Governor Rell's
Hospital System Strategic Task Force
Draft Recommendations – For Discussion Purposes Only

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Introduction

Governor Rell convened a Task Force composed of hospital executives, the hospital trade association, community health clinics, members of the public and consumer advocates, primary care providers, physicians, emergency department physicians, nurses, insurance companies, state legislators and state agencies (a complete listing is on OHCA's web site) to examine the current financial condition of the Connecticut hospitals and to propose strategies to stabilize the system to ensure access to necessary and quality health care services. The resulting Hospital System Strategic Task Force formed three subcommittees to focus discussion on specific aspects of the hospital system:

1. Financial Structure
2. Workforce Issues
3. System-wide Utilization and Planning

The subcommittees have been meeting regularly and are proposing a series of recommendations to the Task Force for their review and discussion. The Task Force would like to receive comment and feedback from the public. The next step for the Task Force is to draft proposed strategies that will address the selected issues that will become part of the report that is due to the Governor no later than December 31, 2007.

Brief Background

The Connecticut hospital system consists of 30 acute care hospitals with a total of 9,256 licensed beds and 7,231 of these beds staffed for patient care. In fiscal year (FY) 2006, there were 424,475 discharges from hospital inpatient services and 1.4 million hospital emergency department visits. Of those patients discharged from an inpatient service, 40% were covered by Medicare, 39% by commercial/private insurance, 17% by Medicaid, 3% were uninsured, and 1% by "other public" programs. Total statewide revenue from hospital operations amounted to $7.1 billion and statewide total net operating expenses amounted to $7.0 billion.

	FY05	FY06
Total Operating Revenue	$6,704,867,645	$7,136,390,071
Total Operating Expenses	$6,587,690,012	$7,091,354,777
Non-Operating Revenue	$110,480,150	$137,739,063
Excess of Revenue over Expenses	$227,657,792	$182,774,357

The statewide average for Connecticut hospitals' total margin in FY06 was 2.5% down from 3.3% in FY05. The operating margin average also declined in FY06 to 0.6% from 1.7% in FY05. Six of the 31 hospitals in FY06 reported negative total margins with an additional 8 hospitals at or below 1.0% total margin. However, there exists significant variation among the individual hospitals. For example, the range of total margin for FY06 is from -7.9% up to +9.1%.

	FY04	FY05	FY06
Operating Margin	1.47%	1.72%	0.62%
Non-Operating Margin	1.59%	1.62%	1.89%
Total Margin	3.06%	3.34%	2.51%

Our 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 the increasing expenses related to recruiting health professionals and acquiring advanced technology, and their weak financial performance is creating a situation where accessing capitol to re-invest into their facilities is becoming problematic.

The members of the Task Force realize that hospitals are one part of the health care delivery system and that for strategies to be successful it will take a combined effort to make changes that will be measurable, attainable, and sustainable so that an impact to the overall financial health of the system is realized.

Each subcommittee is beginning to formulate its proposed recommendations for reviews, discussion, and refinement by the Task Force into strategies to be included in the final report. Below are the preliminary "recommendations" in draft form for the public to review and provide comment. They are listed beneath the subcommittee that is working on that issue.

Financial Structure Subcommittee Draft Recommendations:

MEDICAID Proposed Recommendations:

The state must:

1. Financially support a comprehensive study of the multiple reimbursement systems available to determine the most appropriate system for CT.
2. Increase the reimbursement for services to reflect current 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. Financially support system changes that promote cost-effective service delivery that maintain and improve quality of care offered by providers.

MEDICARE Proposed Recommendations:

1. DSS should pursue an application to CMS for the inclusion of SAGA in Medicaid so that hospitals can receive all available Medicare DSH dollars.
2. The Administration, business, and insurance industries should support Connecticut hospital initiatives to obtain adequate funding from the Medicare program.

Access to Capital Recommendation:

1. Due to weak financial performance, many Connecticut hospitals have had limited access to capital. As a consequence, investment in necessary physical plant improvements, equipment, and advanced technology are lagging by more than one billion dollars. The Connecticut Health and Educational Facilities Authority (CHEFA) should issue revenue bonds backed by contract assistance of the state that would cover at least 60% of the $1.1 billion in needed investment. The revenue bonds would be issued by CHEFA and the debt service is paid by the State of Connecticut. Proceeds of bonds will 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.

Workforce Issues Subcommittee Draft Recommendations:

1. Statewide Workforce Planning

The healthcare industry in Connecticut faces personnel shortages in nursing, physician specialty areas and numerous other healthcare positions. These shortages are expected to continue into the foreseeable future. In order for us to identify workforce needs and attempt to address them in a focused and timely manner, the subcommittee makes the following recommendations.

a. Establish a comprehensive database of licensed healthcare professionals. The database shall include the following information about the licensee: type of license held, if working, position held, how long at current position, name of employer, employer's type of industry, highest level of education, number of hours worked per week. The database shall be developed by the Office of Workforce Competitiveness in consultation with the Department of Public Health and the Department of Labor, and maintained by the Office of Workforce Competitiveness.

b. The Statewide Health Plan shall include a healthcare workforce planning component that includes analyzing projected trends in the healthcare workforce and establishing priorities for allocation of resources. The comprehensive database of licensed healthcare professionals will provide critical information to inform the state plan.

c. Designate one state agency to coordinate all programs designed to increase the training, recruitment and retention of healthcare workers.

2. Hospitals

Given the healthcare workforce shortages mentioned above, it will be increasingly important for hospitals to provide a supportive and professional work environment. Although the subcommittee has specific recommendations focused on recruitment and retention of doctors and nurses, we have some general suggestions about how hospitals can become more desirable places to work.

a. Allocate funding (how much??) to the Office of Healthcare Access to provide grants to hospitals, not to exceed $xxxx per hospital, to be used by hospitals to compare their current practices to national "best practices" and to develop a plan to adopt best practices.

b. Authorize grants to distressed hospitals to purchase patient-lifting equipment.

3. Doctors

The subcommittee heard much anecdotal evidence that for many doctors, both new and experienced, Connecticut is no longer an attractive place to practice medicine. This trend has been attributed to the high cost of living in Connecticut, the high cost of medical malpractice insurance, and the burdensome call requirements for doctors with admitting privileges at hospitals. For these reasons, Connecticut is experiencing a shortage of doctors in many specialty areas. The subcommittee, therefore, has several suggestions focused on recruiting and retaining doctors in Connecticut.

a. Expand current loan repayment and forgiveness programs for doctors in the following ways: i) Create a loan forgiveness program that links loan forgiveness to the number of years that a physician takes call; ii) Create a loan forgiveness program for doctors at the residency level. If a doctor accepts a residency in a defined shortage area, loan forgiveness will be linked to the number of years of post-residency, in-state practice in the shortage area.

b. Provide funding to medical schools for scholarships to clinical providers who are willing to practice in an under-served area or designated shortage field in the state for at least 5 years after completing their residency programs.

c. Create a pilot program for a community-based medical residency.

4. Nurses

In recent years, Connecticut has experienced a significant nursing shortage, which is expected to worsen in the foreseeable future. At the same time, we have experienced a shortage in nursing school faculty, to the extent that qualified nursing school applicants have been denied admission to nursing school. The subcommittee, therefore, submits the following recommendations to recruit and retain nurses and nursing faculty.

a. Expand current loan repayment and forgiveness programs for nursing students.

b. Provide funding for competitive grants to 2 hospitals for pilot nursing residency programs for new nurses.

c. Provide funding to the University of Connecticut (?? elsewhere??) for a Masters level programs to prepare baccalaureate nurses to serve as educators.

d. Provide funding for a pilot program at XXXXX to teach nursing management skills to nurses in clinical practice.

5. Other

a. The subcommittee received much anecdotal evidence from physicians that the high cost of medical malpractice insurance in Connecticut is a significant factor in causing new doctors to establish their practices in states other than Connecticut, and in causing older doctors to limit the scope of their practices or to retire. This cost is directly related to the possibility that a successful medical malpractice plaintiff may be awarded significant non-economic damages. Although the subcommittee acknowledges that comprehensive tort reform is beyond the scope of the Hospital Task Force, we believe this issue is too important to be ignored. We therefore recommend that a Working Group consisting of physicians, insurance industry representatives and others be formed to develop a comprehensive tort reform proposal.

b. The subcommittee also received information indicating that a decreasing number of physicians is available to provide services to patients who are either covered by government-sponsored health plans or uninsured. To increase the availability of health care for this population, we recommend establishing a pilot program at an FQHC in one rural location and one urban location to subsidize physician services in specified shortage areas to this population.

c. Finally, although most, if not all, of the data received by the subcommittee focused on physicians and nurses, we are mindful of workforce shortages in other healthcare fields. The subcommittee, therefore, recommends that these shortages be addressed in the future. We believe that the database of licensed healthcare professionals that we recommend be established within the Office of Workforce Competitiveness would provide information necessary to address these shortages.

System-wide Utilization and Planning Subcommittee Draft Recommendations:

Planning Recommendations

1. **The Department of Public Health shall adopt the following changes to the state health plan required under Section19a-7, CGS:**
   - 1.1. DPH shall update the plan every five (5) years.
   - 1.2. The state health plan should address public health priorities, leading causes of mortality and morbidity, and needed health care delivery systems projected for five (5) and ten (10) years in the future. In making this assessment, special attention should be given to the unmet needs of groups at risk such as persons with psychiatric and/or substance use disorders, Medicaid recipients, the uninsured, and persons with particular conditions or disabilities such as AIDS, autism, and those with major and highly prevalent chronic illnesses such as diabetes, respiratory, cardiovascular and related illnesses.
   - 1.3. Each update of the plan should include a report on the progress being made on the stated goals.
   - 1.4. DPH shall establish an advisory body composed of state agencies, local and state public health partners, health care providers, consumers, and other stakeholders to provide input to and recommendations regarding the state health plan.
   - 1.5. DPH shall develop a communication process with hospitals to encourage incorporation of the state health plan into the hospital long range planning processes, and hospital long range planning into the state health plan.

2. **The Department of Mental Health and Addiction Services shall develop and implement state mental health and substance abuse plans:**
   - 2.1. DMHAS shall develop a state-wide plan for the development of mental health services which identifies needs and outlines procedures for meeting these needs as required by Section 17a-451(h), CGS.
     - 2.1.1. The plan should draw from needs and service analyses of the Regional Mental Health Boards, the annual community mental health strategic plan of the Community Mental Health Strategy Board, the advice of the State Board of Mental Health and Addiction Services, and recommendations from advisory boards of DMHAS state operated facilities.
     - 2.1.2. The plan should be updated every five (5) years with annual progress reports measured against targeted access, capacity and recovery-oriented quality of service outcomes specified in the plan.
   - 2.2. DMHAS shall develop a state substance abuse plan as required by Section 17a-451(j), CGS.
     - 2.2.1. The plan should draw from the analyses and recommendations of the Connecticut Alcohol and Drug Policy Council, Subregional Planning and Action Councils, and the advice of the State Board of Mental Health and Addiction Services.

2.2.2. The plan should be updated every five (5) years with annual progress reports measured against targeted access, capacity and recovery-oriented quality of service outcomes specified in the plan.

2.3. The DMHAS mental health and substance abuse plans should serve to inform the DPH state health plan.

2.4. DMHAS shall develop a communication process with hospitals to encourage incorporation of the state mental health and substance abuse plans into hospital long range planning processes, and hospital long range planning into the state mental health and substance abuse plans.

3. The Office of Health Care Access shall incorporate the following changes into the statewide health care facilities plan:

3.1. OHCA shall develop a State-Wide Health Care Facilities Plan as required by Section 19a-634, CGS.

3.2. The plan should be updated every five (5) years.

3.3. The state-wide facilities plan should address how institutions can assist achieving the goals established in the DPH State Health Plan and the DMHAS State Mental Health and Substance Abuse Plans.

3.4. Each update of the plan should include a report on the progress being made on the stated goals.

3.5. OHCA shall establish an advisory body composed of state agencies, local and state public health partners, health care providers, consumers, and other stakeholders to provide input to and recommendations regarding the state-wide health care facilities plan.

3.6. OHCA shall develop a communication process with general hospitals to encourage incorporation of the state-wide health care facilities plan into hospital long range planning processes, and hospital long range planning into the state-wide health care facilities plan.

Emergency Department Overuse Recommendations

4. The state shall take the following steps to reduce inappropriate use of hospital emergency departments for mental health and/or substance abuse services and increase the capacity and continuum of effective and efficient care to meet the needs of persons with such illnesses presenting at the ED:

4.1. In accordance with the authority under Section 17a-478, CGS, and specifically to address geographical areas where overall demands on emergency departments are documented to be very significant, DMHAS shall identify a limited number of pilot “Behavioral Health High Demand ED Areas.”

4.1.1. DMHAS shall adopt for consideration the hallmark 2006 Institute of Medicine design recommendations relative to combinations of services and strategies appropriate for each identified area, with targeted quality and cost outcome measures tied to each service/strategy.

4.1.2. DMHAS shall consider the population, critical demographics, and adult persons projected in need of mental health/substance abuse services to inform the selection of the areas.

4.1.3. DMHAS shall identify the number of persons actually receiving services in each area within five successive years matched to the DPH state health plan and the DMHAS state mental health and substance abuse plans, the volume and variety of services provided by DMHAS state operated and funded general hospitals and private nonprofit service agencies, the degree of timely access to such services, and the total funding from DMHAS in support of the services.

4.1.4. DMHAS shall include in the aforementioned cost and service compilation the specialized service strategies currently in effect through the partnership of DMHAS and specific hospitals to divert or offset emergency department demand.

4.1.5. DMHAS shall determine the gap in service access based on the difference in projected service need/demand and the actual service penetration rate.

4.1.6. DMHAS shall assess the range of service gaps based on the definition of "community mental health services" included in Sec. 17a-478, CGS.

4.1.7. DMHAS shall identify the total service volume and costs of DMHAS-funded outpatient and residential services being provided to patients being diverted from EDs within each proposed "Behavioral Health High Demand ED area."

4.1.8. Based on total available current funding, service capacity and defined cost and patient outcomes in each proposed "Behavioral Health High Demand ED area," DMHAS may adjust the funding allocations, services designs and the geographic territory from time to time to be served by the facilities and programs under the DMHAS commissioner's jurisdiction in order to reduce the identified gaps in services within an area and offset the inappropriate demand on emergency departments.

4.2. The State shall implement a plan for increased capacity and a broader range of outpatient services, specialty residential service programs and housing settings to more effectively and efficiently meet the care needs of persons who present at hospital emergency departments or are served in state-operated hospitals but do not require sustained emergency department or inpatient hospital-based care. This plan shall be framed to include programs that assure timely access to post acute care.

4.3. The State shall expand access to behavioral health crisis and emergency services for adults and children.

4.4. DMHAS, in consultation with OHCA and working with the Connecticut Hospital Association and other stakeholders, shall identify feasible and effective models for psychiatric emergency assessment or crisis response centers within one or more of the proposed "Behavioral Health High Demand ED areas."

5. **Hospitals shall take steps to reduce inappropriate use of the emergency department by persons with mental health and/or substance use disorders:**

5.1. Hospital leaders should review and adopt the February, 2007, recommendations of the American Hospital Association's *Recommendations for Behavioral Health Challenges in the General Hospital*. This report includes recommendations regarding community needs assessments, hospital behavioral health plans, community collaboration, adequate financing, employer practices, and advocacy.

5.2. Hospitals should move patients from the emergency department to appropriate units to wait for an available bed, in accordance with studies showing improved outcomes for persons "boarded" on appropriate medical units rather than in emergency departments.

6. The state shall take steps to reduce inappropriate use of the emergency department for primary health services:

6.1. The state shall implement programs to assure access to and use of primary care services so as to reduce the instances of individuals needing to get primary care in an emergency room.

6.2. The state shall implement programs for expanding access to primary care services.

6.3. The state shall implement programs to increase access to alternative primary care settings (including but not limited to hospital clinics, community health clinics to include Federally Qualified Health Centers, physician offices, etc.).

6.4. The state shall implement programs to expand primary care hours (i.e., evenings, weekends) and locations.

6.5. The Department of Social Services shall 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.

6.6. The state shall 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.

6.7. The Department of Social Services, in concert with the Department of Correction, the Department of Mental Health and Addiction Services, and the Judicial branch, shall explore primary care and programs 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 in a manner that helps prevent re-incarceration.

6.8. The Department of Social Services should explore the development of and reimbursement structure for specialist services in addition to primary care at the Federally Qualified Health Centers as a way of helping to alleviate emergency department patient traffic.

For more information regarding the financial performance of Connecticut's hospital, please visit the Office of Health Care Access web site at www.ct.gov/ohca