State of Connecticut

Hospital System Strategic Task Force Report

Findings and Recommendations

January 8, 2008

Co-chairs:

Robert Genuario, Secretary
Office of Policy and Management

Cristine Vogel, Commissioner
Office of Health Care Access

Task Force Members

Governor Rell appointed the following individuals to the Hospital System Strategic Task Force:

Co-Chairs:

Robert L. Genuario
Secretary, Office of Policy & Management

Cristine A. Vogel
Commissioner, Office of Health Care Access

Members:

Evelyn Barnum, *Chief Executive Officer, Connecticut Primary Care Association*

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Arthur W. Brodeur, *Chair, Planning Committee, Windham Hospital*

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Mary Anne O'Neill, *Associate Legal Counsel, Office of the Governor*

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Foreword

Concerned about the condition of Connecticut hospitals and Connecticut residents' access to health care, in April 2007, Governor M. Jodi Rell announced the formation of a task force (Appendix A) to develop strategies to stabilize and chart the future course of hospitals in Connecticut, many of which are facing financial hardship. Governor Rell appointed Robert L. Genuario, Secretary of the Office of Policy and Management (OPM), and Cristine A. Vogel, Commissioner of the Office of Health Care Access (OHCA), to chair the Hospital System Strategic Task Force. Task Force members included state agency commissioners, legislators, and individuals representing hospitals, the business community, community health clinics, consumer advocates, primary care providers, physicians, emergency department physicians, nurses, and insurance companies (Appendix B). The Task Force organized itself into three subcommittees to address the major issues facing hospitals: Finance, Utilization and Planning, and Workforce. In addition to input from Task Force members, on November 13, 2007, the Task Force held a public hearing to encourage feedback in response to preliminary recommendations made by the Task Force subcommittees.

The Governor requested that the Task Force examine the current financial health of Connecticut's hospitals, access to care, emergency room utilization, affordability, alternative delivery of primary care and the 'Certificate of Need' process.

The Task Force is part of Governor Rell's broader effort to ensure that all residents of Connecticut have access to quality, affordable health care. In December of 2006, the Governor announced her Charter Oak Health Care benefit plan, which is expected to provide low-cost health insurance to single people and families who cannot currently afford private insurance. The plan – targeted at lower income people, newly graduated college students, and self-employed people, many of whom may not have access to employer-sponsored health insurance and do not qualify for programs such as HUSKY or Medicaid – is intended to provide health insurance for about $250 a month, and includes state subsidies. In addition, Governor Rell has strongly supported Bond Commission funding for expansion and equipment at community health centers, announcing in September 2006 nearly $26 million for expanded medical and dental facilities in communities all across the state, enabling the centers to serve some 85,000 additional new patients.

This report of the Governor's Task Force builds upon the work completed by the Legislative Program Review and Investigations Committee and the action taken by the Administration and Legislature in the 2008–2009 biennium budgets to increase Medicaid funding for hospitals. The goal of this report is to provide recommendations that will further stabilize the health care delivery system in Connecticut as it explores serious workforce challenges, access limitations and some fundamental financial structural issues.

I. Highlights of the Task Force

Health care has changed significantly in recent years from hospital-based to outpatient-based services. More diagnostic and treatment procedures are provided to patients from an office or freestanding facility instead of a hospital. Hospitals, however, have remained cornerstones in their communities both as health care providers and as a safety net for patients who may not have access to the outpatient options due to facilities' suburban locations or patients' insurance status. The role as safety net provider, combined with escalating costs, has financially stressed many hospitals. In hospital Fiscal Year (FY) 2006 (covering the period October 1, 2005 through September 30, 2006), the average statewide hospital total margin was reported at 2.51% and the average statewide hospital operating margin was 0.62%. This low operating margin indicates that hospitals' patient revenue and expenses are practically breaking even. This report, and the recommendations that follow, focus mainly on the hospital delivery system of care and offer some short and long-term strategies to sustain the financial viability of the hospital system.

Due to the complexity of the subject, three task force subcommittees were formed to focus on specific areas of concern: (1) system-wide utilization and planning, (2) workforce issues, and (3) financial structure. The Task Force received recommendations from each subcommittee, from which several themes emerged:

- Connecticut has a relatively strong employer-sponsored health insurance coverage population that could be jeopardized if premiums continue to increase, which may in turn lead to fewer people having coverage.
- Ongoing cost increases, coupled with low reimbursement, have resulted in financial instability for many of Connecticut's hospitals.
- The economic pressure to make up for low operating margins by focusing on the highest-paying reimbursement sources (typically commercial insurance) leads to overlap in services and competition among hospitals for the services they provide.
- Emergency departments continue to experience an increase in volume of non-emergent cases more than likely related to a lack of access to primary care services.
- Emergency departments continue to struggle to provide appropriate and timely access for persons with psychiatric and/or substance abuse disorders (i.e., behavioral health patients in need of diversion or step-down to inpatient, residential, outpatient or other levels of care).
- Cost shifting from government-sponsored programs to private/commercial payers due to relatively low reimbursement rates from the former is unsustainable for both commercial payers as well as hospitals.
- The shortage of health care professionals (e.g., physicians, nurses, and allied health) limits access to primary care, medical specialties and exacerbates emergency department "on-call" coverage pressures.
- The fragile financial stability of many Connecticut hospitals is directly impacting their ability to obtain capital funding in order to provide modern facilities and keep pace with changing technology and patient and workforce safety.

There is no single solution to ensure hospital financial viability, but a combination of strategies will need to be applied before success can be realized. Connecticut has a strong health care delivery system that provides excellent care; this report focuses on the areas of weakness within the system and provides robust recommendations that should have a lasting impact.

II. Discussion of the Connecticut Hospital System

A. Overview of Connecticut Hospitals

Utilization, payer mix and competition are among the key factors that determine the financial strength of a hospital. Utilization is a measure of demand for health care services and directly impacts the revenue stream. Hospitals develop their budget projections using historical utilization measures and the reimbursement that will be received based on the payer source. The payer sources are generally grouped into five major categories: Medicare, Medicaid, commercial/private payers, the "uninsured," and "other" public programs. A hospital charges the same amount for a service to all patients, but what a hospital receives in payment for that service varies among payers. Competition enters into the financial condition of a hospital as they directly market and advertise for the most profitable patients and the most qualified professional staff.

Competition in the health care marketplace has changed. Hospitals compete for patients that require the more profitable services, such as elective angioplasty, specialized diagnostic technology for cancer care, inpatient orthopedic surgery and outpatient imaging and surgery. The nature of competition has also changed. Not only do the hospitals compete against other hospitals, but they also compete against privately-owned, free-standing facilities. Although Connecticut's Certificate of Need program may have slowed the growth and proliferation of such private outpatient facilities in comparison to other states, it is of great concern to hospitals because, unlike private outpatient facilities, hospitals must provide care to all patients regardless of insurance status and provide continuous emergency access. The shift in hospital payer mix attributable to the influx of privately-owned, free-standing facilities may hinder hospitals' ability to reinvest in their facilities and the health of the communities they serve.

The Task Force discussed the impact these issues have on the hospitals' bottom-line, and the report provides recommendations that specifically address these issues. Additional appendices have been included in this document for reference purposes.

B. Utilization of health care services

The Connecticut hospital system consists of 30 acute care hospitals (29 acute general hospitals and one children's hospital) totaling 9,256 licensed beds, with 7,231 of these beds staffed for patient care. Each hospital operates an Emergency Department 24 hours per day, seven days a week with an additional five emergency departments considered satellite facilities to the hospital (Appendices C and D). In FY 2006, there were 424,475 discharges from hospital inpatient services and 1.4 million hospital emergency department visits. It is important to note that statewide, inpatient staffed beds were occupied 78% in FY 2006, however, there are differences among individual hospitals. For example, New Milford Hospital is at 47% while Norwalk Hospital is at 98% occupancy.[1] This indicates that the demand for inpatient services is different throughout the state, and with such variation general statewide assumptions may be misleading. Many hospitals which are at or near capacity of their staffed beds have additional licensed beds that could be used to alleviate crowding within the emergency department. However, there are multiple issues to overcome before these beds can be added to the existing system including: staffing shortages, lack of space to bring the beds into operation and the capital costs associated with adding beds due to high construction/renovations costs.

The number of inpatient discharges has been increasing slightly from 416,300 in 2004 to 424,475 in 2006. Along with increases in discharges, the number of staffed inpatient beds has also increased from 7,182 to 7,231 in the same period. Full time equivalents (FTEs) for the same timeframe have increased from 45,741 to 47,524. However, when comparing number of discharges with the population, the utilization rate has declined overall, as shown in Table 1. In FY 2004, the number of discharges per 1,000 population was 123 while in FY 2006 it was reported at 121 discharges per 1,000 population.

Table 1: Inpatient Acute Care Utilization Rate for CT Discharges, FYs 2004-2006

	FY 2006	FY 2005	FY 2004
Discharges	424,475	423,179	416,300
CT Population	3,504,809	3,394,751	3,389,483
Utilization Rate (discharges/1,000 population)	121	125	123

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database and U.S. Census Bureau 2004-2006 Population Estimates

With the nearly 2% increase in inpatient discharges from 2004 to 2006, the hospitals with the largest three-year percent increases in total discharges were Johnson (+16%), Hospital of Central Connecticut (formerly New Britain) (+13%) and MidState (+9%). Hospitals with the largest three-year percent decreases were Day Kimball (-12%), Rockville General (-10%) and Backus (-8%). As shown in Table 2, a wide variation in inpatient utilization exists and issues of demand and capacity are regional (if not local) and are not statewide.

Table 2: Connecticut Acute Care Discharges, FYs 2004 & 2006

	Discharges		Change	
Hospitals	FY 2004	FY 2006	#	%
Bradley Memorial **	2,319	2,369	50	2
Bridgeport Hospital	20,091	19,582	-509	-3
Bristol Hospital	8,357	7,954	-403	-5
Charlotte Hungerford	6,304	6,195	-109	-2
Connecticut Children's Medical Center	5,498	5,615	117	2
Danbury	19,522	20,403	881	5
Day Kimball	6,475	5,668	-807	-12
Essent-Sharon	3,040	2,880	-160	-5
Greenwich	11,391	12,348	957	8
Griffin	7,341	7,430	89	1
Hartford	37,734	39,490	1,756	5
Hospital of Saint Raphael	25,378	25,354	-24	0
John Dempsey	9,556	9,923	367	4
Johnson Memorial	3,624	4,212	588	16
Lawrence and Memorial	14,869	14,696	-173	-1
Manchester Memorial	8,668	8,958	290	3
Middlesex Memorial	12,089	12,866	777	6
MidState Medical Center	9,038	9,812	774	9
Milford Hospital	5,058	4,971	-87	-2
New Britain General**	16,663	18,623	1,960	12
New Milford	3,316	3,116	-200	-6
Norwalk	15,945	15,341	-604	-4
Rockville General	4,017	3,600	-417	-10
Saint Francis	32,527	31,647	-880	-3
Saint Mary's	12,069	12,984	915	8
Saint Vincent's Medical Center	19,182	19,672	490	3
Stamford	17,231	17,003	-228	-1
Waterbury	15,027	15,003	-24	0
William W. Backus	11,923	11,021	-902	-8
Windham Community Memorial	5,091	5,385	294	6
Yale-New Haven	46,957	50,354	3,397	7
Statewide	416,300	424,475	8,175	2

Source: CT Office of Health Care Access Acute Care Hospitals Discharge Database

** Effective 10/1/2007, the two hospitals merged to become the Hospital of Central Connecticut.

System capacity is generally measured by the number of inpatient beds. When compared with the population to determine a "use rate," Connecticut is below the national average with 2 hospital beds per 1,000 population versus the national average of 3 beds per 1,000 population.[2] Given such a difference, a review to identify the specific contributors and what interventions will be implemented should be completed.

Connecticut's hospitals serve as the safety net, caring for all patients regardless of their ability to pay. In Connecticut, like the nation, emergency departments (ED) are experiencing an overall trend of increased utilization. A small portion of the increase is due to population growth, while a larger percentage is attributable to more frequent use. In FY 2005, there were 1.4 million visits

to Connecticut EDs. For every 1,000 Connecticut residents there were 415 ED visits in FY 2005. This is higher than the national use rate of 387 per 1,000 population.[3] This ED use rate also changes significantly depending upon the hospital and the payer source. For instance, according to Connecticut Hospital Association (CHA) data, privately insured patients seek care at an ED at a rate of 250 visits per 1,000 population as compared to State-Administrated General Assistance (SAGA) patients at 1,578 visits per 1,000 population (Table 3).

Table 3: ED Utilization Rates by Payer Category, FY 2006

Payer Category	# visits/1,000 population
Privately Insured	250
Uninsured Patients	455
Medicare	615
Medicaid Managed Care	791
Medicaid FFS	1,092
SAGA	1,578

Source: *Connecticut Hospital Association*

The Task Force focused on the volume of primary care visits as a major contributor to ED "over-utilization." According to CHA, nearly one quarter, or just under 1,000 ED patients, are treated for non-urgent care on a daily basis. CHA also reported that Medicaid patients are four times more likely and the uninsured are two times more likely than the privately insured to visit the emergency department for non-urgent care. This care could be more appropriately provided in more cost effective settings such as a physician's office or a medical clinic, which would improve the continuity of care since EDs are organized to deliver acute and episodic care, not to address disease management or prevention. The demand for primary care is not adequately being met elsewhere, and consequently hospitals are experiencing noticeable increases in demand for this service, especially during evening hours and on weekends. Some of our larger urban hospitals reported that on an evening shift between 3:00 p.m. and 11:00 p.m., there are approximately 30 patients daily that could have been seen in a clinic or a physician's office.

Connecticut is mirroring a national trend, where more people are becoming dependent on the emergency departments for their primary care. Some reasons patients are choosing the ED for non-urgent care include the shortage of primary care physicians, limited evening and weekend hours in private offices and the convenience of not needing an appointment to receive care. High ED utilization by the Medicaid population is also attributable to the decreased number of primary care physicians accepting Medicaid patients due to the state's low reimbursement rates and administrative difficulties; lack of information regarding the assignment of a primary care physician; and the overflow from Federally Qualified Health Centers (FQHC) due to lack of expanded hours and specialty services. The FQHCs could play a larger role in the care of these patients but they have limited evening and weekend hours during the period of highest utilization and often do not have specialists on staff. Although some FQHCs may be less accessible to the Medicaid population in some areas of the state (see Appendix E), concerted efforts may be needed to educate and direct patients to these facilities before they turn to emergency departments for their primary health care needs. As the demand for primary care continues to increase, the State should examine the number and locations of services and address redirecting non-urgent care from the emergency departments to more appropriate and cost effective settings.

Increased patient wait times are further exacerbated by a shortage of emergency department nurses and "on-call" physician specialists. It is not uncommon for a patient to wait up to two

hours for a specialist to arrive (e.g., a hand surgeon). In prior years, hospitals required physicians to provide a number of hours of on-call coverage, but due to a shortage of physicians, medical liability issues, competition among hospitals and physicians making "quality of life" choices, some physicians are now paid for "on-call" hours -- an additional cost to hospitals. Hospitals are also faced with the difficult challenge of recruiting and retaining nurses in high demand clinical areas such as the emergency department. Nurses in these settings are particularly challenged by high utilization and staffing shortages, complex patients with behavioral health and substance abuse needs, difficult patients who are violent or suicidal, and patients recently released from state prisons. The state contracts with the University of Connecticut to provide health care for inmates, but there are limited options for their health care needs once they are released, so they frequently seek care at emergency departments.

The American Hospital Association (AHA) states that behavioral health disorders are a major public health issue.[4] Hospital EDs are typically the only or the last alternative for patients with behavioral health or substance abuse needs. There is inadequate access to inpatient, residential, skilled nursing, specialized housing and other intermediate and "step-down" levels of care to meet the growing needs of this population. It is common that these patients will present with both mental health and substance abuse issues, as well as physical health problems. Numerous hospitals reported the complexity involved in caring for these patients -- high average length of stay in the emergency department, resource-intensive services, inadequate medical staff training to address their needs, lack of appropriate referral options and a need for more intermediate mental health beds. Hospital EDs are not structured for long stay admissions such as these, which require extensive care. Some of the State's larger hospitals gave anecdotal evidence of very long wait times to place patients in an appropriate mental health inpatient facility. The Task Force heard input that the behavioral health network is fragmented, lacks appropriate inpatient and outpatient facilities, mental health workers and continuity of care. Despite several successful initiatives by the Department of Mental Health and Addiction Services (DMHAS) over the past few years, and over $15 million in expenditures per year to hospitals for those efforts, there is consensus that significant challenges remain in ensuring timely access to preferred, less expensive and appropriate care for some persons presenting at EDs with psychiatric and/or substance abuse disorders.

Utilizing emergency departments for non-urgent care results in excessive waits, lack of continuity of care, costly duplication of testing and services, limited access to specialists, and detracts from the care for those with true medical emergency needs. The emergency departments cannot continue to be the safety net for primary care and mental health/substance abuse visits and maintain the quality care our citizens expect from our hospitals.

Along with the utilization of health care services, the Task Force members acknowledged and agreed that the state should look to the State Health Plan and a State Health Care Facilities Plan to chart the direction of the health care system in the future. Many states in the nation operate under an approved state health plan which provides guidance and direction for the expansion or the reduction of health care services and facilities.

State health planning is the process of assessing health services for and the health status of Connecticut residents and identifying needs for state, local, public and private resources to address identified gaps through policy development and program implementation. A State Health Plan provides the framework for program planning and evaluation with goals and objectives that focus on health status (to reduce death, disease, and disability), risk reduction (to

reduce the prevalence of risks to health), and services and prevention (to increase comprehensiveness, accessibility, and quality of preventive services and interventions). The Facilities Plan addresses the access issues regarding the functions and/or services that providers offer to patients based on the population and disease incidence, according to the State Health Plan, in a particular region of the state.

Having stated the need for more health planning, members did not feel that the financial condition of some of the hospitals was directly related to duplicative services or lack of regionalizing hospital resources. Given the disparity in inpatient bed utilization levels in some regions as noted in Table 2 of this report, this topic may warrant further review. There was some discussion at the subcommittee level that regionalizing certain functions and/or services would reduce competitive costs, overhead costs and may assist in the work force shortage issue. The Task Force felt that a more concentrated effort with state health planning, in particular the facilities component, would benefit the Certificate-of-Need (CON) process. Some states have adopted facilities plans that provide principles, criteria, standards and methodologies that serve as the basis for CON decision-making. Therefore, the current CON process would be adjusted to respond to such a plan.

C. Workforce supply and demand challenges

Workforce shortages are one of the leading factors influencing the rising cost of providing care in Connecticut's hospitals. Hospitals report struggling with expenses related to recruiting and retaining health professionals. The health care industry in Connecticut currently faces personnel shortages in physicians, surgeons, specialty areas, nurses and allied health professionals. The demand for health care services already exceeds the number of health care workers and the shortages are expected to continue into the foreseeable future, as baby boomers age and the need for health care grows. In addition to aging patients, many physicians and nurses are among the baby boomers who will retire in the next three to five years. The Task Force heard testimony that one third of Connecticut's practicing physicians are age 55 or above and the average age of registered nurses in Connecticut is in the mid-to-late forties.

Connecticut's physicians, along with representatives from the Connecticut State Medical Society, highlighted the severity of physician shortages in our state, particularly in subspecialty areas. The shortage is linked to several issues. Since Connecticut has one of the highest costs of living in the nation, it is difficult for the state to retain or attract recent medical student graduates, as they cannot afford to establish and maintain a practice, raise a family and pay back significant student loans. It is believed that physicians and recent medical school graduates are choosing to practice in other states with a lower cost of living, limitations on medical malpractice claims and fewer on-call requirements.

There is an inadequate health care workforce within the state to meet all the needs of every hospital. In some areas of the state, physicians and surgeons are affiliated with more than one hospital in an attempt to meet patient and hospital staffing needs. Consequently, physicians are required to be on-call at more than one institution (either as primary or backup), and when needed, must travel from hospital to hospital to provide on-call services. The Task Force heard anecdotal evidence that one Connecticut subspecialty practice spent five years trying to hire an additional surgeon, while its two surgeons served as backup to each other at two different hospitals.

Connecticut is unable to meet the growing need for surgeons and subspecialty surgeons mainly due to the high cost of malpractice premiums and the on-call burden. Attempting to decrease their liability risk, some surgeons and subspecialty surgeons with high malpractice premiums are either choosing to leave the state or are narrowing their practice by no longer providing surgical, emergency room and trauma care. On-call physicians are also burdened with the possibility of having to provide care in a subspecialty area that is not their area of expertise.

The President of the University of Connecticut (UCONN) provided additional written testimony stating that in the past three years, more of UCONN's medical school graduates receive their advanced training residencies in the state than anywhere else in the country (32% in 2007). It appears, however, that once residencies are completed, these newly-trained physicians may be choosing to practice outside of Connecticut. According to the Association of American Medical Colleges (AAMC), Connecticut ranks in the bottom quartile of physicians under age 40 and in the top quartile of physicians age 60 and older. So, Connecticut is faced with the dilemma of a limited number of new physicians to replace a large number of aging physicians as they retire.

Medical students stated at the public hearing that work/life balance is a top influencer of how they select a specialty; and that they are choosing areas with fewer hours and on-call obligations and higher salaries. Compounding the specialty shortage, aging physician workforce and high costs of living is the decreasing number of medical students choosing to practice in underserved areas. Medical students are also not specializing in primary care due to patient load, long hours, and lower wages.

The medical professional shortage facing the state is not limited to physicians. The federal government has projected that Connecticut will have the fifth highest nursing shortage in both 2015 and 2020.[5] While comprehensive data on hospital costs associated with recruiting and retaining health care employees are not available, preliminary findings from a recent survey by the CHA for the Task Force's Workforce Subcommittee found that hospitals reported significant annual expenditures on travel/agency nurses and other health care professional activities, continuing education, recruiter fees, sign-on bonuses, and tuition reimbursement.

Hospitals face several significant cost issues involving recruiting and the retention of nurses. First, hospitals are continuously competing for available nurses, offering sign-on bonuses and other incentives in an effort to attract staff. In addition, hospitals spend considerable dollars in the recruitment and training of newly hired nurses, whose turnover is the highest in the first two years. Moreover, many advanced degree nurses who are needed to manage and train new nurses move into non-hospital work settings that offer increased salaries, more appealing work hours and environment, and a less stressful workplace. Patient workload strains due to rising patient acuity levels sometimes associated with an aging population and inadequate staffing also contribute to the departure of nurses from hospital-based jobs. Hospitals need to become more desirable places to work and develop plans that take into consideration national "best practices." For example, additional physical challenges face hospital nurses who care for elderly, frail and obese patients. Hospitals that are financially distressed are unable to invest in equipment that may prevent worker injuries, such as specialized patient lifts and carriers. High vacancy rates are being seen in specialty fields such as emergency department and psychiatric nursing. These are specialty areas that often deal with challenging and complex patients and typically experience higher patient loads.

Compounding the problem is the fact that nursing colleges and universities face challenges to expand enrollment levels to meet the rising demand for nursing care. Traditionally, schools of nursing respond to workforce shortages by expanding enrollments. However, it is difficult for academic institutions to attract qualified nursing faculty because they must compete with higher nursing salaries offered in hospital settings or in non-clinical professional positions. Due to the shortage of nursing faculty, the Task Force heard that the state has had to deny a considerable number of nursing school applications. In 2005, Connecticut turned away 2,000 qualified nursing school applicants. Nationally, the number of denied applicants for nursing school is at its highest ever, increasing almost six fold since 2002.[6] According to the written testimony of UCONN's president, a 2005 report issued by the Connecticut League of Nursing Deans and Directors Council states that an additional 33 full-time faculty are needed to combat the current shortage. These positions are in addition to the existing 26 faculty vacancies that exist at UCONN today. The state will continue to see nursing shortages until it can adequately staff its nursing education programs to allow a sufficient number of people into the nursing program to meet the needs of the growing aged population.

Currently, there is no cohesive state action plan that looks at recruitment, retention, mentoring, marketing and education of health care professionals; the Task Force heard that Connecticut's current approach is fragmented. More than one agency is responsible for licensing and student loan forgiveness. Some allied health professionals in Connecticut are not required to be licensed (e.g., ultrasonographers and diagnostic imaging technicians), therefore it is difficult to assess the existing shortages in these fields without adequate data. The state cannot identify the numbers of *licensed and practicing* health professionals in order to accurately project the location, specific professions and extent of workforce shortages. It cannot currently determine if the health professionals being educated in Connecticut remain and work in the state or live here but work in neighboring states, or leave the state entirely. There is a clear need for better data on health care professionals that can be used for education, recruitment, marketing and forecasting purposes.

D. Financial status and challenges

The statewide average total margin for Connecticut hospitals in FY 2006 was 2.5% down from 3.3% in FY 2005. The operating margin average also declined in FY 2006 to 0.6% from 1.7% in FY 2005. Six of the 31 hospitals in FY 2006 reported negative total margins with an additional eight hospitals at or below 1.0% total margin. However, there is significant variation among the individual hospitals. For example, total margins for FY 2006 ranged between -8% and +9.1% (Table 4). The variation is due to the payer mix, reimbursement rates from those payers, investment income, and the competitive market forces faced by each hospital.

Table 4: Five Year Average Total Margin FY 2002 - FY 2006

	FY 2002-2006 5 YEAR AVERAGE	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
CTCMC	-4.05%	-12.87%	-2.88%	1.95%	-3.54%	-4.61%
BRISTOL	-3.13%	0.08%	-0.22%	-3.00%	-3.89%	-7.99%
BRADLEY	-2.08%	-3.95%	-5.43%	-2.01%	-0.24%	0.16%
WATERBURY	-1.23%	-0.30%	-4.72%	1.17%	-0.01%	-2.39%
SAINT MARY	-1.15%	-10.48%	0.38%	7.33%	-4.32%	0.44%
WINDHAM	-0.85%	0.14%	-5.66%	-0.24%	0.79%	0.27%
JOHNSON	-0.45%	0.29%	-1.11%	2.02%	1.21%	-4.30%
SAINT RAPHAEL	-0.32%	-1.37%	1.27%	1.62%	-0.86%	-2.11%
MANCHESTER	0.20%	-0.90%	-2.50%	-0.81%	4.56%	0.12%
NEW MILFORD	0.38%	1.98%	0.94%	1.04%	1.16%	-2.42%
GRIFFIN	0.61%	1.98%	-1.80%	1.30%	0.35%	1.05%
NORWALK	0.84%	0.25%	0.99%	0.98%	1.82%	0.12%
ROCKVILLE	1.01%	5.45%	-0.12%	-2.12%	-4.33%	5.42%
MILFORD	1.10%	-0.63%	0.28%	1.73%	0.72%	2.94%
HARTFORD	1.17%	0.11%	0.26%	2.02%	1.61%	1.58%
SAINT FRANCIS	1.36%	3.02%	2.35%	0.02%	0.80%	0.96%
STAMFORD	1.70%	-2.52%	-5.06%	1.64%	5.13%	6.06%
HUNGERFORD	1.82%	-0.60%	2.86%	3.73%	1.75%	1.15%
DEMPSEY	2.14%	0.64%	1.89%	1.75%	3.85%	2.05%
BRIDGEPORT	2.31%	1.14%	0.41%	1.87%	3.43%	4.06%
NEW BRITAIN	2.31%	-0.97%	-3.73%	3.57%	6.04%	4.28%
DAY KIMBALL	2.61%	0.79%	3.55%	2.92%	4.11%	1.53%
BACKUS	3.50%	3.56%	3.52%	3.71%	2.17%	4.52%
MIDSTATE	3.84%	3.55%	3.86%	3.46%	5.64%	2.67%
LAWRENCE & MEMORIAL	4.31%	0.03%	1.56%	10.75%	2.78%	5.25%
GREENWICH	4.33%	5.80%	4.89%	3.71%	5.60%	2.16%
SHARON	4.48%	-1.44%	2.67%	7.14%	7.02%	2.97%
MIDDLESEX	4.58%	0.90%	2.63%	4.53%	8.46%	5.01%
YALE-NEW HAVEN	5.01%	5.27%	4.84%	4.87%	6.30%	3.88%
SAINT VINCENT	5.88%	-2.21%	-0.02%	7.90%	10.88%	9.10%
DANBURY	6.66%	6.17%	5.71%	5.56%	7.30%	8.04%
STATEWIDE (Note A)	2.27%	0.85%	1.14%	3.06%	3.34%	2.51%
AVERAGE (Note B)	1.58%	0.09%	0.37%	2.59%	2.46%	1.68%
Median (Note C)	1.36%	0.14%	0.41%	1.95%	1.82%	1.58%

Source: *Audited Financial Statements*

Note A: Weighted average by dollar amounts. Revenue in excess of expenses/(revenue from operations+(revenue in excess of expenses - gain/loss from operations))

Note B: Sum of margins divided by number of hospitals.

Note C: Middle margin in numerical order.

Connecticut hospitals are the safety net for the communities they serve and their ability to remain financially viable ensures continuous access to necessary services. Hospitals struggle with increasing expenses related to recruiting and retaining health professionals, acquiring advanced technology, improving and maintaining their facilities, and providing charity care for those without the means to pay for their care. They rely on patient revenue to cover their operating expenses.

Unlike other service industries, health care is an industry in which the patient receives a "service" prior to paying for it. Payment amounts vary by insurance plan and are often subject to negotiation. Rates paid to hospitals by state and federal programs are typically fixed and non-negotiable. Some payers reimburse above the cost of providing the care and some below the cost of providing care. A commonly-used measure that indicates the amount above or below hospitals' average costs and the reimbursement they receive is the "payment to cost" ratio. A ratio result that is higher than 1.0 is favorable (indicates reimbursement is greater than cost) and a ratio that is less than 1.0 indicates reimbursement is less than the cost of providing the service. In FY 2006, the statewide ratio of payment to cost was 0.95 for Medicare; 0.70 for Medicaid; and 1.21 for commercial/private payers. The variation of the payment to cost ratio among hospitals can be significant based upon their geographic location (e.g., two-hospital town, rural versus urban) and the degree to which patients from each of those payer sources utilize services. Hospitals with a large percentage of commercially covered patients and Medicare patients are typically financially stronger than those hospitals that provide services to a large percentage of Medicaid recipients and those without insurance. For a breakdown of inpatient discharges and percentage of total patient base by payer category, refer to Appendix F. The term "cost-shifting" refers to the shifting of reimbursement surplus (above costs) to cover reimbursement deficit (below costs). The Task Force discussed this topic extensively as one of the leading drivers to the financial instability of Connecticut's health care delivery system as it relates to utilization of the emergency departments, access to primary care services, behavioral health care services and inpatient care.

Of concern to the Task Force is the cost shifting to commercial or privately insured patients to cover the losses incurred from treating Medicaid Fee for Service (FFS), HUSKY and SAGA patients. The Task Force concluded that this is an unsustainable practice and leads to false expectation that employers will continue to pay higher premiums to cover shortfalls from public programs. Historically, Connecticut has had strong employer-sponsored insurance (ESI) coverage and a low uninsured rate. However, in recent years the state, like the nation, has seen the erosion of employer based coverage, with fewer employers offering health benefits, less comprehensive benefits packages and higher out-of-pocket costs for employees. If this pattern continues, hospitals' overall margins will be affected negatively by a decreasing share of commercial payers, as some of Connecticut's employers will no longer be able to offer their employees health care coverage. This is compounded by the fact that hospitals are also large employers and are faced with the same increases in employee benefits. It is vital to Connecticut's hospital system to maintain a strong commercial payer base.

Currently, about 60% of the state's residents have ESI, but with increasing premiums some employers, large firms in particular, either no longer provide health insurance coverage, have raised minimum eligibility requirements or have increased employee contribution requirements. Rising premiums are unsustainable for both employers and employees, rendering ESI inaccessible to employees and potentially adding to the ranks of the uninsured and potentially perpetuating the cycle of underpayments.

A close examination by the Financial Structure Subcommittee of costs and payments verified the gains and losses by each payer category. Table 5 shows the breakdown by payer on a statewide basis; however, there is significant variation among individual hospitals. For FY 2006, the losses experienced by hospitals totaled $-220.7 million for Medicaid programs and an additional $-98.3 million for other medical assistance programs. After considering Disproportionate Share Hospital (DSH) payments this $-319 million gap decreased to $-220 million. The loss attributed to Medicare patients was $-95.8 million; and the loss from patients without insurance was $-116.2 million. The only payer category where hospitals realized gains was from commercial payers, the statewide figure was $553.3 million. The statewide "bottom-line" for FY 2006 was a gain of $121 million from $6.4 billion of expenses.

Table 5: Statewide Acute Care Hospital Losses and Gains Attributable to Major Payers, FY 2006 (in Millions)

	Cost		Payment			
Payer	#	%	#	%	Gain/(Loss)	Payment to Cost
Medicaid	$746.9	12	$526.2	8	($220.7)	0.70
Other Medical Assistance	$188.4	3	$90.1	1	($98.3)	0.48
Total Medical Assistance Before DSH	$935.3	15	$616.3	9	($319.0)	0.66
UCP DSH	-	-	$57.5	-	-	-
Urban DSH	-	-	$31.6	-	-	-
Other DSH	-	-	$10.0	-	-	-
Hardship Fund	-	-	$0.0	-	-	-
Total Medical Assistance After DSH	$935.3	15	$715.4	11	($220.0)	0.76
Medicare	$2,659.4	41	$2,563.6	39	($95.8)	0.96
Tricare	$29.5	0	$29.2	0.4	($0.3)	0.99
Total Government Before DSH	$3,624.2	57	$3,209.1	49	($415.1)	0.89
Total Government After DSH	$3,624.2	57	$3,308.2	51	($316.1)	0.91
Commercial	$2,597.5	41	$3,150.8	48	$553.3	1.21
Uninsured	$189.1	3	$72.9	1	($116.2)	0.39
Total Nongovernment	$2,786.7	43	$3,223.7	49	$437.1	1.16
Total Before DSH	$6,410.9	100	$6,432.8	98	$22.0	1.00
Total After DSH	$6,410.9	100	$6,531.9	100	$121.0	1.02

Source: *CT Office of Health Care Access Hospital Budget System 12-Month Filings Schedule UCT & Department of Social Services*

Although the resulting payment to cost ratio was 1.02 (essentially a break-even) there is such variation among hospitals that this does not accurately reflect the individual hospital experience. The Task Force recommends conducting a comprehensive analysis of the current reimbursement system and of the multiple hospital reimbursement systems applicable to these state-funded programs in order to better align hospital reimbursement and costs associated with providing the care.

Today, the annual cost to operate <u>all</u> Connecticut hospitals is about $6.5 billion (Table 6). The single largest expense to a hospital is the people it employs to deliver the care patients need. The cost of employee salaries and benefits is 58% of overall cost. The largest increases to cost in the last five years are in non-physician salaries and benefits. It is this area where competitive tactics in recruiting nurses and other health professionals occur at significant cost to hospitals.

According to OHCA data, a review of the top hospital executive salaries shows an increase of 95% from an aggregated total of $22.9 million to $44.6 million between FYs 2002 and 2006 and a 200% increase (from $4.4 million to $13.7 million) in executive benefits; this accounts for a combined 2% of cost increases. Other areas that experienced significant increases are: "medical supplies and pharmaceuticals," (up 40%) which accounts for 17% of the increase in cost and "other than supplies and drugs," which includes leases and utilities, (up 27%) which also accounts for 17% of the increase in cost. Malpractice insurance grew by 66% and accounts for 3% of the five-year increase in cost. According to CHA, the average annual increase in hospital costs has been 6.3% for the last decade.

Table 6: Statewide Cost of Acute Patient Care

	FY 2002		FY 2006		% Share of	% Change
Expense Item	(in Millions)	% of Total	(in Millions)	% of Total	Increase in Total Expenses	between '02 & '06
Physician Salaries	$184.3	4%	$238.3	4%	3%	29%
Physician Benefits	$41.7	1%	$64.0	1%	1%	54%
Non-Physician Salaries	$2,124.7	44%	$2,680.5	41%	35%	26%
Top Ten+	$76.4	2%	$96.4	1.5%	1%	26%
Executives*	$22.9	0.5%	$44.6	0.7%	1%	95%
Non-Physician Benefits	$481.0	10%	$763.7	12%	18%	59%
Top Ten+	$14.1	0.3%	$22.8	2%	1%	61%
Executives*	$4.4	0.1%	$13.7	0.2%	1%	213%
Physician Fees	$180.2	4%	$210.4	3%	2%	17%
Supplies & Drugs	$686.6	14%	$963.3	15%	17%	40%
Other Than Supplies & Drugs	$1,021.6	21%	$1,298.3	20%	17%	27%
Malpractice Expense	$78.4	2%	$130.4	2%	3%	66%
Depreciation Expense	$285.0	6%	$355.5	5%	4%	25%
Interest Expense	$65.8	1%	$64.1	1%	-0.1%	-2%
Expense Recoveries	($266.3)	-5%	($286.7)	-4%	-1%	8%
Total Expenses	$4,883.1	100%	$6,482.0	100%	100%	33%

Source: *CT Office of Health Care Access Hospital Budget System Schedule 300*

+ Includes both physicians and non-physicians

* Includes presidents, chief executive, operating, finance and operating officers, and (senior) vice presidents. Does not imply exact comparisons of titles and salaries were made.

Every year Connecticut hospitals must overcome three significant fiscal challenges: covering the annual $95.5 million in losses from serving seniors enrolled in the Medicare program; covering the annual $319 million in losses from serving the disabled, mothers and children enrolled in the Medicaid, HUSKY and SAGA programs; and covering the annual $116 million in losses from serving individuals without health insurance. Although these shortfalls vary among individual hospitals, the Task Force heard that some hospitals handle reimbursement shortfalls by postponing much needed investment in technology and infrastructure. Statewide revenue for hospital operations totaled $7 billion last year, just $100 million more than statewide operating expenses. This narrow margin does not allow hospitals to reinvest adequately in their aging physical plants or in new technology necessary to keep them competitive. Hospitals lack access to capital investment funds which limits their ability to reinvest into new technology or plant improvements.

III. Recommendations of the Task Force

The Task Force's recommendations are intended to address many of the obstacles that hinder the financial strength of many Connecticut hospitals and the system as a whole. Although a combination of many recommendations will result in a more stable environment, the one issue that was most widely discussed was the commercial payer essentially "subsidizing" the deficit created by the reimbursement shortfall of the federal and state-funded programs. On the cost side of the equation, hospitals' largest expense is associated with salaries and benefits. There is such competition for qualified health care professionals that hospitals must compete aggressively. When they are not able to fill vacancies, hospitals pay high prices for travel/agency nurse coverage as well as premiums for specialty physician ED coverage. The shortage of physicians in Connecticut and the reimbursement shortfall is leading to access issues resulting in increased utilization of the emergency departments for primary care services and behavioral health services. The following 29 recommendations were developed by the Task Force and Subcommittee members to target the issues of utilization and planning, workforce, and the financial structure of the health care delivery system.

Related to state-funded health care programs:

1. Conduct a comprehensive study of the multiple hospital reimbursement systems applicable to the Medicaid fee-for-service, HUSKY and State Administered General Assistance (SAGA) programs to determine the most appropriate system for Connecticut. This study should be completed by October 31, 2008.

2. Increase hospital reimbursement to reflect reasonable costs to provide care to patients in the Medicaid fee-for-service, HUSKY and SAGA programs to ensure continued access to health care services.

3. Adjust hospital reimbursement rates based on Recommendation #1.

4. Support system changes using financial or other incentives to promote cost-effective service delivery that maintains and improves the quality of care offered by hospitals. Such changes should include, but not be limited to, enhancements in information technology that promote the interoperability of systems and/or organizations, electronic medical records and revenue cycle software systems.

Related to federally-funded health programs:

5. The Department of Social Services (DSS) should explore an application to the federal Centers for Medicare and Medicaid Services (CMS) for the inclusion of SAGA in Medicaid so that hospitals can receive all available Medicare DSH dollars. In exploring this application, DSS should consider the impact on state expenditures, hospital reimbursement and federal revenue to the state and to hospitals, and the likelihood of success of such application.

6. The Administration, business, and insurance industries should support Connecticut hospital initiatives to obtain adequate funding from the Medicare program.

Related to Access to Capital:

7. The Connecticut Health and Educational Facilities Authority (CHEFA) should establish a program to provide proceeds from revenue bonds backed by contract assistance of the state that would assist in making needed investments. The revenue bonds would be issued by CHEFA and the debt service paid by the State of Connecticut. Criteria to access such funding will be established by the Department of Public Health (DPH), DSS, CHEFA and the Office of Health Care Access (OHCA) in consultation with the Office of Policy and Management (OPM). Such criteria may include, but not be limited to, the improvement of quality and safety of patient care, work force safety, financial need, and/or consistency with the State Health Plan to include the state facilities plan. Proceeds of bonds may be made available to hospitals and federally qualified health centers in the form of grants, forgivable loans and very low interest rate loans for investment in plant and equipment or to repay higher costing debt.

Related to Utilization & Planning:

8. Reduce the inappropriate use and/or the extended lengths of stay for emergency department patients waiting to receive mental health and/or substance abuse services by increasing the capacity to provide such services in the appropriate setting within identified "high-demand" areas. The Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and DSS should work collaboratively to accomplish this goal that should include but not be limited to the following:
    - Develop recommendations for each identified "high-demand" area that will include the appropriate combination of services and be measured based on cost and quality outcomes.
    - Assess the existing capacity and volume of community mental health services and other programs as necessary to identify the gaps in services and adjust the funding allocation, services designs and geographic service areas as appropriate.
    - DMHAS, DCF and DSS, in consultation with OHCA and working with the Connecticut Hospital Association, providers and other stakeholders, should identify effective and feasible models of care for psychiatric emergency assessment or crisis response centers in order to expand access to behavioral health crisis and/or emergency services for adults and children.

9. Reduce the number of primary care visits that are being provided by emergency departments. This reduction can only occur with the development or expansion of alternative locations for patients to access primary care services; therefore, recommendations include, but are not limited to:
    - Develop a program to educate and inform patients as to appropriate ways to access primary care services and the choices available to them to receive such care.
    - Develop a program to encourage a shift in patient behavior to utilize available primary care services rather than accessing emergency departments for such care.
    - Support the on-going expansion of hours of operations and locations of primary care services.
    - DSS should implement a pilot program to schedule primary care services in the most appropriate setting utilizing, to the maximum extent possible, federal and other available non-state funding sources.

- The state should implement programs to facilitate information technology initiatives to better enable primary care providers to interrelate with hospitals and other providers in terms of scheduling and patient care.
- DSS, in concert with the Department of Correction (DOC), DMHAS, and the Judicial branch, should identify gaps in services and explore primary care services and other programs available to serve persons recently released from prisons so that they are not inappropriately directed to hospital emergency departments and so that they can be appropriately served in the community.
- DSS should explore the development of and reimbursement structure for specialist services in addition to primary care at the Federally Qualified Health Centers (FQHC) as a way of helping to alleviate hospital emergency department patient traffic.
- OHCA, in collaboration with state agencies, providers and industry stakeholders will conduct a study to measure current capacity of primary care services to identify geographical locations or segments of the population that are in need of additional access. This study should be completed by October 31, 2008.

10. Reduce the number of inpatients that have extended lengths of stay within the emergency department. Due to the complexity of this issue and variation among hospitals, individual hospitals should be allowed the flexibility to develop a plan in conjunction with DPH and in accordance with state and federal regulations.

11. Develop a State Health Plan to identify short-term and long-term strategies to effectively address the issues of access, cost and quality of health care services in Connecticut. The Commissioners, or their designees, of DPH, DMHAS and OHCA, and in consultation with other state agencies as appropriate, should include in the planning process, but not be limited to the following:
    - Update such plan every 5 years.
    - Establish an advisory body (or use existing bodies) that will include, but not be limited to, other state agencies, health care providers, consumers and other stakeholders as deemed appropriate.
    - Consider the unmeet needs of groups at risk such as:
        i. Persons with behavioral health issues;
        ii. Medicaid recipients;
        iii. Uninsured persons;
        iv. Person with specific and/or chronic illnesses or disabilities such as HIV/AIDS, autism, diabetes, etc.
    - Consider and adopt, as appropriate, the advice, guidelines and recommendations of authoritative organizations such as the Institute of Medicine,[7] the American Hospital Association, [8] and others.
    - Develop a communication process for (1) hospitals to encourage incorporation of the health plan into the hospital long range planning process and hospital long range planning into the state-wide health care facilities plan; and (2) other state agencies to be aware of progress, changes and other information that may be necessary.
    - Recommend legislative changes that may be necessary to pursue this overall recommendation.

12. Hospital leaders should consider, for adoption, the American Hospital Association's Recommendations for Behavioral Health Challenges in the General Hospital, published in 2007. This report includes recommendations regarding community needs assessments, hospital behavioral health plans, community collaboration, adequate financing, employer practices and advocacy.

Related to work force issues:

13. Designate one state agency to coordinate all programs designed to increase the training, recruitment and retention of health care workers in conjunction with other work force initiatives such as Connecticut's Mental Health Transformation initiative and its Behavioral Health Workforce project.

14. All programs designed to enhance recruitment and retention of healthcare professionals in Connecticut should include a mechanism for monitoring and evaluation to determine program effectiveness, with an appropriate funding allocation.

15. Expand the capacity of the on-line licensure system approved during the 2007 legislative session to include all healthcare professionals by 2010 and establish a comprehensive database of licensed healthcare professionals that includes, but is not limited to, the following information about the licensee: type of license held, whether the licensee is working, position held, how long at current position, name of employer, employer's type of industry, highest level of education, number of hours providing direct patient care per week.

16. Prior to January 1, 2009, the Department of Public Health should complete a survey of all health care professionals licensed in Connecticut to initially populate the comprehensive database.

17. The State Health Plan should include a health care workforce planning component that includes analyzing projected trends in the health care workforce, identifying demographics of the health care workforce and the patient population, establishing priorities for allocation of resources and development of a strategic workforce plan that includes an evaluation by DMHAS and DPH of mental health services and access to such services as they relate to hospital EDs and the availability of inpatient, intermediate, residential, outpatient and other levels of care.

18. Expand current loan repayment and forgiveness programs for physicians in the following ways: i) Create a loan forgiveness program that links loan forgiveness to the number of years that a physician is "on- call" at a hospital; ii) Create a loan forgiveness program for physicians at the residency level. If a physician accepts a residency in a defined geographic or physician specialty shortage area, loan forgiveness will be linked to the number of years of post-residency, in-state practice in the defined shortage area.

19. Provide funding to medical schools for scholarships to physicians who are willing to practice in a defined geographic or physician specialty shortage area in the state for at least 5 years after completing their residency programs.

20. Create a pilot program, including loan forgiveness, for a community-based physician residency focusing on primary care to support FQHCs. The loan forgiveness component of such pilot program should require that the physician remain in a community-based primary care practice in Connecticut in collaboration with a FQHC for at least five years after completing the residency program. The purpose of this program is to train physicians in community-based primary care, to improve access to primary care and to alleviate pressure on hospital emergency departments.

21. Evaluate and make necessary adjustments to the Connecticut definition of a health care professional shortage area (contained in DPH regulations) to better reflect specific geographic, demographic and physician specialty shortages.

22. Expand current loan repayment and forgiveness programs for 1) nursing students and 2) advanced practice registered nurses in a primary care residency program.

23. Work with the joint standing committee having cognizance of higher education and employment advancement to ensure an adequate number of slots for nursing students in schools of nursing.

24. Establish a pilot nursing residency program to provide mentoring to first-year hospital-based nurses in order to increase nurse retention rates and to smooth their transition from school to clinical practice.

25. The University of Connecticut and the Connecticut State University System should establish Masters level programs to prepare baccalaureate nurses to serve as educators in nursing schools to address the shortage of nursing faculty.
    - Nurses who become educators under this program may be eligible for loan forgiveness programs if they remain members of the nursing faculty in Connecticut for at least five years.
    - Provide methods to increase compensation and/or the availability of nurse educators consistent with applicable state laws and collective bargaining agreements.

26. To increase the availability of health care services for persons covered by public health insurance programs or who are uninsured, we recommend the establishment of a pilot program to address the problem of recruiting and retaining physicians practicing at FQHCs.

27. Establish a working group consisting of representatives of physicians, hospitals, insurance industry, other stakeholders, state legislators and regulators to develop a comprehensive tort reform proposal for submission by January 1, 2009 to the Governor and the joint standing committees having cognizance of public health, judiciary, and insurance matters. This proposal would complement the review of professional liability insurance rates for physicians and surgeons, hospitals, advanced practice registered nurses and physician assistants in Connecticut to be conducted by the Insurance Commissioner pursuant to Public Act 05-275.

28. For each fiscal year from 2009 through 2013, allocate $500,000 to OHCA to provide matching grants to hospitals and FQHCs, not to exceed $50,000 per hospital or FQHC in any year, to be used to implement national "best practices" relating to recruitment and retention of staff. Such grants should be awarded on a competitive basis and should require that each hospital or FQHC awarded a grant provide matching funding equal to the amount of the state grant.

29. Review the composition and membership of the Connecticut Allied Health Workforce Policy Board to ensure that the work force needs of the entire health care field are represented. At a minimum, membership should be expanded to include physicians and representatives of organized labor. The new board should 1) assist the Office of Workforce Competitiveness (OWC) in developing and evaluating programs to increase training, recruitment and retention of physicians, nurses and other health care workers providing care in hospitals in Connecticut; 2) monitor employment satisfaction and attrition rates of all health care professionals in Connecticut; 3) provide support to DPH in its development of the hospital-based health care workforce planning component of the State Health Plan; 4) work with the State Department of Education (DOE) to develop programs at the middle school and high school levels to increase student enrollment in mathematics and science courses necessary to pursue a bachelor or post-graduate degree in health care fields; and (5) collaborate with the State DOE to develop programs aimed at middle school and high school students to encourage an understanding of and promote careers in health care**.**

Appendix A

M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
EXECUTIVE CHAMBERS
HARTFORD, CONNECTICUT 06106

FOR IMMEDIATE RELEASE
April 18, 2007

Contact:
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Governor Rell Announces Task Force to Develop Strategies to Stabilize Connecticut Hospitals

Governor M. Jodi Rell today announced she is forming a task force to develop strategies to stabilize and chart the future course of hospitals in Connecticut, many of which face are facing financial hardship.

The Hospital Task Force will be co-chaired by Robert L. Genuario, Secretary of the Office of Policy and Management (OPM), and Christine A. Vogel, Commissioner of the Office of Health Care Access. Members will include state agency commissioners, legislators, industry representatives and labor leaders.

"All of us count on having a hospital available – close by, there when we need it and prepared for almost any kind of medical emergency, day or night," Governor Rell said. "Yet many of the hospitals in Connecticut are struggling. Some of the largest hospitals in some of our biggest cities, including Hartford and Waterbury, face serious financial problems, while smaller community hospitals battle daily to attract and retain doctors and nurses and buy the high-tech equipment that modern medicine requires.

"This panel will be charged with reviewing a number of issues," the Governor said. "We need to examine not only the current financial health of Connecticut's hospitals but residents' access to care. Another key issue, especially as we work toward making better health care available for all, is emergency room utilization, affordability and alternative delivery of primary care. And the 'Certificate of Need' process – the state permitting process for determining where certain medical services are provided, when hospitals may close or expand and so on – also needs to be reviewed."

The Governor said she like the panel to hold its first meeting no later than June 30 and to report its findings by December 31.

The task force is part of Governor Rell's broader efforts to ensure that all residents of Connecticut have access to quality, affordable health care. In December, the Governor announced her Charter Oak health care proposal, which would provide low-cost health insurance to single people and families who cannot now afford insurance of their own. The plan – targeted at low-income people, many of whom are employed but may not have access to employer-sponsored health insurance and do not qualify for programs such as HUSKY or Medicaid – is intended to provide health insurance for about $250 a month, and includes state subsidies to assist people who find the monthly premium too high.

In addition, Governor Rell has strongly supported Bond Commission funding for expansion and equipment at community health centers, announcing in September nearly $26 million for expanded medical and dental facilities in communities all across the state, enabling the centers to serve some 85,000 additional new patients.

Appendix B

Financial Structure Subcommittee, Facilitator: Cristine A. Vogel, Commissioner, Office of Health Care Access
Participants:
David Benfer, Hospital of Saint Raphael
Patrick Charmel, Griffin Hospital
Kevin DelGobbo, State Representative
Stephen Frayne, Connecticut Hospital Association
J. Robert Galvin, MD, MPH, Department of Public Health
Martin Gavin, Connecticut Children's Medical Center
Eric George, Connecticut Business & Industry Association
Richard Gray, Connecticut Health & Education Facilities Authority
Jennifer Jackson, Connecticut Hospital Association
Timothy Meyer, Connecticut Association of Health Plans
David Parrella, Department of Social Services
John Rathgeber, Connecticut Business & Industry Association
Gary Richter, Department of Social Services
James Staten, Yale-New Haven Hospital
Paul Storiale, Hospital of Saint Raphael
Keith Stover, Robinson & Cole, LLP, representing Connecticut Association of Health Plans
Michael Starkowski, Department of Social Services
Robert Trefry, Bridgeport Hospital
Katherine Yacavone, Southwest Community Health Center

System Wide Utilization & Planning Subcommittee, Facilitator: **Robert L. Genuario,** Secretary, Office of Policy & Management
Participants:
Evelyn Barnum, Connecticut Primary Care Association
Arthur Brodeur, Planning Committee, Windham Hospital
Christopher Dadlez, St. Francis Hospital & Medical Center
Stephen Frayne, Connecticut Hospital Association
J. Robert Galvin, MD, MPH, Department of Public Health
Meg Hooper, Department of Public Health
Jennifer Jackson, Connecticut Hospital Association
Kevin Kinsella, Hartford Hospital
Thomas Kirk, Jr., PhD, Department of Mental Health & Addiction Services
Paul Knag, Esq., Murtha, Cullina LLP
Lawrence Levine, MD, FACEP, Connecticut College of Emergency Physicians
David Parrella, Department of Social Services

Work Force Issues Subcommittee, Facilitator: **Mary Anne O'Neill,** Legal Counsel, Office of the Governor
Participants:
Polly T. Barey RN, MS, Executive Director, Connecticut Nurses Association
Elizabeth Beaudin, Connecticut Hospital Association
David Cappiello, State Senator
Joanne Chapin, American Federation of Teachers Labor Union
Ken Ferrucci, Connecticut State Medical Society
J. Robert Galvin, MD, MPH, Department of Public Health
Matthew Katz, Connecticut State Medical Society
Kevin Lembo, Office of Healthcare Advocate
Denise Merrill, State Representative
Kevin Murphy, Eastern Connecticut Health Network, Inc.
Arvind Shaw, Generations Family Health Center
Colleen Smith, RN, Middlesex Hospital
Kristin Sullivan, Department of Public Health

Appendix C

Connecticut Acute Care Hospitals, FY 2006

Hospital Name	Affiliation/Parent Corporation	Town	County	Teaching	Licensed Beds*	Staffed Beds*
Bradley Memorial**	Central Connecticut Health Alliance	Southington	Hartford		84	46
Bridgeport	Yale-New Haven Health Services Corporation	Bridgeport	Fairfield	√	425	334
Bristol	Bristol Hospital & Health Care Group	Bristol	Hartford		154	154
Charlotte Hungerford	Charlotte Hungerford Hospital	Torrington	Litchfield		122	101
CT Children's Medical Center	CCMC Corporation, Inc.	Hartford	Hartford		135	122
Danbury	Danbury Health Systems, Inc.	Danbury	Fairfield	√	371	251
Day Kimball	Day Kimball Healthcare Inc.	Putnam	Windham		122	72
Essent-Sharon	Essent Healthcare Inc. of Connecticut	Sharon	Litchfield		94	47
Greenwich	Yale-New Haven Health Services Corporation	Greenwich	Fairfield	√	206	201
Griffin	Griffin Health Services Corporation	Derby	New Haven	√	180	94
Hartford	Hartford Health Care Corporation	Hartford	Hartford	√	867	749
John Dempsey	University of Connecticut Health Center	Farmington	Hartford	√	224	224
Johnson Memorial	Johnson Memorial Corporation	Stafford	Tolland		101	85
Lawrence & Memorial	Lawrence & Memorial Corporation	New London	New London	√	308	249
Manchester Memorial	Eastern Connecticut Health Network, Inc.	Manchester	Hartford		283	140
Middlesex	Middlesex Health System, Inc.	Middletown	Middlesex	√	297	177
MidState Medical Center	Hartford Health Care Corporation	Meriden	New Haven		142	136
Milford	Milford Health and Medical Incorporated	Milford	New Haven		118	64
New Britain General***	Central Connecticut Health Alliance	New Britain	Hartford	√	362	321
New Milford	New Milford Hospital Holding Corporation	New Milford	Litchfield		95	72
Norwalk	Norwalk Health Services Corporation	Norwalk	Fairfield	√	366	224
Rockville General	Eastern Connecticut Health Network, Inc.	Vernon	Tolland		118	66
St. Francis & Medical Center	Saint Francis Care, Inc.	Hartford	Hartford	√	682	574
St. Mary's	Saint Mary's Health System, Inc.	Waterbury	New Haven	√	379	178
St. Raphael	Saint Raphael Healthcare System, Inc.	New Haven	New Haven	√	533	474
St. Vincent's Medical Center	St. Vincent's Health Services Corporation	Bridgeport	Fairfield	√	444	336
Stamford	Stamford Health System	Stamford	Fairfield	√	330	319
William W. Backus	Backus Corporation	Norwich	New London		233	188
Waterbury	Greater Waterbury Health Network	Waterbury	New Haven	√	393	271
Windham Community Memorial	Windham Community Memorial Hospital	Willimantic	Windham		144	87
Yale-New Haven	Yale-New Haven Health Services Corporation	New Haven	New Haven	√	944	875
		Statewide			9,256	7,231

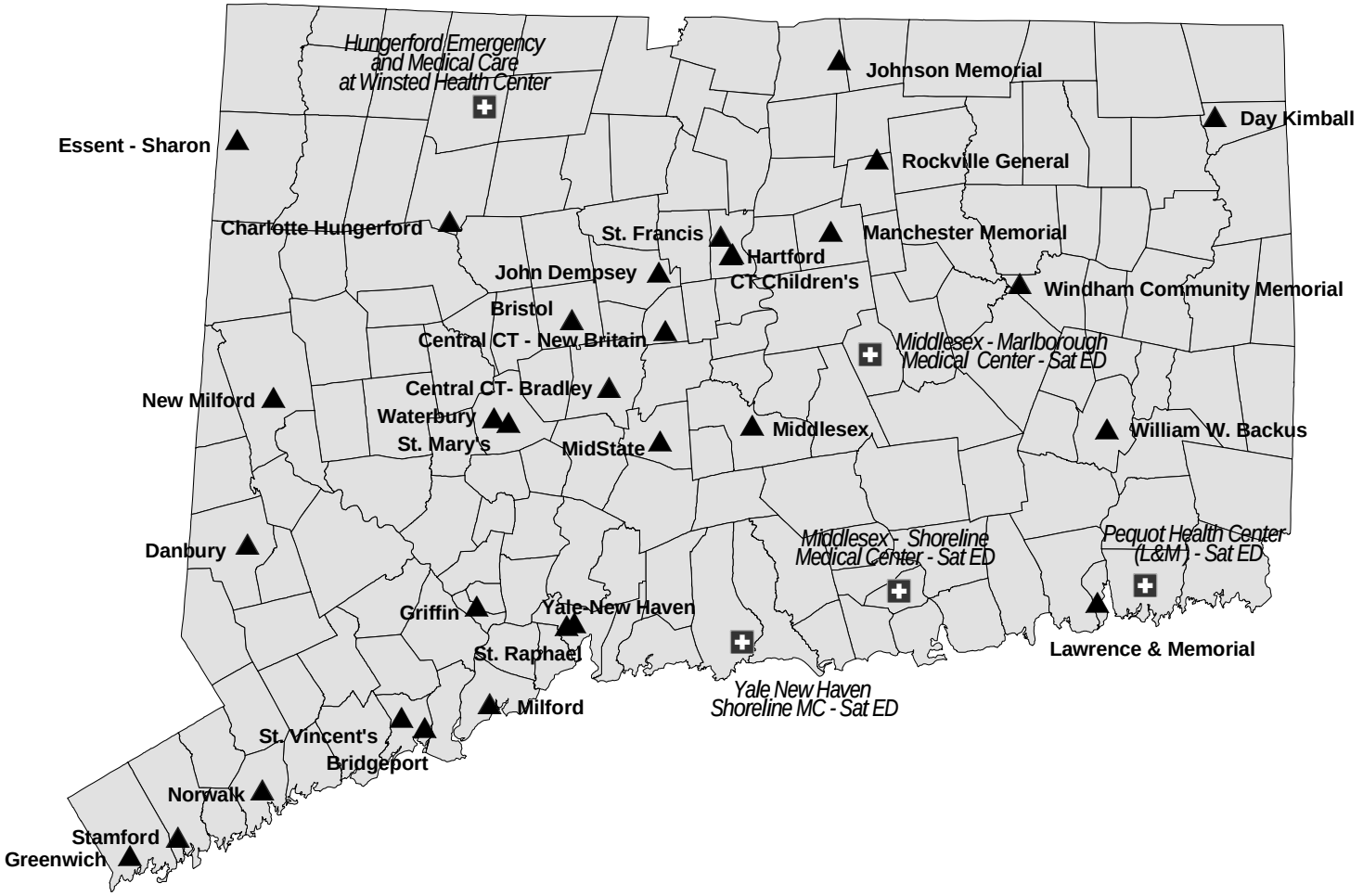
Source: CT Office of Health Care Access Budget System Schedule 500

*Includes newborn bassinets

** Effective 10/1/2007, the two hospitals merged to become the Hospital of Central Connecticut.

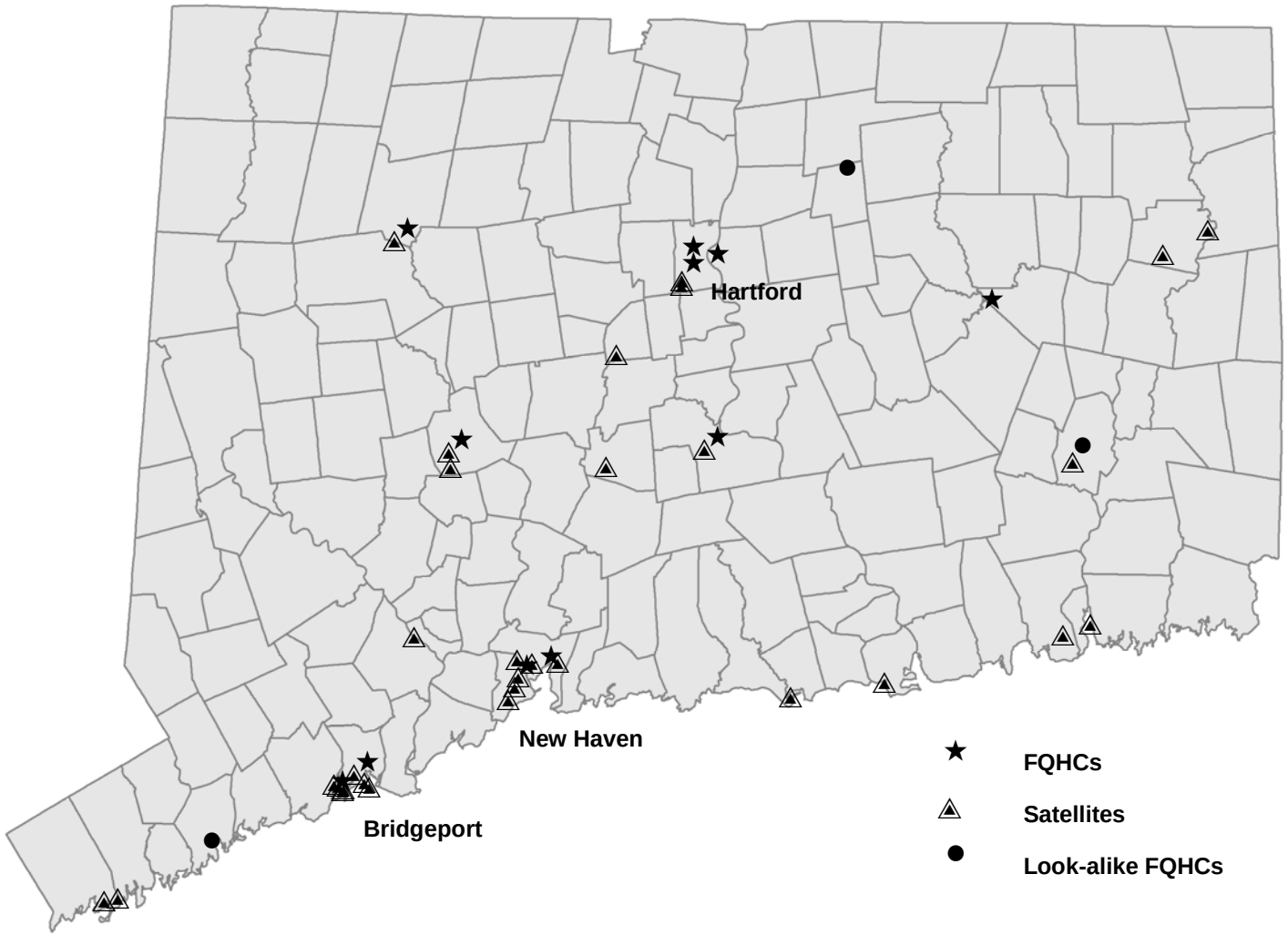
Appendix D

Acute Care Hospitals, Medical Centers and Satellite Emergency Centers



Appendix E

Connecticut Federally Qualified Health Centers (FQHCs), Satellites and Look-Alike FQHCs



Appendix E: Federally Qualified Health Centers (FQHCs), Satellites and Look-alike FQHCs, 2007

TYPE	NAME	STREET	TOWN	ZIP
Main	Bridgeport Community Health Center, Inc.	471 Barnum Avenue	Bridgeport	06608
Main	Charter Oak Health Center	21 Grand Street	Hartford	06106
Main	Community Health Center, Inc.	635 Main Street	Middletown	06457
Main	Community Health Services	500 Albany Avenue	Hartford	06120
Main	East Hartford Community Health Center	94 Connecticut Boulevard	East Hartford	06108
Main	Fairhaven Community Health Center, Inc.	374 Grand Avenue	New Haven	06513
Main	Generations Family Health Center, Inc.	1315 Main Street	Willimantic	06226
Main	Hill Health Center	400 Columbus Avenue	New Haven	06519
Main	Southwest Community Health Center	361 Bird Street	Bridgeport	06605
Main	StayWell Health Center	80 Phoenix Avenue	Waterbury	06702
Main	Community Health & Wellness Center of Greater Torrington	157 Litchfield Street	Torrington	06790
Satellites	Charter Oak Health Center	1 New Britain Avenue	Hartford	06106
Satellites	Charter Oak Health Center	282 Washington Street	Hartford	06106
Satellites	Community Health & Wellness Center of Greater Torrington	157 Litchfield Street	Torrington	06790
Satellites	Community Health Center, Inc.	114 Eat Main Street	Clinton	06413
Satellites	Community Health Center, Inc.	333 Long Hill Road	Groton	06340
Satellites	Community Health Center, Inc.	134 State Street	Meriden	06450
Satellites	Community Health Center, Inc.	635 Main Street	Middletown	06457
Satellites	Community Health Center, Inc.	1 Washington Square	New Britain	06051
Satellites	Community Health Center, Inc.	1 Shaw's Cove	New London	06320
Satellites	Community Health Center, Inc.	263 Main Street	Old Saybrook	06475
Satellites	Fair Haven Community Health Center	339 Eastern Street	New Haven	06513
Satellites	Generations Family Health Center, Inc.	330 Washington Street	Norwich	06360
Satellites	Generations Family Health Center, Inc.	54 Reynolds Street	Danielson	06239
Satellites	Generations Family Health Center, Inc.	23 Wauregan Road	Brooklyn	06234
Satellites	Hill Health Center	226 Dixwell Avenue	New Haven	06511
Satellites	Hill Health Center	232 Cedar Street	New Haven	06519
Satellites	Hill Health Center	62 Grant Street	New Haven	06519
Satellites	Hill Health Center	911 State Street	New Haven	06511
Satellites	Hill Health Center	285 Main Street	West Haven	06516
Satellites	Hill Health Center	121 Wakelee Avenue	Ansonia	06401
Satellites	Southwest Community Health Center	510 Clinton Avenue	Bridgeport	06605
Satellites	Southwest Community Health Center	1046 Fairfield Avenue	Bridgeport	06605
Satellites	Southwest Community Health Center	743 South Avenue	Bridgeport	06605
Satellites	StayWell Health Center	1302 South Main Street	Waterbury	06706
Satellites	StayWell Health Center	80 Phoenix Avenue	Waterbury	06702
Satellites	Bridgeport Community Health Center, Inc.	928 East Main Street	Bridgeport	06608
Satellites	Park City Primary Care Center, Inc.	64 Black Rock Avenue	Bridgeport	06605
Satellites	Ralphola Taylor Center	790 Central Avenue	Bridgeport	06607
Satellites	Stratford Community health Center	727 Honeyspot Road	Bridgeport	06615
Satellites	Stamford Community Health Center	137 Henry Street	Stamford	06902
Satellites	Stamford Community Health Center	245 Selleck Street	Stamford	06902
Look-alike	Norwalk Community Health Center, Inc.	121 Water Street	Norwalk	06854
Look-alike	United Community and Family Services Health Center	47 Town Street	Norwich	06360
Look-alike	Vernon Area Community Health Center	43 West Main Street	Vernon	06066

Source: *Community Health Center Association of Connecticut*

Appendix F:
Acute Care Hospitals Payer Mix, FY 2006

	Discharges						Share of Hospital Total					
Acute Care Hospital	Medicare	Medicaid	Other Public[1]	Private[2]	Uninsured[3]	Total	Medicare	Medicaid	Other Public[1]	Private[2]	Uninsured[3]	Total
Bridgeport	6,738	4,906	68	7,489	381	19,582	34%	25%	0%	38%	2%	100%
Backus	4,331	1,739	264	4,222	465	11,021	39%	16%	2%	38%	4%	100%
Bradley	1,728	65	< 6	530	43	2,369	73%	3%	0%	22%	2%	100%
Bristol	3,583	1,329	21	2,899	122	7,954	45%	17%	0%	36%	2%	100%
CTCMC	45	2,430	31	3,043	66	5,615	1%	43%	1%	54%	1%	100%
Danbury	8,257	2,367	20	9,271	488	20,403	40%	12%	0%	45%	2%	100%
Day Kimball	2,489	1,075	37	1,995	72	5,668	44%	19%	1%	35%	1%	100%
Greenwich	4,318	401	6	7,127	496	12,348	35%	3%	0%	58%	4%	100%
Griffin	3,603	1,131	23	2,588	85	7,430	48%	15%	0%	35%	1%	100%
Hartford	15,056	6,979	64	16,016	1,375	39,490	38%	18%	0%	41%	3%	100%
Hungerford	2,957	1,075	15	1,990	158	6,195	48%	17%	0%	32%	3%	100%
John Dempsey	4,048	1,546	41	3,583	705	9,923	41%	16%	0%	36%	7%	100%
Johnson	2,207	563	22	1,337	83	4,212	52%	13%	1%	32%	2%	100%
Lawrence &Memorial	6,097	2,455	1,069	4,612	463	14,696	41%	17%	7%	31%	3%	100%
Manchester	3,890	1,115	17	3,710	226	8,958	43%	12%	0%	41%	3%	100%
Middlesex	6,029	1,451	24	4,907	455	12,866	47%	11%	0%	38%	4%	100%
MidState	4,620	1,487	14	3,338	353	9,812	47%	15%	0%	34%	4%	100%
Milford	2,557	351	7	1,898	158	4,971	51%	7%	0%	38%	3%	100%
New Britain	7,625	3,995	13	6,452	538	18,623	41%	21%	0%	35%	3%	100%
New Milford	1,318	231	< 6	1,488	74	3,116	42%	7%	0%	48%	2%	100%
Norwalk	6,189	1,322	50	6,675	1,105	15,341	40%	9%	0%	44%	7%	100%
Rockville	1,556	531	26	1,388	99	3,600	43%	15%	1%	39%	3%	100%
Saint Francis	13,000	6,260	87	11,801	499	31,647	41%	20%	0%	37%	2%	100%
Saint Mary's	5,385	2,865	46	4,152	536	12,984	41%	22%	0%	32%	4%	100%
Saint Raphael	13,371	3,176	17	8,421	369	25,354	53%	13%	0%	33%	1%	100%
Saint Vincent's	9,098	2,684	21	6,792	1,077	19,672	46%	14%	0%	35%	5%	100%
Sharon	1,580	257		907	136	2,880	55%	9%	0%	31%	5%	100%
Stamford	5,900	2,686	7	7,791	619	17,003	35%	16%	0%	46%	4%	100%
Waterbury	6,768	2,726	13	5,207	289	15,003	45%	18%	0%	35%	2%	100%
Windham	2,388	907	33	1,742	315	5,385	44%	17%	1%	32%	6%	100%
Yale-New Haven	14,065	12,589	506	22,056	1,138	50,354	28%	25%	1%	44%	2%	100%
Statewide	170,796	72,694	2,570	165,427	12,988	424,475	40%	17%	1%	39%	3%	100%

Source: *CT Office of Health Care Access Acute Care Discharge Database*

[1] Other public includes primary payer categories Other federal, CHAMPUS/TRICARE and Title V

[2] Private includes primary payer categories commercial, Blue Cross , HMO, PPO & Workers' Compensation

[3] Uninsured includes primary payer categories self-pay, other and no charge.

Endnotes

[1] Office of Health Care Access, *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2006.*
[2] Kaiser Family Foundation/statehealthfacts.org., 2005 AHA Annual Survey Copyright 2006 by Health Forum LLC, an affiliate of the American Hospital Association, special data request, March 2007. 2005 population data from Annual Population Estimates by State, July 1, 2005 Population, U.S. Census Bureau.
[3] Kaiser Family Foundation / statehealthfacts.org.
[4] American Hospital Association, *Behavioral Health Challenges in the General Hospital, Practical Help for Hospital Leaders, Recommendations*, February 2007, Page 2.
[5] Health Resources and Services Administration. *The Registered Nurse Population: Findings From the 2004 National Sample Survey of Registered Nurses*, Pages 17-18.
[6] PriceWaterhouseCoopers, What Works*Healing the healthcare staffing shortage, 2007, Page 1.
[7] http://www.iom.edu/CMS/3809/16107/35007/35040.aspx
[8] http://www.aha.org/aha/issues/Mental-Health-Services/taskforcereport.html