REPORT OF THE

COMMISSION ON THE FUTURE OF HOSPITAL CARE IN CONNECTICUT

January 7, 2003

Chairs:

Senator Toni N. Harp

Representative Mary Eberle

Commission on the Future of Hospital Care in Connecticut

Prepared by:
The Connecticut Health Policy Project

For more information contact:
The Public Health Committee
Legislative Office Building Room 3000
Hartford CT 06106
(860) 240-0560
www.cga.state.ct.us/ph

Contents

Executive Summary

Commission structure, process and mission

Status of Connecticut's Hospitals

Challenges facing Connecticut's Hospitals
- **Financial and organizational issues**
- **Access to care issues**
- **Workforce issues**
- **Quality of care issues**

Commission recommendations
- **Financial and organizational issues**
- **Accessibility of care issues**
- **Workforce issues**
- **Quality of care issues**

Appendix
- **Special Act No. 00-12 An Act Establishing A Commission on the Future of Hospital Care in Connecticut**
- **Commission and Workgroup membership lists**

Commission on the Future of Hospital Care in Connecticut

Executive Summary

In 2000, amid growing concerns about the financial stability of the state's hospitals, the CT General Assembly created a commission to investigate in-depth issues facing hospitals and make recommendations to ensure the long-term health of these critical safety net institutions.

Connecticut's hospitals are not alone in facing serious, quickly shifting challenges. While managed care reduces admissions and lengths of stay for relatively healthy patients, the average hospital patient has more numerous and more complex health problems.

Connecticut's hospitals are slowly recovering from a period of financial difficulty over recent years. Revenues were sharply reduced by both private and public payers. While private payer pressures will likely continue, public payers have provided relief. Nationally, Wall Street predicts recovering margins, Medicare rate stabilization, and improved credit ratings for hospitals. An increasing climate of corporate integration among hospitals and the concentration of ownership and control will come under increased government scrutiny to ensure competition and full access to specialized services.

Connecticut's hospitals face serious challenges including significant health care workforce shortages, reduced Medicare rates, Medicaid rate shortfalls, increasing pressure from government and private payers to both improve quality and reduce costs, increasing pharmacy costs, continuing tight capital markets, new regulation of electronic transmissions of information and privacy restrictions, fragmented data systems reporting to multiple state agencies, growing numbers of uninsured patients seeking care, increased demand on emergency departments, a severe lack of capacity in the state's behavioral health treatment system, increasing malpractice and other liability costs, and potential bioterror threats. As the state and national government budgets move from surpluses to deficits, the ability to support hospitals will be tested.

In response to this information, the Commission made a series of recommendations to strengthen CT's hospitals in the areas of workforce, quality of care, financial & organizational issues, and access to care.

Commission structure, process and mission

In 2000, Connecticut's hospitals faced serious challenges. Many were losing money for the first time, Winsted Hospital had already closed, and others were said to be in danger of closing. Connecticut was experiencing its first conversion of a hospital to for-profit status.

The Commission on the Future of Hospital Care in Connecticut was created under Special Act No. 00-12 to review the status of Connecticut's hospitals, including financial stability, system capacity, access to care for Connecticut residents, the impact of public and private funding trends, relationships between hospitals, workforce issues, and new technologies. The Commission is to make recommendations to strengthen Connecticut's hospital system and residents' access to care.

The Commission has seventeen members, including legislators, state agency heads, hospital representatives, third party payers, unions, and physicians. Senator Toni Harp and Representative Mary Eberle served as Co-Chairs. The Commission met thirteen times between July 24, 2000 and February 4, 2002. The Commission issued an Interim Report on January 8, 2001.

The Commission invited a number of presentations from the Departments of Public Health (DPH), Children & Families (DCF), Mental Health & Addiction Services (DMHAS), and Social Services (DSS), the Office of Health Care Access (OHCA), the US Centers for Medicare & Medicaid Services (CMS, formerly the Health Care Financing Administration), the Connecticut Hospital Association, the Connecticut Health & Education Facilities Authority, Hartford Hospital, the Eastern Connecticut Health Network, St. Francis Behavioral Health, Hall-Brooke Hospital, Natchaug Hospital, the Lewin Group, Ernst & Young, and the Attorney General's office. After collecting information about the status of Connecticut's hospitals, the Commission divided into four workgroups to focus on specific challenge areas and make recommendations. The workgroups included both Commission members and other stakeholders invited to participate. The Accessibility of Care Workgroup was chaired by Senator Harp and Michael Meacham of the Eastern CT Health Network assisted by Christopher Hartley of St. Francis Hospital. Representative Mary Eberle chaired the Financial & Organization Issues Workgroup. The Quality of Care Workgroup was chaired by Representative Vickie Nardello and Dr. Edward Kamens. The Workforce Issues Workgroup was chaired by Representative Dennis Cleary, Marc Lory of the Eastern CT Health Network and Jean Morningstar of University Health Professionals.

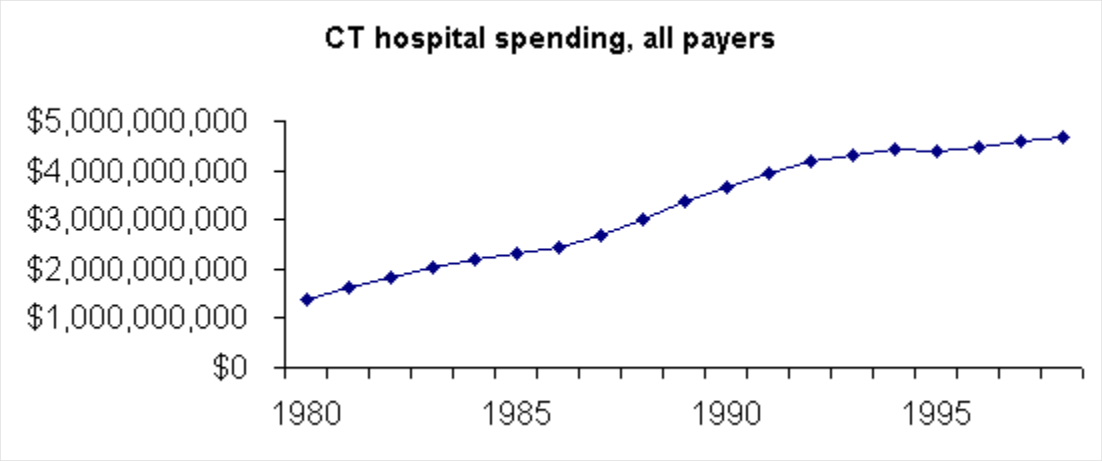
The workgroups completed their analysis and made recommendations to the Commission, which were adopted with minor modification. Commission and workgroup membership lists, workgroup issue areas, meeting minutes, and the Interim Report are included in the Appendix.

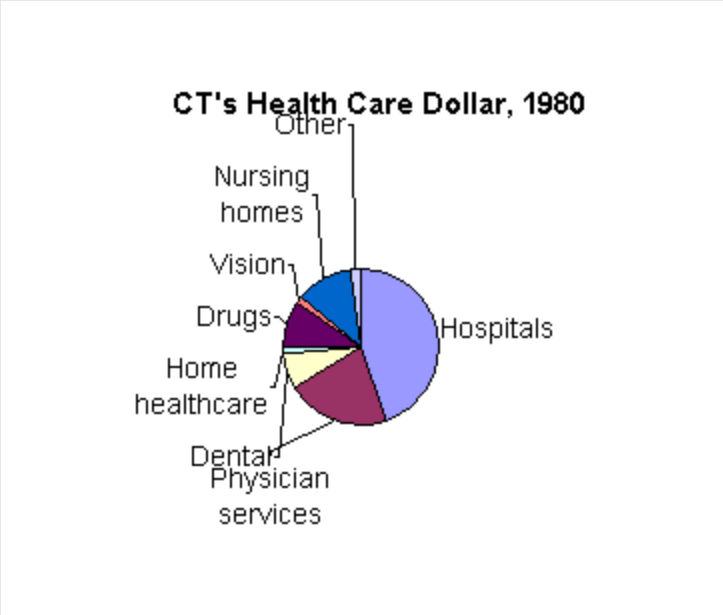
Status of Connecticut's Hospitals

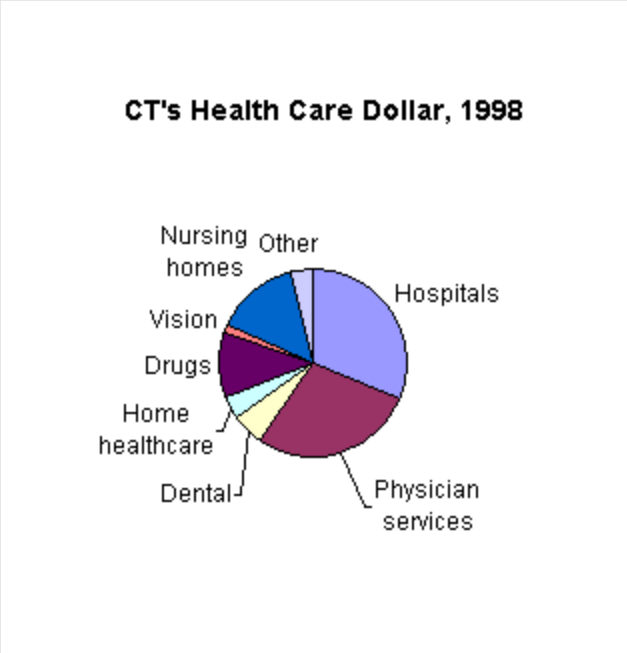
Hospital Spending

In 1998, the last year for available data, Connecticut spent $4,798,000,000 or $1,478 per person on hospital care, from all payers.[1] This amount has been rising each year.

Source: Center for Medicare and Medicaid Services

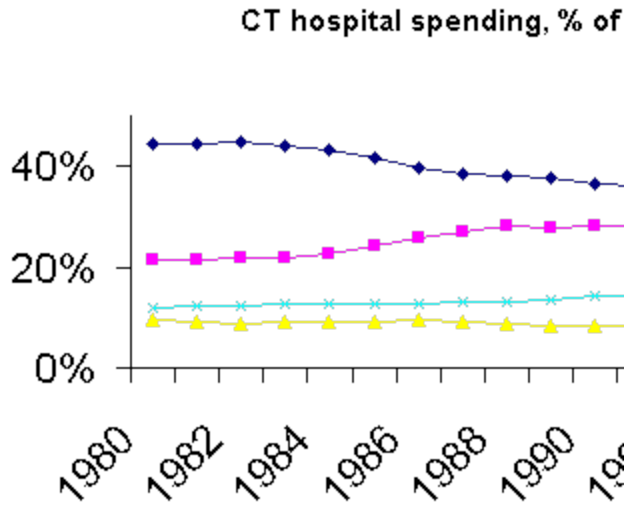






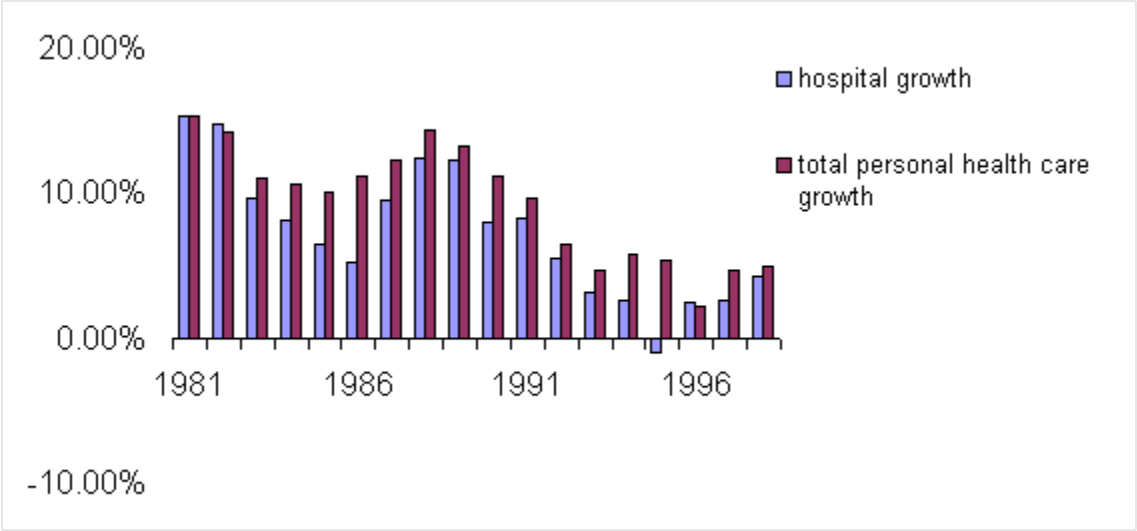
In 1998, hospital care consumed 31.3% of all CT personal health care spending, down from 44.5% in 1980.

The proportion of CT's health care dollar that is spent on hospital care is declining.



Source: Center for Medicare and Medicaid Services

While costs for CT's hospital care have risen over time, they grew at only two thirds the rate of growth in CT's total personal health care spending from 1981 to 1998. However, nationally in 2000 and 2001 increases in hospital spending has become the key driver of overall health care cost growth, accounting for more than half the total increase in costs. Hospital spending has outpaced other areas, including prescription drug spending growth, which declined in both 2000 and 2001.[2] Hospital spending growth rates are expected to stabilize over the next ten years.[3]



System Capacity

With 2.3 hospital beds per 1,000 residents, Connecticut is below the US average hospital bed capacity of 3.0 beds/1000 residents. Connecticut admissions are also lower than the national average (105 vs. 120/1000 population). However, Connecticut residents are more likely to visit the emergency room than other Americans (399 vs. 374 visits/1,000 population)[4].

Hospital Financial Health

While Connecticut hospitals are financially healthier overall than they were in 1999, they still face significant challenges. The 2002 report by the Office of Health Care Access (OHCA) (based on fiscal data from 2000) finds that most hospitals are financially strong, and none are at risk of closing[5]. However, six hospitals are classified as moderately distressed and, since the 2001 report (based on 1999 data), four new hospitals joined the four already classified as significantly distressed[6].
Source: Center for Medicare and Medicaid Services

Financially Strong	Moderately Distressed	Significantly Distressed
William W. Backus Hospital	CT Children's Medical Center	Bradley Memorial Hospital
Bristol Hospital	Charlotte Hungerford Hospital	Bridgeport Hospital
Danbury Hospital	Manchester Memorial Hospital	John Dempsey Hospital
Day Kimball Hospital	Rockville General Hospital	Johnson Memorial Hospital
Greenwich Hospital	Hospital of St. Raphael	New Britain General Hospital
Griffin Hospital	Stamford Hospital	St. Mary's Hospital
Hartford Hospital		Sharon Hospital
Lawrence & Memorial Hospital		Waterbury Hospital
MidState Medical Center		
Middlesex Hospital		
Milford Hospital		
New Milford Hospital		
Norwalk Hospital		
St. Francis Medical Center		
St. Vincent's Medical Center		
Windham Community Hospital		
Yale New Haven Hospital		

Overall, Connecticut's hospitals have become financially more stable, moving from an average operating margin (profit/loss on hospital operations alone) of –0.7% in Fiscal Year (FY) 1999 to a small profit of 0.12% in FY 2000. Total margins (including non-operating income) rose from 2.3% in FY 1999 to 3.2% in FY 2000. Large urban hospitals are doing better, as a group, than smaller community hospitals.[7] Wall Street generally demands and national healthcare consultants believe that hospitals need to achieve higher margins to be able to reinvest in facilities and new technologies.[8]

Hospital Margins							
Hospital	Total margins		Operating margins		Ratio of cost to charges		Uncompensated care share of total expenses
	2000	Change from 1998	2000	Change from 1998	2000	Change from 1998	
William Backus	6.75%	-2.21%	4.27%	-2.87%	0.59	-.04	2.59%
Bradley	-3.53	1.32	-8.96	4.11	0.63	-.01	3.11
Bridgeport	5.55	0.94	4.63	1.47	0.50	-.07	2.96
Bristol	7.66	3.03	5.10	4.77	0.46	.05	3.61
CCMC	-6.58	19.47	-11.73	15.52	0.68	-.08	3.41
Danbury	8.20	1.39	5.54	1.86	0.51	-.07	4.46
Day Kimball	2.81	0.85	2.26	0.50	0.58	-.04	3.20
John Dempsey	-13.75	-5.58	-13.75	-5.58	0.68	-.04	1.12
Greenwich	6.48	1.97	-0.76	1.50	0.56	-0.03	3.60
Griffin	3.31	6.53	0.93	6.29	0.37	0.01	3.61
Hartford	5.08	-5.01	0.56	-1.74	0.66	-0.08	4.39
Charlotte Hungerford	0.71	-4.36	-3.69	-4.78	0.64	0.01	2.55
Johnson	0.98	0.95	-2.18	-0.70	0.45	-0.06	6.62
Lawrence & Memorial	5.15	3.02	1.76	1.56	0.51	-0.05	4.48
Manchester	-8.18	-10.04	-11.43	-9.95	0.48	0.03	3.14
Middlesex	6.74	3.18	3.11	-1.13	0.63	-0.01	3.26
MidState Med. Center	7.64	9.16	5.03	8.42	0.57	-0.12	3.35
Milford	5.59	-5.20	0.08	-6.18	0.39	-0.02	2.41
New Britain	-2.97	-5.93	-6.97	-5.57	0.66	0.01	3.26
New Milford	3.47	1.45	3.33	1.46	0.44	-0.04	2.67
Norwalk	4.13	2.61	0.23	0.97	0.61	-0.02	4.69
Rockville	-3.92	-12.45	-7.28	-11.67	0.46	0.02	2.70
St. Francis	7.85	7.55	4.56	8.35	0.65	-0.07	3.12
St. Mary's	6.13	4.03	0.71	1.31	0.51	-0.07	3.94
St. Raphael's	0.44	-3.81	0.85	-2.66	0.51	-0.02	1.81
St. Vincent's	4.51	-9.35	-1.60	-9.42	0.56	0.05	5.96
Sharon	-6.81	-1.75	-7.82	5.24	0.57	0.02	4.24
Stamford	-3.10	-9.71	-4.56	-8.10	0.57	0.04	5.26
Waterbury	-8.23	-7.58	-11.08	-7.76	0.56	0	4.84
Windham	5.69	0.97	3.96	1.79	0.49	0.03	4.40
YNHH	5.79	-0.52	3.28	0.69	0.56	-0.02	3.49

Source: *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals* 2002, OHCA

Wall Street is more optimistic about the future for hospitals nationally anticipating Medicare rate stabilization, recovering margins, and stabilizing credit ratings. The Centers for Medicare and Medicaid Services' financial forecast for hospitals predicts that non-profit hospitals will recover from recent revenue challenges. Current hospital profit margins are similar to historic averages. Bond investors predict revenue stability for non-profit hospitals and expect strong growth from for-profit hospitals. Stability in

government payment rates, especially Medicare, is key.[9] Hospitals are finding themselves in better negotiating positions as managed care loosens some tight restrictions.[10]

Affiliated Organizations

Like hospitals across the country, CT hospitals have created alliances both between hospitals and with other health and non-health related organizations in recent years. There are currently four multi-hospital corporations in CT - three with two hospitals and one with three. CT's other 22 hospitals are the only hospital in their corporate network.[11]

Over 200 organizations are affiliated with Connecticut hospitals, both for-profit and non-profit, health and non-health related. Only two hospitals, Dempsey and Lawrence and Memorial have no for-profit partners. For-profit affiliates include pharmacies, real estate companies, rehabilitation services, medical practices, outpatient surgical centers, collection agencies, insurers and lab services. Non-profit partners include hospice centers, home health and long-term care providers, childcare, mental health services, fundraising organizations, and dental groups.[12]

Concerns have been raised about special designations under the Certificate of Need process giving some hospitals the ability to offer specialized services. Contract negotiations between specially designated hospitals and payers have threatened access to these specialized services for some Connecticut residents.[13]

The Federal Trade Commission has announced its intention to increase scrutiny of hospital mergers and potential anti-trust violations nationally. Sharply rising medical costs, driven in large part by hospital rate increases, precipitated the shift in priorities. National analysts cite an increasing environment of hospital consolidation linked to 20 to 40 percent increases in rates.[14]

Demand for Services and Average Length of Stay

Connecticut hospitals are experiencing a steady growth in demand for their services. Inpatient days and discharges have increased modestly, while outpatient and emergency room visits have increased sharply. Emergency room visits were up by 15% from FY 1998 to FY 2000. The Average Length of Stay (ALOS) in CT is at a relatively constant 4.8 days. Large urban hospitals have higher ALOS than smaller community hospitals.[15] CT hospitals' ALOS for the top 10 Diagnosis Related Groups are generally lower than those for MA, NY or RI hospitals.

	Average Length of Stay (ALOS) [16]			
DRG description	**CT**	**MA**	**NY**	**RI**
Normal newborn	**2.2**	3.1	2.3	2.3
Normal vaginal delivery	**2.2**	2.4	2.3	2.3
Psychoses	**9.0**	10.2	16.6	8.1

Heart failure and shock	**5.0**	5.2	6.6	4.7
Simple pneumonia	**5.6**	5.4	7.5	5.6
Pacemaker implant or arterial stent	**2.9**	4.2	3.6	3.2
Caesarean section	**4.2**	4.5	4.0	4.3
Limb/joint reattachment	**4.3**	5.4	6.1	4.7
Chest pain	**1.7**	3.0	2.2	1.7
Chronic Obstructive Pulmonary Disease	**5.0**	4.6	6.3	4.6

Regulatory Environment

Connecticut's hospitals answer to an array of state agencies. They are licensed by the Department of Public Health, including random inspections and chart reviews. The Department of Social Services is responsible for Medicaid rate setting. The Office of Health Care Access monitors the financial activities of hospitals and approves of any changes in services through the Certificate of Need process. The Office of Policy and Management is intimately involved in hospital financing and state assistance. Hospitals also have relationships with other agencies through their health-related programs. The Connecticut Office of Attorney General monitors hospital mergers and affiliations and offers assistance in developing agreements that preserve competition. The Centers for Medicare and Medicaid Services regulate Medicare services and hospital cost reports.

Adverse Event Reporting

Until very recently, requirements for CT hospitals to report medical errors were minimal. Hospitals were required to report only untimely deaths to the medical examiner; in a majority of cases, hospitals did not comply with this requirement. Sixteen states require hospitals to report adverse events. Incorporating many aspects of the Commission's Quality of Care Issues Workgroup's recommendations, in May 2002 the legislature passed and the Governor signed PA 02-125, An Act Creating A Program for Quality in Health Care. Effective October 1, 2002, the act requires hospitals and outpatient surgical centers to report adverse events within 24 hours to the Dept. of Public Health. Reports will be confidential for six months until the department decides what action to take, and then will become public information.

Challenges Facing CT's Hospitals

Financial and Organizational Issues

Changes in Medicare Reimbursements to Hospitals

Fifteen percent of Connecticut residents are Medicare beneficiaries, compared to 14% nationally. While CT Medicare recipients cost an average of $6,433 (2000), compared to the national average of $5,490, utilization of hospital care is lower than in other states. CT Medicare discharges per 1,000 enrollees are 316 compared to the national average of 371; outpatient hospital service use was 651 per 1,000 enrollees compared to 654 nationally (1998). However, CT Medicare beneficiaries are using more than the national average of skilled nursing facility days (2,577 vs. 1,452 per 1,000 enrollees), and home health services, both persons served (123 vs. 96 per 1,000 enrollees) and home health visits per person served (60 vs. 51 per 1,000 enrollees).[17]

While Medicare is the largest payer of hospital care in Connecticut (43.7% of costs)[18], individual hospitals vary in Medicare reliance between 0.2% (CCMC) and 57.7% (Bradley Memorial).[19] In FY 2000, Medicare paid 96% of hospitals' costs for providing that care.[20] Connecticut hospitals have been very successful in restraining Medicare costs. Between 1995 and 1997, average cost per Medicare case in CT hospitals dropped by 2.2% while the US average dropped only 0.4%.[21]

In recent years, there have been several changes in federal funding that have had great impact on CT hospital financing. The Balanced Budget Act of 1997 (BBA) reduced payments to hospitals over a five-year period based on concerns that Medicare could become insolvent and the belief among federal policymakers that the program was over-paying hospitals[22]. It is estimated that the BBA cost CT hospitals $1,099,900,000 between FFY 1998 and 2002. These cuts were not sustainable and in response to significant pressure from hospitals some relief came through the Balanced Budget Refinement Act (BBRA) and the Benefit Improvement and Protection Act (BIPA). These two acts partially mitigated the impact of the BBA, reducing the net loss to Connecticut hospitals to an estimated $844,600,000. [23] As of October 1, 2002, reimbursements to hospitals for indirect medical costs were again reduced.[24]

Beginning in 1983, Medicare rates have shifted from a cost-based reimbursement system to one based on a prospective payment system (PPS), which pays a pre-determined per-discharge rate. Each discharge is classified under a diagnostic-related group (DRG) based on clinically similar patients needing similar resources. The DRG determines the operating payment for each case. Payments are later adjusted for labor costs in the regional market, capital costs attributed to the hospital's Medicare cases, unusually high cost cases (outliers), and an adjustment for revenue losses from treating low-income cases (see DSH section below). Hospitals are also reimbursed through Medicare for bad debt due to beneficiary failure to pay deductibles and coinsurance.[25]

In response to hospitals' concerns over declining Medicare revenues, federal proposals to raise Medicare rates by only 2.75% on October 1, 2002 were revised to 2.95% on July 31, 2002.[26] However, the Center for Medicare and Medicaid Services estimates 2003 hospital inflation at 3.3%. [27]

Changes were also made in the way the federal government reimburses hospitals for outpatient services. In 2000 the Center for Medicare and Medicaid Services implemented the Outpatient Prospective Payment System that was designed to reduce payments to hospitals for outpatient services. This system presented and continues to present significant challenges to both hospitals and CSMS to implement and has reduced payments to hospitals.[28] On Oct. 31st the Centers for Medicare and Medicaid Services announced Medicare hospital outpatient service payment increases averaging 3.7%, effective Jan. 1, 2003.[29]

In 1999, seventeen Connecticut hospitals received $151,342,453 in total to reimburse for costs of training medical residents (Graduate Medical Education); 97 percent of those funds were paid through Medicare reimbursements. Hospitals are reimbursed for both the direct (e.g. residents' salaries, teaching physicians' salaries, related overhead) and indirect (e.g. administrative costs, costs of treating patients with more complex medical needs) costs of training. The BBA capped the number of eligible residents at 1996 levels and Graduate Medical Education funding to CT hospitals in 1999 was down 15 percent from a high of $178 million in 1997.[30]

Medicaid Rates

In 1998, Connecticut spent $6,273 per Medicaid enrollee, compared to the national average of $3,822. However, only 22% of Connecticut's funding, or $1,380 per person, went to hospitals (through fee for service), compared to the US average of 41%, or $1,567 per person.[31]

In FY 2000, Connecticut's fee-for-service rates to hospitals covered 76% of costs.[32] In 1998, CT's ratio of payments to costs was the third lowest in the US. Until 2001, the state's rate setting methodology (TEFRA) had not been updated since 1994 and is still cost-based as opposed to a PPS as for Medicare[33]. Since 1994, most Medicaid clients have moved into a mandatory managed care system. Medicaid clients left in the traditional fee-for-service program tend to be high utilizers of care, with more complex medical needs. Average cost per case grew from $4705 in 1995 to $6926 in 1998. However, rates were not adjusted to account for the change in case mix or for new technologies and changes in the practice of medicine until 2001. From 1995 to 1998, the shortfall between Medicaid payments and the costs of care grew from $680 to $2,049 per case. In 1998, Medicaid payment to cost ratios for hospitals was the third lowest in the US. In 1999, the Medicaid payment shortfall to CT hospitals was $148 million.[34]

In response, the state passed legislation in 2001 increasing both in-patient and outpatient Medicaid rates significantly. Effective June 1, 2001, the act raised inpatient hospital rates to at least 62.5% of costs and updated the estimates based on 1999 hospital costs to better reflect changes in technology and case mix. The act also increased outpatient rates by 10.5%. There is no statutory provision for future Medicaid rate increases.[35] Inpatient rates increased for 21 of Connecticut's 31 acute care hospitals.[36] Also in response to concerns regarding Medicaid underpayments, the act increased net DSH payments to hospitals (see below).

Disproportionate Share Payments

Medicaid Disproportionate Share Payments (DSH) are paid by the state and federal governments, administered through DSS, to compensate hospitals for state coverage program underpayments, bad debt, and charity care. Each hospital's DSH payment is based on several criteria including 1) the number of General Assistance patients served, 2) services provided to uninsured and underinsured children in the custody of the Dept. of Children & Families, 3) the difference between payments and the costs of providing care to Medicaid recipients, bad debt or charity care, 4) uncompensated care provided to low-income inmates of correctional facilities, 5) uncompensated care provided in distressed municipalities, and 6) uncompensated care provided by free-standing, short-term children's hospitals. State psychiatric hospitals are also reimbursed under DSH.[37]

There have been numerous changes to CT's DSH program over the years. In the past, the system relied on taxes levied on hospitals, returned to a pool and redistributed to

hospitals based on a complex formula. In 2000 and 2001, those taxes were eliminated, while payments to hospitals continued. [38] Elimination of the taxes exempts the state from several rules in operating the DSH program.[39] In 2001, the sales tax on patient care services was suspended for two years and a pool was established for hospitals located in distressed municipalities. Without legislative action, the sales tax on patient care services will be reimposed on May 1, 2003.[40]

Medicaid DSH Payments[41]				
	FFY 1998	FFY 1999	FFY 2000	FFY 2001
William Backus	$4,336,354	$4,813,261	$3,770,312	$4,369,748
Bradley	$308,341	$704,417	$385,957	$29,283
Bridgeport	$14,657,744	$14,679,745	$17,268,601	$13,031,513
Bristol	$3,775,664	$6,281,205	$3,963,991	$2,607,144
CCMC	$64,800	$3,639,940	$125,050	$127,714
Danbury	$11,993,115	$4,625,214	$9,645,191	$11,809,638
Day Kimball	$1,211,670	$923,259	$2,792,785	$2,435,113
John Dempsey	$1,342,912	$815,228	- $2,691,559	$2,002,573
Greenwich	$4,552,490	$2,614,498	$1,323,572	$4,600,498
Griffin	$4,837,122	$3,254,263	$2,002,343	$2,287,729
Hartford	$24,090,454	$27,937,240	$32,977,975	$24,140,599
Charlotte Hungerford	$3,358,693	$880,989	$1,232,344	$3,094,920
Johnson	$1,369,525	$195,257	$961,572	$685,946
Lawrence & Memorial	$9,102,796	$4,319,171	$4,472,811	$11,300,048
Manchester	$3,040,250	$6,446,168	$4,652,703	$1,719,707
Middlesex	$10,762,319	$6,449,045	$6,440,550	$6,054,206
MidState Med. Center		$5,302,378	$5,146,864	$4,482,039
Milford	$1,764,317	$2,474,180	$507,521	$897,461
New Britain	$10,328,359	$4,799,884	$8,191,428	$9,190,139
New Milford	$918,531	$1,884,968	$2,172,264	$1,810,350
Norwalk	$13,115,494	$10,230,637	$6,770,323	$6,036,165
Rockville	$1,317,747	$128,188	$103,584	$1,414,417
St. Francis	$25,327,171	$25,141,763	$23,962,677	$14,540,371
St. Joseph[42]	$2,006,964	$116,489	$6,752	
St. Mary's	$18,007,568	$13,732,213	$8,766,326	$5,208,476
St. Raphael's	$13,950,013	$10,710,376	$6,432,466	$10,366,314
St. Vincent's	$8,081,605	$14,006,141	$12,731,533	$11,266,568
Sharon	$24,529	$557,525	$1,869,868	$1,635,473
Stamford	$10,864,629	$7,868,045	$11,440,748	$8,108,470
Waterbury	$4,784,783	$11,387,714	$11,597,373	$7,125,948
Windham	$1,776,464	$3,172,655	$917,157	$2,820,489
YNHH	$44,251,549	$38,584,346	$39,105,165	$28,006,587
Total hospital DSH[43]	$266,862,863	$239,777,011	$229,066,982	$203,205,646

Sources: DSS DSH Report to CMS 12/31/01, State Plan Amendment 01-010 (9/27/01), DSS Annual DSH Expenditure Reports 4/12/00 and 12/11/01, DSS Revised DSH Payment Schedule 4/19/00

Medicare payments also incorporate a DSH enhancement for hospitals that serve a disproportionate share of low-income patients. Hospitals qualify for Medicare DSH adjustments if their share of low-income patients is 15% or more. That share is measured as the proportion of a hospital's Medicare inpatient days to the number of patients eligible for Supplemental Security Income benefits and the proportion of a hospital's total acute inpatient days provided to Medicaid patients. Federal legislation in 2000 expanded the number of hospitals eligible for DSH payments under Medicare.[44]

Managed Care

Forty percent of Connecticut residents were enrolled in managed care plans in 2001, the fifth highest rate in the nation, including both traditional HMOs and point-of-service (POS) plans through group/commercial plans, Medicare, Medicaid, the Federal Employees Health Benefits Program, direct pay plans and other HMO products. The US average HMO penetration rate is 28%.[45] Managed care companies use their market clout to negotiate volume discounts with providers, including hospitals. Those discount rates have been growing steadily in CT. In 1996, the average discount for CT hospitals was 19.7%; by 2000 discounts had grown to 35.8%.[46] Discount rates vary between hospitals and between contracts.

Interaction between payers

Traditionally government payers have paid below costs and private payers have made up the difference. In 2000, the largest payer of hospital care in Connecticut was Medicare at 43.7% of total spending, for which payments averaged 96% of costs. Medicaid paid for 12.1% of hospital care, but those payments only covered 76% of the costs. Private payers, overwhelmingly through managed care arrangements, constituted 36.7% of hospital payments. The payment to cost ratio for private payers was 111% for 2001, down from 120% in 1998. Not surprisingly, hospitals with high Medicaid caseloads had lower margins and were more likely to be in distress than hospitals with more private pay patients.[47] DSH provides significant relief for underpayments and charity care; in FY 2000 Connecticut hospitals incurred $151 million in uncompensated care costs, and received $229 million in Medicaid DSH payments.[48]

Shifting between payers is demonstrated below. The table aggregates balances for payer source across all hospitals. As Connecticut's hospitals vary significantly in payer mix, these influences will play out in varying ways at individual hospitals.

Payer[49]	Payments	Costs[50]	Net
Total Medical Assistance[51]	$493.9	$514.1	-$20.2
Uninsured[52]	$152.6	$126.9	$25.7
Medicare	$1,760.7	$1,842.1	-$81.4
Sub total	$2,407.2	$2,483.1	-$75.9
Private Payers[53]	$1,710.8	$1,646.0	$64.8
Other[54]	$48.2	$32.1	$16.1
Net Operating per OHCA Filing[55]	$4,166.2	$4,161.2	$5
Net Operating per AFS Filing[56]	$4,526.7	$4,583.5	-$56.8

Unlike nursing homes, Connecticut does not directly review or limit hospital costs. Each hospital defines their costs differently.[57] Medicare, despite movement toward a PPS system, does require that hospitals report costs to calculate adjustments and other payments. Medicare guidelines require that costs reported must be "based on the reasonable cost of services covered" and comparable to similar institutions in the area. Allowable costs "include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities" and "common and accepted occurrences in the field of the provider's activity."[58] CT reviews hospitals' Medicare cost reports and adjusts Medicaid payments accordingly.[59] While CT's Medicaid program is still a cost-based reimbursement system, Medicaid rates represent only 12.1% of CT hospital payments. Pressures to reduce costs from Medicare and private payers, who fund over 80% of the total, will help control costs for CT's Medicaid program. However, between individual hospitals with varying payer mixes, these factors will have differing influences.

Access to Capital

Connecticut hospitals face serious constraints in accessing capital for investment. Capital structure ratios for Connecticut's hospitals, measuring the ability to pay long-term debt are lower than the rest of the Northeast and the rest of the US. CT's large, urban hospitals have even lower ratios than small community hospitals. While no hospital has defaulted on a loan, several have not met the debt service coverage requirements of their bonds.[60] The CT Health and Educational Facilities Authority (CHEFA), a quasi-public agency, which facilitates borrowing by CT's hospitals, reports that due to operating losses and a growing reliance on non-operating income, CT hospitals are having greater difficulty in attracting capital. As of October 2000, there were no insurers willing to secure any CT hospital's bond, requiring hospitals to borrow at a far higher interest rates for longer terms. Difficulty in borrowing money and investing in facilities will place hospitals at a competitive disadvantage and affect their ability to serve CT residents.[61] CT hospitals are not unique in this concern, however in other states for-profit hospitals have enjoyed strong gains in the stock market, allowing access to capital. Nationally, bond issues dropped by 33% in 1998-1999 and another 40% in 1999-2000. Moody's downgraded credit ratings for 56 hospital organizations in 2000 and upgraded only 12. There was some stabilization in 2001.[62]

HIPAA

The goal of the federal Health Insurance Portability & Accountability Act (HIPAA) is to simplify health care administration, standardize the electronic transmission of certain health information, and protect patient record confidentiality. Hospitals, insurers, employers, and providers will be required to comply with a standard set of codes and transmission standards. The scope of protected information is very broad and applies to dozens of departments within hospitals. While the eventual savings for hospitals and the overall health care system are significant, implementation will be complex and extremely costly. Compliance deadlines are approaching. Penalties for non-compliance

range from modest sums for transaction infractions, to serious criminal and civil penalties for non-compliance with security and privacy standards. No CT hospitals were fully compliant as of April 2001. Hospitals varied in the level of compliance planning and in system needs for compliance. While the costs of HIPAA compliance were not available, the Hospital of St. Raphael reported an estimate of $10 million to comply for their institution.[63] As of this writing, federal regulations are not final.

Data Systems

Many state agencies collect data on CT's hospitals, however most hospital data is collected first by the CT Hospital Association's ChimeData Program and then delivered to the state. Chime's data goes back to 1980 and includes clinical, financial, service, provider and demographic data. Chime edits the data, ensuring validity and completeness.[64]

While many state agencies use hospital data, the major consumer is OHCA. OHCA's databases include the Hospital Budget System and the Hospital Inpatient Discharge Database. OHCA receives quarterly patient level data from all 31 acute care hospitals. Data include billing and discharge records and is used for health planning and hospital monitoring.[65]

November 5, 2001, the Commission's Co-Chairs sent a letter to OHCA requesting a list of data elements. The correspondence is included in the Appendix.

Access to Care Issues

Uninsured and Uncompensated Care

Estimates of the number of uninsured in Connecticut vary between 185,200[66] and 323,000.[67] Those numbers are expected to rise as the effects of the current recession, medical inflation and a softening labor market lead to a loss of employer-sponsored insurance.[68] In March 2002, enrollment in CT's HUSKY program of public coverage for the uninsured had its greatest increase in enrollment since the beginning of the program in 1995.[69]

The uninsured are much more likely to go without needed health care, receive fewer preventive services, and less regular care for chronic conditions.[70] They tend to delay care until problems worsen and are more likely to access care in a hospital emergency room. Once admitted to a hospital, uninsured patients are more likely to die there.[71] Hospitals in other parts of the country are so overwhelmed with demand from uninsured patients that they have begun curtailing services and limiting who may be admitted.[72]

In 2000, CT hospitals averaged 3.6% of overall costs in uncompensated care. One half of the total uncompensated care for the state was borne by the nine urban hospitals in Hartford, New Haven, Bridgeport and Waterbury.[73] Nationally in 1999 hospitals averaged 6.1% in uncompensated care of total costs, up from 5.1% in 1980.[74]

Emergency Room Overcrowding

Connecticut residents are more likely to visit the emergency room than other Americans - 399 for CT vs. 374 US visits/1,000 population in 2000.[75] Connecticut emergency room visits grew by over 15% between 1998 and 2000.[76]

Nationally, one third of emergency rooms are so crowded that they must periodically divert ambulances to other hospitals. New England leads the nation with 52% of hospital emergency rooms over capacity and 54% reporting some time on emergency room diversion during the month of November 2001 in a study by the Lewin Group for the American Hospital Association. Larger, urban and teaching hospitals were at the highest risk. Almost 90% of Level I trauma centers (most complex care) reported being at or above capacity. The number one reason given for emergency room diversion was a lack of available staffed critical care beds. Hospitals reporting 20% or more time on diversion had an average RN vacancy rate of 16%. [77] From 1997 to 1999, ten percent of US emergency rooms were cited by the Centers for Medicare and Medicaid Services for failing to comply with EMTALA, a federal law requiring them to provide emergency care to all patients regardless of ability to pay. Four CT hospitals were cited during those years; no CT violations have been cited since 2000.[78]

Behavioral Health

One in ten CT residents reports poor mental health for at least a week during the last 30 days.[79] According to testimony given to the Commission, CT's behavioral health system is in "gridlock". Acute care emergency rooms are routinely holding patients for days who need acute psychiatric care, because no beds are available. Patients who do not need acute psychiatric care are being held because there is no appropriate place for discharge. One example given was a 14-year-old patient who overdosed was in the emergency room for 72 hours as no adolescent beds were available in the entire state. Eventually the patient was discharged to home with appointments for outpatient care.[80] The average length of stay for a child in a DCF facility rose by 73% to almost 180 days between 1997 and 2000.[81]

Between 1999 and 2000, total psychiatric patient days grew by 15.5%. The state's 16 large and medium urban hospitals accounted for 78% of the state's acute care psychiatric beds, 77% of all discharges and 80% of total patient days. Between 1997 and 2000, children and adolescents showed the greatest increase in use of psychiatric services. Over half of patients were admitted through the emergency room. The vast majority (78%) of acute care psychiatric patients are discharged home, back to the community.[82]

Despite the great need, increasing pressures are causing some acute care hospitals to attempt to reduce the number of psychiatric beds they staff. Danbury Hospital has closed their Child and Adolescent Unit entirely. The reason for this trend is that payments, particularly by Medicaid managed care plans, do not cover costs. Statewide losses range from $5 to 7 million. General hospitals are the largest provider of behavioral health care to the poor in CT. [83]

Speakers emphasized the need for a separate system of care for mental health emergencies.

Bioterrorism

A significant challenge faces CT hospitals if there is another bioterror attack in the state. While CT is planning for a coordinated response, in the event of an attack a great deal of the responsibility not only for treatment, but also for early warning, identification, will fall to hospitals. CT is just now receiving its $14.1 million share of the funding the President signed into law five months ago. Of that, only $1.6 million will go to hospitals under the current proposal. [84]

The funding is intended to upgrade the preparedness of hospitals and collaborating entities to respond to bioterrorism. The program will focus on the development of regional plans to improve the capacity of hospitals and emergency rooms, emergency medical services and outpatient systems. Hospital Preparedness Centers of Excellence have been identified based on clinical expertise - burn centers, Lifestar, and Level 1 trauma centers, geographic locations, population centers and systems capacity.[85]

Workforce Issues

Connecticut faces serious shortages in its health care workforce, including nursing, pharmacy, radiology, and diagnostic imaging, laboratory science, and others.

The nursing shortage is most severe for Connecticut currently. Vacancy rates for nurses in CT hospitals in 1999 averaged 7 to 8%, up from 3 to 4% in 1997. Vacancy rates for specialty areas are over 10%.[86] CT currently ranks 38th in the nation in RNs per population.[87] CT nurses are older than the US average (45.1 vs. 42.3); as CT's baby boomers grow older and need more nursing care, fewer nurses will still be employed in the profession. Licensed RNs in CT are less likely to be employed than the national average (78.1% vs. 82.7%).[88] A study by the US Dept. of Health and Human Services in July 2002 indicates that Connecticut's nurse vacancy rate in 2000 was 12%, and predicts that the rate will double to 24% in 2005 and increase to 34% in 2010. [89]

More nurses are choosing not to work at the bedside. One in five current nurses are considering leaving the profession. Reasons include seeking a less stressful job (56%), regular hours (22%), more money (18%), advancement opportunities (14%), to raise children (14%) and fewer hours (11%). Morale is very low, and the vast majority (78%) of potential leavers believe the situation is getting worse. Almost half of all nurses would pursue a different career if they were just starting out. The number one issue among nurses is staffing. Two thirds report that patient loads are a serious problem. Sixty four percent said that they do not have enough time to spend with patients.[90] Pharmaceutical, law, business and insurance companies are actively recruiting nurses. [91]

The nursing shortage is not simply a customer service or comfort issue for patients, it can mean the difference between life and death. In a study of over 6 million discharge records, researchers found that patients in hospitals with lower nurse to patient ratios were more likely to suffer cardiac arrest, shock, urinary tract infections, hospital-acquired pneumonia, and stomach and intestinal bleeding. Patients in highly staffed hospitals had shorter average stays. Surgical patients in the highest staffed hospitals were less likely to die from surgical complications. [92] Hospital patients have begun to hire private nurses to attend to their personal needs.[93] The Joint Commission on the Accreditation of Healthcare Organizations, the national organization that accredits hospitals, is incorporating nurse staffing level standards in their requirements for hospitals.[94]

The shortage of nurses has created not only quality concerns for hospitals, but is also a serious driver of costs. Hospitals have been forced to raise salaries dramatically, offer large signing bonuses, extensive advertising, overseas recruitment of foreign-trained nurses, and more flexible hours.[95]

There are efforts underway to address the problem. The Nursing Career Center of Connecticut was created by the CT League for Nursing and the CT Nurses' Association to attract middle and high school students into the profession.[96] The CT League for

Nursing, in collaboration with Charter Oak State College and the CT Distance Learning Consortium, has made web-based Refresher Courses available to RNs and LPNs. The CT State Board of Nurse Examiners has recognized the Refresher Programs as meeting requirements for reinstatement of lapsed licenses. Norwalk Community College has established a satellite nursing program at Gateway Community College in New Haven. Goodwin College, in East Hartford, is active pursuing plans for a new associate degree nursing program.[97]

The CT Hospital Association has undertaken an ambitious initiative including public education, securing resources for training, retention and recruitment, identify best practices in retention, explore alternative delivery systems, system monitoring and coordinate with other workforce initiatives.[98] In 2002 Congress passed and President Bush signed into law legislation expanding existing programs and established new programs for scholarships, loan repayments, and recruitment, however this legislation has not been funded.[99]

Hospitals are facing shortages of other health care workers as well. Recently, there have been strong efforts both nationally and in Connecticut to limit the hours worked by medical residents.[100] Contrary to popular opinion, new analyses of economic and demographic trends predict physician shortages in the near future – a deficit of 50,000 physicians by 2010 and 200,000 physicians by 2020.[101]

Quality of care

A 1999 Institute of Medicine study found that between 44,000 and 98,000 Americans die in hospitals each year due to medical errors. This death rate exceeds motor vehicle crashes, breast cancer and AIDS. The study estimated that beyond the costs in lives, hospital medical errors cost the US economy between $17 and $29 billion/year[102]. More recent studies suggest those numbers may be conservative although other research suggests that the IOM numbers are overstated.[103] One in five Americans reports that they or a family member experienced a medical or prescription drug error.[104] Medical errors include improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries, falls, burns, pressure ulcers, mistaken patient identities and medication errors, such as a patient receiving the wrong drug or an overdose of the correct drug. Medication errors caused preventable injuries to hospital patients at a rate of about 10 per week at each of two large urban teaching hospitals; one in five were life threatening.[105] The causes of medical errors are varied including language barriers[106], system fragmentation and complexity, and staff shortages. Of even greater concern is a study showing that while hospitals are doing a better job of reporting medication errors, they continue to make the same mistakes over and over.[107]

In response to these studies, employers and other payers are holding hospitals to higher standards of quality. Medicare data show that in 1988-1999, only 55% of hospitalized patients with atrial fibrillation received anticoagulation, a proven treatment to reduce the risk of stroke. CalPERS, California's public employees benefits system

with 1.3 million members, is developing a $ 15 million database to allow managers to track which doctors, hospital and treatments best serve its members, especially those with chronic problems.[108] Four New York employers have offered a total of $2 million to area hospitals who reduce medical errors by implementing electronic error-prevention programs.[109]

The Leapfrog Group, a consortium of over 100 Fortune 500 companies and other large private and public health care purchasers, have agreed to base their purchases on more stringent patient safety standards. As Leapfrog members and their employees spend over $53 billion on health care each year, the group's standards are moving markets. Leapfrog has identified three initial safety standards for hospitals. Computer physician order entry systems allow physicians to enter medication orders via computers linked to prescription error prevention software these systems have reduced serious medication errors by more than 50%. Evidence-based hospital referrals ensure that patients needing complex medical procedures will be sent to hospitals offering the best odds of survival based on scientifically valid criteria; this referral system could reduce a patients' risk of dying by more than 30%. Leapfrog standards require that Intensive Care Units be staffed by physicians with credentials in critical care medicine; this standard has been shown to reduce the risk of death by more than 10%. The state of Massachusetts requested that all hospitals report to their insurance providers whether they meet Leapfrog standards.[110] Hospitals have not objected to the Leapfrog goals but many have been unable to implement the standards at this time. Leapfrog is surveying hospitals to identify those meeting these standards and educating consumers about preventable medical mistakes. Leapfrog has initially targeted other areas of the US. In Connecticut, only St. Vincent's Medical Center has reported Leapfrog survey results.[111] While the costs of implementing Leapfrog's current and future standards will be expensive for hospitals, the initiatives will save considerable sums in the long run. As employers and other payers become more sophisticated and demand more accountability for growing health care costs, hospitals' participation in programs like Leapfrog will become a necessity.

The federal Dept. of Health and Human Services is developing a system to allow physicians, pharmacists and other providers to report medical errors and adverse outcomes electronically.[112] A bill introduced in the US Senate would create "patient safety organizations" to analyze confidential reports of medical mistakes and advise on how to avoid them, creating a "culture of safety rather than a culture of blame." [113] The federal Agency for Healthcare Research and Quality is spearheading an initiative to inform consumers about errors and to conduct research on medical errors and how best to prevent them.[114] The Joint Commission on Accreditation of Healthcare Organizations requires hospital reporting and investigation of "sentinel events" or adverse outcomes and has initiated a consumer education campaign – Speak Up: Help Prevent Errors in Your Care.[115]

While payers are beginning to use quality standards in purchasing health care, a general system requires government oversight and leadership. The Quality of Care Workgroup researched successful quality initiatives in Minnesota, Massachusetts,

Rhode Island, Indiana, California, Maryland, and Oregon as well as several national organizations dedicated to patient safety. Initiatives among states include hospital patient surveys and outcome data used to develop consumer education materials, mandated error reporting, establishing best practices, benchmarking projects, permanent commissions and steering committees to review patient safety systems and procedures. Engaging all stakeholders early in an on-going process led by government is critical to success.[116]

In response to the workgroup's efforts, in May 2002 the legislature passed and the Governor signed HB-5715, An Act Creating a Program for Quality in Health Care. Under the act, the Department of Public Health will create a quality of care program for health care facilities, including a performance measurement, patient satisfaction surveys, medical error reduction methods, systems to share best practices, continuum of care and outcomes reporting systems. The program will initially apply to hospitals, with other facilities to follow. A Quality of Care Advisory Committee will be created; membership will include representatives from hospitals, nursing, business, home health care, unions, OHCA, peer review organization, health plans, health care facilities, non-profit providers, consumers and the Dept. of Public Health. The act becomes effective October 1, 2002.

Commission Recommendations

On February 4, 2002, the Commission on the Future of Hospital Care in Connecticut adopted the following recommendations.

FINANCIAL & ORGANIZATIONAL ISSUES

The complexity of the factors associated with the financing and organization of hospital care raises many questions. All parties, providers, payers, policy makers and regulators believe that the collection and analysis of benchmark and comparative data will allow for a better understanding of the issues and the development of solutions to improve the health care delivery system in the State of Connecticut. Therefore, the Financial and Organizational Issues Work Group recommends:

1. The Office of Health Care, with the assistance of Connecticut Hospital Association, should develop benchmark data elements, as contained in the letter drafted by Representative Mary Eberle of November 5, 2001.

2. The Office of Health Care Access should explore comparative data for the most frequently used DRG's from regional and national sources.

3. The Commission should request from the Department of Insurance a breakdown of commercial rates by primary medical expense categories, such as physician, pharmacy, in-patient and outpatient hospital costs. The Commission should work with payers to generate other relevant data for analyzing health care cost in Connecticut.

4. The Commission and the Legislature should focus on programs and where appropriate develop legislation to address:

(a) labor shortages issues
(b) increasing pharmacy cost
(c) cost and availability of malpractice and other insurances
(d) study the sources of capital funding and the effect of bonding agency rating on hospitals and their cost implications.

5. The Commission and the Legislature should study and develop recommendations to address the Medicaid shortfall and its resulting cost-shifting effect on the states' employers. Such study should include an analysis of the impact of rebasing Medicaid rates, increases to Medicaid reimbursements, and/or redefining the scope of coverage under Medicaid.

6. The Legislature should study the cost implications of federal legislative Initiatives, e.g. HIPAA implementation and OSHA mandates as well as private sector initiatives such as LEAPFROG

ACCESSIBILITY OF CARE ISSUES

The work group heard presentations and reviewed issues in a variety of areas related to hospital accessibility: the state's overall health care system: special populations; state payment for services, particularly in the Medicaid program; and alternative financing mechanisms. Based on this review, it recommends:

SYSTEM COORDINATION

1. Encourage the coordination of the wide array of services available through Connecticut's health care system and the reduction of the system's fragmentation and duplication.

2. Develop a mechanism in the Medicaid program that permits patients to transition from one system (e.g. juvenile) to another (adult).

3. Reduce barriers to physicians' participation in existing programs.

4. Develop future utilization projections for Medicaid services based on an actuarial analysis of the Medicaid-eligible population in Connecticut.

5. Develop a single application process for all state health care benefits (e.g., Medicaid, HUSKY, SAGA medical).

SPECIAL POPULATIONS

1. Explore development of nonhospital alternative systems for people to access appropriate care in community settings.

2. Explore development of nonhospital alternatives for people experiencing mental health crises to access service.

3. Eliminate disparity in prior authorization process for hospital admission between people experiencing behavioral health and medical health crises.

4. Provide more community-based services, particularly mobile emergency crisis services, for people experiencing mental health crises.

5. Consider a Department of Social Services mechanism to include undocumented aliens in state reimbursement for emergency room and outpatient care, and, potentially, other alternative levels of care, if no other reimbursement is available.

6. Increase the capacity of child and adolescent mental health case management, residential service capacity, crisis intervention services and mental health acute care beds with incentives to hospitals

FINANCING

1. Develop a formula, based on the Medicare system, to align hospital outpatient rates for specified services with costs for all providers.

2. Increase Medicaid rates for specialist services by more closely aligning them with Medicare rates. This should encourage more physicians to participate in Medicaid.

3. Develop broad-based revenue sources to fund higher Medicaid reimbursement rates.

4. Pay the true costs of Medicaid health services to providers.

5. Explore ways to maximize federal resources for health care.

WORKFORCE ISSUES

The Workforce Issues Work Group of the Commission on the Future of Hospital Care in Connecticut convened its first meeting on October 9, 2001 with a charge to develop recommendations to alleviate the current nursing and allied health care workforce shortage in Connecticut. The Work Group met again on October 22, November 5, and November 19, 2001, and heard presentations by the Connecticut Hospital Association, the Connecticut Department of Labor, the Connecticut Department of Public Health, the Nursing Career Center of Connecticut, the Connecticut League for Nursing's Articulation Oversight Committee, the Office of Workforce Competitiveness, the State Board of Examiners for Nursing, and by a member of the American Hospital Association Workforce Commission.

The Work Group heard testimony about and discussed shortages in the healthcare professions of nursing, pharmacy, radiology and diagnostic imaging, laboratory science, and others. Common issues include an abundance of career alternatives, lack of perceived value/appeal of healthcare careers, aging current workforce, workload and work design issues, and a lack of diversity in the workforce (limiting access to candidate populations of male and minority workers).

At the outset, the group agreed that focusing on supply issues would be most productive. There was agreement that broadening the base of potential workers is essential, as is partnering between healthcare employers, educators, and agencies

involved with workforce development. While there is universal concurrence regarding the importance of work environment in the success of retention strategies, the work group agreed that a focus on supply would be most constructive since staff shortages are often the most significant contributor to work environment stress. The group also agreed that success of workforce initiatives will require collaboration and cooperation between management and the entire workforce.

The Work Group thus makes the following recommendations to the Commission on the Future of Hospital Care in Connecticut:

1. **Seek out and take full advantage of all existing sources of educational assistance for students in nursing and allied health programs in Connecticut, and where none exists, secure additional resources to make education more accessible and manageable**. It is essential that today's students, particularly non-traditional students, have adequate support services in place to enable them to complete their healthcare education program. Collaborate with public and private sectors to develop new/creative solutions to meet defined financial needs:

    - Identify and take advantage of all financial resources available (grants, scholarships, loan forgiveness) for non-traditional students pursuing nursing or allied health education who have minimal financial resources for education. Expand eligibility criteria for existing state assistance to such students where possible.
    - Ascertain availability of access to Connecticut's childcare and transportation systems. Supplement and expand such resources where required to ensure adequate support to students who are juggling work, school and family.
    - Link financial support to a future commitment to work in the Connecticut healthcare system for a designated period of time.
    - The Connecticut Department of Public Health (DPH) should research the existence of additional federal funding and loan forgiveness programs that may be available for registered nurses and students enrolled in other health professional educational programs as well as the feasibility of participating in such programs.
    - DPH should pursue a federal waiver (Public Health Service Act, Section 3381, 42 U.S.C. 254q-1 as amended; National Health Service Corps. Amendments Act of 1990, Title II, Public Law 101-595) that will allow Connecticut to expand its loan repayment program to include nurses in federally designated underserved areas. Although the Connecticut General Statutes were amended to include registered nurses in the State Loan Repayment Program, registered nurses are not eligible to receive federal and state matching funds under this program. Under federal guidelines, registered nurses were not included in the list of disciplines eligible to participate in the State Loan Repayment Program in 2001.

2. **To the degree possible, fully access existing resources and where not available, secure additional resources for providers of nursing and allied health education in Connecticut in order to expand programs where enrollment capacity is already exceeded and to increase flexibility in scheduling**.
    - Expansion of off-hours programs is essential for non-traditional students currently employed.
    - The ability to attract additional faculty to staff such off-hours programs is critical. Educators and healthcare employers should explore, utilize and encourage the dual appointment concept. Educators need to be flexible in the use of non-traditional faculty, and healthcare employers should encourage qualified staff to participate as faculty as a retention/ professional development mechanism.
    - Educators must also be able to provide requisite support services for students, especially adequate scholastic support (via tutoring, study groups, counseling).
    - Expansion of the use of technology and Web-based education is essential.
    - There was much discussion on the entry into practice question for nurses; while members agreed that as hospitals' patient populations have become more complex, an increase in the number of BS-prepared nurses would be preferable, they also recognized that in today's shortage environment, getting licensed nurses on staff has become the top priority. As a result, a focus on securing additional resources for Associate's Degree nursing (ADN) programs where enrollments are highest is appropriate with the understanding that a clear articulation process and support for ongoing education (through hospital tuition assistance, scholarships, etc.) is essential.

3. **Provide additional resources for hospitals to ensure they are able to attract and retain qualified healthcare workers by providing competitive salaries, adequate staffing levels, and thorough training and orientation programs**.
    - Training and orientation programs must be expanded to ensure a successful transition from education to practice (hospitals must have resources to maintain trainees in such orientation or "residency" programs rather than incorporating them into the regular staffing schedule).
    - Expand federal Graduate Medical Education (GME) training funding for teaching hospitals to those providing education and training to nurses and certain allied health professionals as well as physicians.
    - In order to ensure an adequate flow of candidates into healthcare education programs, hospitals must have resources to implement or expand job shadowing programs and related outreach programs (e.g., Explorer Scout programs).
    - Hospitals must focus on retention strategies and mechanisms, including creating career paths across the spectrum of healthcare professions.

4. **Focus resources on underlying skills and preparation**. **Work with all levels of education to ensure early recognition of healthcare work as a good career option and ensure that students have the basic educational background necessary. Enhance the elementary and secondary curriculum, focusing on math and science and on health and health careers**.
    - Pilot an existing tested curriculum enhancement model such as National Health Science Curriculum.
    - Encourage both schools and healthcare providers to participate in community service assignments for students.
    - Consider mandatory volunteer requirement of 20 hours for all graduating high school seniors.
    - DPH, through its Office of Public Health Workforce Development, should continue to collaborate with local and statewide partners (e.g., local health directors, state agencies, professional trade organizations, hospitals, institutions of higher education, the Department of Education, local primary and secondary school systems) to provide educational sessions and mentoring programs within primary and secondary schools.
    - Address the lack of diversity in healthcare professions by actively recruiting and providing development and outreach programs to target populations, particularly to those for whom a healthcare career would be perceived as well paid and upwardly mobile.

5. **Remove remaining barriers to effective, comprehensive, articulated healthcare education**. While there has been much work done on LPN to RN and RN to BSN nurse articulation in Connecticut (which is now managed through the Connecticut League for Nursing's Articulation Oversight Committee), there remain barriers that need to be examined and addressed where possible. They include the lack of credit for work experience, accessibility, and lost time from current work. There is also no articulation process for CNAs interested in pursuing a career as an LPN or RN. Both CNAs and LPNs are a rich source of candidates for RN or allied health programs since they are already interested in the field and have a good sense of the work environment. DPH, the State Board of Nurse Examiners and other interested parties should also work with nursing and allied health educational institutions to address advancement tracks and to develop innovative approaches to bringing new students into nursing and allied health programs in addition to fostering an environment that encourages nurses and other healthcare professionals who are not working or not working in healthcare to return to work in Connecticut's healthcare system.

6. **Ensure that state agencies have adequate resources to automate the license renewal process in Connecticut for nurses and other healthcare professionals to ensure efficiency and access to critical licensure and demographic data**.
    - DPH should continue to research participation in national databases.

- DPH should continue working with representatives of nursing and other healthcare professions and boards to address issues related to the licensure and re-licensure processes.

7. **Hospitals and other healthcare employers should fully participate in all elements of Connecticut's workforce development system.**
   - Hospitals should seek representation and participate actively on local Workforce Investment Boards and with the Connecticut Employment and Training Commission.
   - Hospitals should collaborate wherever possible with the Governor's Jobs Cabinet and all state workforce agencies.

8. **Address the key issues of regulation and paperwork reduction**. The current generation of workers is not interested in working in a repetitive, paper-flooded environment when all their experience and preparation has been computer-based. A 50% reduction in the paperwork required of nurses on the floor would virtually address the current nursing shortage. Eliminate duplicate regulation and inspection requirements and standardize certain patient information systems where practical. (Most of this work must be done at a federal level given the comprehensive and costly approach required.)

9. **The healthcare industry, both labor and management, should work together to continue researching and analyzing current staffing practices and identify functions performed by licensed staff that do not require the level or ability of a licensed practitioner** (e.g., preparing and maintaining staffing schedules, filing documents, arranging for ancillary services such as blood work and radiology, passing fluids, transporting patients and other similar tasks), and continue exploring alternative staffing models and models of care that take appropriate advantage of skill mix.

10. **Monitor and support actions to modify regulations or statutes at a state and national level that inhibit continued employment past a certain age**.

11. **Complete additional research on nursing and allied healthcare attrition rates to determine causes for lack of successful program completion**.

12. **Continue all collaborative efforts between state agencies, employers, professional trade associations, educators and others in the ongoing monitoring, evaluation and assessment of healthcare workforce shortages in Connecticut, and more importantly, in efforts to address such shortages**.
    - Recognize and support the Nursing Career Center of Connecticut as a major force in nurse recruitment, retention and career enhancement, and use it as a model for other healthcare professions. Consider creating such a "center" to coordinate all statewide efforts for healthcare workforce shortages and healthcare careers.

QUALITY OF CARE ISSUES

This committee met weekly from October 3 –Nov 20. During that time the committee discussed elements of healthcare quality, what measures were integral to quality improvement, studied action in other states, conducted conference calls with officials in Rhode Island, Massachusetts and Maryland, and determined necessary processes to be put in place. The committee agreed that quality improvement was an ongoing process and therefore should be addressed on an ongoing basis. The following are the committee's recommendations to the full hospital commission.

That the Public Health Committee raise legislation, which establishes a quality improvement program in the state of Connecticut. The goals of this program will be to establish an ongoing healthcare quality improvement program for the state and to develop systems that will provide public accountability. These systems will be developed in compliance with state and federal confidentiality laws and regulations In order to meet these goals the program shall develop a standardized data set of clinical performance measures that are risk adjusted as applicable. The data shall be collected and reported periodically and shall include comparable statistically valid patient satisfaction measures.

This program shall be established within the Department of Public Health and all data submissions will be to the Department of Public Health.

This program shall develop a state health care quality performance measurement and reporting program for state licensed facilities that will be phased in over a multi year period beginning with a program for hospitals.

A steering committee will be established to advise the program. The Commissioner of Public Health or his designee shall chair the steering committee. The committee will include four representatives from the Connecticut Hospital Association with one from an academic medical center in this state, one representative from the Connecticut Nursing Association, two representatives from the Connecticut Medical Society with one an active provider of medical services in the community, two representatives from the Connecticut Business and Industry Association with one representing a large business and one representing a small business, one representative from the Home Health Care Association, one representative from the Long Term Care Association, two representatives from the AFL-CIO, one consumer representative, one representative from a school of Public Health in Connecticut, one representative from the Office of Health Care Access, one from the Department of Public Health, one from the Department of Social Services, one from the Office of Policy and Management, two representatives from licensed Health Plans, one representative from the federally designated state peer review organization, one representative from the Pharmacists association, a majority and minority representative from the House and a majority and minority representative from the senate. Each association will be responsible for submitting the name of their representative to the Public Health Commissioner. The

commissioner may make recommendations for changes to the steering committee membership by obtaining a 2/3 majority of the members. The commissioner may designate working groups to research and address specific issues who will then report back to the full committee.

The steering committee shall meet at least quarterly and advise the quality improvement program on the following matters:

1. determination of comparable performance measures to be reported on
2. selection of patient satisfaction survey measures and instrument
3. methods and format for standardized data collection
4. format for the public quality performance measurement report
5. the relationship between human resources and quality beginning with measurement and reporting for nursing staff
6. medical error reduction
7. systems for sharing and implementing universally accepted best practices
8. systems for reporting outcome data
9. systems for improving the continuum of care
10. other related issues as determined by the committee

The Department of Public Health must report annually on the quality improvement program and its progress beginning one year from the effective date of this act to the Public Health Committee and the Governors Office. The report shall include activities to date with recommendations and a strategic plan for the following years activities. The Department of Public Health shall produce a public report, which includes quality performance measures comparing licensed hospitals within eighteen months from the effective date of the legislation.

The subcommittee recognizes that start up funds will be necessary to implement this program and recommends pursuing funds from state and federal sources as well as developing public private funding partnerships to insure that resources will be available to meet the stated goals.

---

[1] Connecticut Personal Health Care Expenditures, All Payers, 1980-98, Centers for Medicare and Medicaid Services, www.cms.gov/stats, Martin, A., et. al., *Health Care Spending During 1991 – 1998: A Fifty State Review*, Health Affairs, July/August 2002, 21: 112-126.
[2] Strunk, B., P. Ginsberg and J. Gabel, *Tracking Health Care Costs: Growth Accelerates Again in 2001,* Health Affairs Web Exclusive, www.healthaffairs.org, Sept. 25, 2002.
[3] Heffler, S. et. al., *Health Spending Projections for 2001 – 2011: The Latest Outlook*, Health Affairs, 21:207-218, Mar/Apr 2002.
[4] State Health Facts On-line, Kaiser Family Foundation, www.statehealthfacts.kff.org

[5] *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals 2002*, June 2002, OHCA, http://www.ohca.state.ct.us/Publications/2002FinStabReport.pdf
[6] *The Health of Connecticut's Hospitals*, January 2001, OHCA, http://www.ohca.state.ct.us/Publications/Hospital%20Study/hospitalstudy.htm
[7] 2002 OHCA report
[8] *Health Care Review*, Deloitte & Touche Consulting, July 2002, *The State of Hospitals' Financial Health*, American Hospital Association.
[9] *Health Care Industry Market Update: Acute Care Hospitals*, CMS, 4/29/02.
[10] *Hospitals More Often Able to Negotiate Higher Rates from Insurers*, Kaiser Daily Health Policy Report, Apr. 12, 2002, *With New Muscle, Hospitals Squeeze Insurers on Rates*, Hartford Courant, April 14, 2002.
[11] OHCA response to Nov. 5, 2002 Commission letter
[12] OHCA response to Nov. 5, 2002 Commission letter
[13] Medicaid Managed Care Council, 7/02.
[14] *US to Step Up Antitrust Efforts on Health Care*, NY Times, 8/9/02.
[15] 2002 OHCA report
[16] OHCA response to Nov. 5, 2002 Commission letter.
[17] Centers for Medicare and Medicaid Services, www.hcfa.gov
[18] Lewin Group presentation to the Commission, Feb. 23, 2000.
[19] OHCA, *Medicare Spending in Acute Care Hospitals, FY 1998*
[20] OHCA, Annual Report on the Status of Connecticut's Short Term Acute Care Hospitals, 2002
[21] Lewin Group presentation to Commission, Feb. 23, 2000.
[22] Commission presentation by Ernst & Young, April 16, 2001.
[23] Commission presentation by Ernst & Young, April 16, 2001.
[24] 42 USC 1395ww
[25] *Health Care Industry Market Update: Acute Care Hospitals Vol. II, Appendix: Medicare Payment Systems*, CMS, 4/29/02.
[26] Centers for Medicare and Medicaid Services Annual Update and Payment Rule for Inpatient Hospitals FY 2003, www.cms.gov, 7/31/02.
[27] *Hospitals Say Medicare Rate Hike Falls Short*, Reuter's Medical News, 5/9/02.
[28] Federal Register, April 7, August 3, and November 13, 2000,
[29] http://www.cms.gov/regulations/
[30] *Second Annual Report on Graduate Medical Education in Connecticut*, OHCA, Jan. 2001, *Health Care Industry Market Update: Acute Care Hospitals Vol. II Appendix: Medicare Payment Systems*, CMS, 4/29/02.
[31] State Health Facts On-line, Kaiser Family Foundation, www.statehealthfacts.kff.org
[32] 2002 OHCA report.
[33] DSS presentation to Commission, Dec. 11, 2000
[34] Lewin Group presentation to Commission, Feb. 23, 2000.
[35] Public Act No. 01-03, June Special Session, 2001.
[36] State Plan Amendment, 01-011
[37] DSS DSH Report to CMS, 12/30/01.
[38] *Hospital Uncompensated Care*, OLR Report 2002-R-0124, Jan. 25, 2002.
[39] Commission minutes, July 9, 2001.
[40] Commission minutes, July 9, 2001 and *2001 Major Public Acts,* OLR.
[41] Does not include effects of changes in tax policy.
[42] In 1998 St. Joseph Hospital was divided between St. Vincent's and Stamford Hospitals
[43] Does not include Psychiatric DSH, total reflects minor payments to out of state and other facilities
[44] *Health Care Industry Market Update: Acute Care Hospitals Vol. II Appendix: Medicare Payment Systems*, CMS, 4/29/02, Commission presentation by HCFA (CMS), 1/8/01, DSS report to CMS on DSH methodology, 12/31/01.
[45] State Health Facts On-line, Kaiser Family Foundation, www.statehealthfacts.kff.org
[46] 2002 OHCA report
[47] 2002 OHCA report and Lewin presentation to the Commission, Feb. 23, 2000.
[48] OHCA data.

[49] *(The table is a transmittal from the Office of Health Care Access and was not reviewed by the consultant.)*

[50] Costs were calculated using the FY 2000 payer gross revenue multiplied by the statewide Ratio of Costs to the sum of Charges and other operating revenue of 56%.

[51] Total Medical Assistance is comprised of 80% Medicaid and 20% other medical assistance. Other State of Connecticut programs (i.e. state assisted general assistance or SAGA) make up the majority of other medical assistance.

Total Medical Assistance payments include $110 million in accrued DSH Payments for FY 2000, based on FY 1998 actual total medical assistance underpayments.

[52] Uninsured Payments include $102 million in accrued DSH payments for FY 2000, based on FY 1998 actual cost of uncompensated care.

[53] Private Pay costs include $146 million in sales and gross earnings tax.

[54] Other includes TRICARE and payments and costs associated with other operating revenue.

[55] The OHCA Filing excluded all adjustments that did not accrue to FY 2000. Therefore all third party settlement adjustments, including Medicare, Medicaid, and other third party final settlement adjustments as well as bad debt adjustments that did not accrue to FY 2000 were excluded. Commencing with FY 2001 and consistent with Audited Financial Statements (AFS), the OHCA Filing amounts reported include any subsequent revisions attributable to patient services provided in prior years.

Courtesy discounts, allowances associated with private payers contract that are not on file with OHCA and other allowances must be excluded from the OHCA Filing amounts. This results in OHCA Filing net patient revenue being higher than AFS Filing net patient revenue.

Other differences between the OHCA filing and AFS Filing include:

> Bad debt is treated as a reduction to net patient revenue in the OHCA filing and an operating expense in the AFS filing
>
> Amounts reported as expense recoveries in the OHCA filing are sometimes reported as Other Operating Revenue in the AFS filing

[56] AFS net patient revenue and bad debt expense includes estimated amounts in the period in which they accrue and are adjusted in future periods when the final amount is determined. Similar to net patient revenue, bad debt expense is estimated in the period in which they accrue and are adjusted in future periods.

[57] Communications with DSS, OHCA, CMS, and hospital administrators.
[58] *Medicare Provider Reimbursement Manual, Pub. 15-1,* CMS.
[59] Communications with DSS, OHCA, CMS, and hospital administrators.
[60] 2002 OHCA report
[61] CHEFA presentation to the Commission, October 16, 2000.
[62] Robinson, J. *Bond-Market Skepticism and Stock-Market Exuberance in the Hospital Industry*, Health Affairs, Jan/Feb 2002, 21:104-117.
[63] Commission presentation by Ernst & Young and meeting minutes, April 16, 2001.
[64] ChimeData presentation to Commission, Oct. 16, 2000.
[65] OHCA presentation to Commission, Oct. 16, 2000
[66] OHCA 2001 Household Survey, http://www.ohca.state.ct.us/Publications/2001Householdbrief.pdf
[67] US Census, www.census.gov
[68] Gilmer, T. and R. Kronick, *Calm Before the Storm: Expected increase in the Number of Uninsured Americans*, Health Affairs, 20:207-210, Nov/Dec 2001.
[69] DSS monthly enrollment reports.
[70] Coverage Matters: Insurance and Health Care, Institute of Medicine, 2001
[71] Care Without Coverage: Too Little, Too Late, Institute of Medicine, 2002.

[72] *Facing Increasing Costs for Uncompensated Care, Denver Hospital Begins to Turn Away Non-Denver Residents*, Kaiser Daily Health Policy Report, May 20, 2002.
[73] OHCA 2002 report
[74] *Trendwatch Chartbook 2001*, American Hospital Association.
[75] State Health Facts On-line, Kaiser Family Foundation, www.statehealthfacts.kff.org
[76] 2002 OHCA report
[77] *Emergency Department Overload: A Growing Crisis,* The Lewin Group for the American Hospital Association, April 2002, http://www.aha.org/info/content/EdoCrisisSlides.pdf
[78] CMS communication, 2002.
[79] Behavioral Risk Factor Surveillance System, 2000.
[80] Commission testimony of Richard Moed, St. Francis Care Behavioral Health, Nov. 13, 2000.
[81] OHCA, Behavioral Health Utilization in Connecticut, Nov. 13, 2000.
[82] *Acute Care Hospitals' Psychiatric Discharges in Connecticut, State Fiscal Years 1997-2000,* OHCA, July 2001.
[83] Commission testimony of Kevin Kinsella, Hartford Hospital, Nov. 13, 2000.
[84] Lightman, Halloran and Wong, *Local Security May Get Lost in Bureaucracy,* Hartford Courant, June 19, 2002.
[85] *CT Bioresponse Summary*, Commissioner Joxel Garcia, DPH
[86] CT Nurses Association/ CT Nursing Career Center
[87] *Nurse to Patient Ratio Study: A Report on the Current Nursing Environment in CT Hospitals*, OHCA, Feb. 2000
[88] Colleagues in Caring, 1998.
[89] *Projected Supply, Demand and Shortages of Registered Nurses: 2000-2020,* US HHS, July 2002.
[90] *The Nursing Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses*, The Federation of Nurses and Health Professionals, April 2002
[91] Danielle Reh, RN, MSN, *The Nursing Shortage*, Master's Thesis, Yale University School of Nursing.
[92] Needleman, et. al., New England Journal of Medicine, 346:1715, 5/30/02, http://content.nejm.org/cgi/content/abstract/346/22/1715
[93] *Staffing Shortages Cause Hospital Patients to Hire Private Nurses*, Kaiser Daily Health Policy Reports, Jan. 9, 2001.
[94] *JCAHO Nurse Staffing Standards*, OLR Reports, 2002-R-0555, June 3, 2002
[95] Janofsky, M., *Shortage of Nurses Spurs Bidding War in Hospital Industry*, New York Times, May 28, 2002.
[96] www.NursingCareerCenterCT.com
[97] Diantha McMorrow, communication, 10/02.
[98] CT Hospital Association presentation to the Workforce Issues Workgroup, October 2001
[99] CHA communications, 2002.
[100] *AMA Considers Endorsing New Resident Hours Guidelines*, Kaiser Daily Health Policy Reports, June 17, 2002.
[101] Cooper, R., et. al., *Economic and Demographic Trends Signal an Impending Physician Shortage,* Health Affairs, 21:140-154, Jan/Feb 2002.
[102] *To Err is Human: Building a Safer Health System*, Institute of Medicine, November 1999, www.iom.edu
[103] Thomas, E., Annals of Internal Medicine, 6/4/02, C. McDonald, M. Weiner, and S. Hui, JAMA, 284:93-95, July 5, 2000, L. Leape, JAMA, 284:95-97, July 5, 2000.
[104] Davis, K. et. al., *Room for Improvement: Patients Report on the Quality of Their Health Care*, Commonwealth Fund, April 2002, www.cmwf.org
[105] Becher, E. and M. Chassin, *Improving Quality, Minimizing Error: Making it Happen*, Health Affairs, May/June 2001, 20:68-81.
[106] *What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency*, April 2002, The Access Project, www.accessproject.org
[107] US Pharmacopeia study, a national standards setting organization, reported in Reuters Medical News, 5/20/02.
[108] *CalPERS to Develop Database to Determine Quality of Providers*, Kaiser Daily Health Policy Reports, 4/30/02.

[109] *Companies to Launch Hospital Bonus Program to Reduce Medical Errors*, Kaiser Daily Health Policy Reports, 10/18/01.
[110] *Some Hospitals Balk at Initiative to Compare Care Among Providers*, Boston Globe, 5/28/02.
[111] Leapfrog Group, www.leapfroggroup.org
[112] HHS Release, 6/10/02.
[113] J. Rovner, *Bill Would Create System to Report, Prevent Mistakes*, Reuters Medical News, 6/5/02.
[114] www.hrq.gov
[115] www.jcaho.org
[116] Becher and Chassin, Leapfrog.