Sunnyview Rehabilitation Hospital: A Ninety-Year Journey
By James Strosberg and Robert Bylancik

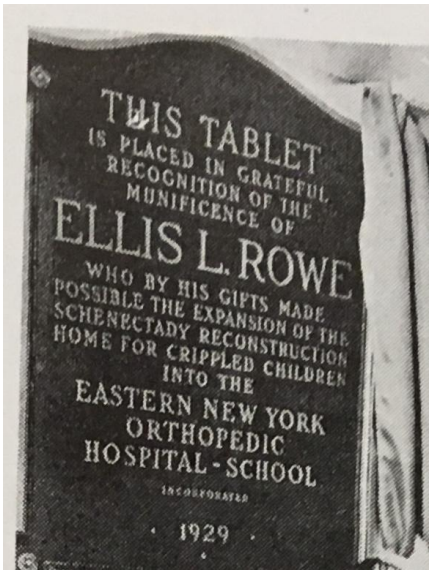
The story has it that Schenectady Fire Chief Henry Yates and Kiwanis Club President Dr. Alfred Warner spied a young crippled boy struggling to sell newspapers when they were driving along the street on a September afternoon in 1922. The boy had polio. But it could just as well have been tuberculosis of the spine, osteomyelitis, or a number of other maladies. Sadly, the sight of crippled children and adults was not rare in Schenectady. Spinal and skeletal deformities were a major cause of draft deferment from the recent Great War. The image of the boy spurred the men and their organizations into action.

As a result of a public meeting held at the Chamber of Commerce, the Schenectady Reconstruction Home for Crippled Children was incorporated on November 4, 1926 with Dr. Warner as board chairman. Soon after its formation, a house was leased on Rosa Road to be its home. Tragically, fire destroyed the house on December 12, 1926 before any patients could be admitted. However the community rallied around the fledgling institution. Due to the efforts of the Permanent Firemen of Schenectady and the Kiwanis Club, an outpouring of contributions from Schenectadians allowed the Schenectady Reconstruction Home for Crippled Children to purchase land on Rosa Road and construct a 10-bed facility. The first children arrived in August 1928.

Over the next 90 years, Sunnyview Hospital, the name the institution became known by, underwent remarkable transition. It expanded its geographical reach, from just Schenectady to an area extending from Canada to the lower Hudson Valley and from Vermont to Central New York. It greatly expanded its outpatient and its inpatient capacity. It added adults to the population of children that it served. And it greatly increased the types of services it delivered including dedicated programs for stroke, pulmonary disease, brain injury, amputation, speech and hearing problems, driving education for the impaired, and cardiology rehabilitation. These are just a few examples. Today there are few rehabilitation hospitals nationally that can match the comprehensive programs available at Sunnyview.

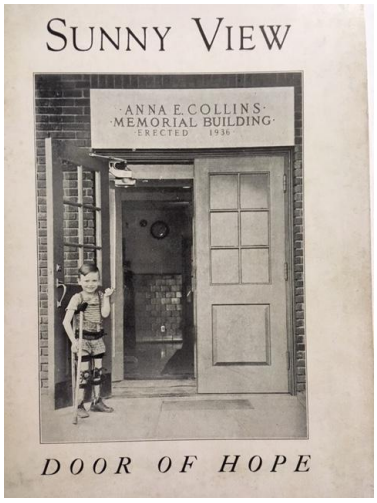
The 90 years of remarkable progress and growth could not have happened without the extraordinary civic and medical leadership that Schenectady has always seemed to produce when the occasion warrants. But in addition to local leaders, national leaders and organizations -- governmental, civic, and medical -- played an important role in Sunnyview's history. In particular, government policies shaped the fate of Sunnyview and continue to shape its fate.

EXPANSION: GEOGRAPHICAL REACH AND PHYSICAL CAPACITY



In 1929, Troy industrialist and philanthropist Ellis L. Rowe, president of the Rensselaer Valve Co., proposed to the Board of Trustees of the Schenectady Reconstruction Home for Crippled Children that it be reorganized to serve the counties of eastern New York. To this end, the Eastern New York Orthopedic Hospital and School was incorporated on October 23, 1929 to supersede the older institution. At the same time, the Eastern New York Orthopedic Foundation, Inc. was formed with Mr. Rowe as Chairman. Its purpose was to was to help pay for services for poor children for the 14 counties of eastern New York and to generally support the new institution through its endowment. The members of the Foundation board also served on the hospital board. Mr. Rowe's generosity also enabled the purchase of additional land at the Rosa Road site with an eye toward future expansion.

In 1937, Sunnyview expanded from 10 to 35 beds in a new fireproof addition that included boys' and girls' dormitories, three classrooms, nurses' quarters, auditorium, library, dental clinic, cast room, nursery, isolation quarters, and elevator.



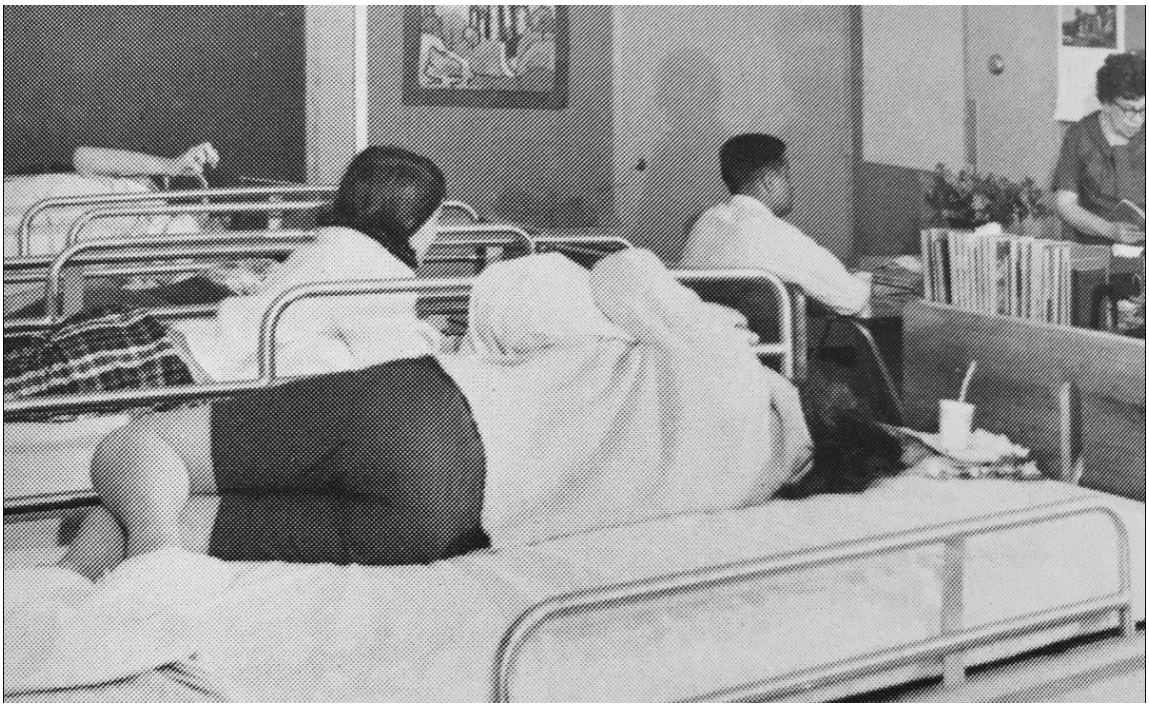
The expansion was made possible by Anna Electra Collins (1845-1922). Anna grew up in Scotia in a very wealthy and charitable family. Her father built railroad tunnels, bridges, and aqueducts. Collins Park is named in their honor.

In her will, Anna left $140,000 to a religious order to establish a home for crippled children in the Schenectady-Scotia area, but to be accessible to any child in the area. Surprisingly, the order declined the money because it was deemed insufficient. Several years later a judge granted the bequest to Sunnyview.

The Anna E. Collins Memorial Building was dedicated in May 19, 1937 with much fanfare. Governor Herbert Lehman gave the main speech, broadcast over WGY. In conjunction with the dedication, a medical conference with over 200 participating physicians took place.

The institution exclusively served children and the children stayed a very long time, some more than a year. Some had to remain horizontal in bed, their bodies encased in long plaster casts so their spines could heal in good position. During this time, children attended school, even while remaining in bed. Sunnyview and its patients received wide community support especially from the Firemen of Schenectady and the Kiwanis Club. Visiting celebrities included Eleanor Roosevelt, Phil Rizzuto, Emmett Kelly, and selected animals from the menagerie of the Ringling Brothers, Barnum and Bailey Circus.

Since 1937 Sunnyview undertook several major expansions financed through private contributions and federal construction grants. General Electric and its employees were particularly active in fundraising. With regard to government aid, the federal Hill-Burton Act of 1946 paid up to one-third of construction costs. Hospitals receiving Hill-Burton money were supposed to render a certain amount of free or reduced-price care.



DR. GAZELY: MEDICAL DIRECTOR

Much of the early success of Sunnyview was due to Dr. William Gazely, the first medical director. Dr. William Gazely was a 1917 graduate of Albany Medical College whose only formal post-graduate medical training was a one-year internship at Ellis Hospital. After a brief stint in the Army (W.W. I ended November 1918), he practiced general surgery for several years, but he was drawn to orthopedics.

Orthopedics as a formal specialty was in its infancy. This was a decade before the founding of the American Association of Orthopedic Surgeons and half-century

before the publication of the *Journal of Pediatric Orthopedics*. Dr. Gazley was a pioneer. From the beginning, he held a monthly clinic at the Schenectady Day Care Center, founded in 1902 and still in existence, to identify and treat kids with orthopedic abnormalities. (The Schenectady Kiwanis Club, at the urging of Fire Chief Yates, provided the necessary splints and braces for needy children at the Day Nursery.)

After a period of spending one weekend a month assisting orthopedic surgeons at major New York teaching hospitals, Dr. Gazely started performing surgery on patients in Ellis Hospital, inviting experts from New York to assist him. Within a short period of time, Dr. Gazely's reputation grew to national stature and other major teaching hospitals (e.g., Mayo Clinic) sent their residents to Sunnyview and Ellis to train with him. He served as medical director and later as chief of staff until 1971.

TRANSITION FROM A CHILDREN'S ORTHOPEDIC HOSPITAL TO A COMPREHENSIVE REHABILITATAION HOSPITAL

Since its founding, Sunnyview had been essentially a children's orthopedic hospital with the primary admission being polio. Hospitals from a 23-county region transferred their polio patients to Sunnyview after the communicable phase of their disease was completed. The average length of stay was 120 days.

Polio, a dread infectious disease and the leading crippler and killer of children, grew in incidence during the first part of the 20th century. Surprisingly, it was more common among middle and upper classes. The most famous polio victim was President Franklin Roosevelt, former New York Governor, who contracted the disease at age 39. Under FDR's leadership, the National Foundation for Infantile Paralysis (NFIP) was formed in 1938 with major aims "to find a cure for polio while providing the best treatment for those already afflicted." The Schenectady County chapter of the NFIP was founded in 1939. The NFIP became one of the most successful fund-raising organizations of all time. Its "March of Dimes" campaign (a name coined by Eddie Cantor) helped fund research institutes and researchers (e.g., Dr. Jonas Salk and Dr. Albert Sabin) in addition to supporting local polio rehabilitation services.

The late 1950s saw a dramatic decline in the number of pediatric patients. The Salk and the Sabin vaccines eliminated new cases of polio and antibiotics prevented much of the damage from osteomyelitis. By 1957 there were only a handful of polio patients in the hospital. Additionally, newer orthopedic techniques and procedures decreased the length of stay of non-polio patients. In light of the precipitous decline in admissions, the Sunnyview board made the decision to change its mission to become a comprehensive rehabilitation hospital.

In 1957 Dr. Gazely invited Dr. Robert S Hoffman, newly appointed director of the 26-bed rehabilitation unit at Albany Memorial Hospital, to also join the consulting

medical staff at Sunnyview. Dr. Hoffman previously was a general practitioner in Colonie. After World War II, he went to New York University School of Medicine to train under Dr. Howard Rusk in the new specialty of physiatry or rehabilitation medicine.

Physiatry, associated with the specialized services available in the rehabilitation hospital, focuses on the patient's disability, rather than a specific disease. To goal is to maximize patient function and activities of daily living. The physiatrist is usually a member of team that includes physical and occupational therapists, social workers, speech therapists, vocational counselors, rehabilitation nurses, psychologists, amongst others.

The significance of Dr. Hoffman's association with Dr. Rusk and its impact on Sunnyview cannot be overstated. The politically connected and astute Dr. Rusk is considered one of the most important pioneers and advocates for rehabilitation medicine in the world. In 1946, he established the world's first comprehensive medical training program in rehabilitation. In 1951, he established and became director of the NYU's nationally recognized Institute of Rehabilitation Medicine (later named the Howard A. Rusk Institute of Rehabilitation Medicine). Like his mentor, Dr. Hoffman became an innovator and an institution-builder.

At this time, the active medical staff of Sunnyview was composed mainly of orthopedists. The specialty of physical medicine and rehabilitation, struggling to overcome resistance from the more established specialties, was finally emerging as a specialty in its own right.. Rehabilitation medicine made tremendous strides treating and rehabilitating wounded soldiers during W.W. II and the returning veterans at the VA hospitals. Now it was time to make contributions to the civilian sector. Dr. Hoffman became the first Diplomate of the American Board of Rehabilitation Medicine to practice in the Capital District.

In 1957, Dr. Hoffman admitted the first non-orthopedic patient to Sunnyview, an elderly hemiplegic stroke patient for rehabilitation. This was a seminal event in the evolution of Sunnyview to a specialized rehabilitation hospital, notwithstanding that the orthopedic service at that time already had 25% adults. In 1962 Dr. Hoffman left Memorial Hospital and became full time Chief of Rehabilitation at Sunnyview. Through his vision and leadership along with that of Hospital Administrator Robert Ward, Sunnyview became a trendsetter in rehabilitation medicine. He started the Amputee Clinic, Multiple Sclerosis Clinic, Spinal Cord Clinic, and Stroke Clinic. He founded the Department of Rheumatology and helped develop the Departments of Social Work, Speech Therapy, Occupational Therapy and Vocational Rehabilitation. The rehabilitation medical staff expanded to 5 physicians. Especially after the 1967 expansion of adult inpatient beds, almost the entire hospital became dedicated to adult rehabilitation. As we shall see, this transition was greatly aided by the passage of Medicare in 1965 that gave the hospital a new lease on life after the remarkable decline in the pediatric patient population.

In 1976, Dr. Hoffman started the Department of Rheumatology and eventually staffed by four physicians. At that time rheumatoid arthritis and other rheumatic diseases were not as successfully treated with drugs as they are today, and bed rest along with multiple rehabilitation therapies were required. For two years *US News and World Report* voted Sunnyview one of the top rheumatology hospitals in the nation. This was because the patients were admitted to a specialized rehabilitation hospital, with all the needed staff and facilities rather than to an acute care general hospital.

In 1987 Sunnyview opened its therapeutic pool with an elevator floor, funded in part by a gift from William and Estelle Golub, at the time only the second one in the United States. And later Sunnyview obtained the first bone densitometer in the Capital District for the early diagnosis of osteoporosis.

Sunnyview has played a leading role in professional education with affiliations with dozens of physical therapy and occupational therapy colleges. Residents from Albany Medical College, and Ellis Hospital as well as foreign medical schools came for training in orthopedics, rheumatology and physiatry.

MEDICARE: A BOON TO SUNNYVIEW AND ADULT REHABILITATION

The 1965 passage of Medicare as part of Social Security created an important new revenue stream for Sunnyview resulting in a remarkable expansion and enhancement of its adult rehabilitation services. A major watershed in national healthcare reform, Medicare filled the gap left by the failure of private health insurance to cover the population over 65. According to the law, Medicare (Part A) covered not only acute care hospitals but also rehabilitation hospitals "providing care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons." Physician services (Part B) were covered in both the office and hospital. Physical therapy, occupational therapy, and speech therapy services were also covered.

The 1965 legislation did not include Medicare coverage for disabled persons under 65 even though they qualified for Social Security Disability payments. However, the Social Security Amendments of 1972 extended Medicare coverage to this population. These Amendments also created a new program called Supplemental Security Income (SSI) for poor persons who were disabled, blind, or disabled who were not eligible for Social Security Disability payments. This population was eligible for hospital and physician services under Medicaid.

How were acute care general hospitals and rehabilitation hospitals paid under Part A? Initially they were paid on the basis of their costs, including an allowance for capital costs. Cost-based reimbursement encouraged hospitals to expand their facilities and services. However by the 1980s Congress felt that some of the more perverse incentives of cost-based reimbursement (e.g., the more days a patient spends in the hospital, the more revenue for the hospital) were leading to unsustainable increases in national health expenditure and the federal budget. Congress's answer was to impose the DRG (diagnosis-related group) system on acute care hospitals, designed to pay hospitals on the basis of a fixed price for a particular diagnosis and corresponding treatment rather than how many days a patient spent in the hospital and the cost of services used during those days. Due to successful lobbying efforts by its advocates, rehabilitation hospitals were initially excluded from the DRG system and remained on the cost-based system. (The reasons for the exclusion are explained in the next section.) As a consequence, acute care hospitals, where patients generally receive short-term treatment for severe injuries or episodes of illness, now were incentivized to discharge their patients sooner rather than later to rehabilitation hospitals, still reimbursed on the basis of cost. This development was not only a boon to Sunnyview but also a catalyst for other acute care hospitals in the area to start up their own rehabilitation units. By the 1990s, the vast majority of Sunnyview admissions were covered by Medicare.

At the turn of the century, Sunnyview was one of four free-standing, independent rehabilitation hospitals in New York State and there were only 12 comparable hospitals in the United States. Controlled by its own board, Sunnyview was in charge

of its own destiny. As the next section will show, the financial forces unleashed by Medicare drastically changed the institutional landscape in the Capital District.

MERGERS: NORTHEAST HEALTH AND ST. PETER'S HEALTH PARTNERS

In 2007, Sunnyview merged with Northeast Health, a healthcare system headquartered in Troy, NY. To understand why Sunnyview chose to merge with Northeast Health, one must look at the conditions that existed in 2002 influencing the operation and financing of hospitals. Dramatic changes were occurring throughout the entire healthcare system with most being driven by changes in Medicare, administered by the federal Centers for Medicare and Medicaid Services (CMS). Local competition with other hospitals and increasingly new competition from nursing homes was also a factor. For Sunnyview, as for all inpatient rehabilitation facilities (IRFs), upheaval was associated with what came to be known as "the 75% rule."

The origin of the 75% rule goes back to the creation in 1983, by Medicare, of the inpatient DRG reimbursement payment system for acute care general hospitals. Since CMS did not have a system for paying IRFs under this new program, they continued to pay the Sunnyviews of the world on a cost basis. Since this was a very favorable system for rehabilitation hospitals, CMS wanted to insure that only IRFs would qualify. But there was a problem. How would they differentiate the acute care general hospital, characterized by short average lengths of hospital stay, from the rehabilitation hospital? They asked the rehabilitation field how they should tell this difference. The field responded with the statement that most, but not all, of the patients they treated fell into 10 diagnoses. The diagnoses included: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, polyarthritis (including rheumatoid arthritis, neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease), and burns.

Accordingly, CMS basically said "as long as 75% of your discharges fall into one of those diagnoses, we will count you as an IRF and pay you your cost". This provided substantially higher payments for IRFs than for acute care general hospitals. Most significantly, CMS never enforced the rule that would have constrained the rehabilitation field to only treating those original 10 diagnoses.

With such favorable reimbursement, it is no surprise that this caused an explosion in the development of rehabilitation hospitals and rehabilitation units within acute care general hospitals. Such hospitals and units provide acute rehabilitation care -- medically-based, multidisciplinary and intensive in its approach to treatment. It helps patients experiencing a loss of function from injury or illness to become as independent as possible in the activities of daily living so they may return to their communities and jobs. Acute rehabilitation care is more time and resource intensive than sub-acute care, usually provided in skilled nursing facilities, but which also underwent significant expansion.

By the turn of the century, the total cost of providing care in the IRFs became significant enough to get the attention of CMS. The result was a change to a DRG reimbursement system for acute rehabilitation (somewhat similar to the one for acute care general hospitals) and a simultaneous proposal to enforce the 75% rule, using the original 10 diagnoses. Without enforcement of the original 10 diagnoses, acute medical care as well as acute rehabilitation care, unconstrained, advanced significantly in its ability to benefit those with other diagnoses, particularly orthopedic joint replacements, cardiac and pulmonary conditions as well as post-transplant surgery, cancer, pain, etc. But CMS, without updating the original list of 10 rehabilitation diagnoses, decided to enforce the rule.

By this time, most acute rehabilitation providers across the nation were not meeting the 75% rule and forced closure became a real possibility. Faced with the possibility of having to greatly shrink its size or close completely, the Sunnyview board considered its options which included seeking a "Schenectady solution" by combining with Ellis and St Clare's, who presumably might be willing to join forces rather than compete with each other, or choosing to merge with one of the three largest healthcare providers (Albany Medical Center, St Peter's Healthcare Services or Northeast Health). Other options explored and discarded included waiting to see if its local competition would fail (the "last one standing option") or to build its own "Sunnyview System," a capital intensive, lengthy project.

The Schenectady solution was pursued including meeting with the Albany Bishop, whose diocese "owned" St Clare's. However, the Bishop declined to pursue this path after a proposed merger between Nathan Littauer Hospital (Gloversville) and St. Mary's (Amsterdam), which he supported, went awry. That left the three major local systems. After extensive contacts and due diligence, the decision was made to merge with Northeast Health and become part of their full continuum of care (acute care, acute rehabilitation care and several levels of post-acute care, home care, and retirement communities). Additionally, NEH agreed to use Sunnyview as their acute rehabilitation provider and eventually close its 37-bed rehabilitation hospital in Cohoes.

It was often asked why the board chose to pursue NEH when the hospital was physically connected to Ellis Hospital, the major source of referrals. It was carefully explained to the community that the unique historical relationship with Ellis had resulted in both hospitals enjoying most of the benefits that any further actual merger would provide. It had long been an established tradition for the hospitals not to compete but to complement each other. As such, each traded services based on cost. Sunnyview provided some inpatient therapy services to Ellis and purchased pharmacy, laboratory, high-end radiology (MRI, etc.) and other hospital-based diagnostics. Since the costs also covered overhead, whenever Sunnyview admitted a patient, the Ellis bottom line improved.

The unique Ellis-Sunnyview relationship also included the joint building of the present boiler plant serving both hospitals. Even the 99-year lease on the Sunnyview land for the present Ellis MRI unit was made for $1! Such was the extent of the historical cooperation. So, when considering a merger with Ellis, there was little additional benefit to be gained and no added competitive advantage.

The merger with NEH became effective on January 1, 2007 and within two years the Cohoes Rehabilitation Hospital was closed and Sunnyview was receiving all acute rehabilitation referrals from Samaritan Hospital in Troy and Albany Memorial Hospital (NEH hospitals.)

Four years later Northeast Health merged with St. Peter's Healthcare Services and Seton Health in Troy to become St. Peter's Health Partners. While a much more elaborate and difficult merger both technically and politically, the decision for NEH and St Peter's to merge was in some ways easier for the boards to make. Both systems were strong and financially stable. Each lacked, however, pieces that the other held. The world of healthcare was, and still is, moving toward larger systems that encompass the entire continuum of care from tertiary acute care to the many components of the post-acute continuum. Northeast Health had two community hospitals (Albany Memorial and Samaritan in Troy) but no large tertiary hospital with its attendant high-end medical and surgical services, especially cardiac and orthopedic. At the same time, St. Peter's had limited pieces of the post-acute continuum. NEH had several skilled nursing facilities, the region's largest home care agency, hospice, durable medical equipment and home infusion companies, plus senior housing with independent and assistive living, including dementia units, and skilled nursing. Ultimately Sunnyview became the only institution offering acute rehabilitation service for the entire system, St Peter's having closed its competing rehabilitation unit.

Eleven years later in 2018, what has been the result of the Sunnyview mergers? In 2007 Sunnyview was unable to fill its beds with patients in compliance with the 75% rule diagnoses. A budgeted bed census above 80 was difficult to maintain and projected to be impossible as orthopedic joint replacement patients increasingly could be treated without an acute rehabilitation stay in the hospital. Financially, Sunnyview was facing a downhill spiral. Producing a positive operating margin did not seem possible. The merger with NEH and subsequently St. Peter's Health Partners changed the dynamic. Instead of having to downsize to survive, Sunnyview increased its bed capacity to 115 with growing, sustainable operating margins and strong bottom line while remaining in full compliance with the now 60% CMS rule (a compromise solution to the original 75%).

Chief Yates and Dr. Warner would be extremely gratified by the progress made by their 10-bed home for crippled children as it grew to a remarkable, regional 115-bed comprehensive rehabilitation hospital. Clearly this 90-year journey could not have been made without dedicated and talented medical and civic leaders supported by donors, volunteers, and the wider community.

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Authors:
James M. Strosberg, MD was the first Chief of Rheumatology at Sunnyview and also served as President of the Medical-Dental Staff. He is a past Chief of Medicine at Ellis Hospital and past President of the Schenectady County Medical Society.

Bob Bylancik, MSW joined Sunnyview as a Social Work Intern in 1969, later ran the social work department and retired as CEO serving from 2000 until 2007. He is currently on the Board of St Peter's Health Partners where he serves on the Quality Committee and Chairs the Continuing Care Committee.