

**Report to Members of The General Assembly**

**Sponsored by:**

**UHP (University Health Professionals) /AFT Local 3837/AFT CT**

**Council 4 / American Federation of State, County and Municipal Employees**

**Connecticut Employees Union Independent / Service Employees International Union**

**Local 1199 / Service Employees International Union**

**Protective Services Employees Coalition (PSEC)**

**By**

**Fred Hyde, M.D.**

**Fred Hyde & Associates, Inc.**

**March 5, 2009**

Dear Member of The General Assembly:

Those of you with long memories will realize we have been here before. Governor John Rowland sponsored an effort in the year 2000 to “eliminate the losses” at The John Dempsey Hospital, proposing closure of the facility. A committee of Dempsey’s competitors was dutifully assembled by the “Office of Health Care Access,” and concluded that Dempsey should be closed.

Now there is a new effort to “eliminate the losses” at Dempsey by giving it away to Hartford Hospital. The University President, fearing controversy from other hospitals, is ready. Consultant reports that might improve the hospital’s performance (\$2.5 million to PricewaterhouseCoopers for reports delivered but not yet fully examined, much less implemented) have been completed, but lack attention.

But what has happened in the last decade—that is, since the last time there was a concerted attempt to give up? First, The John Dempsey Hospital has served more patients each year. Second, outpatient visits to the hospital have increased dramatically, from 140,000 a year in 2000, to this year’s projected figure of over 300,000. Finally, the overall economic impact (CASE report, page XV) of the University of Connecticut Health Center on the State of Connecticut, which was nearly \$500 million in 1995, was approaching \$900 million in 2007, or about 12% of the State’s total economic activity.

Are you ready to give away the State’s only teaching hospital? Six unions representing 3,500 employees at UCHC have asked me to reflect on the current situation, and to make suggestions, for your consideration. The opinions in this report, however, are mine only.

Very truly yours,



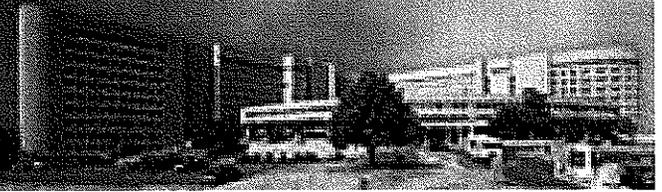
Fred Hyde, M.D.

.....  
Dr. Hyde is a management consultant, with forty years’ experience in the field of hospitals, health services and health care finance. He is also a Clinical Professor in the Mailman School of Public Health, Columbia University, teaching hospital management and health care financial management. In Connecticut, Dr. Hyde was vice president for planning at Yale-New Haven Hospital, general counsel of the Connecticut Hospital Association and president/chief executive at Windham Hospital, Willimantic. While working his way through school, Dr. Hyde was the (only) staff member of the Public Health and Safety Committee. His medical and law degrees are from Yale, his business degree is from Columbia.

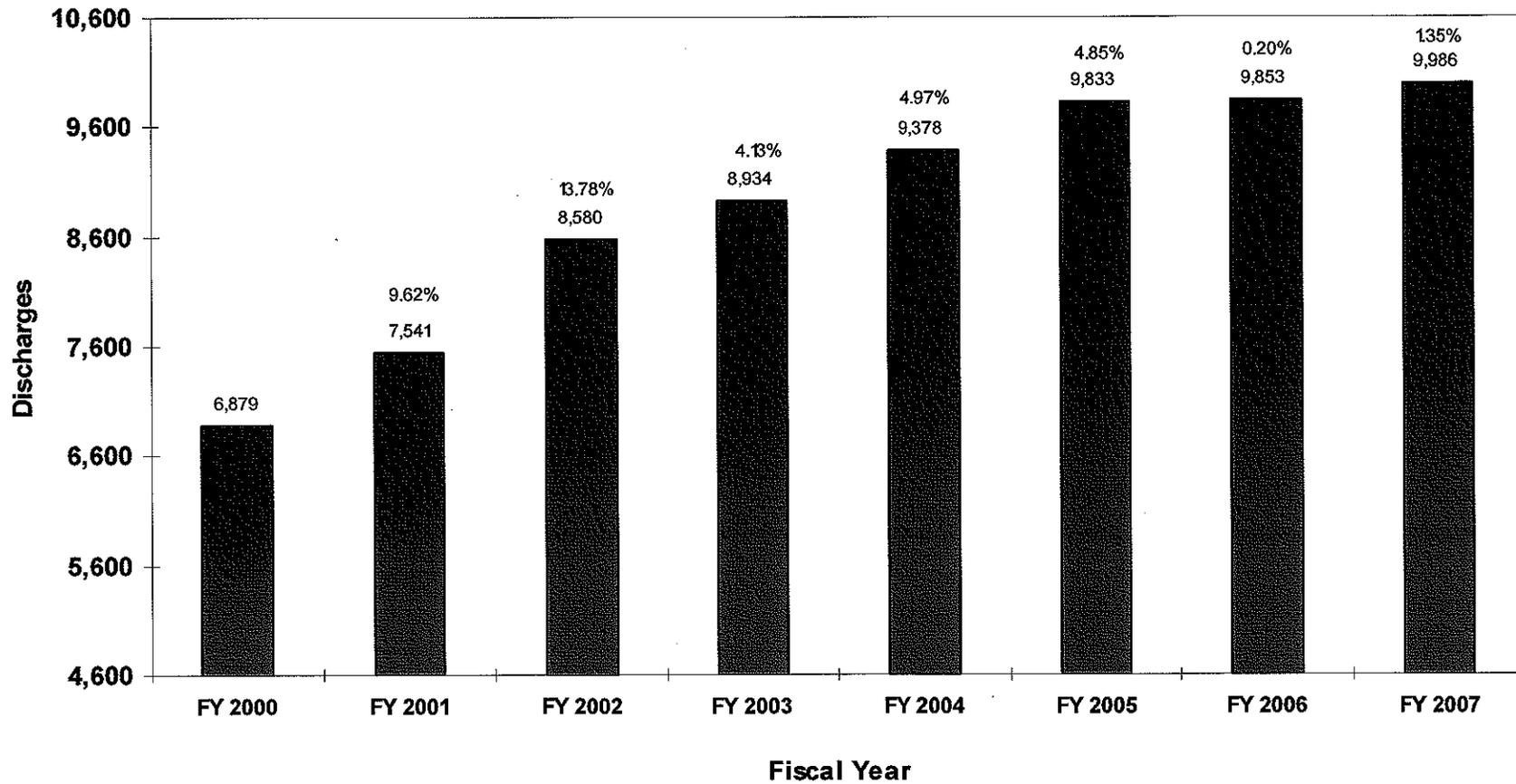


University of Connecticut  
Health Center

KNOW BETTER CARE



**JOHN DEMPSEY HOSPITAL**  
**TOTAL INPATIENT DISCHARGES BY FISCAL YEAR**



## **The Past and the Future**

The proposal to turn over the John Dempsey Hospital to Hartford Hospital follows a pattern eerily close to the history of the health center at the end of the last century. Then we had a long period of structurally conflicted leadership, with prominent officials occupying leadership roles at both the University of Connecticut Health Center and Hartford Hospital. Preparation began for failure. A “blue ribbon” task force, consisting of competitors of the John Dempsey Hospital, concluded, reluctantly, that the John Dempsey Hospital should close. Ultimately, the Legislature disagreed.

As an alternative, the health center at that time had undertaken studies to demonstrate how its financial performance could be improved. These studies, by “The Huntington Group,” were costly, with estimates varying up to \$1 million; little evidence exists that the recommendations were implemented. Now, again in an unusual echo of history, the proposal to turn over Dempsey comes just as the final stage of a \$2.5 million PricewaterhouseCoopers study is being completed. With what diligence will UCHC supervisors, department heads, managers and executives be pursuing implementation of this new report, suspecting that their positions and careers might soon be taking a very different direction, and that unpopular actions on their part might identify them as likely (but unfair) targets for “operating efficiencies?”

The bottom line is this: expensive studies have been undertaken, with uncertain likelihood of success, given the divided attention and loyalties of the health center’s and the university’s leaders. Even with these diversions, the aggregate of deficits for this decade associated with the John Dempsey Hospital, if one is to believe all projections in the current budget, will be roughly \$70 million. At the same time, the revenue generated by patient care at this hospital will be about \$2 billion. In fact, counting only revenues and expenses from operations, the performance of John Dempsey Hospital has been better than that at either Hartford or Saint Francis, on average, for the past three years (see chart, next page). This is from operations only, and is evidenced by audited financial statements collected by the Office of Health Care Access. The most recent on file are for 2007.

John Dempsey Hospital, Comparison of Total and Operating Margins

Hospital	2003-2007, Average Total Margin	2007	2006	2005	2004	2003
John Dempsey	1.49%	-1.72%	2.05%	3.85%	1.75%	1.89%
Hartford Hospital	1.56%	2.13%	1.58%	1.61%	2.02%	0.26%
Saint Francis Hospital	1.29%	2.27%	0.96%	0.80%	0.02%	2.35%
Average	2.10%	2.60%	1.70%	2.50%	2.70%	0.60%
	<b>Operating Margin, Average 2005-2007</b>	<b>2,007</b>	<b>2,006</b>	<b>2,005</b>		
John Dempsey	\$2,557,062	(\$4,908,440)	\$4,543,345	\$8,036,280		
Hartford Hospital	(\$1,880,714)	(\$3,023,205)	\$284,275	(\$2,903,211)		
Saint Francis	\$2,486,947	\$8,427,725	(\$617,236)	(\$349,649)		

The difference in financial performance for these hospitals is not in the operating margin, but rather in the total margin. The total margin of the private hospitals is augmented by philanthropy and non-operating income. Hartford alone, for example, has a \$70 million free bed fund. The operating margin of the John Dempsey Hospital is augmented by you, intermittently, after extraordinary headlines and unusual proposals.

But the recent attention of the leaders has been directed to merger or structural rearrangement, not to operations, although it is the alleged shortcomings of the operations that “justify” the proposed new arrangements. At the conclusion of a star-crossed attempt to merge his private hospital with the University of California at San Francisco hospital, Stanford’s president ruefully said a decade ago, “It might have been easier to confront the issues if we were fully responsible for our own destiny.”

### **Governance**

Nine years ago, governance was an issue in the analysis of proposals to close The John Dempsey Hospital. Specifically, governance was faulted for the potential duality or outright conflict of interest of those who held positions at Hartford Hospital, and, at the same time, held positions (with control of resources, potential influence, patient referrals, sway over appointments) at The University of Connecticut Health Center. In the interim, through resignation and realignment, some of the conflicts have diminished, but others remain.

A continuing and serious challenge to good governance is the failure to develop a board of directors for The John Dempsey Hospital. The University of Connecticut Health Center has a board, which meets quarterly, and which considers hospital, student tuition, research funding, security for the health center, the usual amalgam of issues. No serious oversight can be expected, however, from quarterly meetings of a board with so many diverse activities, while *every* other hospital in the State of Connecticut is governed by a board dedicated to hospital issues, meeting monthly, seeking accountability from the executives they employ.

Failure to distinguish and focus on the interests of the hospital, in turn, leads to misunderstanding, about the hospital's financial performance, for example. UCHC leaders bemoan operating losses at The Dempsey Health Center, but also recognize that funds are drained from Dempsey for purposes and programs not met by other hospitals. In his March 14, 2007 update on the replacement hospital, for example, Dr. Deckers (then Executive Vice President) noted that the gap between academic expenses and revenues "*can no longer be closed by transfer of clinical profits from JDH.*" For another example, the profitable field of ambulatory surgery has been partially outsourced; the current volume of cases is not representative of the potential of an academic health center.

The governance issue is this: Who is paying attention? If only the management, subject to the tug and pull of forces above their pay grade, small wonder that the Dempsey Hospital is squeezed as a source of cash for other activities, hampered by its potential regional competitors, hardly the engine it might be for robust economic growth.

### **Analysis of Past Merger Failures**

Hartford Hospital and the University have proposed a combination of public and private organizations, of a community teaching and an academic hospital. We have troubling precedent for these public-private combinations. In 1996, the leaders of the University of California at San Francisco tried to combine their clinical facilities with those of Stanford University. Within three years, the "merger" fell apart, with a \$100 million repair bill. The same (a public-private merger) was tried by Penn State and the Geisinger Health System, at about the same time, and with the same results. In New York City, the combination of Mount Sinai and NYU medical centers was disastrous, with a similar large bill to "undo" the damage to both.

Why don't these proposals work? Why is it difficult to combine academic health centers, public and private organizations, community teaching and university teaching hospitals?

Past failures of mergers in this field have been most notable for these characteristics:

(1) The fantasy of an easier, softer way: leaders focus on the presumption of success, where the glow of strategic goals blaze, not on the “details” such as employees, money and any economies to be realized. UConn’s President has said, with regard to Hartford Hospital’s acquisition of control of The John Dempsey Hospital, “It sure beats going back to the Legislature and to the Governor every year, hat in hand, asking for another \$20 million to cover a structural deficit that is not going to go away.”;

(2) Cultural incompatibility: in these matters, the people involved - - human beings who are faculty, employees, patients - - seem consistently to be an afterthought. In the breakup of the Stanford – University of California at San Francisco (UCSF) merger, Stanford University President Gerhard Casper told his faculty senate that with difficult challenges “it is very much harder to get people to focus on the joint endeavor rather than on all the sacrifices that seem to be coming.” Casper observed that “in recent weeks” (after the failure of the merger had become obvious to all) his medical school faculty said, “Stanford will make it alone because we *have* to make it alone,” and that it might be easier to confront issues alone “if we were fully responsible for our own destiny...” In the combined organization, according to Casper, “people did not have a direct enough sense that their efforts would actually benefit their institution, their part of the institution.” (Source: “Stanfordonline” November 2, 1999).

In our region, the most notorious and expensive failure - - based entirely on different medical cultures - - was that of Mount Sinai and New York University Medical Center. The spectacular failure - - put together by executives and the respective boards - - cost about the same as the UCSF – Stanford repair job to undo, and in recovery set both institutions on courses that required leadership change and restraint.

The Mount Sinai – NYU merger was originally proposed in 1996, as an enterprise that sought to merge both hospitals and medical schools, but it unraveled within eight months. The original merger halt (*The New York Times*, February 15, 1997) focused on the issue of governance. “The issue of governance was always fuzzy and nobody really focused on the differences...there was always an ambivalent understanding of how the medical school piece would work.” The story went on to note that, “The proposed union seemed to get off to a strong start, with the trustees of

both institutions unanimously approving the deal...” However, the doctors demurred; some 350 of the NYU faculty - - about three-quarters of the total - - began their opposition with an open letter to the *Times*, then hired the former Brooklyn District Attorney to represent them in suing. They lost the suit, in July of 1998, but their continued intransigence, as well as the lack of any demonstrated operating economies, or other planned benefits of the merger, doomed it once again. By September of 2002 Moody’s downgraded Mount Sinai NYU Health’s bonds, primarily due to Mount Sinai’s considerable operating losses.

(3) Ambiguity in control—until the ambiguity disappears. In “The Folly of Teaching Hospital Mergers,” (New England Journal of Medicine, 2-2-1997), an academic with direct experience examined the cases above, as well as that of the University of Minnesota. He notes that the sale of the University’s hospital to Fairview Health Care Services in Minneapolis “which university officials preferred to describe publicly as a merger, was intended to remove the university from the hospital business.” The transaction was “repeatedly put on hold because of labor-union opposition, faculty objections and disagreement over the structure of governance. *Eventually, the university won the right to appoint the majority of the members of the new board, as well as a commitment from University of Minnesota-Fairview to provide ongoing support for academic programs.*” [emphasis added]. There you have it—university control of a board, resolution of the concerns of the people (employees and faculty involved) and support from the hospital for the academic mission. Of course, that is not the proposal before you.

### **State Support**

It is unclear what impact the proposed merger would have on requirements for state support. Nor is it clear what amount of state support would be compatible with Connecticut’s needs (service, education, research). Finally, it is not clear that this “state support” - - if kept within the State apparatus - - does not bring back many times the investment.

First, with regard to public support for health care, The Universal Health Care Foundation of Connecticut, in a report from The Economic and Social Research Institute and the Urban Institute (February 2006), noted that less than 2% of Connecticut’s economy was spent on state-funded

health care, the 49<sup>th</sup> lowest percentage in the country, well below other affluent states and below other New England states.

Second—there seems little assurance that, even under the merger, support from the State of Connecticut would diminish. The University’s President (*The New York Times*, December 14, 2008) noted that the merger “hinged” on a request for \$500 million in state bonds to build a new, larger complex, “and more than \$10 million a year in *additional* state support” [emphasis added]. Additional to what? Finally, local leadership, unconflicted, dedicated to the success of the hospital, concentrating on the hospital, might look at these numbers: With access to state numbers through the end of fiscal year 2005, economists from ESRI and The Urban Institute concluded that Connecticut officials left almost \$100 million unclaimed (which could have been used for reimbursement of hospital expenses at Dempsey) under the disproportionate share hospital formula (DSH, a program for hospitals with high Medicare and Medicaid patient volumes) at the end of that fiscal year, and had returned in the previous four years more than \$80 million in unspent State Children’s Health Insurance Program funds originally allotted to the state. Leaders of which state would not be embarrassed (1) attempting to give away their only public academic health center, but (2) giving money back to the federal government that could have been used for medical education and for care of the uninsured?

### **Public Service**

Something should be said about commitment to public service, notwithstanding the cost. Individuals vary in such commitment, of course, and sincere support today may, from irresistible pressure, turn to flight tomorrow. Only structural (organizational) protection for public service will last. For example, the “University Hospital” envisioned by the current UConn initiative would, in all likelihood, be run by Hartford Hospital and the Hartford Health Care Corporation. An attempt by Hartford Hospital--located in and facing the challenges of the City of Hartford--to acquire control of a suburban hospital would make sense to an organization moving toward an insured future, and away from an uninsured present. You might otherwise ask, “Why would Hartford, with the many challenges of integrating its far flung operations, want to take on a ‘money losing’ hospital in Farmington?” The answer is simple: precisely because Hartford’s leaders realize that The John Dempsey Hospital, properly managed, with appropriate governance, will not lose money. To the contrary, Dempsey is well located to serve the affluent and still growing communities of

the Farmington Valley, and will prosper. By the same token, Dempsey could prosper without this acquisition, but not to Hartford Hospital's benefit, rather in competition.

Here, by contrast, is a current commitment to public service of which you can be proud. Ask yourself, which cities and towns are served by The John Dempsey Hospital? The answer is "A surprising number of them." A review of discharges for 2007 and 2008 (see charts, next two pages) shows nearly 100 towns throughout Connecticut served by inpatient or outpatient visits at The John Dempsey Hospital. Many of these are for patients with difficult diagnoses. Moreover, The John Dempsey Hospital serves Medicaid patients from many of your towns, even ones far from greater Hartford. For fiscal year 2007, Medicaid inpatient discharges came from 98 Connecticut cities and towns, from southwest to northeast, and all parts in between.

The John Dempsey Hospital is affected by State Medicaid rates. How are these rates set? The basis is a 1982 cost report, with no target base rate update since September of 2000. Because it has a relatively high percentage of both Medicare and Medicaid patients, The John Dempsey Hospital does receive Disproportionate Share (DSH) payments. Even with the DSH "add-on" amount, for fiscal 2007 the State rate was actually \$331 or about 4% less than the rate for the period covered by fiscal 1999. So for Medicaid, Medicaid managed care and State administered general assistance, the average amount of subsidy each year (the \$52 million put in three installments since the year 2000) is actually considerably less than the "subsidy" provided by Dempsey to Medicaid patients from throughout the State. Put alternatively, in the absence of a substantial endowment, the subsidies asked of the Legislature might be seen as surrogates for non-operating income (especially investments) used by the wealthier and older hospitals to offset Medicaid shortfalls.

### **Some Things Don't Change**

Since its origin, beginning in 1944, the State's medical school (in its various iterations) has been coveted by Hartford Hospital.

The John Dempsey Hospital  
Total Visits by City or Town, 2007 and 2008

City/Town	2007	2008	Change	City/Town	2007	2008	Change
HARTFORD	21,049	23,373	2,324	NORFOLK	143	161	18
FARMINGTON	25,934	27,718	1,784	COLEBROOK	42	59	17
WEST HARTFORD	30,063	31,760	1,697	NAUGATUCK	640	657	17
SIMSBURY	8,485	9,657	1,172	STONINGTON	164	180	16
BRISTOL	13,546	14,528	982	BOZRAH	51	67	16
NEW BRITAIN	18,511	19,463	952	LEBANON	371	386	15
MANCHESTER	6,556	7,456	900	BOLTON	457	472	15
EAST HARTFORD	10,340	11,083	743	EAST LYME	412	426	14
BLOOMFIELD	5,932	6,621	689	BRIDGEWATER	3	16	13
PLAINVILLE	4,600	5,282	682	ANSONIA	42	54	12
MERIDEN	2,513	3,085	572	MADISON	192	203	11
GRANBY	2,102	2,648	546	SUFFIELD	987	996	9
SOUTHINGTON	6,422	6,938	516	GREENWICH	67	76	9
WATERBURY	2,646	3,106	460	PUTNAM	180	188	8
SOUTH WINDSOR	2,704	3,094	390	KENT	63	69	6
TORRINGTON	3,868	4,234	366	WESTON	18	23	5
NORWICH	1,008	1,373	365	NORTH HAVEN	231	236	5
AVON	10,261	10,610	349	BROOKFIELD	79	83	4
WINDHAM	1,408	1,671	263	WOODBURY	194	197	3
WINDSOR	4,628	4,854	226	ASHFORD	294	297	3
WALLINGFORD	1,050	1,258	208	DARIEN	16	18	2
THOMASTON	472	676	204	LITCHFIELD	915	917	2
HADDAM	331	515	184	SCOTLAND	33	35	2
BARKHAMSTED	721	898	177	NEW CANAAN	18	19	1
EAST GRANBY	851	1,027	176	THOMPSON	111	112	1
KILLINGLY	293	463	170	NEW FAIRFIELD	107	107	0
NEWINGTON	8,393	8,548	155	SEYMOUR	95	94	(1)
PLAINFIELD	368	520	152	LYME	10	9	(1)
GRISWOLD+LISBON	374	510	136	MONROE	127	126	(1)
MANSFIELD	1,564	1,698	134	NORTH STONINGTON	113	111	(2)
NEW LONDON	222	346	124	STRATFORD	162	159	(3)
MONTVILLE	307	431	124	FAIRFIELD	106	102	(4)
EAST HADDAM	373	496	123	NORWALK	112	107	(5)
TOLLAND	1,316	1,436	120	WOODBIDGE	64	59	(5)
WOLCOTT	735	843	108	ANDOVER	248	240	(8)
PLYMOUTH	1,879	1,986	107	FRANKLIN	60	51	(9)
HAMDEN	512	618	106	BETHLEHEM	107	98	(9)
CANAAN (TOWNSHIP)	58	161	103	STAFFORD+UNION+S.SPRG	693	683	(10)
GUILFORD	154	251	97	ORANGE	68	57	(11)
ENFIELD	1,976	2,069	93	WATERFORD	376	364	(12)
LEDYARD	221	312	91	CROMWELL	1,861	1,849	(12)
BURLINGTON	3,329	3,419	90	WILTON	40	27	(13)
EAST WINDSOR	946	1,029	83	EASTON	26	13	(13)
ROCKY HILL	3,061	3,134	73	HAMPTON	174	160	(14)
NEW HARTFORD	1,244	1,314	70	OXFORD	107	91	(16)
EAST HAVEN	60	130	70	ROXBURY	28	12	(16)

The John Dempsey Hospital  
 Total Visits by City or Town, 2007 and 2008

City/Town	2007	2008	Change	City/Town	2007	2008	Change
HEBRON	675	739	64	BEACON FALLS	74	58	(16)
MARLBOROUGH	577	636	59	OLD LYME	278	261	(17)
PROSPECT	397	482	55	ESSEX	189	171	(18)
NEW HAVEN	372	425	53	SALEM	179	161	(18)
ELLINGTON	1,197	1,250	53	MORRIS	112	93	(19)
WATERTOWN	662	713	51	BETHEL	119	99	(20)
WETHERSFIELD	4,147	4,196	49	DERBY	76	55	(21)
HARWINTON	1,176	1,222	46	SHELTON	125	102	(23)
SHERMAN	21	62	41	POMFRET	141	116	(25)
MIDDLETOWN	3,705	3,746	41	WEST HAVEN	175	149	(26)
KILLINGWORTH	122	163	41	STERLING	100	72	(28)
CHESTER	82	103	41	BETHANY	49	20	(29)
HARTLAND	290	329	39	CANTERBURY	216	184	(32)
WILLINGTON	522	558	36	REDDING	66	33	(33)
DANBURY	412	447	35	COVENTRY	1,177	1,143	(34)
WOODSTOCK	202	236	34	OLD SAYBROOK	313	279	(34)
PRESTON	112	146	34	BRANFORD	180	145	(35)
WESTPORT	49	82	33	EASTFORD	161	124	(37)
CANTON	4,904	4,937	33	NORTH CANAAN	214	176	(38)
GOSHEN	341	372	31	SOUTHBURY	449	410	(39)
WASHINGTON	105	134	29	TRUMBULL	183	143	(40)
STAMFORD	199	228	29	VERNON	2,976	2,936	(40)
MIDDLEFIELD	164	193	29	MILFORD	214	174	(40)
SPRAGUE	108	136	28	SALISBURY	188	147	(41)
WINCHESTER	1,620	1,646	26	SOMERS	455	406	(49)
PORTLAND	666	692	26	DURHAM	298	235	(63)
CHESHIRE	1,174	1,199	25	NEWTOWN	337	274	(63)
DEEP RIVER	137	161	24	WESTBROOK	228	164	(64)
CLINTON	120	143	23	NEW MILFORD	382	311	(71)
BROOKLYN	210	231	21	GROTON	622	548	(74)
CORNWALL+WARREN	123	144	21	EAST HAMPTON	1,036	937	(98)
MIDDLEBURY	175	195	21	WINDSOR LOCKS	1,024	925	(99)
RIDGEFIELD	45	65	20	COLUMBIA	646	534	(112)
VOLUNTOWN	40	59	19	COLCHESTER	1,211	1,055	(156)
SHARON	79	98	19	BERLIN	3,509	3,292	(217)
NORTH BRANFORD	82	101	19	GLASTONBURY	3,699	3,473	(226)
CHAPLIN	146	164	18	BRIDGEPORT	458	204	(254)
				Other	8,825	6,816	(2,009)
				<b>Grand Total</b>	<b>279,614</b>	<b>295,937</b>	<b>16,323</b>

The well-known Citizens' Committee, original sponsor of the school in the 1940s, opposed location of the school adjacent to Hartford Hospital, on grounds that "the Hartford Hospital administration was 'elite and restrictive' and, most important, that they doubted if Hartford Hospital would relinquish its autonomy to a University administration." Eight different studies on proposed location took place between 1946 and 1959.

The 1957 public hospital commission, appointed by the Legislature in 1955, according to Dr. Hedva Shuchman in her now well-known thesis on this subject, found that "Hartford Hospital was actively working for the medical school to be located at the hospital with an exclusive affiliation between itself and the University," but that the Citizens' Committee opposed that location. According to Dr. Shuchman, "they wanted the school in Hartford and they wanted a four-year school, controlled by the University. The President of the University preferred the Hartford Hospital site." (Source: Testimony of Hedvah L. Shuchman, Ph.D., December 24, 2007, to the Connecticut Academy of Science and Engineering, on UCHC Facilities Plan Study).

The final decision was made by the Legislature in its 1963 session, authorizing \$7 million for capital costs, followed by eight years during which there was no legislative oversight of the medical-dental school project.

In a "briefing document" for the Public Health Committee, submitted November 10, 1999, UCHC indicated that the financial difficulties of UCHC were the result of health care market place reform. The document noted that the hospital "has historically provided approximately \$14 million per year in support to UConn Medical Group (UMG) and the School of Medicine." These funds generally create a base of support for faculty salaries. The UConn Medical Group, which should be generating a profit, based on the practice of medicine, in fact is draining money from the hospital, about the same as the "losses" being generated by the hospital. The other issue cited in this and related presentations is the low charge (or complete absence of charges) by the University for the provision of resident coverage to Hartford area hospitals. Reasonable adjustment in these rates would offset the "losses," as well, and provide income directly to the school.

## **Options**

The extent of any State commitment in an effort to transfer responsibility for The John Dempsey Hospital will be difficult to predict. First, there will be considerable confusion concerning the State's current commitment; for example, the so-called "fringe differential" has not been clearly presented or costed, in such a way that the hospital could assume the entirety of that responsibility. Second, there will be understandable attempts to disguise costs that may seem excessive; some will ask, "With this much money, why don't we (the State) do this ourselves?" As an example, a presentation was given on January 23<sup>rd</sup> entitled "Principal partnership between University of Connecticut Health Center & Hartford Health Care Corporation," featuring two hands shaking, and labeled "draft." Page nineteen indicates that the "Proposal: State commitment" includes \$130 million in fringe differential for the first ten years, and, during the same time period, \$475 million for a replacement hospital, for a total of \$605 million, but with footnotes indicating that all of this "assumes continual annual funding of UCHC/SoM at current levels plus inflation (\$146 million annually)," and "UConn to supply \$25M\$ for technology transfer over ten-year period." Finally, the level of complexity involved in merging a public and private, teaching and community, current and future will make it difficult or impossible to oversee these expenditures. The PowerPoint presentations are interesting, in other words, especially the \$605 million commitment on top of existing expenditures, but even if accurate must be reviewed with caution, and, under any circumstances, must become the obligation of the parties. Of course, the parties will resist, and finally refuse, illustrating their difficulty in estimating these costs, as well.

## **CASE Report**

The General Assembly commissioned the Connecticut Academy of Science and Engineering to analyze the proposal to construct a 352-bed hospital, to replace the current 224-bed facility, with an eye on financial implications for other hospitals in the greater Hartford area. The CASE report, released March 18<sup>th</sup> last year, called for UCHC to formalize and strengthen its relationships with clinical care hospital partners. Unfortunately, without political backing, UCHC is very much in the passenger seat in any attempt to "formalize and strengthen" these relationships. The CASE report did not, for example, call for the State to essentially give away what should be (based on location, services and

future growth) the profit from hospital operations. Nor did it call on the State to essentially allow a private corporation to determine the public service obligations of its only teaching hospital. Finally, the CASE report called for excellence, not the assumption of academic responsibility by one or more community hospitals. The goals are correct, in other words, without controversy - - excellent, "world class" this and that, a distributor cap for new energy in the State's economy, etc., but the politics are entirely mixed up: without backing from the University President, the Legislature and the Governor's office, the private hospitals will continue to pick apart the UCHC program, taking those pieces which are desirable for their own operations, avoiding responsibilities which are not, and complaining loudly whenever the State attempts to strengthen The John Dempsey Hospital.

### **Hospital Size**

For years one strike against The John Dempsey Hospital was that it was, in comparison, the smallest primary teaching hospital in the nation. Of course, there are schools of medicine that have no primary teaching hospital, Wayne State, for example. However, of those that do, the relatively small size (224 beds, unchanged from 1979) has been a negative, on grounds that (1) smaller size leads to financial instability, and (2) smaller size avoids this reality, that students in training, residents and faculty need a large body of patients to serve/practice on/treat for income.

A strategic mistake was made by the University in proposing a larger size hospital, on these grounds: (1) the larger size provided an easy target for critics, and (2) the larger size probably was not necessary. What has happened over the thirty year history of The John Dempsey Hospital is that outpatient services have grown (Dempsey itself has more than doubled the number of outpatient visits since the year 2000), while inpatient services have shrunk (Dempsey's, however, have continued to grow). As a consequence, what was small is now medium, what was medium is now large. In fact, in a recent ranking of "Top 100" hospitals in certain categories, the sponsor decided that "large" hospitals would begin at a 250 bed measure.

Even the CASE report, however, indicates that “additional staffed beds are required throughout the State at this time,” with additional licensed beds needed somewhere beginning around 2025. In fact, nobody in the hospital industry uses licensed beds as anything except a bargaining chip in negotiation with certificate of need authorities; no serious projections are done based on license capacity. Staffed beds, the ones actually used, are of greatest import, and, as the CASE study indicates, of “possibly greater significance is the tremendous growth of the 65+ population and the implications for the health care system in Connecticut.” As shown on the next page (chart), growth in outpatient services at The John Dempsey Hospital easily outstrips population increase projections, indicating (a) a comfort level of Medicare beneficiaries in using The John Dempsey Hospital, and/or (b) the absence of available community physician (especially primary care) resources, and/or (c) the presence at Dempsey of primary care, gerontology, family practice, cardiology and other resources compatible with the needs of the Medicare population.

So the hospital size is a red herring, an inadvertent stalking horse, which brought on resistance from the area hospitals, in full force, which resistance was unopposed by University or State leaders. To the contrary, faced with moderate protest, the State has essentially tried to give the hospital away.

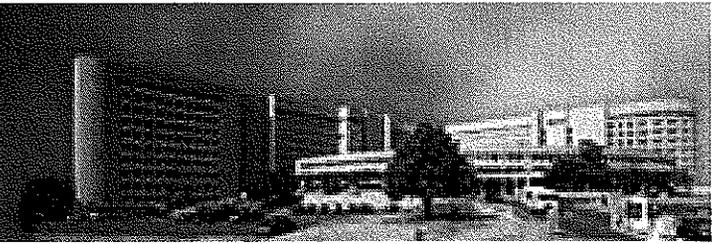
Ironically, the entire process of the past year has diverted attention from internal growth, from the type of wisdom that Dr. Kasper got as the president of Stanford, at the end of his failed institutional marriage, which is that minding one’s own business, and building from within, is a much more realistic (and perhaps more honorable) way of addressing such problems as occur.

There is no deal without a price, in other words, but the necessity for making any of the deals under discussion is not obvious. The alternative, using the recommendations from the \$2.5 million worth of consulting reports just delivered, should be seriously addressed, overseen through a new governance mechanism, and supported fully by each of you.

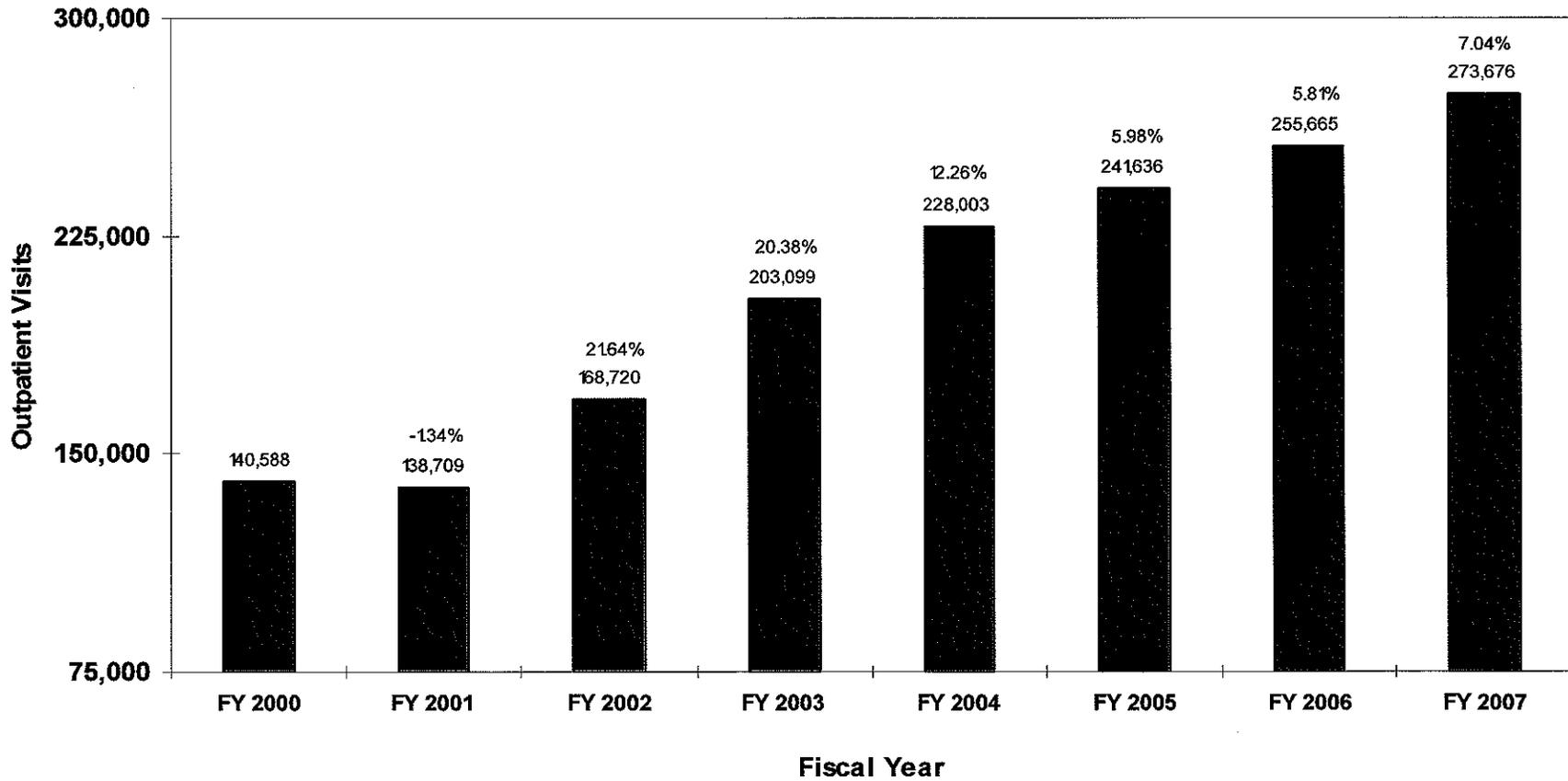


University of Connecticut  
Health Center

KNOW BETTER CARE



**JOHN DEMPSEY HOSPITAL**  
**TOTAL OUTPATIENT VISITS BY FISCAL YEAR**



**JOHN DEMPSEY HOSPITAL  
MEDICARE OUTPATIENT VISITS BY FISCAL YEAR**

