



## **Save Our Safety-Net Campaign (SOS-C) Policy** **Memo on the “Berger” Brooklyn report**

January 11, 2012

*The Save Our Safety Net – Campaign (SOS-C) is a broad-based coalition of community, advocacy and labor organizations protecting the health care safety net in New York.*

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## EXECUTIVE SUMMARY

The health care system in Central and North Brooklyn is being challenged with specific recommendations recently released in the Health Systems Redesign: Brooklyn Working Group report (Berger report). Five hospitals are fiscally challenged and subject to the proposals within the Berger report: merger of Brookdale with Kingsbrook Hospital, and merger of Wyckoff and Interfaith with Brooklyn Hospital. Two added recommendations came as a surprise: the closing of Kingsborough State Psychiatric Hospital, and a movement of SUNY Downstate facility to the site of their new partner Long Island College Hospital in Brooklyn Heights.

The hospitals are enticed to take these actions through an offer of state funding to assist in this restructuring. Funding is also available to increase the hospital's Medicaid reimbursement rate for a two to three year period. Serious concerns have been raised that the proposed restructuring of the hospitals in Brooklyn could very well lead to a closing or reduction in services in one or more of the hospitals. Central and North Brooklyn are currently medically underserved, health professional shortage areas. The community is in need of additional services so that any reductions will only make the situation worse.

Primary care, as an important part of the health system, is mentioned often in the Berger report, but there is no plan for the expansion of primary care; there is no specific funding for expansion of primary care; and there is no timetable proposed for this expansion.

This policy paper contains health care statistics from the Berger report, the state health department, and other sources. Clearly there is currently overuse and inappropriate use of hospital Emergency Rooms. Many of the problems that bring people to the Emergency Room could be better cared for in a community health setting, if these services are available.

The Save Our Safety Net – Campaign (SOS-C) was a part of and endorses the recommendations in the Brooklyn Healthcare Task Force Report put forth by Senator John Sampson and the Brooklyn Borough President, Marty Markowitz. This report cites as a top priority the expansion of the primary care infrastructure, noting that services must be developed that are Brooklyn-centric, culturally competent with language access, and at times and places that work for residents. It goes on to say that a planning process should be initiated immediately that includes all stakeholders and experts to develop a plan for expansion of available community-based primary care services. A system should be developed that incorporates community-based and social services organizations into partnerships with hospitals and other health care providers to incorporate prevention, social and environmental health into the delivery system. The report further recommends payment reform so that the hospitals and other providers “doing the right thing” by providing services to low-income patients in their communities are not weakened financially and challenged to remain open.

SOS-C recommends the need to develop the political will and muscle to fight for implementation of these proposals – to include elected officials, community and advocacy organizations, and health care providers. SOS-C urges that:

- 1). A concrete plan for increasing primary care in the borough, including identified funding, and an implementation timeline for the same be made available to the public *before* any of the most disruptive recommendations of the report be carried out;
- 2). The makeup of the Brooklyn Health Improvement Board require a majority of board members have direct experience with primary care services, the health needs of Central Brooklyn, and the consumer/community perspective;
- 3). The grant application process be committed to openness and transparency, and that all public meetings of the same take place in an area of Brooklyn that corresponds to a Health Professional Shortage Area;
- 4). Establishment of a Council of Consumers and Consumer Advocates, along with some MRT committee members, and staff from the Department of Health to flesh out the details of these and other MRT proposals and to oversee their implementation.

## CURRENT SITUATION

**5 Challenged hospitals in North and Central Brooklyn (Brooklyn, Brookdale, Interfaith, Kingsbrook Jewish, and Wyckoff) as the focus from State Health and MRT**

A *New York Post* article was the first to break the news that five hospitals in Central and Northern Brooklyn are financially vulnerable to closing. Since that time, there have been several other articles raising these concerns.

**The State may make funding available for vulnerable hospitals.** The Medicaid Redesign Team, (MRT), appointed by Governor Cuomo in January 2011, to close a state budget gap with a \$2.3 billion cut in the state share of Medicaid included as one of its 79 recommendations a proposal to make funding available to help hospitals close, merge, or restructure. The proposal was initiated by Ken Raske, Greater New York Hospital Association.

**Stephen Berger, an investment banker, was appointed to lead a team of five to study Brooklyn's Hospitals.** In May, post-budget season, the Governor and his staff proposed to initiate 9 committees to provide proposals for budget implementation, and develop proposals for Medicaid reform. A tenth committee was added in June, through a letter from the State Health Commissioner, Dr. Nirav Shah, to Stephen Berger inviting him to lead a Medicaid redesign initiative to evaluate the hospital system in Brooklyn. Mr. Berger invited four other people to join him on the Health Systems Redesign: Brooklyn Working Group. Three of the five members of this group were also involved in the state "hospital closing commission" initiated by former Governor Pataki, including Mr. Berger who chaired the Commission. **Not one of these five members represented the affected communities of Central and North Brooklyn.** Unlike the nine other committees of the MRT, this group was scheduled to submit its report to the State Health Commissioner, not the MRT itself.

**Inadequate Public Input into the Berger Work Group.** The Brooklyn Work Group held two public hearings, giving little public notice for these hearings, at one of these hearings more than 60 people testified. There was one public meeting in which "experts" reported to the committee on various aspects of the hospitals situation, including: the financial status, the physical plants, ER use in Brooklyn, private capital investments in hospitals, and free-standing Emergency Rooms. The Work Group also visited each of the hospitals in Brooklyn. The Work Group was scheduled to submit its report in November, but it was not finished until December.

### **Need for the Special services the hospitals provide**

There are five hospitals in Brooklyn that have been identified as financially vulnerable: **Brookdale, Brooklyn Hospital, Interfaith, Kingsbrook Jewish, and Wyckoff.** All of these hospitals are located in the **medically underserved, low-income, communities of color in Central and North Brooklyn.** (See attached maps developed by Infoshare for SOS-C for location of hospitals relative to: poverty, medically underserved designation, race and ethnicity). These maps also show the location of hospitals that have closed in these communities since 1963. One of the most recent hospitals to close was St. Mary's

located on Buffalo Avenue, which also had federal funding to operate community health centers. When the hospital closed, five of the seven centers were initially transferred to Kingsbrook Jewish but 18 months later four were closed, leaving only the Pierre Toussaint Family Health Center still in operation. (See attached map of closings of health services by June 2007 provided by the Brooklyn Perinatal Network).

A September 2006 report by PCDC and the Health and Hospitals Corporation, raised concerns about the potential of hospital closings in New York City and its impact on Primary Care Shortage Areas. The attached map shows Primary Care Physician Shortage Areas by zip codes, with much of Central and North Brooklyn designated as serious shortage areas. This report also rated all 59 counties in the state based on health status condition and provider rank with the lower number indicating the worst ranking. For Brooklyn, the health condition rank was 2 (the second worst in the state) and the provider rank was 34<sup>th</sup>, making Brooklyn rank ninth of the 59 counties overall.

An August 2008 report entitled ***Primary Care Initiative Community Health Assessment*** prepared by the Health and Hospitals Corporation, targeted communities in the city with the worst poverty and health status. In Brooklyn, eight zip codes encompassing the following neighborhoods were part of this study: East Williamsburg, Bushwick, Bedford-Stuyvesant, Brownsville, Crown Heights, East New York, New Lots, Flatbush, and Ditmas Park. Residents were surveyed in two ways: by community-based organizations and through a random sample of telephone surveys. In all of these neighborhoods, less than 66% surveyed were able to access care in their communities whereas more than 85% expressed that it would be **more convenient to get their health care in their neighborhood.**

**Primary care is a key element** of a health care network, but these areas of Brooklyn have manpower shortages and are designated medically underserved areas. Since the reports discussed above were completed, there has been some state and federal resources allocated to these communities for expansion of primary care. Four health centers and Diagnostic and Treatment Centers (D&TC's) and one hospital received HEAL grants from the State. Three Brooklyn Health Centers received federal health center funding: Sunset Park Health Council, Housing Works, and ICL Healthcare Choices, Inc (focusing on the homeless).

**From a *New York Times* article, July 29, 2011, we learned that if the five hospitals were to close, "11,000 people would lose jobs, and other hospitals would have to absorb 325,000 Emergency Room visits, 83,000 hospital admissions and about 760,000 clinic visits."**

**Some special services each of the five hospitals provides:**

- **Brookdale** has an extensive ambulatory care network, Level 1 trauma designation in the ER, a stroke center, rehab and long term care, a community mental health center, 16-chair dental suite, and an OB center.
- **Brooklyn Hospital** has ambulatory centers for children and women, dental clinic, WIC centers, a designated AIDS Treatment Center, rehab program and cancer support center.

- **Interfaith** has behavioral health services (including 120 psychiatric beds), mental health and substance abuse services, dentistry, rehab, and a mobile crisis unit.
- **Kingsbrook Jewish** has long-term care, adult and pediatric rehab; pain treatment management, dialysis, ophthalmology, mental health, non-invasive vascular services, podiatry, and orthopedic joint replacement.
- **Wyckoff Heights** has elder care, designated stroke center, center for advanced wound healing, a bloodless medicine and surgery service.

### **Brooklyn Community Health Status**

Brooklyn has more than 2.5 million residents. Over 20% of Brooklyn residents live below the poverty level. Poverty is concentrated in Central and North Brooklyn, where some communities have more than 30% of residents living in poverty. **About 1 million residents are Medicaid beneficiaries. Eighteen percent of Medicaid beneficiaries are people living with one or more chronic or complex, high-need conditions.** The same communities have the highest rates of inpatient care that might be avoided (PQI). (State Health Department presentation, July 2011).

In 2008 and 2009, the uninsured rates for adults in some Brooklyn communities, was very high. **In Bushwick, for example, nearly one in three adults have no health insurance.**

In New York City, there is a mismatch between health care need and health care availability. More affluent neighborhoods are often oversaturated with health care resources, while low-income communities of color are severely underserved. Central Brooklyn, for example, is home to more than 500,000 people, 90% of whom are Black and Latino. **Recent data show that infant mortality in the Central Brooklyn area is nearly four times higher than the rate in more affluent communities.** WIC centers, OB/GYN, NICU, and prenatal services at some of the remaining hospitals have all been shuttered. These are all services important to reduction of infant mortality.

**A study by the University of Wisconsin** ranks each of the counties in each state based on a number of factors including: quality of care, individual behavior, education, jobs, and the environment. These rankings are for the entire borough, so some rankings may be skewed. For example, Brooklyn ranked 58<sup>th</sup> of the state's 62 counties on health outcomes, and was 60<sup>th</sup> on morbidity. Brooklyn ranked 54<sup>th</sup> of all counties in the state on clinical care which includes access to care and quality of care. On social and economic factors Brooklyn ranked 61<sup>st</sup>, measuring education, employment, income, and family and social supports. **Brooklyn ranked 59<sup>th</sup> of the counties on physical environment including air quality and built environments.** In an anomaly of findings, Brooklyn ranked well on health behaviors with a 7<sup>th</sup> place. This factor includes tobacco use, diet and exercise, alcohol use, and high risk sexual behavior.

The State Health Department reported that more than 20% of admissions for Brooklyn residents occurred in Manhattan Hospitals. A preliminary evaluation of data by the Committee of Interns & Residents shows that the larger percent of patients going to Manhattan hospitals live in the Southern

part of the borough and that many admissions were for specialty services not found in Brooklyn hospitals. Approximately 10% of Central and North Brooklyn residents are hospitalized in Manhattan.

**The Committee of Interns & Residents released a study that shows four of the five hospitals are currently training 415 primary care physicians.** At Interfaith and Wyckoff, almost all residency slots are devoted to primary care while Brookdale and Brooklyn train a mixture of primary care physicians and specialists. In CIR's analysis, hospitals in federally designated Health Professional Shortage Areas (HPSA) train a disproportionate share of primary care physicians who chose to practice in HPSA. **Forty four percent of primary care physicians in New York State shortage areas received at least part of their training at a safety net hospital, despite receiving only 28% of the CMS-funded residency slots in the state.** It is likely that due to recommended mergers, some of these residency training slots will be eliminated or severely curtailed. The consequences of such a reduction would be to even further increase the shortage of primary care physicians in these neighborhoods.

**Finally, the Brooklyn Healthcare Information Project (B-HIP), a state funded planning project,** presented fascinating data at the September 21<sup>st</sup>, Brooklyn workgroup public meeting. B-HIP targets 15 zip codes in Central and North Brooklyn. Almost 11,000 patients were surveyed in the ER's of 6 hospitals: Brookdale, Downstate, Interfaith, Kings County, Kingsbrook, and Woodhull. 84% of the patients surveyed are Black. **Patients were asked why they came to the ER that day.** 55% said for an emergency and 45% said non-emergency. Of the 45% non-emergency patients, the responses included: 17% said convenience; 16% indicated it was where they come for care; 15% said they could not reach their Primary Care Provider (PCP); 14% indicated they do not have a PCP; 5% indicated they have no insurance. When patients were asked where else they would go for care, 65% indicated they would go to another Emergency Room; 15% to their primary care physician; and 12% indicated that they either did not know or would go nowhere else. For 18-24 year olds interviewed, 21% with no health insurance do not have a primary care physician, but 26% with insurance also do not have a PCP. When asked if the patient has a PCP, 31.2% said no, 8.3% said yes but they do not use the PCP, and 5.1% said they did not know. 21% of people surveyed said they always use the Emergency Department for their care; 51% said they last had care at their private doctor; and 15% said a clinic/health center.

Emergency Department staff was also surveyed. They were asked their opinion of the reason that patients come to the ED for primary care: 20% said people don't have a PCP; 16% said nowhere else to go; 15% said no available appointment with PCP; 13% said for comprehensive care; 12% said closest location; 7% said better care; and 6% said the PCP office was closed.

**The highest number of admissions for ambulatory care sensitive conditions (conditions that should be treatable as an outpatient) was identified as coming from Crown Heights, Flatbush, Brownsville, and Starret City. The top five hot spots for asthma included Crown Heights, Ocean Hill, Brownsville, and Flatbush.**

## **BERGER PROPOSALS INAPPROPRIATE**

The Health Systems Redesign: Brooklyn Working Group recently released their report. Media reports quote Mr. Berger as saying that they will recommend **relying on the private, for-profit sector for some financing for the hospitals**. We also gather from the types of presentations that were made at the one public meeting of the group, that recommendations will not only include going to the for-profit market, but may also include developing free-standing Emergency Rooms as well as mergers and restructuring of hospitals.

**The for-profit sector has not worked well in ensuring continuing health care services.** For example, St. Vincent's Medical Center in Manhattan relied on for profit financing before it closed. Most recently, Peninsula Hospital in Rockaway, is in the process of being taken over by a for-profit home care agency. Crain's reports serious questions about who is involved in the operation of the facility and some complicated financing arrangements.

### **SOS-C concerns about Berger Report**

- Nearly one-third of the residents of Central and North Brooklyn lack a Primary Care Provider according to the Berger report. Although primary care is mentioned over and over again in the **Berger report, there is no plan, no dollars identified, and no timetable to expand primary care.** There is widespread agreement that even if not one of the hospitals closes, **there is a tremendous shortage of primary care services which has yet to be adequately addressed.**
- Although the report does not recommend the closing of any hospitals (at this time) it does state there are 1,235 too many hospital beds. The estimate of excess beds is based on the number of certified beds on the license of the 5 hospitals. **For health planning purposes, the appropriate measure is the number of staffed beds over daily occupancy. The staffed beds are those beds that the hospital is using. This proposal needs recalculation, as the incorrect measure was used.**
- **The Berger report proposes mergers of hospitals in Brooklyn. Brookdale would be merged with Kingsbrook, Interfaith and Wykcoff would be merged with Brooklyn Hospital.** The mergers could portend future closings. When St. Mary's closed, Kingsbrook took over five of St. Mary's federally funded community health centers and within 18 months closed all but one. Moreover, Kingsbrook has no extended record with primary care and no experience being a Trauma 1 emergency facility, which Brookdale does.
- Serious **questions have been raised about the financial status of Brooklyn Hospital** and its' ability to take-over two other financially troubled hospitals. Although some NYS DOH resources are being made available, it is not clear how a turnaround might be possible, given all of these facilities' financially "trouble" status.

- Long Island College was added to the list of hospitals with financial difficulties, even though it has merged with SUNY Downstate, so now 6 hospitals are the “focus” of this report. The Berger report recommends moving Downstate to LICH facility in Brooklyn Heights which means that **more hospital beds and another ER would be moved away from Central Brooklyn.**
- **The Berger report also recommends closing Kingsborough Psychiatric Hospital. There is overwhelming agreement that Brooklyn has a severe shortage of behavioral health services so that removing any facility would have a dramatic impact on access to these services.**
- **Safety-net hospitals have problems because they do not receive enough funding from reimbursement and other sources.** These hospitals, because of their location, treat a large percentage of Medicaid patients, and some uninsured patients –meaning there is not enough dollars available to provide services. This fact is mentioned in the report, however specific actions are needed to change Medicaid reimbursement so that safety net hospitals get an add-on to their Medicaid reimbursement, and the charity care pool is allocated to hospitals based on the providing of care for the uninsured.
- Recent experience has shown that involving private for-profit interests in development of capital or operation of hospital is not necessarily successful. St. Vincent’s went belly-up and Peninsula is now owned and operated by a for-profit company with questionable practices.

## SAMPSON PAPER AND PROPOSALS

With a nod from the State Health Commissioner, Senator John Sampson the State Senate Minority Leader, and an elected official from Brooklyn, **set up a Task Force to “Create a Vision for Brooklyn’s Health Care System.”** Senator Sampson, with assistance from the Brooklyn Deputy Borough President, Yvonne Graham, developed a Working Group, which met twice. Three SOS-C organizations were represented on the working group: Brooklyn Perinatal Network (BPN), Commission on the Public’s Health System (CPHS), and New York Lawyers for the Public Interest (NYLPI). Four of the five financially vulnerable hospitals were represented on the group. This group represents an immeasurably important step toward being representative: The MRT Brooklyn Working Group as set up is not related to the communities of Brooklyn and would be imposing an outsiders plan. The Sampson group encompassed institutions and organizations steeped in the communities of Central and North Brooklyn.

At the second meeting of the Sampson Working Group, the stakeholders and experts were asked to identify the major issues facing the hospitals and communities in North and Central Brooklyn. Out of this exercise, six committees were formed to focus on these issues: Payment Reform; ER Overuse and Diversion/Decreased Hospitalizations; Brooklyn Healthcare/Hospital Redesign; Brooklyn Wellness; Role of Community-based organizations and community networks; and primary care capacity and development/community physicians. **A series of recommendations were identified by these committees and fall within three overall recommendations:**

- Bolster Brooklyn’s primary care infrastructure as a first and top priority.
- Formulate an active, coordinated care model to streamline collaboration and partnerships between providers currently existing in Brooklyn.
- Ensure that community-based organizations and the community in general, are integrated into the health care delivery system in Brooklyn to promote patient wellness and link patients to the appropriate services at the appropriate time.

## SOS-C RECOMMENDATIONS AND PROPOSALS FOR ACTIONS

SOS-C strongly supports the recommendations coming from the Sampson Brooklyn Working Group.

- **A top priority must be the expansion of the primary care infrastructure**, particularly in North and Central Brooklyn. Services must be developed that are Brooklyn-centric, culturally competent, with language access, and services offered times and places that work for residents. A planning process should be initiated immediately that includes all stakeholders and experts to develop a plan for expansion of available community-based primary care services.
- An additional focus of this planning process could be a review of services that are available with a focus on **maintaining and strengthening services that are needed in the community**.
- **Develop a system that incorporates community-based and social service organizations** into partnerships with hospitals and other health care providers to incorporate prevention, social and environmental health into the delivery of services. Research has shown that community-based organizations are uniquely placed to develop and maintain the relationships needed to satisfy the ingredients of good health management, which in turn would save in overall costs.
- **Move toward payment reform** so that the hospitals and other providers “doing the right thing” by providing services in their communities are not weakened financially and challenged to remain open. Pools of public funds must be distributed in a transparent and accountable way. Charity care pool funding would follow patients and be allocated to hospitals based on providing services for the uninsured. For those safety net hospitals providing high numbers of care for Medicaid patients, a Medicaid bump should be added on to their reimbursement rates and these facilities should be exempt from across-the-board Medicaid reimbursement reductions. There is also a need to increase the charity care dollars in the pool distributed to community health centers and D&TC’s, which serve large numbers of uninsured but are paid a lower percentage than hospitals for the care of these patients.
- **Develop a pool of funding to stabilize and maintain safety-net providers financially** (termed Vital Access Providers, VAP) by the State Health Department. Ensure that federal funding requested by the state to the federal government in an 1115 Medicaid waiver is primarily directed toward direct patient care, addressing health care disparities, and saving health care services in medically underserved, low-income communities.
- Develop the political will and muscle to fight for implementation of these recommendations – to include elected officials, community and advocacy organizations, and health care providers.

**Specifically SOS-C urges the following:**

- 1. That a concrete plan for increasing primary care in the borough, including identified funding, and an implementation timeline for the same be made available to the public *before* any of the most disruptive recommendations of the report be carried out;
- 2. That the makeup of the BHIB require a majority of board members have direct experience with primary care services, the health needs of Central Brooklyn, and the consumer/community perspective;
- 3. That the grant application process be committed to openness and transparency, and that all public meetings of the same take place in an area of Brooklyn that corresponds to a Health Professional Shortage Area;
- 4. That you establish a Council of Consumers and Consumer Advocates, along with some of your MRT committee members, and staff from the Department of Health to flesh out the details of these and other MRT proposals and to oversee their implementation.