. It was questioned whether, if the Commission decided that one of the independent hospitals needs to come under common governance with one of the three systems, the DOH was prepared to help make this happen. Furthermore, it was questioned that if an independent hospital resisted this, what resources could the DOH bring to bear to make this occur. Mr. Clyne stated the state had made \$150 million in HEAL-7 funds available to 1) help institutions impacted the Berger Commission and 2) Berger look-alike proposals that would allow institutions to come together. Even without money, Mr. Clyne stated the DOH could help with rate issues. Mr. Clyne stated the DOH had no legal teeth to enforce a merger but could use everything short of that to aid a merger. Mr. Clyne stated they are looking at regional planning as the driver of such ventures. Mr. Clyne noted hospital boards are charged with making responsible decisions and can't take on expensive ventures without money and providers willing to come together. It was asked whether if the Commission thought it was the right thing to do, if the DOH would withhold CON approval. Mr. Clyne responded the DOH had the power to do this under the Berger Commission but not under normal circumstances. Mr. Clyne stated more money would be available a year from now, which might be a good time for facilities to come together.

MOTION FOR EXECUTIVE SESSION

Mr. Ashley thanked the DOH for attending the meeting. Mr. Ashley stated in light of information that would be presented in the facilities regional master facilities assessment referring to financial and strategic matters proprietary to the hospitals and systems, the Chair asked for a motion to move into Executive Session. A motion was made and seconded. Mr. Ashley thanked the members of the public and media for attending the meeting and closed the meeting. No decisions were made nor votes taken during the Executive Session.

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OTHER BUSINESS

There was no other business.

ADJOURN

The meeting was adjourned at 8:05 PM.

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