Testimony
Commission on the Public's Health System
By Judy Wessler, Director

Planning Committee – SHRPC
SEPTEMBER 18, 2008

PROPOSED REFORMS TO THE NEW YORK STATE CON PROCESS

A new paradigm for health planning and the CON process

Thank you for the opportunity to testify today. Thank you also for the important task you are undertaking in reviewing the certificate of need process (CON) "to ensure that the process accomplishes its intended objective – the development of a high quality, accessible and cost-effective health care delivery system." (Invitation) The Commission on the Public's Health System (CPHS) applauds the department and this body for even opening up the dialogue on this important issue, and we are anxious to work with you to ensure that CHANGE happens.

The CON process is one of the only tools – the state budget is another – that can be used to begin to address the problems and inequities in the current medical care system in this state. Planning, in so far as it exists, is focused on institutional needs rather than patient care or community needs. We unfortunately saw this all too clearly during the Berger Commission process. Utilization and ostensible cost-savings were the focus with little or no emphasis on access to health care services or the critically important arena of income, racial, and ethnic disparities in the distribution and location of services. The process was greatly flawed as it was conducted with little or no accountability to the public. The board and task forces little resembled the public that was affected by the decision-making process. Government gave away its' responsibility by allowing the decision making to be final. Beginning in 2006, CPHS spent 18 months co-coordinating the Save Our Safety Net – Campaign (SOS-C) to ensure that the final decisions were not worse than we anticipated they would be. Clearly a commitment to a new paradigm is needed to change these dynamics.

We can however learn from the flawed Berger Commission process. The most important learning experience for CPHS was that even under difficult circumstances, strategizing, information-sharing, and organizing can make a difference. Think how much of a difference can be made if we start from a different premise. Linking community-based planning (a term that we will more completely explore) and the legality of the CON process can make an awesome difference.

Looking back to inform the future

Sometimes we need to look back and learn from the past. Health Systems Agencies are widely reviled, but there were some important efforts and lessons learned during their time. We need to look at these lessons and choose which would be helpful moving ahead into future. Some of the benefits for communities:

- There was data available that was quite helpful in determining community need.
- With sub-area councils, the provider community was forced to sit at the same table as consumers and talk about their plans and proposals.
- Some of these discussions led to horse trading – the setting up of facility Community Advisory Boards; services expanded to evening hours.
- Discussions, and sometimes the actuality, of interpreters being hired to meet the changing language needs of communities.

- Often local communities have more information about developing needs that can be shared in these forums.
- In New York City a schedule was circulated listing which providers had requested CON's and for what services. Local community groups could request a public hearing on almost any application so that there could be an airing of the intent of the institution. When conditions were placed on approval of an application, the community could be involved in monitoring the implementation.

Note that I am talking about health planning and CON in the same sentences. They can and should be linked! Without a commitment to health planning we will continue to see growth for the "rich" hospitals and a continued stripping of services from the low-income, medically-underserved, immigrant and communities of color. This is just unacceptable.

Another learning experiment from the past is the requirement of data from health care providers when they are filing CON's. In the early 1980's I worked at Legal Services. This work centered around community needs and priorities, in my case it was health care. I was also a member of the Health Systems Agency Board, and for awhile its' Executive Committee. In reviewing CON applications, community organizations realized that the city HSA and the State Health Department were violating federal and state laws and regulations. The legal and regulatory requirement was for review of applications included consideration of access to care for: low-income consumers; racial and ethnic minorities, women, the handicapped, and the elderly. Neither the state nor the HSA were collecting data with which they could review access to care issues. Legal Services and New York Lawyers for the Public Interest filed a Civil Rights Complaint representing ten community organizations.

One outcome of the settlement of this complaint was an agreement by the State to jointly develop a new schedule for the CON application that would request access data. I was actively involved in these negotiations with the State Health Department's Office of Health System Management. Attached to this testimony is "Schedule 18 – the Facility Access" schedule. This schedule was used in the review of an application to expand the emergency room at NYU and to move OB and pediatrics from St. Luke'/Roosevelt. It was put into use probably in 1986. It is not the best instrument for now, but is useful as the basis for negotiating a new Access Schedule. I do not know when the Department stopped using this schedule, but do know that it seems that no one in State Health even knows, or will admit, that it ever existed. A renegotiation of the content of this schedule and a commitment to use it in certain applications should be a priority for the State Department of Health, particularly if some of the language in the invitation to this hearing is truly intended to make a difference.

We understand that Schedule 17A, the Needs section is inadequate and does not provide enough guidance to organizations as to what useful information to provide to demonstrate need. We strongly believe that it is critical to clearly define the concept of need within the CON application and to use a revised version of the old "Schedule 18" in developing that concept.

What are the priorities – How to make a difference?

CPHS will attempt to answer some of the questions posed in the letter of invitation to this hearing. But we first want to say that the starting point for any new system should and must be the consumer/community. Starting from an institutional perspective, particularly to consider their needs, will leave us exactly where we now are – with a system that is not working for the good of many communities.

With this in mind, we would urge that the order of priorities in the listing of four issues for discussion must be changed. Number two, the local planning and public notice has got to come first and be given top priority in the context of change.

Some specific comments in response to the department's questions

1a. In this age of technology, notifying many people, at least through their local community organizations, schools, and houses of worship is truly just a click away. It should not be that difficult to develop an email list that can be used to notify organizations that an application has been filed, by whom and for what. If there is a health planning mechanism in place, such as in Rochester, people can be asked to file comments through that agency. If there is no agency, then the State Health Department should be responsible for gathering comments. For any large application, there should be a public hearing with adequate notice to the public.

1b. The question is not how, but in what way must the department support collaborative efforts to assess community health needs. Real ground level collaborative efforts are the only way that the State can change the way that resources are used to address health care needs. CPHS has been involved in several collaborative efforts recently which I will briefly summarize to give a sense of what is possible – and how important it is to do.

- CPHS directed and has led a year-long Child Health Initiative. We raised money to fund five borough coalitions to celebrate the 100th Year Anniversary of the city's Child Health Clinics. Each of the borough coalitions have been very creative in how they reach out to people and organize their coalition. We developed a survey for parents to answer questions about their children's health status and their access to health care services. We are in the process of finalizing this effort and it has yielded a very exciting picture of different communities in each of the five boroughs. We are also working on the development of a Child/Teen/Family Health Policy Agenda for the city of New York. This is being done in a bottoms-up approach where the survey data and local needs will be the driving force of the agenda. We are planning to continue this effort.
- CPHS was approached by the City Council Speaker's office to talk about the need for expansion of primary care services. We recommended, and helped in forming, a Task Force to develop ideas for expansion of care. Many of the people at the table pushed aggressively for a community health needs assessment targeting underserved communities. The Mayor and the Council Speaker funded the Health and Hospitals Corporation to undertake this

assessment with the Task Force. The report of this effort was released on September 16th and should serve as the blueprint for expansion of much-needed care in underserved communities.

- CPHS is actively involved in the Central Brooklyn Health Crisis Coalition which is led by the Brooklyn Perinatal Network. Alarmed over the closing of a much-needed hospital, the subsequent closing of community clinics, the closing of maternal and pediatric services, BPN, pulled together the coalition to determine ways to address this crisis. CBHCC has galvanized community and political support in this effort. An application for a new expansion of a community health center is one important outcome of this effort, which is continuing. Another important outcome is having convinced the state Department of Health and the governor's office that Central Brooklyn is medically underserved.

1c. Communities are very capable of initiating and leading efforts that are of benefit to their community. I have often said that "Public health is too important to be left solely in the hands of health professionals." This does not mean that health care professionals are not important and not needed. It does heavily suggest that the leadership should be in the hands of the community with supporting roles by health providers. Given the opportunity, and some resources, this direction could lead to better resource distribution, and increase in services where they are needed, an ability to address the awful racial and ethnic disparities in access to services and outcomes of care. This is the direction that we need to take.

3b. We were very pleased to see this question. Yes, tertiary care facilities are increasing their market share at the expense of community hospitals. This is all to evident in New York City. We have seen large networks headed by tertiary care hospitals, usually located in Manhattan, that have stripped services from underserved communities in other boroughs, and increased the capacity at their home institutions. We need only look at St. Vincent's Catholic Medical Center which started with ten hospitals, with St. Vincent's in Manhattan as the "flagship." This network closed: St. Mary's in Central Brooklyn, St. Joseph's in South Queens. It sold off: Mary Immaculate in South Queens, and St. Vincent's in Staten Island after closing one of the satellite hospitals. After depriving all of the communities of services, and coming out of bankruptcy, St. Vincent's in Manhattan wants to reward itself with a brand new, expensive building. Not acceptable, but may be allowed to happen. Currently, Continuum appears to be stripping Long Island College Hospital, in North Brooklyn of important services and selling off buildings for profit. These actions benefit three tertiary hospitals in Manhattan – Beth Israel, St. Luke's and Roosevelt. Not acceptable!

3a. It is critical that the department do a full review of the hospital networks to determine how they work and whether they should continue to exist. One might find that they raise the cost of care while not improving quality or access to care. In order to encourage collaboration, we need to be committed to reinstituting local, community-based health planning. There has to be public accountability and some sunshine on the entire "planning" process.

Principles

We believe that there are some principles that are necessary to change the way that "business" is currently done. Each piece is important and interrelates to the others. So the principles that should be applied to any new CON process and health planning should include the following:

- Re-examine the state's definition of the concept of need in the CON process. Establish some principles for approvals of CON's.
- Racial and ethnic disparities in access to health care should be a primary consideration in planning, expansion and decreases in services.
- Community-based health planning should include community health needs assessments and collaborative efforts between community and providers.
- Make expansion of prevention and primary care services the priority.
- Require that almost all CON's be based on this collaborative effort
- Use community data and tools – such as a revised and updated Schedule 18 to assess applications
- Redistribution of wealth and resources – stop the empire building and concurrent draining of services from poor and underserved communities.
- Strengthen the CON process for the reduction/closing of services, particularly in medically underserved communities.

These are some of the steps that CPHS believes need to be taken in order to reform the CON process and reinstitute health planning in this state. Some of our recommendations are quite general, but give our perspective of a direction for change. If any of the ideas are adopted, and we hope that they are, CPHS would be more than happy to work directly with the department and others in making the concepts more concrete.

This is a worthy journey and we would like to take it with you.