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Recommendations and Next Steps

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CHAPTER 5. RECOMMENDATIONS AND NEXT STEPS

RECOMMENDATIONS

As planning is a dynamic process and planning for the rapidly changing health care environment covered by the CON program is especially so, planning practices and the standards used by OHCA should reflect and incorporate current best practices, whenever possible. OHCA will be continuously attentive to technological advances, research findings, demographic changes, shifting economic incentives and significant changes in the organization and delivery of health care and planning and quality standards.

Next steps and recommendations address and are grouped by behavioral health, acute care/ambulatory surgery and primary care categories. These recommendations were suggested by, or evolved from discussion with subcommittee and advisory body members, or provided by various OHCA staff or reviewers of the Plan.

The next steps/recommendations are intended to build upon the efforts of and discussions that occurred during the initial planning process in 2011 – 2012 and further discussions held for this supplemental plan in 2014.

Behavioral Health

1) Determine the resources available and options and approaches for further exploration of ways that Connecticut's behavioral health service delivery system can be measured to determine capacity as it relates to need and access to care;
2) Develop further understanding of recovery supports and how they relate to the overall care for behavioral health clients across all age groups;
3) Determine the feasibility of and resources available for a future inventory of distinct service levels as opposed to broad categorization of facilities using behavioral health licensure categories;
4) Provide more focus in future plans which specifically discuss the coordination, interrelation, provision or co-location of mental health, primary care and/or oral health services within the various settings and how such interrelationship will benefit the behavioral health patient population.

Acute Care/Ambulatory Surgery

5) Investigate the development of planning regions that best facilitate the ability to assess the availability of and future demand for care, taking into consideration existing hospital service areas;
6) Research, investigate and quantify the use of observation stays in Connecticut hospitals and determine how these data can be standardized in a way that would allow them to be incorporated in the acute care bed need model;
7) With respect to ambulatory surgery standards and guidelines, discuss and consider including backlogs in the service area, ability of physicians to schedule block times, patient throughput at other facilities, the quality of care at other facilities as additional factors for consideration in the next Plan, if such data is available to OHCA to verify and analyze.

Primary Care

8) The DPH Primary Care Office will collect and report real-time health workforce data and will support the analyses necessary to interpret this data to estimate both current and future health workforce needs;[113]
9) Utilize data from Behavioral Risk Factor Surveillance System and/or other surveys which have large enough samples so that results for questions related to health care access may be used for town, city or county level assessment and solutions;
10) Consider assessing/evaluating primary care provided by hospital-affiliated entities (e.g., urgent care centers) and determine if beneficial to patients;
11) Provide additional Plan focus on the provision of mental health and oral health services in primary care settings and assess the interrelation of these services with primary care.
12) Align OHCA planning efforts with SIM Grant activities (e.g., physician data collection, goals and objectives, etc.) and other relevant State planning efforts.

NEXT STEPS

As discussed in Chapters 5 and 6, OHCA is charged with evaluating the unmet need of persons at risk and vulnerable populations and projecting future demand for health care services. In addition, the mandate allows OHCA to recommend expansion, reduction or modification of health care facilities or services and requires OHCA to develop a process, in consultation with hospitals, to incorporate the Plan into hospital long-range planning efforts.

In C.G.S. 19a-613(b)(2), OHCA is charged with overseeing and coordinating Connecticut's health system planning. Using information and data currently available, **Table 27** provides:

- hospital financial performance measures grouped into an A, B or C category based on results of a comparative analysis of three year average ratios benchmarked against the statewide average of each ratio (see Appendix I for detail);
- the availability and need for inpatient beds indicated by excess or deficit of staffed or licensed beds;
- towns that may have unmet need based on indicators of residents' health status and access to care;
- priority health needs identified in hospitals' CHNAs; and
- towns not covered by any CHNA and not considered part of any hospital's primary service area.

It should be noted that, utilization data used in this table is limited to hospital inpatient and emergency department care; outpatient care, a significant portion of health care utilization, is not included as data is currently unavailable to OHCA. In addition, while hospitals have been grouped based on counties of location, a hospital may be part of a system or affiliated with one or more hospitals, as shown in **Table 27**. This may influence a hospital's financial performance like other factors such as location, sociodemographic characteristics of communities it serves, service offerings, proximity to other hospitals and their service offerings, patient payer mix and discount rates negotiated with payers. As a result, the information in the table may not be used to make direct, hospital-specific findings.

Rather, the table provides a starting point for examining potential opportunities to transform existing health care systems to better meet the health care needs of Connecticut's communities. For example, while all Connecticut counties are shown to have an excess of licensed acute care beds, future demand for services and evolving age demographics may require the reallocation of hospital resources. For example, additional staffing of medical/surgical, maternity and psychiatric beds may be necessary to satisfy 2020 patient demand for inpatient services. Additionally, CHNAs show the need to increase availability and access to outpatient care, especially primary, substance abuse, mental and dental care, to manage identified health priorities, gaps in health care systems and address health inequities. The table also helps to identify communities most likely to have unfavorable health care outcomes compared to the state. The latter could serve as a guide to hospitals in determining what communities or geographic areas to cover in their health needs assessments and/or in their CON applications to terminate, expand or modify their service offerings.

Table 27: Hospital Overall Performance and Unmet Health Care Need, FYs 2011-2013

						Unmet Health Care Needs											
						Additional Inpatient Beds Needed to be Staffed or Licensed by 2020 - Excess (-) or Deficit (+)[5]						Towns Below Overall State Health Status and Access Indicators					
		Hospital Financial Measures[1]				Staffed						Health Status		Access to Care			
County	Hospitals	Profitability[2]	Liquidity[3]	Solvency[4]	Licensed Beds	Medical/ Surgical	Maternity	Psychiatric	Rehabilitation	Pediatric	Total Licensed	Towns	Indicators	Town	Indicators	Hospital Community Needs Assessments Priority Health Needs	Towns neither covered by a CHNA nor in a hospital primary service area
Fairfield	Bridgeport Hospital	A	C	A	373	136	79	36	16	-5	-236	Bridgeport Danbury Norwalk Stamford	Poverty Education Unemployment Transportation Language proficiency Disability Uninsured Minority	Bridgeport	ACSC Infant mortality	Overweight & obesity Chronic disease Nutrition Physical activity Tobacco use Substance abuse Mental health Primary care Specialist care	
	Danbury Hospital, The	A	A	A	345												
	Greenwich Hospital	C	A	A	174												
	Norwalk Hospital Association, The	A	A	A	328												
	St. Vincent's Medical Center	A	B	A	473												
	Stamford Hospital	A	C	C	305												
Hartford	Bristol Hospital, Inc.	C	C	C	134	34	72	-13	0	-25	-416	Bloomfield East Hartford Hartford New Britain Newington	Poverty Education Unemployment Transportation Language proficiency Disability Uninsured Minority Elderly	Bloomfield Bristol Hartford New Britain Newington Plainsville East Hartford South Windsor Windsor Locks	Mortality ACSC 30-day readmission Infant mortality	Overweight & obesity Chronic disease Maternal & child health Healthy aging Substance abuse Mental health Dental care Primary care Specialist care	East Granby Granby Hartland Malborough
	Connecticut Children's Medical Center	C	C	B	115												
	Hartford Hospital	C	C	A	819												
	Hospital of Central Connecticut	A	C	A	414												
	John Dempsey Hospital	C	B	A	224												
	Manchester Memorial Hospital	C	C	C	249												
	Saint Francis Hospital and Medical Center	C	A	C	617												

						Unmet Health Care Needs											
						Additional Inpatient Beds Needed to be Staffed or Licensed by 2020 - Excess (-) or Deficit (+)[5]						Towns Below Overall State Health Status and Access Indicators					
		Hospital Financial Measures[1]				Staffed						Health Status		Access to Care			
County	Hospitals	Profitability[2]	Liquidity[3]	Solvency[4]	Licensed Beds	Medical/ Surgical	Maternity	Psychiatric	Rehabilitation	Pediatric	Total Licensed	Towns	Indicators	Town	Indicators	Hospital Community Needs Assessments Priority Health Needs	Towns neither covered by a CHNA nor in a hospital primary service area
Litchfield	Charlotte Hungerford Hospital	C	B	A	109	35	3	-5	0	-1	-100	North Canaan Torrington	Poverty Education Unemployment Disability Uninsured Elderly Medicaid	Thomaston Torrington Watertown	Mortality ACSC 30-day readmission	Overweight & obesity Chronic disease Tickborne disease Primary care	
	Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital	C	C	B	78												
	New Milford Hospital, Inc.	A	C	B	85												
Middlesex	Middlesex Hospital	A	B	A	275	24	7	4	0	0	-60	-	-	Westbrook	-	Chronic disease Nutrition Physical activity Tobacco use	
New Haven	Griffin Hospital	C	C	C	160	-32	65	33	-6	-31	-377	Ansonia Derby Meriden New Haven Waterbury West Haven	Poverty Education Unemployment Transportation Language proficiency Disability Uninsured Minority Elderly Medicaid	Ansonia East Haven Middlebury Naugatuck New Haven Meriden Waterbury West Haven	30-day readmission Mortality ACSC Avoidable ED use Infant mortality	Overweight & obesity Chronic disease Respiratory health Tobacco use Substance abuse Mental health Maternal & child health Influenza Healthy aging Mental health care Primary care Socioeconomic disadvantage Transportation Housing Safety	
	Midstate Medical Center	A	B	B	144												
	Milford Hospital, Inc.	C	C	C	106												
	Saint Mary's Hospital, Inc.	A	C	B	347												
	The Hospital of Saint Raphael	C	C	B	-												
	Waterbury Hospital	C	C	A	357												
	Yale New Haven Hospital	A	B	C	1,407												

						Unmet Health Care Needs											
						Additional Inpatient Beds Needed to be Staffed or Licensed by 2020 - Excess (-) or Deficit (+)[5]						Towns Below Overall State Health Status and Access Indicators					
		Hospital Financial Measures[1]				Staffed						Health Status		Access to Care			
County	Hospitals	Profitability[2]	Liquidity[3]	Solvency[4]	Licensed Beds	Medical/ Surgical	Maternity	Psychiatric	Rehabilitation	Pediatric	Total Licensed	Towns	Indicators	Town	Indicators	Hospital Community Needs Assessments Priority Health Needs	Towns neither covered by a CHNA nor in a hospital primary service area
New London	Lawrence & Memorial Hospital, Inc.	A	A	A	280	7	-4	-2	1	-4	-70	Norwich New London	Poverty Education Unemployment Transportation Language proficiency Disability Uninsured Minority	East Lyme New London Norwich	Mortality ACSC Avoidable ED use 30-day Readmission Infant mortality	Overweight & obesity Chronic disease Respiratory health Substance abuse Maternal & child health Primary care	
	William W. Backus Hospital	A	A	A	213												
Tolland	Johnson Memorial Hospital	C	C	C	92	3	-1	-7	0	0	-86	-	-	Stafford Union Vernon	Mortality Avoidable ED use Infant mortality	Overweight & obesity Chronic disease Nutrition Physical activity Tobacco use Substance abuse Mental health care	
	Rockville General Hospital	C	C	C	102												
Windham	Windham	C	C	C	104	-1	-5	2	0	1	-99	Windham Putnam	Poverty Education Unemployment Transportation Language Disability Uninsured Minority	Killingly Windham	Mortality ACSC Avoidable ED use Infant mortality	Mental health care Dental care Specialist care Transportation	
	Windham Community Memorial Hospital, Inc.	C	C	C	130												

Source: CT DPH Office of Health Care Access Financial Stability Report, 2011-2013; Almanac of Hospital Financial and Operating Indicators, OPTUM, 2014; Also, see Appendix I; Hospital Inpatient Discharge Database; CT Hospitals Community Health Needs Assessments and U.S. Census Bureau.

[1]Three year average ratios for each measure were benchmarked against their respective three year statewide average for FYs 2011, 2012 and 2013. A measure for a hospital is assigned:

"A" if the number of ratios above statewide averages exceed the number below statewide averages

"B" if the number of ratios above statewide averages equal the number below statewide averages

"C" if the number of ratios above statewide averages was less than the number below statewide averages.

[2]Measures hospital's ability to generate earnings and is based on three year average of hospital operating, non-operating, and total margin ratios.

[3]Measures hospital's ability to quickly convert assets to cash and is based on three year average of hospital current ratio, days cash on hand, days revenue in patient accounts receivable and average payment period.

[4]Measures hospital's ability to repay total debt and is based on three year average hospital equity ratio, cash flow to total debt ratio, long-term debt to capitalization ratio, and debt service coverage ratio.

[5]Number represents difference between 2014 bed need methodology estimated 2020 bed need and Hospital Reporting System Report 400 FY 2013 staffed and licensed beds. Please note that staffed beds reported in the Hospital Reporting System Report 400 is the average number of staffed beds over the fiscal year and may be higher or lower depending on patient volumes.

The PPACA's requirements for value-based care are driving providers to focus on creating new models of care that bring higher quality and improved outcomes at a lower cost. Providers will need to continue to assess their organizations, service array and delivery structures in order to best manage population health through efficient and effective care across all settings.

In future planning efforts, OHCA will examine available data and the evolving health care systems in an attempt to determine how to best meet the unmet needs of residents in ways that benefit the community and assist providers in transforming to meet those needs. Activities that may be undertaken to facilitate this realignment of care around community needs for more integrated health care delivery systems include:

- Analyzing health care service specific data by health care systems, utilization and physician referral patterns to determine if there could be logical regionalization of certain services;
- Evaluating patient data and provider revenue patterns to identify shifts in demand for inpatient to outpatient services and between types of services for geographic regions;
- Identifying modalities through which the state may direct and/or assist providers to be more responsive to health care needs of communities;
- Analyzing all payer claims data to identify availability of and access to health care services, utilization patterns and the impact of expanded health insurance coverage through the PPACA;
- Monitoring the various settings where health care is now being delivered as additional data sources become available to OHCA;
- Reviewing Certificate of Need statutes and regulations to ensure they are responsive to the evolving health care environment and make recommendations to better align the process with health care reform;
- Providing consumers with access to all available data.

Additionally, as more information becomes available to OHCA, the next Plan will attempt to:

- Address the impact that technology may have on the demand, capacity or need for health care services; and
- Facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning.