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Transcript of the Meeting of the
COMMISSION ON HEALTH CARE FACILITIES
IN THE 21ST CENTURY
Held on Thursday, February 9, 2006,
365 Fifth Avenue, Proshansky Auditorium
New York City

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1 Meeting convened at 1:30 p.m.

2 P R E S E N T:

3 STATEWIDE MEMBERS:

4 STEPHEN BERGER - Chair

5 ROBERT HINCKLEY - Vice Chair

6 KRISTIN PROUD

7 G. NEIL ROBERTS

8 ROBERT GAFFNEY

9 CRAIG DUNCAN

10 HOWARD HOWLETT

11 ALBERT SIMONE

12 DR. ROSA GIL

13 RUBEN KING-SHAW

14 RUFORD SEARS

15 BISHOP JOSEPH SULLIVAN

16 DARLENE KERR

17 MARK KISSINGER

18 PATRICK P. LEE - (via telephone)

19 COMMISSION/DOH STAFF:

20 DR. DAVID SANDMAN

21 MARK USTIN, ESQ.

22 DENNIS WHALEN - Department of Health

23 NEIL BENJAMIN - Department of Health

24 LISA WICKENS - Department of Health

25

1 COMMISSION/DOH STAFF: (Cont.)
2 TOM JUNG - Department of Health
3 REGIONAL MEMBERS:
4 PATRICIA ACAMPORA
5 STEPHEN L. ALBERTALLI
6 PAUL S. BOYLAN, ESQ.
7 BERT BRODSKY
8 SUSAN M. CROSSETT - (via telephone)
9 JEFFERY DAVIS - (via telephone)
10 ROBERT DOAR
11 ABEL GARRIGAN
12 RICHARD V. GUARDINO
13 JOHN F. HAGGERTY
14 DOROTHY M. HARRIS
15 PATRICK MANNION
16 WILLIAM MOONEY
17 HEIDI A. NAULEAU
18 DONNA O'BRIEN
19 JOHN O'CONNELL
20 DR. JEFFREY SACHS
21 ANDREW SICHENZE
22 ARTHUR WEINTRAUB
23 LELIA WOOD-SMITH
24
25

1 LIAISONS:
2 DR. WILLIAM STRECK
3 PAUL MACIELAK, ESQ.
4 LAURA LAFABVRE
5 MARY ANN GRIDDLEY
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1 P R O C E E D I N G S

2 CHAIRMAN BERGER: Thank you very much. I
3 would like to welcome you all to the fifth public
4 meeting of the Commission on Health Care Facilities
5 in the 21st Century.

6 I would like to once again apologize to
7 the regional commission members, we chose this
8 location, but couldn't find another one.
9 Unfortunately, I wish all of you were up here with
10 us. If you have questions or discussion during the
11 meeting, I'll recognize you, we have a mic and we'll
12 try to get you into the discussion because we do
13 want you involved. And I'm sorry about the format,
14 but life -- that's life. So, thank you.

15 Let me do -- I know who is here as to the
16 roll call, but as to who is on the phone.

17 Just to confirm, Jeff Davis, are you on
18 the phone?

19 MR. DAVIS: I am.

20 CHAIRMAN BERGER: Thank you.

21 Susan Crossett, are you on the phone?
22 Maybe not.

23 Pat Lee?

24 Well, those are the three people, two
25 regional commissioners, and Pat is a member of the

1 commission, that's supposed to be joining us by
2 phone.

3 The meeting is called to order and I
4 would, David, why don't you give us a progress
5 report on what's happened since the last meeting.

6 DR. SANDMAN: Thank you, Mr. Chairman.

7 I'm pleased to report on our progress
8 since our last meeting. I'll make this a brief
9 report.

10 Since our last meeting, the Assembly has
11 appointed some of their regional members. We are
12 pleased to welcome them to the Commission and
13 welcome them to our meeting here today.

14 The new regional members include Patrick
15 Mannion, from the Central Region; John O'Connell,
16 from Long Island; Kim Kubasek, also from Long
17 Island; and Abel Garrigan, from Hudson Valley.

18 With respect to our work plan, we are in
19 the early part of phase three and on schedule. As
20 the Chairman said at our last meeting, much of the
21 focus now is on our regional advisory committees and
22 providing them with the analytic materials and the
23 support they need in order to be successful.

24 The Commission staff has been divided
25 into discrete work teams who are assigned to work

1 specific regions. And the staff is assisting the
2 RAC by attending their meetings and their hearings,
3 providing background research, compiling and
4 analyzing additional data at the request of the
5 RACs, providing various logistical data as needed.

6 All of the RACs in every region are
7 launched, all of them a number of times. The RACs
8 are currently reviewing background data relevant to
9 regions and identifying areas for opportunity,
10 holding discussions with providers and with other
11 stakeholders in their regions, as well as conducting
12 public hearings, which I will talk a little more
13 about later on in the agenda today.

14 As reported at our last meeting, Mark
15 Ustin, the Commission's Deputy Director and General
16 Counsel was appointed as our liaison to the Public
17 Health Council, as well as SHRPC, and he has begun
18 attending meetings of those bodies.

19 Also as reported at our last meeting, we
20 continue to work on collecting data, identifying
21 right-sizing analytic framework, that was
22 unanimously adopted by the Commission.

23 We continue to engage in an active
24 communications program, both for us to receive
25 information from the public and interested

1 organizations, as well as to make information
2 readily available to the public, as well as to our
3 membership. We do continually update the website
4 for the Commission.

5 Some of our recent meetings and
6 presentations with various constituencies have
7 included the NYU Policy Forum, the New York State
8 Health Facilities Association, the membership of the
9 New York Association of Homes, and Services to the
10 Aging. And coming up next week, Central New York
11 Health Systems Agency in Syracuse.

12 So, Mr. Chairman, in summary, we are on
13 schedule and making good progress in our work.

14 CHAIRMAN BERGER: Thank you.

15 We have a couple of major presentations
16 which we're going to go through today, which we
17 think are important. So, as framework and
18 background for the discussions that will be taking
19 place among the Commission members over the next
20 ten, 11 months, David, why don't you begin and start
21 with a discussion of needs for a changing system,
22 trends and needs. So, why don't you begin with
23 that.

24 DR. SANDMAN: Thank you, Mr. Chairman.

25 The members will recall that an element

1 of our work plan called for us to evaluate the
2 system trends and to determine how those trends
3 might effect the need for bed capacity going
4 forward. And this is especially important because
5 as Chairman Berger constantly reminds us: The world
6 is not standing still, tomorrow is certainly going
7 to look different from today and the Commission's
8 job is to plan for a new and for a redesigned
9 system.

10 As we began this effort, a quote from
11 Yogi Berra runs through our minds: "The future
12 ain't what it used to be." The world of health is
13 care changing. The Commission does not exist in a
14 vacuum. Instead, we're living in a very dynamic
15 environment. A lot of factors combine in the shape
16 change, including governmental regulatory policies,
17 economic forces and reimbursement policies, what's
18 been done in the past as well as what the consumers
19 and patients want and what they demand.

20 Dynamic change is not without risks, and
21 here in New York recent changes have not been kind
22 to the stability of our system. Recently HANYS
23 reported that our hospitals as a group lost money
24 for the past seven years straight and most observers
25 predict that we are heading for year eight. On the

1 long-term care side, the situation is similar. The
2 majority of our nursing homes in this state have
3 operated at losses. And that bleak financial
4 picture results in enormous turbulence. Market
5 forces alone have forced the closure of more than 30
6 hospitals in the past decade across the state. A
7 number of our providers, including some of the
8 oldest and proudest names in health care, have been
9 forced to declare bankruptcy. And that sort of
10 instability is not in anyone's best interests, but
11 it's especially not the patients'. The reason we
12 care about the fiscal instability is that it
13 threatens the available safety net, it jeopardizes
14 access to care and it jeopardizes quality of care.

15 Clearly the status quo cannot and should
16 not be sustained. Instead we need to adapt our
17 system to fit with the changing reality. The
18 massive institutional infrastructure that
19 characterizes New York's health system is inflexible
20 and costly. It requires a large capital investment
21 and it requires a fairly long planning horizon that
22 is not particularly nimble. As the Health Care
23 Reform Work Group that preceded this Commission
24 said, "We need to embrace change, we need to master
25 it, we need to realign our resources to tomorrow's

1 reality and we need to reinvest in the system to
2 ensure that patients receive appropriate access to
3 care."

4 Before diving into the deep end of this,
5 it needs to be said that forecasting the future is
6 obviously a risky proposition. And since none of us
7 have that proverbial crystal ball, the exercise
8 contains a large measure of uncertainty and it gets
9 particularly complicated because even the trends
10 that we can see can be interrelated, they can be
11 multi-directional. For example, some new
12 technologies can reduce costs, but other new
13 technologies can be cost drivers. And sometimes the
14 trends contradict each other and collide. In
15 addition to the apparent trends, the ones that we
16 can see, it's a pretty safe bet that some unforeseen
17 events may also emerge. And so it's important to
18 retain an element of flexibility in anyone's
19 predictions.

20 Having said that, it is incumbent upon us
21 to assess the current patterns, to examine a range
22 of future projections and ultimately the challenge
23 is to determine the dominant direction of change so
24 that we can plan for it. Specifically, the analysis
25 examines three megatrends, including demographics

1 and population dynamics, clinical innovation and
2 change in the organization and delivery of health
3 care.

4 I'm going to review each of those three
5 trends in detail, but taken together, they reveal
6 fundamental changes, namely care has been and
7 probably will continue to shift out of large
8 institutions. It will continue to shift into
9 ambulatory, community, and home-based settings.
10 Lengths of stay at both hospitals and nursing homes
11 are getting shorter, with substantially more
12 churning of patients in and out of them. Those
13 patients who will be served in hospitals and nursing
14 homes are likely to be those with more acute and
15 more complex care needs, while evolving a continuum
16 of care to meet the needs of lower acuity patients.

17 So, let's take a detailed look at
18 demographics because the total size of the
19 population and its composition are key starting
20 points in projecting use rates and demands in health
21 care capacity.

22 Both recent history and projected trends
23 indicate that New York State's population is growing
24 both modestly and unevenly. In the 1990s, New York
25 State's total population grew by only five and a

1 half percent. In contrast, the population of the
2 United States grew by more than twice that rate,
3 increasing 13 percent over the same period. And
4 among the five most populous states in the nation,
5 New York experienced the smallest rate of growth
6 between 1990 and the year 2000.

7 Experience varied across the state, but
8 some regions are actually shrinking in population
9 and others growing. New York City was the main
10 driver of population growth. Its population
11 increased by 9.4 percent, the city accounting for 70
12 percent of the entire state's growth in the 1990s.
13 The Hudson Valley also experienced greater than
14 average growth. The southern tier counties of the
15 Central Region saw population declines, as did both
16 state counties and cities, like Plattsburg, Buffalo,
17 Syracuse, Troy and Schenectady. The growth that
18 occurred in New York City is largely attributable to
19 a stream of new immigrants. According to the New
20 York City Department of City Planning, the city's
21 foreign born population was at an all time high in
22 2000 and comprised about a third of the City's total
23 population. Together, immigrants and their
24 U.S.-born children account for approximately
25 55 percent of the entire City's population.

1 And I mention growth of immigration
2 because their health care needs can affect the
3 system in several different ways. First, immigrants
4 do tend to be relatively young compared to the
5 native born population. They are disproportionately
6 between the ages of 18 and 64. And this age range
7 includes a large number of women of childbearing
8 age. So, internal and child services may be heavily
9 used. But their relative youth also means that they
10 tend to use fewer health care services in general.
11 Refugees and immigrants sometimes come from
12 developing countries with higher rates of infectious
13 disease, but at the same time it's a well-documented
14 healthy immigrant phenomenon where first-generation
15 immigrants often are in good health upon their
16 arrival in the United States and it is in part their
17 better health status that enables their immigration.
18 Finally, immigrants are more likely to be uninsured.
19 Individuals without coverage, of course, can
20 constitute a substantial and uncompensated burden
21 and demand for emergency room care and other
22 resources.

23 Looking into the future, the State's
24 population is projected to remain essentially flat,
25 growing by just two percent over the next 30 years.

1 In fact, New York's projected growth rate is the
2 lowest among the 50 states. And as a result, we are
3 expected to drop from the third most populous state
4 to the fourth by the year 2015.

5 Just as in the past, the experience is
6 not expected to be uniform across the state.
7 Patterns that we've seen are expected to continue.
8 It's expected that the New York City and Hudson
9 Valley Regions will grow. Long Island and the
10 Northern Regions will likely remain stable in
11 population. And the Central and Western areas are
12 projected to continue losing population.

13 Just as important as the total population
14 size is its composition, especially by age because
15 the elderly have historically higher use rates for
16 hospitals and long-term care services. The expected
17 changes in our State's population by age cohort are
18 very similar to national trends. We are going to
19 have a higher proportion of elderly, both as a
20 result of the aging of the baby boom generation, as
21 well as increases in life expectancy. It is very
22 important to note, however, that the aging of the
23 population will occur pretty gradually.
24 Specifically, adults ages 65 and older now comprise
25 13 percent of the State's population, by 2015 that

1 will only increase to 15 percent and then to
2 20 percent by the year 2030.

3 The slow and gradual nature of the aging
4 of the population is important to understand in
5 order to assess how it might affect demand for
6 services, especially for long-term care. The usual
7 kind of man-on-the-street hypothesis is simply that
8 we have an aging populations and that should
9 automatically translate to a need for more beds.
10 But that is not necessarily so. In fact, the demand
11 for nursing home beds is expected to remain flat in
12 the near term. The full impact of the baby boom
13 generation will not be felt until the 2020s when the
14 baby boom generation first begins to reach their
15 mid-70s, the age at which people are most likely to
16 start needing long-term care.

17 Another factor that must be considered is
18 the changing health status of the elderly.
19 Generally, older people today are healthier than
20 older people of decades ago. People live longer,
21 people retire later, they have less functional loss
22 and as discharge shows the self-reported health
23 status of the elderly is improving sharply with far
24 fewer reporting themselves to be in fair or poor
25 health. Similarly, all the trends indicate a clear

1 downward slope in the proportion of the elderly who
2 have a chronic disability.

3 The previous slides are really
4 encouraging as they indicate that the nature of the
5 aging is changing in many ways for the better. But
6 by no means should we be complacent. And we have to
7 remember that these health improvements are not
8 shared equally by all. While some health indicators
9 are moving in the right direction, we also need to
10 be concerned about other indicators, such as the
11 growing prevalence of obesity and diabetes among the
12 elderly. Also important to keep in mind is the
13 changing racial and ethnic mix of our elderly
14 populations. Projections show the proportion of
15 minorities in our New Yorkers will grow and rates of
16 disability historically are more pronounced among
17 racial minorities, suggesting the possibility that
18 the number of functionally-dependent seniors in
19 years to come could increase. Similarly, older
20 women are the fastest growing segment of New York's
21 population. The women generally require assistance
22 in greater numbers than men. So, this, too, could
23 contribute to the number of functionally-impaired
24 seniors.

25 In addition to the changing health of the

1 elderly, their attitudes are changing just as
2 rapidly. Patients are now more engaged in medical
3 decision making, they participate as active partners
4 in their care and they act much more aggressively as
5 consumers. The cultural expectations and the
6 desires of different generations are already
7 affecting demand for health care. The impact of
8 this is most likely to be felt most keenly on the
9 long-term care side. Today's frail elderly are
10 generally more trusting of institution and more
11 accepting of the traditional nursing home model.
12 But consumers increasingly value independent living
13 arrangements and shun institutional care
14 arrangements. And the boomers, who actively
15 participate in medical decisions, are
16 technologically sophisticated and largely reject
17 institutional models of care, are likely to further
18 exacerbate this shift in preferences.

19 So, in summary, a review of demographic
20 trends indicates that the State's total population
21 will not grow much, the State's population is aging,
22 but its impact on demand for health care will be
23 felt only gradually over several decades, the
24 elderly are getting healthier, consumers are likely
25 to increasingly prefer alternatives to institutional

1 care and the aging population will most certainly
2 require health services, but we cannot easily
3 conclude that it will require more in-patient bed
4 capacity.

5 And finally, demography is not destiny,
6 there are many other factors as well that must be
7 considered as part of our planning efforts.

8 So let me turn to one of the other
9 factors, namely clinical innovations and technology.
10 And this is a very big category, it includes things
11 like procedures, pharmaceuticals, imaging devices
12 and therapies. And it is a harder category to
13 forecast compared to demographic shifts that can be
14 predicted with a fair degree of confidence.

15 Changes in technology do effect how much
16 care is delivered and where it is delivered. And
17 sometimes it can produce results that contradict
18 each other. Some innovations decrease use rates,
19 while others may increase use rates. Some make it
20 possible to move a lot of care out of the hospital
21 setting, while other new procedures are
22 hospital-based. Furthermore, even when the
23 direction of change is known, the pace of change is
24 uncertain because it depends on a lot of other
25 factors, including whether reimbursement will be

1 there to pay for it and how quickly providers adopt
2 the new technologies.

3 So that said, let's take a look at some
4 of the new innovations and what their impact has
5 been.

6 The ongoing development of minimally
7 invasive approaches to surgical procedures and
8 diagnosis should extend the trend to shorter stays
9 and a shift in in-patient to out patient settings,
10 thereby reducing the need for in-patient capacity.
11 This chart shows that lengths of stay for minimally
12 invasive procedures are much shorter than for open
13 procedures. And there is still a lot of room for
14 growth in less invasive procedures. You'll see the
15 numbers at the very bottom show what percent are
16 currently performed on a minimally invasive basis.

17 But the next example, the proliferation
18 of implantable devices could raise the rate of
19 in-patient surgical procedures. The list of
20 possibilities here is really long. It includes
21 ventricular assist devices, artificial hearts,
22 livers, discs, nerve, deep brain stimulators. If
23 these kinds of things really take off it could boost
24 surgical rates. At the same time, since some of
25 them provide close monitoring of high risk patients,

1 it's also conceivable that they could reduce
2 hospitalizations by preventing acute crisis. So,
3 the jury is still out. And I deliberately chose
4 this as a sort of counter balance example to the
5 minimally invasive one by showing how there is an
6 element of an on one hand, on the other hand to all
7 of this.

8 There are other types of innovations that
9 could drive demand use rates. Medical and drug
10 treatments have replaced some surgeries. For
11 example, in the cardiac area, statins and
12 drug-eluting stents could replace a lot of open
13 heart surgery. New research is showing promise that
14 angioplasty could be safely performed on an
15 outpatient basis.

16 New imaging technologies can also swing
17 both ways. Since we can do a lot more things to you
18 and we can do them on a less invasive basis, the
19 number of problems detected and the treatment given
20 could rise. But if we end up detecting things at
21 earlier stages, that could conceivably reduce the
22 need for more complex inpatient care later on.

23 So we need to be extra cautious in
24 interpreting the impact of technology and clinical
25 innovations. They can both increase and decrease

1 the use of health services. The mere existence of
2 technology by itself doesn't drive utilization.
3 Things like reimbursement and regulation are also a
4 big part of the picture. And with some exceptions,
5 the main directional change produced by innovations
6 has been to move care to less intensive outpatient
7 settings. And it is reasonable to believe that this
8 overall direction will continue.

9 Some of the things that I've been talking
10 about, demographics, consumer preferences,
11 technology, financing, they all sort of come
12 together to influence how we're organized and how we
13 deliver care. And what has been happening is a big
14 shift in the focus of care to less intensive
15 settings. Some acute care is migrating out of the
16 hospital and some long-term care is migrating out of
17 the nursing home. The next few slides I'm going to
18 show you illustrate a declining focus on the
19 hospital.

20 As you can see, over the past two
21 decades, a lot fewer of our health care dollars are
22 spent in hospitals. The total number of hospital
23 beds has been declining and the number of beds per
24 capita has also been declining even faster.

25 The average length of stay in hospitals

1 is getting shorter. Here in New York, our average
2 length of stay has historically been much longer
3 than the national average. It still is. But it,
4 too, has been declining rapidly and becoming closer
5 to national norms.

6 Also, procedures with surgeries are
7 increasingly performed on an ambulatory basis rather
8 than in hospitals. Even sophisticated things like
9 cardiac catheterization, colonoscopy, radiation, and
10 chemotherapy are now provided on an ambulatory
11 basis.

12 The picture is pretty similar on the
13 long-term care side. There has been a diminishing
14 focus on the traditional nursing home. And it's
15 amazing that the proportion of people over age 75
16 who reside in nursing homes has declined by over
17 25 percent, despite the fact that we have a growing
18 elderly population. As a result, the average
19 occupancy rate in New York State nursing homes has
20 been dropping steadily for the past decade from
21 97 percent to 93 percent in 2003.

22 The composition and the needs of those
23 who are in nursing homes is also changing. First,
24 they are getting older. In 1977, residents ages 85
25 and older made up 35 percent of the nursing home

1 population, but by 1999, it had increased
2 substantially to 46 percent.

3 Just like hospitals, nursing homes are
4 increasingly caring for more high intensity
5 patients. The number of residents who need help
6 with activities of daily living, like eating,
7 walking, dressing and bathing, keep going up.

8 Some of the changes in nursing homes can
9 be attributed to a rise of alternatives to those who
10 are able to remain out of institutions. Home care,
11 in particular, is depicted on this slide, has grown
12 dramatically as a focus of care and for our health
13 spending. And then as you project it, it continues
14 growing at a pretty rapid clip.

15 For those who have the means to afford
16 it, there has been a growth of attractive supportive
17 housing alternatives. Assisted living, for example,
18 has grown rapidly as one sort of arrangement. But
19 because it is costly and public reimbursement is
20 limited, olderpeople with limited means generally
21 are not able to afford this option so far. But
22 there are a few early efforts to try and make this
23 option more available to lower income seniors and
24 it's something we should all keep an eye on.

25 So, in summary, a lot of acute services

1 have migrated out of hospitals and we expect that
2 trend to continue. The focus of long-term care
3 delivery is shifting out of the traditional nursing
4 home and into home and community-based settings.
5 With this shift, the acuity level of patients in
6 both hospitals and nursing homes is general growing
7 and they will continue to take care of our sickest
8 patients with the most intense and most complex
9 needs.

10 Taken together, these trends clearly
11 suggest a declining need for inpatient beds.

12 No discussion of the future would be
13 complete without the consideration of major
14 uncertainties. And it is necessary and appropriate
15 to maintain some degree of surge capacity to handle
16 large unexpected events that could confront our
17 system. In rough terms, when you think about these
18 events in at least two broad categories, there are
19 immediate emergencies, like a natural disaster or a
20 terrorist attack, that could bring about sudden mass
21 casualties. And these present all kinds of
22 challenges for hospitals, as all of us who are New
23 Yorkers who lived through September 11th are well
24 aware of. Hospitals are able to free up beds fairly
25 quickly. Our hospitals responded admirably and did

1 so on September 11th. They used strategies
2 including discharging patients early, they even set
3 up discharge holding areas. They converted
4 outpatient procedure beds to inpatient beds. They
5 could cancel elective procedures. They could double
6 up in private rooms. Having done so, a lot of our
7 hospital personnel were waiting in RVs and parking
8 lots for patients who never arrived. And according
9 to the CDC, this is fairly typical. In terrorist
10 attack, the CDC estimates that two-thirds of
11 casualties will be treated and released from the
12 emergency departments.

13 The CDC identifies the number of
14 operating rooms and radiology capacity, not the
15 number of beds, as the major factors in determining
16 a hospital's ability to respond to a disaster.

17 A different type of concern would be in
18 the form of a pandemic which could potentially place
19 a huge and sustained demand on hospitals, rather
20 than a short and intense peak of an emergency
21 situation. The New York City Department of Health,
22 for example, has done some modeling. They predicted
23 a flu outbreak at its peak would require a need for
24 21 percent more acute care beds than normal.

25 On a practical and on a financial basis,

1 it may not be possible to have the beds and the
2 equipment in place at all times to meet the most
3 extraordinary demands that might ever confront the
4 system. And even if we were to have the beds and
5 the equipment, there are both underlying and
6 disaster related staff shortages that could limit
7 the systems ability to respond. Accordingly, the
8 Department of Health, as well as federal agencies,
9 stress that surge capacity is not just about
10 hospitals. In fact, it must also include alternate
11 care locations, such as primary care centers,
12 long-term care facilities, hotels, armories, schools
13 and others which could help ease the burden on
14 hospitals during a major or sustained disaster. If
15 it were ever to occur, it would be necessary to
16 respond to this kind of situation on both an
17 outpatient and inpatient basis and to rely on a
18 variety of surge capacity partners.

19 So, I have gone over a lot of
20 information. Allow me to just quickly sum up and
21 offer a few final thoughts.

22 A review of the overall direction of
23 future trends does support prudent right-sizing and
24 restructuring of our hospital and nursing home
25 systems. We need a system that's nimble enough to

1 respond to the ever changing health care landscape
2 and the large institutional infrastructure that we
3 have now is both costly to maintain and it lacks the
4 flexibility we so clearly need.

5 I started this talk by emphasizing that
6 predicting the future is a very risky game, that is
7 worth reemphasizing. If you're going to try to do
8 this, as we did, you should exercise a very healthy
9 dose of both caution and humility in trying to
10 predict the future. Expect that something
11 unexpected will probably occur as well. And the
12 best way to remain prepared for those emerging
13 developments is to keep a measure of flexibility
14 that will allow us to respond appropriately.

15 Thank you very much. Be happy to have
16 questions or a discussion.

17 CHAIRMAN BERGER: Before I open it up to
18 the members around the table, I want to thank you
19 and staff for working on this report. Predicting
20 the future is very hard. On the other hand,
21 ignoring the fact that there are trends and events
22 taking place out there is just as foolish and
23 perhaps more dangerous.

24 The full report, the full text will be on
25 the website and available for people to read. And I

1 think it helps us as we go forward in terms of
2 shaping some of our discussions and trying to get
3 our arms around a vision or at least a reasonable
4 shape of what the future looks like.

5 I commend you and your staff for putting
6 this together.

7 Questions? Comments? Members?

8 This is a very intimidating room. Thank
9 you.

10 By the way, as we go forward in our
11 discussions we will be revisiting some of these
12 assumptions and try to put them in context of the
13 regions and the judgements that we're making. So
14 this is -- I want you to understand, one of the
15 reasons this was an important document for the staff
16 and for the Commission -- this is not a shelf
17 document. I emphasize that. This is a part of sort
18 of our intellectual working capacity that we'll keep
19 coming back to during our discussions later on this
20 year. And I think that's why it is important. I
21 would like people to look at it, get it up on the
22 website, so people can look at it and give us
23 comments if they have any.

24 DR. SANDMAN: I would also add a lot of
25 the material -- we took a lot of the analysis down

1 to the finest level of granularity that we could.
2 So in the full paper, there are extensive appendix
3 tables and so on that, for example, put all the
4 demographic projections down to the county level and
5 so on. So, you can drill a little bit deeper than
6 that was in this presentation.

7 CHAIRMAN BERGER: That's what we will be
8 doing later on at the regional levels and in the
9 regional groups, we'll all be doing that as we go
10 forward.

11 Thanks. It was a very nice piece of
12 work.

13 Trying to set a framework for the long --
14 for the discussions that we're going to be having
15 over the next eight months and trying to create an
16 intellectual context and a shape of the context,
17 talking both about what exists now and where we're
18 going in the future, I think is an important part of
19 what our mandate is. And we have talked a bit and
20 we will talk more about hospitals and nursing homes
21 in the future. We have talked a little bit today
22 about trends and directions, some demographics, some
23 population changes, a little bit about therapeutics
24 and therapies. And now we're going to spend some
25 time talking about hospitals and nursing homes of

1 in the private physician side as well. And we'll
2 tie that in a little bit later.

3 Patient preference and acuity: I think
4 what David just had up there shows what has been
5 happening there. The patients are much more
6 educated and the acuity level of services that are
7 provided now is changing quite a bit. Not only are
8 procedures moving out of the hospital, inpatient
9 setting, but the acuity level of those services is
10 increasing also.

11 Fiscal pressures: I think we all know
12 what they are. A common buzzword here,
13 affordability, affordability to payers, both
14 governmental and private. The fiscal pressures
15 afforded by that on providers themselves, and
16 certainly with employers in terms of the cost that
17 they deal with.

18 The next thing, what we have called
19 "reserve capacity," because you can talk about it in
20 many different ways. The point is: How many beds
21 are enough and what types of beds? So, many
22 different ways you can define bed capacity, but the
23 point here, though, is as we move forward through
24 some of the things you saw earlier, the planning for
25 the appropriate number is subject to a whole host of

1 assist providers in operating more efficiently and
2 being more responsive to the patient communities.
3 But nevertheless we do get stymied at times by our
4 own types of regulations.

5 And on construction, Tom will talk later
6 a bit about that.

7 And this last piece before facilities,
8 Lisa.

9 MS. WICKENS: Green technology. We've
10 talked a lot about this. This is something we've
11 really had to look at for the future, not just only
12 for the environment, but for energy efficiency,
13 saving dollars. But it's also important to the
14 consumers. That's actually something that they're
15 thinking about when they are making their decisions
16 in what institution or setting they want to choose.

17 Improved flexible work environment:
18 Right now we've mentioned this, but staffing is a
19 big issue right now for all our institutions and
20 actually for community models. One of the important
21 things is you need to have the work force there.
22 And improving where they work, how they work and
23 being able to make their work easier and more
24 efficient is something that's really, really
25 important.

1 sophistication of acute care clinical services. We
2 had dedicated units, in this case we had TB units,
3 we had units for polio, we started to break out
4 especially in maternity, for delivering babies. I
5 guess that's for the baby boomers that were coming.
6 And emergency care emerged as a major clinical
7 space.

8 By the 1970s the Hill-Burton standards
9 started to seek public comment and input. And
10 nursing units actually became more universal in
11 design and construction. So, we started to see
12 nursing units being just medical surgical units,
13 with the exception of the emergence of intensive
14 care units, which actually became more specialized.
15 We're also starting to see at this time the growth
16 or the development of medical office buildings,
17 which started to become more common as hospitals
18 tried to meet the requests and demands of their
19 physicians.

20 Early on hospitals were originally
21 focused on the provision of clinical services. They
22 were clinical-centric basically. They were the only
23 place to go for acute clinical care. Hospitals
24 today are increasingly physician-centered, where
25 physician referral and practice patterns can

1 actually have a very significant impact on the
2 market share of the hospital in particular regions.

3 Today, in 2005, our modern facilities
4 reflect an increasing appreciation of the
5 environment of care as it relates to all users. The
6 important thing, the mantra that I think you're
7 hearing more and more today, is patient safety.
8 There is a desire to reduce medical errors. There
9 is a desire to improve infection control. And this
10 environment of care is a very key aspect of that.
11 The important thing to note is that environment of
12 care doesn't just relate to the patient, it also
13 relates to staff and visitors. So, nursing units
14 are now trying to meet the needs of the patients,
15 families and staff. Critical care is becoming even
16 more specialized and we have medical units, we have
17 surgical units, we have pediatric units. And
18 emergency rooms are becoming much more prominent as
19 a reflection of the success, I think, of preventive
20 medical care and outpatient care.

21 Today it's no secret to anyone that a
22 significant percentage of admissions to hospitals
23 actually come from the emergency room. And previous
24 efforts to divert less urgent patients from the ER
25 have essentially fallen by the wayside. Today we're

1 really if something is flexible, it means it can do
2 a lot of things, but it doesn't necessarily do any
3 of them very well. And I think in terms of
4 construction, where we're moving is towards
5 adaptability, which is where something is designed
6 so that it can be easily converted and adaptable to
7 another use, but it is originally designed to do
8 something very, very well.

9 This hospital of the future is going to
10 be -- and we'll get into more detail later -- but
11 it's going to be arranged around variable acuity
12 rooms, which are the ultimate, actually, in
13 adaptability and flexibility as it relates to
14 clinicians, or clinical services. These rooms can
15 be configured to accommodate wide ranges of patients
16 in terms of type, they can have adult, pediatric,
17 obstetric with a child, add an acuity and they can
18 be converted from an intensive care to step down
19 monitored beds or to traditional medical and
20 surgical beds. So, these variable acuity patient
21 rooms will be stacked in vertical modules. And the
22 reason for that is oftentimes when a contractor or a
23 construction manager goes into a hospital, they have
24 to stop at every floor and say, okay, this is a
25 med-surg floor. The next floor is maybe acute care,

1 it is rather intensive care, it's going to be a
2 separate layout, a separate design. And they have
3 to transition their workers into building a
4 different floor. If we start building these
5 vertical modules, what will happen is every single
6 floor will be the same. And it'll be much easier
7 and, in fact, less expensive to build the rooms
8 because the contractors just go right up the
9 building.

10 The central core of the hospital will be
11 all interventional, diagnostic services, treatment
12 services.

13 Emergency will continue to be a major
14 service component.

15 And, of course, the ubiquitous medical
16 office building will ensure the proximity of your
17 clinical and your physicians.

18 MR. BENJAMIN: One of the things I just
19 wanted to interject here is what I said earlier,
20 when you look at all of the new relationships that
21 Tom just described, the success of those
22 operationally, again, I can't emphasize it more, to
23 a large degree, depends on us changing and being
24 more flexible on a program and a regulatory side.
25 We are recognizing that more now than we ever had

1 Basically, can hospitals be designed with walls and
2 partitions that in fact can be reconfigured while
3 maintaining that core infrastructure. And I refer
4 to those as "dismountable partitions."

5 Changes are also occurring in the medical
6 equipment. Hospitals already frequently lease major
7 medical equipment that's expensive to purchase and
8 maintain, particularly when that technology advances
9 so quickly. So, if hospitals are already leasing
10 MRIs, CT scanners, manufacturers of other components
11 are starting to consider and develop arrangements
12 based on the life of the item. And it's possible
13 that hospitals of the future will actually be
14 leasing lights and partitions and when the
15 technology changes or the needs change, they can
16 recycle them and get new equipment. Similar
17 arrangements actually already occur in the hotel and
18 retail industry now. So, it's not really a new
19 technology, but it can be applied to health care, we
20 believe.

21 This discussion refers to patient bed use
22 and I think it's important to bring up. That's why
23 I'm highlighting it. One of the most important and
24 controversial elements of the patient care evolution
25 we see today is the ratio of room. In the 1920s,

1 where we were in the '70s, and that's kind of where
2 we've been stuck.

3 What we're starting to see now is a
4 movement towards the all single-bedroom hospital.
5 It's starting to gain significant momentum. There
6 is a number of studies that have been done --
7 unfortunately there aren't a lot of studies that
8 relate to the cost of building singles, but I have a
9 couple of -- a couple of facts are important to
10 note.

11 Number one, the initial capital cost of
12 building a hospital, the initial one-time cost is,
13 over the life of that hospital, only about ten
14 percent of the total cost of running that hospital.
15 So virtually 90 percent of the cost is staffing,
16 services, supplies, real estate, heat and light and
17 things of that nature. So, you got to remember, if
18 we're focused on the capital costs, it's really only
19 about ten percent of the lifetime cost of that
20 facility. So that's one thing to note.

21 The other fact to note is that some
22 studies have been done and they seem to bear out
23 that operating costs for all single bedded room
24 hospitals are actually less than non-single bedded
25 hospitals. So it's interesting to note that we

1 change that -- and that was referenced earlier. We
2 have artificial lungs, ventricular assist devices
3 for hearts and some day we'll have emergency rooms
4 where -- they won't all have specialties in this --
5 but you'll have an evaluation room where if you're
6 visiting somewhere and you're having a problem, you
7 can go in, get plugged in and they can check you
8 out. So there is a lot of changes happening in
9 implant technology.

10 MR. BENJAMIN: Lisa talked about this a
11 little earlier, new hospital models. Again, trying
12 to be as flexible as possible.

13 The definition of critical access
14 hospital: That has evolved over the past 15 years.
15 The model was first introduced by the federal
16 government. It's had a few different name changes.
17 But basically it's a way for a hospital to meet the
18 baseline needs of a community as long as it has a
19 full-service affiliate. It's been incredibly
20 important to sustaining hospital care to rural areas
21 in the state, as well as every other state. And we
22 continue to work very closely with the feds on
23 expanding the services in that model that are
24 available.

25 LTACH is something that is not very

1 Tom, you never even stopped, you went right by
2 interoperability with physicians. That was a curve
3 ball to the outside corner. Nobody even got a
4 chance to swing at it. But the fact of the matter
5 is there are some pieces that you raised here which
6 we're going to be talking about and having to do
7 think about in some detail.

8 So, I want to stop for a second and see
9 if anybody has any questions on the presentation so
10 far? Because if we do, we may not get to the
11 nursing home piece today. It's been so dense.

12 Questions.

13 MR. DUNCAN: The presentation was superb,
14 very exciting. I lived through a lot of those
15 configurations.

16 But one of the things that harkened to me
17 was the discussions about reimbursement. New York
18 State has the, I think, second oldest plant,
19 hospital plants in the United States of America and
20 we're talking about construction and what we've got
21 to do to keep the vitality of the community and the
22 fact we've got two percent to reinvest capital, so
23 it's a ring snake with today's economy. It's hard
24 to ever obtain the sort of vision that is necessary
25 to drive the future without really driving home a

1 CHAIRMAN BERGER: Thank you all very
2 much. And thank you, staff.

3 (Time noted: 3:07 p.m.)

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