

The Post-Standard

From the Post-Standard 2006 Progress Edition

There is no magic target that needs to be hit

Wednesday, February 08, 2006

Gov. George Pataki and the state Legislature created the Commission on Health Care Facilities in the 21st Century to identify hospitals and nursing homes throughout the state that are candidates for closure, consolidation or conversion. The Commission, known as the “hospital closing commission,” is made up of 18 statewide members and 36 regional members. The commission will work with six regional advisory committees that issue their own non-binding recommendations for “right-sizing” the hospital and nursing home systems in their regions. The commission will make final recommendations by Dec. 1. If the recommendations are approved by the Governor and the Legislature, they will become law. David Sandman, the commission’s executive director, recently discussed how the commission will go about this process in an interview with Post-Standard staff writer James T. Mulder.

Q Have other states established commissions like yours, or is New York breaking new ground here?

A New York to my knowledge is the only state to undertake a process like this to its credit. Most other states in the country are grappling with the very same problems of New York but have not been as proactive in addressing them. Community health planning has been out of fashion in this state and the country for the part two decades. New York seems to be in the forefront of reigniting that dialogue.

Q How many excess hospital and nursing home beds do we have in New York?

A It's a difficult question to answer. One of the reasons our effort will be successful is that it did not start with a magic number. Other efforts in the past from other states that have not been successful often started with a magic target. Go out and achieve that number no matter how you do it. The statute that created this commission did not establish any target numbers and provided appropriate flexibility to the commission. There is no magic target that needs to be hit. The issues are somewhat different on the hospital and nursing home sides. Without focusing on a number, it is clear there is a signifi-

cant excess supply of hospital beds in this state. New York state probably has too many nursing home beds, but the issues are more that they are maldistributed geographically. There are regions that are overbedded. There are regions that may be underbedded. And the real challenge is to build the continuum of care so that we have more home and community-based services available as alternatives to nursing homes.

Q Why do we have so many excess hospital beds in New York state?

A New York state has historically had a strong bias for institution-based care. New York state has a major training program for new physicians. Managed care was relatively slow to come to New York compared to other parts of the country. In many cases, the system has not caught up with new realities. There has been a major evolution and shift of care from the hospital to the outpatient settings. All kinds of procedures that used to be done in the hospital can now be done in a physician's office on an outpatient basis. Some areas of the state have been depopulated but their hospital systems have not shrunk accordingly. There are a multitude of reasons that have led to an excess of hospital beds.

Q Why is it important to go through this exercise?

A New York state's hospital system is in a state of crisis. The trade group for the state's hospitals just reported last month that for the seventh straight year the state's hospitals have lost money. You cannot provide care that you cannot pay for. Financially unstable institutions are not able to serve patients' needs well. It's crucial that we stabilize and strengthen the health-care system and better align it to meet patients' needs.

Q How will the commission go about identifying hospitals and nursing homes that should either be closed or somehow downsized or reconfigured?

A Initially the commission has identified six core criteria that are being used to evaluate facilities. These include service to vulnerable populations; the availability of services they provide; their quality of care; utilization statistics such as occupancy rates; their viability, which is largely financial in nature; as well as their economic impact what they contribute to their communities in terms of employment and so on. . . . And that (statistical) process will be combined with a very local and regional based planning process. Part of our infrastructure is that we have six re-

gional advisory committees. There's one for every region of the state. They will be meeting on an ongoing basis with local stakeholders and providers. They will be convening a series of public hearings all across the state. So we will be combining the fact-finding and local understanding of markets with what some of the statistical data is telling us.

Q Among the six core criteria, will some of them carry more weight than others?

A They carry equal weight.

Q So occupancy or utilization won't necessarily be more important than quality of care or any of these others?

A For this purpose, they carry equal weight. It's not just a numbers game. If it was, we would need a computer instead of a commission. The commission's approach is a combination of an art and a science. It is combining a strong basis in evidence with local and regional input and professional judgment.

Q Why did health planning fall by the wayside?

A It did fall out of favor in the 1980s during the Reagan administration when there was more of a preference for market-based solutions than any form of planning. There used to be something called the health systems agencies. There are only two left in New York. The most active one is in Rochester, the Finger Lakes HSA. Then there is the Central region HSA in Syracuse. They were defunded. HSAs for the most part went out of existence.

Q Have the market-based solutions not worked?

A Well, that's in large part why this commission has come into being and why it has gained such broad support, even among the provider community. Market forces have been very much at work. Over the past decade, dozens of hospitals have either closed or filed for bankruptcy across the state. Those have been

solely voluntary closures driven purely by market forces. And they do not necessarily jibe with our public policy perspective. The real goal is preserving and improving patient access to care. So the commission is about trying to get out in front of those changes and direct them in ways that better support our policy objectives. The world is not standing still. And the commission is an attempt to control change rather than just let the market take us wherever it wants to go.

Q When you are evaluating institutions, what alternatives are there other than closure?

A There are many possible reconfiguration schemes beyond outright closure. These could range from some kind of merger situation where one system agrees to absorb a facility into its system of care. It could result in the conversion of a hospital into an outpatient diagnostic and treatment center more of a primary care clinic, which is often what communities are very much in need of. It could result in some sort of regionalization of shared clinical services, especially the very costly and high-tech services that don't need to be on every street corner, such as an MRI or a transplant center. Those are the kinds of services that cry out for more regional solutions.

Q Are there parts of the state that that have more excess capacity than others?

A There is excess in every region of the state.

Q I keep hearing again and again that the greatest excess is in the New York City metro area and Western New York in the Buffalo area.

A Those are clearly areas. But all six of our regions have excess capacity.

Q Many hospitals and nursing homes around the state are carrying a significant amount of outstanding debt. What will happen to that debt if an institution is identified for closure and the decision is made to close it?

A A staggering debt load is often the biggest impediment to closing an institution that is demonstrated to be superfluous. However there are very significant financial resources available to support reform of the system. The first is a program called HEAL New York. It was passed by the legislature in conjunction with the commission. It puts a billion dollars of state funds on the table to support system restructuring. In addition, New York state is currently negotiating with the federal government over a potential waiver, it's called F-SHARP (Federal-State Health Care Reform Partnership), which would recapture another \$1.5 billion in savings also to support system restructuring. So potentially there is a large pool, up to \$2.5 billion, available to support the implementation of the commission's recommendations. One of the uses of the funds could be to pay off capital debt or pension obligations of a facility.

Q One of the concerns among the hospitals is the whole idea of the commission coming out with a hit list of institutions that may be potential targets for closure or reconfiguration. How is that process going to be handled?

A That's a legitimate concern that we share. Our mission is to stabilize and strengthen the system and we would not want to place institutions in jeopardy. So it's critical to avoid premature conclusions or self-fulfilling prophecies. We are doing some preliminary statistical analysis now. Then we are going to let the regional process play out. The regional advisory committees they need some time and space to do their work. They will come back to us in a few months time and tell us as the regional experts where they think the problems and the opportunities within their region exist. We will then combine that local intelligence with some of the more quantitative analysis we are doing. It's a cautious and slow approach that is consistent with our overall mission of stabilizing the system.

Q When will the commission come up with its recommendations?

A December 1 is when our report of recommendations is due.

Q Then what happens?

A After we submit our report to the governor, the governor has five days in which to forward it on to the Legislature. The Legislature has until the end of the month, Dec. 31, in which they have the opportunity to reject the commission's recommendations in their entirety. They must do so on a straight up or down vote, which was done to protect the recommendations from NIMBY (not in my backyard) or parochial politics. No affirmative approval is required. Unless both houses of the Legislature reject the entire set of recommendations prior to January 1, then the rec-

ommendations become state law and the commissioner of health is instructed to begin implementation.

Q Obviously some of the commission's recommendations could be politically unpopular. Do you think the governor and the legislature have the intestinal fortitude to go ahead and ratify your recommendations?

A I'm optimistic both the governor and the legislature have recognized that our health-care system cannot be sustained in its current form. New York state is paying way too much and getting far too little in exchange for what it's spending on health care. I think all of our leaders recognize there is a need for reform and that's why the commission was established, to make the necessary changes and do so in a way that's more immune to the normal political pressures.

Q You will be having hearings around the state?

A Correct. There will be a minimum of 12 public hearings statewide. I expect there will be many more. The central region is quite large geographically. It includes areas as diverse as Rochester, Syracuse and the northern counties such as St. Lawrence.

Q Is there anything I didn't ask you about that you believe is worth mentioning?

A Some people call us the closing commission. And while closure is very much on the table, the breadth and the depth of the commission's vision is far more than just closure. The guiding principle for the commission's work is the perspective of the patient in creating a system that is more accessible and more responsive to the needs of patients.