These notes are not taken from transcriptions of the meetings, but are the reports of the League of Women Voters of the Mid-Hudson Region who attended most of the meetings of the GHHCC Task Force.

Golden Hill Task Force Committee Meetings

LWVMHR Observer Corps

Margaret Sellers, Observer

Tuesday, June 1, 2010 3-5 PM

The Task Force has been appointed by the County Legislature. Legislator Walter Frey, Jr. is Co-Chairman along with Legislator Jeanette Provenzano. Legislator Wayne Harris, Lee Cane, Dr. Laurie Cassel, Kenneth Hyatt, Lew Kirschner and Dr. Chester Robbins are also Task Force members.

Other attendees included: Paul Vosburgh, Architect; Marshall Beckman, Deputy County Executive, Sheree Cross, Director, GHHCC; and Nettie Tomshaw, Legislative Staff.

The meeting was addressed by the Architect, Paul Vosburgh. He gave some back round, then compared the plans and costs of building new with doing a renovation of the current facility. He showed options for both a 200 bed facility and a 280 bed facility. The most recent, though not current study indicated that Ulster County was short 15 beds and the existing beds are not well distributed for access by all parts of the County. The "ideal" nursing home size was said to be 120 beds.

The current facility has 280 beds, built in 1969 and is 41 years old. The site work condition is poor, as is the building envelope, the HVAC, the electric and the data/phone systems. The roof is good. The building has problems with water pipes (corrosion with related Legionella), code compliance deficiencies, program deficiencies and has an institutional feel. It does not meet current "Green energy standards". It does not support the Skilled Nursing Facility mission of patient centered care. It does not facilitate the development of patient communities. It would enable the needed culture change and

Plans were presented for both new construction and rehabilitation.

Rehabilitation of the existing facility would take 5 years. It would involve reducing the current census of patients by about 40 to create swing space. It would have a life expectancy of 20 years, due to expected changes in standards. It would correct the current deficiencies and replace the aged infrastructure and would meet LEEDS green building standards. A 200 bed facility would cost $40.1M for construction with a total project cost of $50.3 (or $251,500 per bed.) A 280 bed facility would require adding another wing for swing space during construction and would cost $62.1M, with a $84.5M total project cost (or $302,000 per bed.) When the building was finished, there would be space available for offices, perhaps for the Office for the Aging. A negotiated percentage of construction costs would be reimbursed by the State. Some energy related funding might be available from NYSERDA.

New construction takes two years and would consist of a large rectangular building with 3 floors for 200 residents or 4 floors for 280 residents. It would have a life of 40 years (presumably changes and rehab would be needed sooner as the "state of the art" changes), and would be approximately the same kind

of construction that would be expected in a Motel 6. While it would be "state of the art" programmatically, it would not be fancy or exceptionally durable. Costs for the 200 bed facility are estimated at $44.3 M for basics, with a total project cost of $60.1 M (or $300,500 per bed) for the whole project not including cost over runs, land costs and disposal of the current facility. Costs for the 280 bed facility would be $52.6 M and $71.3 M (or $255,000 per bed.)

Facility Tour

The presentation was followed by a tour of the facility, which was clean and well kept. We encountered an architect who helped design the building who is now a resident. He said, "Don't mess with the building, it is a good one." We saw the plain, institutional environment, the mechanicals and pipes that had hidden the Legionella infection. We noted spaces that had no ground level exterior access, which is important for fire safety, and parts where residents could not move around to other areas easily. We were shown where reconfigurations and additions to the structure would be made for social space, solariums, connections and new space. The building is a strong structure built mainly of brick and concrete block.

Monday, June 7, 2010 6-9 PM

The Task Force gathered for two presentations, Finances and Demographics. David Bonk, CMA ; Toski, Schaefer & Co. gave the presentation which began with general cost drivers.

The key drivers affecting the public nursing home strategic alternative decision process come from national, state, county and facility levels. They include:

- **Regulation** and reimbursement changes (big changes are coming)
- **Economics** including personal income, reimbursement, inflation, financial markets which all effect the cost and profitability of doing business
- **Industry trends** towards community based care, shorter stays and increased use of technology
- **Technology**
    - Medical- prolong life and how care is provided
    - Information –
        - increases speed in which information is processed and care is given
        - Increases efficiency and ability to adapt to changes in care
- **Demographics** including age both of potential residents and the support population, education influences resident expectations, income the type of financial payers, gender and race effect facility culture.

Ulster County experienced a net influx of US citizens that peaked about 2004. There is now a net decline. There has been a steady international in-migration. The total population of the County has been gradually increasing, as has Medicaid spending.

Area **Culture,** expectations of elder care, care quality, workforce culture, value systems and social awareness all effect what care can be provided. The **mission,** or the belief and commitment to the

type and place of care and whether it is provided publically or privately will effect what the community is willing to do as will the influence of **unions**. Local and national history will also effect us.

Public facilities tend to serve indigent populations who use Medicaid, and have low measured needs and a low reimbursement rates or high levels of need and high costs which are not fully reimbursed. They are generally older and more institutional looking which is less appealing to higher paying "self pay" people. Public perception may be tied to their poorhouse ancestry and substandard, poor quality care. Public expectations may exceed their performance creating a lack of market competitiveness.

Reimbursement mechanisms starting from the 1935 Social Security Old Age Assistance benefits which forbids payments to Alms or Poor houses were reviewed. **The current situation is very uncertain.** As of 6/7/10 facilities continue to receive payments under an old rate based back in the early 1980's, with additional budget cuts planned.

Ulster County Nursing Home financial data using accrual accounting, shows, as of 12/31/2008 that Golden Hill Health Care Center (GHHCC) had a $8.35 M loss for the year, by far the highest of the six homes listed in Ulster County. Next highest loss was the Northeast Center for Special Care (NECSC) at $1.26M. These figures differ from the County numbers ($4.04 M net County costs) which consider Inter-Governmental Transfers (IGT), use of fund balances ($2.1M), and costs borne directly by UC taxpayers ($1.9 M). There is also a difference in the period of time in which certain costs and payments are counted and a $2M charge for Workers Compensation. The future of IGT payments is unknown, and recent payments have a different formula than previous payments, with the County having to put matching funds up front to get payment through Medicaid funding. The net loss per resident day for GHHCC was $84.03, NECSC was $13.37. Both have 280 beds. GHHCC counted 99,413 resident days, NECSC, 94,538 in 2008. The expenses/resident day at GHHCC was $315.54, at NECSC, $348.46.

The study also compared GHHCC **resident demographics** with public nursing homes in Albany and NE Central NY. The GHHCC population was 75. 25% Medicaid, compared to the non-profit percentage of 56%. GHHCC was the lowest Medicaid percentage of the three publics compared. It had the lowest Medicare at 9.16%. (Medicare is often the payer for out of the hospital rehab.) The non-profit had 16.7% Medicare. Medicaid pays the least, Medicare pays more and Self Pay, the most. The non-profit also had more admissions due to the facility's sub- acute and rehab programs. The majority of all admissions came from hospitals. GHHCC discharged fewer patients to home and had a higher proportion of residents who died in house (42%).

Expenditures for salaries and benefits make up about two-thirds of the operating budget of a nursing home. GHHCC pays about $142.17/resident day and $100.38 for benefits. Benefits are 71% of wages. Wages and benefits are 77% of total costs. Comparable public facilities had salaries of $104.21 and $129.27 per resident day and benefits of $53.73 and $48.32 per day. The non-profit facility had wages of $134.16/ resident day and benefits of $26.35. Supplies and purchases were in

the upper quartile of the comparison. Capital rates were within reasonable standards at $7.88/resident day, however newer public facilities had a capital rate of $16.81.

Of the total expenditure of $31.37 M in 2008, $9.8M was paid for benefits. $3.2 M was paid for health benefits for active employees and $1.9M additional for Other Post Employment Benefits due to GASB 45. This was much higher than comparable institutions for similar plans. The County administered self-funded Worker's Compensation costs were also higher at GHHCC due to additional reserves recorded as an expense. Pension costs were considerably higher than other public or non-public facilities.

Over a five year period of 2005-2009, GHHCC has had a $36.5 M net operating loss. County subsidies have amounted to $23.7 M, the IGT has provided $8.1 M, and other Non-Operating subsidies, $6.8 M for a net income of $2.1M which was positive fund balance used the next year.

Cost containment strategies used nationwide were listed. Most were familiar.

The Current Reimbursement Environment trends continue to be **downward**.

NYS facilities are still waiting for re-based nursing home rates due to the Budget crisis. The Governor has proposed reductions of 10% for Nov 15, 2009 to March 31, 2010 with an estimated impact of $532,000 to GHHCC. Additional proposed reductions amount to an estimated $533,000 over the next 16 ½ months estimated by NYAHSA. The IGT funding continues through 2011.

There is a cap on capital cost base for new facilities of $239,000 a bed. This would yield a maximum total project cost of $77,567,885 for 280 beds for new construction. For renovations, negotiations would produce 60 to 80% reimbursement of costs. All reimbursement would occur through the rates in the future.

The presentation is available including Tables and Charts.

Dennis Doyle, Director of Ulster County Planning Department

Demographics of Nursing Home Bed needs in Ulster County

Population Trends

There are three different projections ranging from about 180,000 to 310,000 people in 2035. The Planning Department uses a moderate trend, projecting about 215,000. In 2000, the Kingston Metro area had about 58% of the people over 65 years old and 59% of those over 85. Southern Ulster had 26% and 27%, Southwest Ulster 10% and 8%, and the Mountain communities 6% and 5%.

As the baby boomer population ages, Ulster County will, like the rest of the country grow older. Those over 80 will double from about 6000 in 2000 to 12,000 in 2035. They will also increase as a percentage

of the population from about 4% to 7%. Those over 65 will grow from about 23,000 to about 43,000. (The average age of GHHCC residents is about 89.)

Population growth is projected to take place largely in areas with water and sewer, including Kingston City, Saugerties, Ulster, Esopus, Lloyd, Marlborough, New Paltz, Shawangunk, Plattekill and maybe Warwarsing.

Economic Trends

Gross regional product is forecast to increase in the 1-2% per year range, while median personal and household income would average 3 to 4% increases in the next 10 years.

Location

Existing nursing homes are largely located along the **I-87** corridor. They group around Kingston. The Ellenville area is lacking nursing homes.

Trend in Nursing Home Patients

- Likely to be older
- Likely to have specialized care needs
- More likely to rely on government assistance

Friday, Jun 11, 2010

A discussion meeting.

Sheree Cross explained the impact of NYS budget reductions on GHHCC financing.

- The trend factor was cut, but the increase was not included in the UC budget, so there is no effect.
- $16.9 M in rate appeals were cut, but UC has no rate appeals, so there is no effect.
- Reduced “bed hold” payments (when a resident goes to the hospital, the GHHCC still gets reimbursed) is complicated and the effect is unclear.
- The GHHCC has no waiting list, as it used to have.
- The occupancy rate has been relatively high.
- Pharmacy cuts are about $1/day per resident

Lee Cane asked where the September 1 deadline came from. She thought it would be hard to meet.

The Executive set the deadline, with UC budget requirements in mind.

A new study of needs for Residential Health Care Facilities (RHCF) beds for the planning target year of 2016 was released showing that Ulster County had 21 too many beds. This does not confirm earlier anecdotal information and Sheree Cross will look into it.

Jeanette Provenzano talked about subsidizing the GHHCC. She pointed out that we subsidize the Community College. Why shouldn't we subsidize GHHCC? All of the Legislators present felt that the Legislature did not support privatization and there was little opposition to maintaining a GHHCC, that the Blue Ribbon Panel report was never accepted by the committee or on the floor.

Arthur Smith, UC Budget Director, talked about the difference between the charts used by the Budget Office and the Legislature, and the accrual accounting used by the consultant. Basically the budget uses charts based on expected payouts in any one fiscal year, while accrual accounting tracks expenditures in that year. These can be quite different.

Inter-Governmental Transfers (IGT) were also discussed. The old IGT ended in 2003. These were purely an additional source of revenue from State and Federal sources. The new IGT is part of the FMAP (Federal Medicaid Participation). To get the federal funds the County has to put up the equivalent of the State and Local match. In 2009-10, Ulster County had to advance $2M from the GHHCC fund to draw down $2M in federal matching funds, using a 50% Federal match. The Federal matching rate now varies with the unemployment rate, producing even more uncertainties.

The use of Bond Anticipation Notes (BANs) were also discussed. Depending on the financial markets, the short term interest on these notes is often less than the bonds that will eventually replace them. Capital costs are paid back in the rates over the life of the facility. Rates are higher for residents that need more care such as AIDS, ventilator and dialysis patients. A high occupancy rate ensures maximum reimbursement.

Ulster County currently carries $109,664,734 in outstanding debt subject to the debt limit. That is 7.81% of the constitutional limit for the 2010 adopted budget. Most of the debt is related to the jail.

John Rohrbaugh, consultant from SUNYA Rockefeller Institute gave the Task Force homework. He asked them to add briefly worded items to the three lists below and email them to him:

A) Stakeholders who would be affected by any decision concerning Golden Hill (for example, current residents of Golden Hill or current employees of Golden Hill)
B) Future circumstances that would worsen the consequences of any decision concerning Golden Hill (for example, reduction in Medicare funding or some county emergency requiring millions of dollars of expenditures)
C) Actions that could be taken (decision options) concerning Golden Hill (for example, renovate the facility or build a new facility.) In other words what are the alternatives that should be considered?

June 21, 2010 (Wayne Harris excused)

Proposed Options for Consideration RE the Future of Ulster County Golden Hill Nursing Home

Don Pryor, Director of Human Services Analysis of the Center for Governmental Research led the discussion. Wayne Harris was excused for the latter half of the meeting. Committee discussion both preceded and followed the presentation.

Ken Hyatt asked about the question on statewide bed allocation numbers that had been raised at the previous meeting. Is Ulster Co. over or under bedded? Sheree said she had not heard yet. Jeanette Provenzano commented on a lack of support for GHHCC compared to the community college. Ken Hyatt commented that when people thought about building costs, they thought about the county jail. Jeanette Provenzano said the situation was different now that we have contract managers and the Comptroller has auditors. Walter Frey, Chair said that the public thinks that GHHCC is well funded. Lee Cane was concerned about the image painted in the press. Ken H. wondered exactly what was wrong with the building? It is not being shut down now. Chair Frey also wondered. Sheree Cross called the groups attention to the architects report that stated that every mechanical system was rated poor to fair with a life expectancy of less than five years. The roof is good. (It was done in 2002) Lee C. commented that DOH does not pass or fail a facility based on its future life expectancy, but on its present functioning. Chair Frey said their was no master plan for GHHCC. Lou K. commented on BOCES 10 year capital plan that was updated. That is how BOCES and UCCC maintain their properties. The County buildings fall into grave disrepair, such as the Information Systems building. The group sense was to get the facts on GHHCC, then go on a road show to educate the public.

Marshall Beckman introduced Don Pryor. His prepared report included eight options. An abridged version follows.

Option 1: No change/Status Quo

The Center will remain under County control. No Actions whatsoever will be taken to change the current situation. Operating deficit will persist. No changes to facility infrastructure. County will continue to monitor changes in reimbursement and other funding mechanisms at State level to project future conditions.

Summary Value and Implications of Option 1

Under this option, the County maintains direct control over the provisions of nursing home services, and the ability to assure that the historic mission and "safety net" functions of the Center are maintained. Current employment and wage and benefit structures for employees are protected. If IGT payments remain in place at significant levels, the Center has some possibility of remaining financially viable, but even that scenario is likely to require increased County matching funds to access such payments in the future. From a purely financial perspective, this option offers the least hope for a long-term solution for the County, and may make it harder for the County to consider investing in other lower levels of

community-based long-term care services in the future. On the other hand, if the County is willing to trust that IGT payments will continue at significant levels into the future, and is willing to consider modest taxpayer contributions to the Center in order to maintain its historic mission—and wishes to avoid likely public confrontations and political conflicts if the future of the Center is threatened—the status quo could under such circumstances be viewed as an acceptable option, at least for the short run.

Option 2: Implement Facility and Management Changes to Reduce Budget Deficit

The Center will remain under County control. A broad range of actions will be considered to reduce or eliminate County contribution for the Center. Infrastructure needs may be addressed; capital costs wil be absorbed in the budget deficit plan.

- Staffing, efficiencies and cost reductions
- Shifting case mix, payer mix, short-term rehab
- Revenue enhancements, maximizing billing
- Creating a separate bargaining unit for the Center and/or recognition of the unique 24/7 jobs
- Exploring reforms and possible "givebacks" with the union
- Aggressive marketing of facility to maintain high occupancy
- Management consultant
- New services, changes in service mix
- Renovation or new construction

Summary Value and Implications of Option 2

This option appears to provide the County with the most realistic possibility of continuing to sustain operation of the Center in a financially viable mode. If some combination of facility and management changes such as those suggested above can be successfully implemented in a way that significantly reduces or eliminates the budget deficit for the County, the odds of the County continuing to operate the facility would seem to increase substantially. If, on the other hand, none of these possible actions results in significant reductions to the budget deficit, the County is left with a choice between essentially the status quo option and the options involving various levels of divestiture. This option would require time to explore one or more of the sub-options. Some could be explored within a mnth or two, others might take a few months to explore thoroughly, but most could probably be explored, at least at the conceptual level, in less time than any of the potential divestiture options that follow. It may also be possible to carry out aspects of this option simultaneously with early stages of exploring divestiture options, rather than having to carry out the tasks in a sequential fashion.

Option 3: Establish a Public Benefit Corporation

The Center will no longer remain under County control. The County will establish a Public Benefit Corporation, which would need State approval, to reduce or eliminate County contributions, other than the County matching share of IGT payments, plus any potential remaining "legacy obligations." Employees would remain public employees, but not on the County payroll. The County would receive immediate infusion of cash via the PBC's issue of Bonds through the Dormitory Authority that would be

used to purchase assets from the County. Infrastructure needs could be addressed, capital costs will be absorbed by the PBC.

Summary Value and Implications of Option 3

This option would perhaps be the least onerous, from the County's perspective, of the likely divestiture options. It would technically accomplish the goal of removing the County from the burden of being responsible for covering budget shortfalls of the Nursing Home, while at the same time maintaining an "arms length" continuing concern for the interest in the facility. From the residents' perspective,' perspective, it is likely that their interests would be well protected, along with continuity of services. From the employees it is likely that most if not all would retain their jobs under the same agreements as under the County, at least initially, and they would remain public employees, subject to Civil Service protections,

Option 4: Privatize the Facility

The County will sell the bed license for the entire facility to another operator who would take over and administer the Center operation on site. The County would continue to own the land and facility and would rent or lease them to the new operator. The new operator would be able to staff the facility at its discretion. This option would reduce or eliminate County contributions, other than any potential remaining "legacy obligations." In addition, the County would receive an immediate flow of cash from the sale of the bed license. An RFP process may be needed to determine interested operators of the facility.

Summary Value and Implications of Option 4

This option would enable the County to give up the responsibilities of operating the County Nursing Facility, while also eliminating the responsibility of subsidizing any future annual operating deficits incurred by the Center. It would also provide a one-time infusion of cash as well as ongoing rent/lease payments, while enabling the County to continue to own the Center's land and facility. In exchange, unless specifically negotiated, the County would give up any future ability to hold the new owners accountable for ensuring continuity of care for existing Center residents, for maintaining the historic mission of the Home, or for any ability to ensure the future employment, salary or benefit status of current employees. Some potential enhancements of broader long-term care options in the future could result from additional resources generated by the sale of the bed license.

Option 5: Sell the Center with No further County Obligations

The Center will no longer remain under County control. The County would simply sell the license and all related assets for the Center and would have no further financial or other obligations, other than the remaining "legacy obligations." The County would receive an immediate flow of cash from the sale of the facility to a new owner. An RFP process may be needed to determine interested purchasers of the facility.

Summary Value and Implications of Option 5

Under this option, the County may or may not be able to make significant amounts of money from the direct sale of the Home, but it would be able to save County contribution money annually, potentially make one-shot purchase money in the short run, and remove itself from the responsibilities of operating the Center in the future, thereby protecting itself from the changing and unknown financial realities related to the long-term care and overall health care systems in the coming years. In so doing, it could potentially generate financial resources that could help set in place an expanded network of community-based long-term care services in the future. There may be political fallout from a decision to even consider selling the Home, but a decision to at least undertake an RFP process to "test the waters" could be an important part of a "due diligence" process by the County, without in any way committing to what will happen at the end of the process once all the information is known, enabling a comparison of the known current Home operations with the proposals and subsequent discussions resulting from the RFP process.

Option 6: Sell the Center with Employee "Protections"

The Center will no longer remain under County control. The Nursing Home license and all related assets would be sold to eliminate any County responsibility for the Center, other than "legacy obligations." However, as part of the potential sale process, the County could seek to provide employee protections to assist current staff in finding jobs and having access to competitive salaries and fringe benefits (e.g., and agreement that the buyer would consider interviewing and hiring existing employees; an additional severance package would be negotiated; etc.). The County would receive an immediate flow of cash from the sale of the facility. An RFP process may be needed to determine interested purchasers of the facility.

This option is identical with Option 5 except for the guarantees and provisions built in to protect the interests of existing Center employees.

Option 7: Sell Bed License and Close the Facility

The County will close the facility and in the process sell the operating bed license. By selling the license and closing the Nursing Home facility, the County would be selling the right to use the beds in a different location to an independent potential operator and the staff would be discharged. The County would have no further financial or other obligations related to the Center, other than potential remaining "legacy obligations." The County must give 90 days notice of its intent to close the facility, must obtain written approval from the NYS DOH prior to implementation of a closure plan, and would be responsible for arranging for the discharge or transfer of all current residents prior to closing the facility. It is our understanding that the facility beds must be sold prior to the discharge of the last Center resident. There would be no further investment in the Nursing Home facility, but the County would be free to consider alternate uses of the facility upon closure. An RFP process may be needed to determine interested purchasers of the license.

Summary Value and Implications of Option 7

Of all the options considered for limiting or eliminating the County's role in the provision of nursing home care in the future, this offers among the fewest benefits and the greatest concerns for the County and its residents. Other than eliminating ongoing costs to the County and offering some potential to raise some one=time proceeds from sale of the facility license, the option offers few advantages and many potential negative consequences for Center residents and employees, and for the overall long-term care delivery system in the community in the future.

Option 8: Close the Facility.

The County will simply close the facility and surrender the operating license (no sale). The GHHCC would cease to exist, and the staff would be discharged. The County would have no further financial or other obligations related to the Center, other than potential remaining "legacy obligations." The County must give 90 days notice of its intent to close the facility, must obtain written approval from the NYS DOH prior to implementation of a closure plan, and would be responsible for arranging for the discharge or transfer of all current residents prior to closing the facility. There would be no further investment in the Nursing Home facility upon closure.

Options 7 and 8 are virtually identical with one significant exception: Option 8 would simply involve closing GHHCC outright, with no attempt (or ability) to sell the bed license for the facility, thereby eliminating the only possible significant virtue of Option 7. Option 8 becomes the most disruptive, troublesome and least beneficial option of all the divestiture options.

Each option was further described and the implications explored in the report.

Options 7 and 8 would be a tough sell with the State.

Lee Cane asked about the possibility of getting a Medicaid Waiver, (such as the Home and Community-Based Waiver) from the State and Feds. Jeanette Provenzano did not think that Option 1 was feasible. She thought that reimbursement needs to be considered. She noted that Option 2 covers both renovation and building new. She doesn't think that the issue of County subsidies should rule. Wayne Harris was active in the Cabrini closure process, which he viewed negatively- 280 people left homeless.

Option 3, establishing a Public Benefit Corporation has been tried three times with hospital/nursing home combinations. It has not been a great success, probably due to the complexity of that kind of combination. It has never been tried for a stand-alone nursing home. With this option the County would have a great deal of control as to how the enabling legislation was drawn up, but the proposal would also have to be approved by the State Legislature and the Governor, which may take months and be problematic. It might take two years to go through the process. Public Benefit Corporations can access the State Dormitory Authority for bond funding to pay for the nursing home license and renovations. Financially, it would be off the County rolls. There was interest in getting an expert in.

Jeanette Provenzano wanted to talk to the State soon. Chair Frey said that we need to gather all the facts before we approach the State. Ken Hyatt thinks we need to look at the mission and the core values. An RFP could be done to explore privatization only for interest, without any commitments, but it may cause a local firestorm. Marshall Beckman stressed that the infrastructure problems have to be corrected. The need for a long term plan was brought up again. Considering all of long-term care was brought up. Chair Frey said that was not part of the charge—only the GHHCC, not a whole county aging program. Question: how many UC residents are served in Orange Co.? There are 172 UC residents in Ferncliff.

It was agreed that **something** must be done. Doing nothing is not an option.

June 22, 2010 5 to 9 PM

Chair Frey was excused, Lew Kirschner came in very late.

Ken Hyatt wondered about Eugene Laks and the Public Benefit Corporation information. Co-Chair Jeanette Provenzano wondered who had invited the speakers. Marshall Beckman said that he had conferred with Co-Chair Walter Frey and made the invitations.

John Rohrbaugh, SUNYA led a group process. He characterized it as a complicated, multi-dimensional task . He said he was a group process expert, not a GHHCC expert. He felt that choreography is important and he did not want any bias. He had compiled lists based on the task force's answers to the questions that he had posed on June 11.

Key Stakeholders

1. Current residents of GH
2. Current employees of GH
3. GH volunteers
4. Future hard-to-place, long-term care residents
5. Families who no longer have necessary skills as care givers
6. Working poor (Medicaid eligible)
7. Legislators
8. Vendors who do business with GH (or groups representing them)
9. Taxpayers
10. Families of current residents
11. Friends of current residents
12. Physicians caring for current residents
13. Community members; general public
14. Government administrators concerned with fiscal responsibility(county/state/federal
15. Educators who train care givers
16. Seniors whose services could be increased

17. Attorneys specializing in elder law
18. Clergy and other religious leaders
19. Individuals with disabilities (or groups representing them)
20. County workers who assist GH (e.g. Personnel, Attorney, Purchasing, Highway)
21. Local construction firms/contractors
22. Department of Social Services
23. Office of the Aging

Rohrbaugh asked the group these items so that stakeholders that were similar could be clustered together. He will report the results back to the group.

He then turned to the **Future Circumstances** list**:**

1. Reduction in Medicaid funding
2. County emergency requiring millions of dollars in expenditures
3. Increase in senior population
4. Closing of private UC nursing homes
5. Structural Damage to GH from fire or weather
6. Failure of any GH facility system (e.g. water, waste) necessitating resident evacuation
7. Lack of state support and cost shifting
8. UC being handed new unfunded mandates
9. New national health care has no provision for long term care
10. Continuing or increasing economic/financial stresses on UC and taxpayers
11. Long delays in determination of reimbursement rates
12. Continued avoidance/neglect of GH repair and renovation

He then asked:

Which of these Future circumstances are most likely to occur?

And

Which, if they did occur, would be the most troubling?

These lists had fewer overlaps than expected, and Rorhbach said he would bet back to us.

Turning to **Possible Actions**:

1. Renovate/remodel current facility to bring to code
2. Privatize specific services (e.g. dietary, housekeeping, rehabilitation)
3. Continue “as is” to subsidize GH (“status quo”)
4. Add new, specialized services to increase GH revenue (e.g. assisted living)
5. Political action in Albany to protest/increase current Medicaid reimbursement
6. Partner with other nursing homes for more purchasing power/cost audits

7. Examine administrative positions and duties at GH ("management audit")
8. Total privatization of GH
9. [Partial privatization][**not allowable**]
10. Partnership with local hospitals
11. Downsize and lease space to privates
12. Build a new, central facility
13. Build several facilities in various locations in UC
14. Develop a public benefit corporation model

Lee Cane said we need to take care of the building first. Marshall Beckman said we must do the "pipes" (water, sewage and vent pipes) and that would cost $24M.

The Possible Actions list was grouped according to which would apply to **sole** county ownership, j**oint** county ownership with another entity, and if the county decided to get **out** of the nursing home business.

Rohrbaugh split the group into two. The first dealt with possible actions if the GHHCC remained under the sole control of the County (Lee Cane and Jeanette Provenzano). The other group dealt with possible actions if the GHHCC entered into a joint control agreement.

At this point the group work over the next sessions becomes more difficult to characterize. Much of the work is broken up into three smaller sub-groups. Most often there were only six of the eight Task Force members participating.

June 24, 2010 12-4 PM (Dr. Chester Robbins excused)

Marshall Beckman confirmed from Charles P. Abel, NYS DOH, that current DOH policy permits the sale of beds of a NY that is closing subject to certain criteria and CON approval of the buying applicant's project. A nursing home that is staying in business may not sell a portion of its beds, but may submit an application to convert some of its beds for a more community oriented program such as adult day care, long term care or assisted living. Beckman is also in contact with Eugene Laks about more information on Public Benefit Corporations. He clarified the fact that the Legislature controls the process. Chair Walter Frey has always made the decisions on speakers and process. Chair Frey said that he kept a notebook of all their conversations about possibilities, and Task Force Members were welcome to see it.

John Rohrbaugh grouped the stakeholders, and further work was done by the group. Prominent were the current residents (A), those who will need care in the future (B), Legislators and government administrators (C), vendors, construction firms and unions (D), taxpayers (E) and related professionals-educators, attorneys, clergy (F)

He also shared the groups work on Future Circumstances. More Worrisome and More Likely included:

- Reduction in Medicaid funding
- Continuing or increasing economic/financial stresses on UC and taxpayers
- Decrease in the IGT (added by Marshall Beckman)
- ? Decrease in UC subsidy to GH (added by Marshall Beckman)

More Worrisome but Less Likely

- Failure of any GH facility system (e.g. water, waste, vents) necessitating resident evacuation
- Continued avoidance /neglect of GH repair and renovation
- County emergency requiring millions of dollars in expenditures

New Options Identified

John Rohrbaugh had identified the possible options largely based on the work of Donald Pryor. The group later accepted Rohrbaugh's list

Option A: Absolute minimum

- Continue to subsidize GH
- Replace sewer, water and vent pipes ($24M)
- Add new specialized services
- Conduct a management audit

Option B: Full renovation

- Work with NYS DOH to fully renovate
- Initiate contracting out dietary, housekeeping, maintenance and cleaning
- Add new rehab services
- Conduct a management audit

Option C: New building

- Work with NYS DOH

Option D: Public Benefit Corporation (PBC)

- Investigate and form a PBC

Option E: Partnership 280 beds

- Work with local hospitals to form a mutually beneficial partnership
- Work with other nursing homes
- Convert some beds to alternate care- day care, Alzheimer's etc,

Option F: Partnership 200 beds

- Downsize, decertify, rent out unused space to others
- Convert some beds to alternate care

Option G: Sell bed license

- UC sells license, keeps land and facility

Option H: Sell bed license and property

Looking at these options from the prospective of major stakeholders

- **Current employees** – Working for five years in building renovations is difficult, compared with moving to a new building after two years. Renovations would also require staff and resident reductions of first 40 beds, later 80 beds.
- **Residents**- What would happen if there is a crisis in the building (water, sewage, vents)? Reducing population during renovations would also reduce access to the facility. Reconstruction would also be difficult for residents.
- **Taxpayers**- All options except sale probably require taxpayer subsidies in the face of county deficits.

Other discussions occurred that were not fully captured.

June 29, 2010 (Walter Frey and Lew Kirschner excused, Wayne Harris leaves early)

Marshall Beckman clarified that of the County Fund Balance of $18M, $14 is dedicated to preserving the bond rating, with $4M available to the budget. The FMAP federal legislation is stalled, which may result in a funding shortfall of $4.6 M. The county shortfall is estimated at about $25M.

John Rohrbaugh wanted the group to rate the different Options by the following criteria to get some sort of a measure of what is “cheaper, better and faster”:

- Access to care
- Quality of Care
- Uncertainty to the County
- Beneficial to GHHCC employees
- Quality of infrastructure

See the chart for the ratings on these options

June 30, 2010 (Walter Frey and Lew Kirschner excused. Lew came in late)

Eugene Laks will address the group on Public Benefit Corporations on July 6 at 10 AM.

Marshall will e-mail the previously discussed RFP- a document that will inquire about interests in purchasing the GHHCC. This will help give closure to the consideration of the "Out" options.

From the chart, the most acceptable Options are C, New Building; B, Full Renovation and A, Minimum Renovation.

Rohrbaugh noted that while information is needed, judgment is important. If the ordering done by the Task Force is true, Option C dominates. Uncertainty to the County would have to be 10 to 12 times more important than the other criteria to change the order to make A, minimal renovation, go to the head of the list. What the County can afford is not considered.

Options F, partnership with 200 beds and E, partnership with 280 beds are intermediate, while Options H, sell beds and property and G, form a Public Benefit Corporation (PBC) had lots of variability. It was noted that considerable information on the PBC was yet to come.

Rohrbaugh suggested taking Option B, full renovation of the current GHHCC off the table. The group strongly objected, saying that building new and renovating were more equal than it appeared on the chart. They attributed this to the forced choices of the process. They decided that they wanted to take Option C, minimal renovation , off the table because they felt there was not wise to spend the money on pipes when the structure would not support residents with greater technical needs (specialized rehab, bariatric care, ventilator patients, dialysis, geriatric psych, all with higher reimbursement) and meet the current standards for social livability (to attract clientele). The facility needs both aspects to be fiscally supportable in the future. Currently the number of vacant beds is increasing to about the 14 bed level. In the past, there was a waiting list. Only 20% of the current residents do not have some degree of cognitive impairment. The group wanted to consider leasing some space in any event, to provide a broader, more integrated community. Such space would not be reimbursable by NYS as a nursing home, but could be rented. Medical groups, centralized services, pharmacy, physical therapy and podiatry were mentioned. They wanted a management audit done by a nursing home specialist. The UC Comptroller would not have the expertise required. Only a financial audit is done yearly. It was noted that 280 beds produced more revenue to support the administrative overhead. The group also thought that partnering with hospitals was problematic, as hospitals are losing money and tend to spread their administrative costs over other entities. Sheree Cross suggested that there may be ways that all County nursing homes across the state could get together to save money beyond the NYS contract process they already use. We were also reminded that the CSEA contract does not allow layoffs when services are contracted out. Closing services altogether is allowed.

Further exploration of the Public Benefit Corporation is needed.

Wayne Harris said that about 30,000 people live in towns that he now or formerly represents and **none** of them are in the GHHCC. Sheree Cross said that about 154 of them are in other nursing homes on

Medicaid. He uses this to dispute the need for a county owned and run facility. He believes that the quality of care and access in the private sector can take care of the people. He felt that the options of selling the bed license, with or without the property should remain on the table. People talked about the lack of county services in the Southern part of the county and in Ellenville.

Ken Hyatt wanted a "global" decision.

Draft Recommendation of the GHHC Task Force (as noted from the meeting)

- Consider both new building or full renovation
    - Renovation will temporarily reduce the total number of employees and bed
    - Must firmly establish the costs of each, including the site

- Hold work on the pipes until the choice is made
- Support proposal to devote space for specialized rehabilitation (increase GH revenue, better service)
- Either new building or full renovation should include space to lease to increase GH revenue and centralize services
    - Medical groups and outpatient services
- Conduct a management audit to review the efficiency of GH operations (including contracting out some services, partnering with other nursing homes for purchasing)

The Task Force will receive the draft from John Rohrbaugh and the RFP draft from Marshall Beckman by email.

Golden Hill Health Care Center (GHHCC) Task Force Meeting July 28, 2010

Walter Frey was excused due to illness. Jeanette Provenzano chaired the meeting.

Stan Wojciechowski, NYSAC/CNFNY (New York Association of Counties/County Nursing Facilities of New York), was the invited guest.

He did not have prepared remarks, but noted the following.

He said that the Health Care System in NYS is broken. The staff has been decimated in the last 20 years. Medicaid rates have been cut to the point where 40 nursing homes have closed. The New York State Department of Health (NYSDOH) is now alarmed by these actions. County public homes, including nursing homes, have a history of meeting the needs of those who are most difficult to care for. They have adjusted their mission to meet current needs, and are adjusting again.

Look at our current situation. We will probably have more last resort patients, which is essentially the Medicaid population. More people will be on Medicaid with the new healthcare legislation. The aged population is increasing. Those in the most able young caregiver range of 18 to 40 are leaving the state. Many of those working are single Moms. The state has not supported Home and Community Based Services in the last 15 years. NYS closed many Adult Homes in the last 15 years. They want more Assisted Living beds (which have an Adult Home SSI component), but are having difficulty encouraging them to open. The IGT (Inter-Governmental Transfer of federal funds) is uncertain as is the future of rates. There are 8000 rate appeals at NYSDOH. County homes still have not received the 2009 rate increase yet. Instead, the budget wanted to go to a new regional pricing system, which the State Legislature turned down. The IGT is involved in a debate with the Feds CMS (Center for Medicaid and Medicare Services) over a Medicaid Plan amendment.

If the County were to sell GHHCC, the residual value would be $1.2 M that would be reimbursable to the new owner in the Medicaid rates. Ulster County has not been making new capital investments in GHHCC that would be eligible for reimbursement in the Medicaid rates, albeit with about a 2 year lag.

The State does not care about the counties. There are no policy experts left at NYSDOH, only budget people. Policy suggestions need to be budget neutral or present a cutting opportunity. Most of the recent support has come from the Legislature. NYSDOH is trying to increase Federal dollars, so the IGT which is in Federal Statue and currently involves no State dollars is welcome. He claims that the Feds like it too. It is in Federal statue. With the redo of the IGT methodology, the abuses of using the money for all state expenses including roads and bridges has ended. NYS only used the money for health related issues, but not necessarily public nursing homes. The other state nursing home associations support the IGT, as they want to see the Counties take care of patients that do not have high reimbursement value (Medicaid patients, Physical A's and B's) so they can take care of private pay patients.

For profit nursing homes pay property taxes. They are able to arrange sales of their property, usually to another family member and in doing this, rebase their Medicaid rates to a current year level. The Counties only recently rebased the 1982 rates to 2002 and are still waiting for the 2009 adjustment, which should be included in the NYS budget when it is finally passed. Counties can't plan because there are constant State level changes.

County homes provide a living wage for their staff, continuity of care (low staff turnover) and good care. If the County homes go away, for profits won't pay a living wage so they can make a profit, patients will likely have to wait in hospitals longer, be placed further from home, perhaps in the next county or state as Medicaid patients are difficult to place, especially those who are clinically complex.

No new dollars are available from the State or Feds. We have to find efficiencies. He recommended the formation of a statewide or regional Public Benefit Corporation (PBC), which

would cut overhead by centralizing supplies and administrative functions. Perhaps it would serve 5 or 6 counties, headed by a Board of Directors with representation from each county. He expected to have a proposal ready for the next meeting of county administrators in September. Maybe a Robert Wood Johnson Foundation type organization could provide seed money. It would take about two years to complete this process. A lot of counties are interested. He has been talking to Eugene Laks. (Laks spoke to the committee before.)

Erie Co. is building a new nursing home. They applied for 450 beds. NYSDOH said that it had to be bigger. The Burger Commission reports do not seem to apply. Ulster Co. is probably too small to go for a pilot or individual PBC.

He believes that a PBC is the best solution for Ulster Co. When questioned on the time it takes to form it, he thought it was too bad that maintenance on the home had not been done for 20 years, and if something broke, it would have to be fixed. He thought that labor concessions would have to be reached along with the efficiencies.

The meeting went into Executive Session to discuss the RFP.

Margaret Sellers

Addenda (8/3/10)

Lee Cane, GHHCC and LWV member, said that after the executive session Sheree Cross stated that the pipes could be fixed by running them outside the building for a lot less money. I checked with Sheree today, and she said that only the sewer pipes (not the water or vent pipes) had been estimated for about $10M. She said that since the original study was done in 2003-4 which estimated the cost of all the pipes at $24M, (a figure that would be a lot higher now) no major decisions have been made, and there have been 6 to 10 pipe type repairs. They have been doing hot water flushes for the last 6 months for the Legionella.

Margaret Sellers

LWV Observer Corps