



SATURDAY, AUGUST 9 • 8 PM
 THE SENECA ALLEGANY EVENTS CENTER
 Tickets starting at \$65



THE BUFFALO NEWS

PRINT THIS

Struggle over system restructuring holds key to this community's health

HEAL THE HOSPITALS

By Mike Vogel NEWS EDITORIAL PAGE EDITOR

Updated: 06/01/08 7:38 AM

Understand this: The current health care structure in Buffalo is a prescription for disaster. Anchored in too many hospitals with too many beds, and with too few neighborhood clinics to provide the kinds of less-acute care that could ward off hospital visits, it threatens both the quality of medical treatment and the financial health of this region.

The Berger Commission on hospital closings was designed to address that, closing some hospitals to eliminate 1,400 to 1,500 unneeded hospital beds and retire the kind of health care debt that would burden future generations. So far, it has not done that.

Progress, in fact, has been painfully slow toward next-generation health care that provides what's best for Buffalonians — enough doctors and nurses to care for them; an efficiently structured, medically skilled, technology enhanced and financially sound hospital system; clinic-augmented access to quality care for everyone from the wealthy who can afford to go elsewhere to impoverished residents lacking transportation; and affordability bolstered by procedural streamlining and consolidated high-cost diagnostic and treatment centers.

To get from here to there, this region — with stronger backing than provided so far by the state and its Health Department — will have to recruit physicians and nurses rather than lose them. It will have to recruit medical “stars” to anchor centers of excellence in treatment and research. And it will have to close hospitals and use state and federal funds to handle such controversial needs as expensive contract-provision buy-outs for public employees at Erie County Medical Center.

Indeed, there have been changes both because of the commission and before it — transitions of beds from hospital to geriatric care, for instance, or the re-designation of free-standing hospitals as campuses of larger institutions. The Catholic Health System closed Our Lady of Victory Hospital long before New York State convened the Berger Commission.

Lafayette, Columbus and St. Francis Hospitals closed even earlier, Deaconess became a Kaleida long-term care center and Sheehan Memorial engineered its own transition in health care focus. Kaleida Health System is planning a transition in focus for DeGraff, and will close Millard Fillmore Hospital Gates Circle.

But all of these moves have been painful — look no further than the fights for OLV, St. Joseph Hospital and the



now-renamed Women and Children's Hospital for proof of that.

And the bottom line is still the same — overcapacity, debt and diluted quality in such key areas as cardiac care.

And now the city is embroiled in yet another round of mortal combat. The Berger Commission's recommended merger of Kaleida Health with Erie County Medical Center is not going well. ECMC's board and attorneys have adopted a strategy of stonewalling the merger, in hopes of procedurally derailing the current effort.

Now the subject of yet another change-challenging Western New York lawsuit, the watered-down merger — no longer a true merger at all, but a more politically palatable consolidation of separate hospitals under one management umbrella — has become a heated corporate struggle. And in its latest twist, it has become, literally, a struggle for the hearts of Western New Yorkers.

ECMC's bid to win community support by proposing to build a new \$125 million heart center has been met, and raised, by the consolidation board's proposal to build an even bigger \$250 million heart-vascular institute at the Buffalo Niagara Medical Campus.

There can be only one such center in this region. Proficiency in heart surgery depends on volume — enough procedures, which studies put at a minimum of 100 to 200 per year, to finely hone surgical skills, learn how to deal with complex problems and increase successful outcomes. Splitting the local workload — as competing hospital systems already have done here, in attempts to capture the revenue from such surgeries — can drop individual facilities or individual surgeons below that number, fragment the learning and even add to patient mortality.

“This community needs just one,” said Dr. Michael W. Cropp, chief executive officer of Independent Health. “It needs to be where both the patients and the professionals find it accessible, and where it can help drive the economic revitalization of our community. And it needs a whole new kind of approach that has clinical leadership built into it from the ground up.”

“The problem is we only have pockets of excellence in Buffalo,” was the recent assessment of Dr. Robert Gatewood, president of Buffalo Cardiology and Pulmonary Associates. “Doctors and their staffs are stretched too thinly. We need to take the talent and resources that we have and try to create something that is more effective and that allows us to learn from each other.”

But where? Creating a much-needed center of excellence in health care, in a region with a high incidence of heart disease and a health care reputation that now is sending 15 percent of its surgical candidates to Cleveland, Pittsburgh and Rochester, isn't easy. And it's not just a power struggle, although that's now the dominant factor as ECMC slugs it out with “Newco,” the consolidation board that includes representatives from the community, the University at Buffalo, Kaleida and ECMC — when ECMC's members aren't boycotting the meetings.

There are three far more important factors. Two of them argue for the medical campus location over ECMC, and the third raises real questions of cost.

- Centers of medical excellence aren't really built of bricks and mortar, they're built around people. State-of-the-art facilities and equipment are important, but the heart of a cardiac center — pardon the pun — is the core medical staff.

For the Buffalo Niagara Medical Campus proposal, that core could center on a world-renowned physician— Dr. L. Nelson Hopkins III, who is both chief of neurosurgery at Kaleida Health, chairman of neurosurgery at UB and director of the Toshiba Stroke Research Center that would move from UB to the new center. Add in the relocation of the region's largest stroke center from Millard Fillmore Gates, and some key pieces are in place. And Newco wisely has let physicians take the lead in planning.

- Centers of excellence develop not just as places of health care, but as places of health care plus health care research. The synergy with a research-based medical campus that includes not just Buffalo General Hospital but also Roswell Park Cancer Institute, the Hauptmann-Woodward Institute and UB, is obvious. That combination is

far more of a magnet for top-quality doctor- researchers than the ECMC campus can offer. And UB's presence can be critical in attracting doctors and staff— *if* the state continues its commitment to university funding at a level that allows UB expansion.

- Centers of excellence also require centers of money — and so far, only ECMC's numbers add up. The county hospital has the land and the money, some of it from hospital revenues and some from taxpayers, to build immediately. The more ambitious \$250 million Newco proposal is far more speculative at present, and raises questions.

Newco's response to the Berger Commission's call for a cardiac/vascular center here envisions a lot of state money, at a time when state tax revenues are in a tailspin. It would use \$35 million from Kaleida Health, \$65 million already committed to the process by the state, \$30 million to \$40 million in private donations, \$25 million to \$45 million from center operations and an additional \$40 million to \$50 million in future cycles of state Health Care Efficiency and Affordability Law (HEAL) grants. Absent any estimated contribution from ECMC were it to become part of the team— and Newco Board Chairman Robert D. Gioia says that hasn't even been discussed so nothing has been factored in — there's still a gap. That total of \$195 million to \$235 million is short of the \$250 million target, although costs still are only estimates.

The state's currently committed \$65 million, though, is the same \$65 million Kaleida is to get for closing its Gates Circle hospital, so none of that money will be used to retire the bulk of that hospital's debt — a key concept in Berger Commission recommendations to restore this region's hospital health. And the statewide commission only has another \$12.5 million set aside for the entire Western Region in this funding cycle.

Given the shortfall in funding commitments — and this region's often-crippling paucity of corporate donors — it's impossible to completely assess the chances of making the Newco vision real. More work needs to be done on funding, and Western New York could argue legitimately that a lot more of the \$1.5 billion in federal funds the state is working with, or of the \$250 million follow- up, bond-funded incentive pool set aside under the state's HEAL program, should flow here — to the region that triggered the state health system studies after a federal report identified the Buffalo area as a prime example of over-capacity and unsustainable long-term hospital debt.

But there is a June 30 state deadline still looming for consolidation legislation. And it's the heated consolidation argument that colors the cardiac center debate, the larger arguments over the future of specific hospitals, the drive to restructure health care in Buffalo and the hopes of Western New Yorkers for better local health care.

ECMC fears a hostile takeover by Kaleida from within the Newco structure — a takeover that could result in Kaleida stripping away revenue- generating departments, tapping ECMC money for the new center or other uses, leaving ECMC (and, by extension when Erie County becomes responsible for revenue shortfalls in a few years, county taxpayers) holding the bag. ECMC leaders are demanding, with good reason, more detailed contractual arrangements for the consolidation under a new board.

But one aspect of its stance — three of its four Newco board members boycott meetings, with only the head of its medical staff attending — is unacceptable. The state Department of Health will agree to a decision only from the Newco consolidation board, more formally known as Western New York Healthcare System, and ECMC should be at the table as its fate is being determined.

Gioia, Newco's chairman, sees some gains for ECMC from the partnership. The region's two relatively small transplant centers, at ECMC and Buffalo General Hospital, could be consolidated at ECMC. Such ECMC specialities as its trauma center, psychiatry, neurology and behavioral medicine, would stay. So would ECMC's cardiac care unit, which currently does about 7 percent of the region's surgery, because it's an important link for the trauma center.

“There has been no discussion of taking anything away from them, and we may be able to expand some things,” Gioia said recently. “The things they do well, they will continue to do well.”

But the issues of consolidation run deeper than debates over control. There are major obstacles to combining the

operations and the union-represented staffs of a private hospital system with those of a public benefit corporation with a county public-union work force. Trying to get that done by June 30, Newco leaders decided late last year, was impossible. The concept of two hospitals under one umbrella looked more doable, but so far that hasn't been the case.

Mergers, though, are not impossible. In New York, one now is under way in the Schenectady area, where the Catholic St. Clare's Hospital is handing over its license and facilities to Ellis Hospital. Ellis already had absorbed nearby Bellevue Hospital.

The Catholic-private merger there is not as philosophically unusual as the one that created the oddly named Jewish Hospital & St. Mary's Healthcare system in Louisville, Ky.

And in the New York City area, where some mergers have failed, a national success story emerged in 1997 with creation of the North Shore-Long Island Jewish Health System.

That merger involved 13 hospitals, most of them North Shore's, into a combined system with 30,000 employees, 700 staff physicians and 7,000 attending physicians, 5,671 beds and an annual budget of \$2.8 billion. There were initial struggles — including over who got to run the system — but within three years the red ink stopped and the system was turning a profit, one that stemmed not just from economies of scale but from increased clout in negotiating reimbursement schedules with insurance companies. Today, the merger often is cited as a national model.

At some point, health care restructuring here must happen. This is not just a struggle over whose hospital survives — it's a struggle for the survival of Western New Yorkers needing critical health care. It's a debate over the quality and the future of medical treatment in this region. It's not about the power, or at least it shouldn't be. It's about the patients.

Those who are wrestling with this health care future should keep that in mind.

Find this article at:

<http://www.buffalonews.com/367/story/360079.html>

Check the box to include the list of links referenced in the article.

© 2008 The Buffalo News.