

Spring 5-9-2010

The State of the University of Connecticut Health Center

Ankeet S. Bhatt

University of Connecticut - Storrs, ankeet.bhatt@gmail.com

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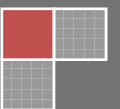
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2010

The State of the University of Connecticut Health Center

Ankeet Bhatt
University of Connecticut
Honors Program



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History the University of Connecticut Health Center (UCHC)

The University of Connecticut Health Center (UCHC) has long been a necessary and integral part of the healthcare landscape of the State of Connecticut. UCHC, located in suburban Farmington, CT, functions as part of the larger University of Connecticut academic system, which consists of the main campus in Storrs, CT, five satellite campuses throughout the state, Schools of Law and Social Work, and a Graduate Business Learning Center in downtown Hartford.

The vision for creation of the UCHC began at the University Board of Trustees meeting held on January 15, 1946. After discussing routine matters, University of Connecticut President, Albert Jorgensen, read a letter to the board from Governor Raymond Baldwin proposing the establishment of a medical school as an addition to the University. The Board appointed three members – New Haven physician Creighton Barker, West Hartford resident Edward A. Suisman, and J. Raymond Ryan – to study the matter. The study was expanded when Governor Baldwin sent a second letter regarding the establishment of a School of Dental Medicine as well. The study’s conclusion relied on varying definitions of the word “need.” In one sense, the state’s population was sufficiently supplied with physicians for the then foreseeable future, eliminating any immediate need for workforce expansion. Yet, on the other hand, the Creighton Barker Committee concluded that it would be “difficult to forsake a proposal that would broaden the usefulness of the University by making medical education available to the state's sons and daughters” (Roy).

The matter of medical education was set aside by the university during its massive growth and expansion in the 1950s. The State, however, still sought to investigate the matter,

appointing the Commission to Study Establishment of Medical, Dental and Veterinary Colleges on a New England Regional Basis in July 1953. The Commission's report, dated November 1954, concluded that a need for additional medical and dental educational facilities existed, citing that the "most practical method of putting a New England Regional Compact together would be for Connecticut to build its own Medical-Dental School to be operated as part of the University of Connecticut, in the City of Hartford" (Roy). In such an arrangement, the educational institutions would benefit from close proximity to the major hospitals in the region, then known as Mt. Sinai, Saint Francis, Hartford Hospital and McCook Hospital.

After more discussion, the General Assembly of the Connecticut State Legislature approved the resolution to build the medical and dental schools in July 1955. Funding for the project, originally projected to cost about six million dollars, came from a variety of sources. The University received \$1,037,500 from the Kellogg Foundation, a \$2 million appropriation from the General Assembly, and a \$1 million grant from the National Institutes of Health (NIH). The General Assembly gave an additional \$7 million in May, 1963, and University President Homer Babbidge announced that Lyman Stowe, Associate Dean of Stanford University's School of Medicine, would be the first Dean of the School of Medicine and Lewis Fox would be the first Dental School Dean (Roy).

The original plan for building a Hartford campus would have utilized Hartford Hospital as the major teaching hospital of the University. This hospital had grown to be the premier health care center in the region. It would have been an excellent site for delivering clinical education, effectively competing with other large academic teaching hospitals in New England. In 1963, after almost violent lobbying by other hospitals, most prominently St. Francis, the General Assembly instead chose a 107-acre tract in Farmington to build the medical and dental

schools. Dr. Stowe passed away prematurely, and his successor, Dean John Patterson, oversaw the construction and formation of the University of Connecticut Health Center as we today know it. Phase one of the project, completed in May 1972, consisted of the medical and dental schools, as well as several research facilities. Located away from the healthcare center of the state, Hartford, the schools required their own hospital to teach medical and dental professionals. Phase two of the project, the construction of John Dempsey Hospital (JDH), was subsequently completed and the facility dedicated in 1975. The original plan called for two towers and a total of 448 beds; yet, in light of economic restraints, only one tower was completed, as it stands now, at 224 beds. Through the years, the UCHC has weathered triumphs and struggles, many of which are directly derived from its history. I intend to expand on these struggles and their causes in the following pages.

The establishment of a large, full-service university hospital to provide the necessary clinical education has long been the academic goal of the UCHC. In particular, this was the dream of the third Dean of the School of Medicine, Robert U. Massey. His vision was to build a clinical enterprise that would provide sufficient patient exposure in order to nurture medical students. This idea has been perpetuated by Massey's successors, but has not yet come to fruition. An opportunity presented itself when the Newington Children's Hospital closed in the early 1990s, and plans began to build a new children's facility in the region. UCHC envisioned constructing the abandoned second tower on the health center campus, thus providing enough space in a large facility able to house many pediatric sub-specialties. Unfortunately, after an analysis conducted by Lewin Associates, the plan to build a pediatric facility in Farmington was discarded, replaced by children's hospital consisting of 157 beds (and eventually downsized to 98) to be built adjacent to Hartford Hospital on Washington Street. The final plan called for

increased cooperation between the new children's hospital and the UConn School of Medicine and St. Francis. With a brand new, \$90 million children's hospital in Hartford equipped to treat a wide range of pediatric conditions, a deal was struck in which the entire UCHC pediatric department, excluding the Neonatal Intensive Care Unit (NICU), would move from UCHC to the new Connecticut Children's Medical Center (CCMC). This arrangement precipitated an unusual situation in which many physicians practicing at CCMC were full-time UConn School of Medicine faculty. Therefore, what began as an opportunity to build a large pediatric facility on the UCHC campus ultimately ended in a free-standing children's hospital in Hartford, housing much of the UConn Department of Pediatrics and all of the Hartford Hospital's and Newington Children's pediatrics. Again, the quest for expansion for UCHC/JDH was thwarted in the halls of the legislature and in private meeting rooms filled with much political smoke.

The UConn Health Center Today

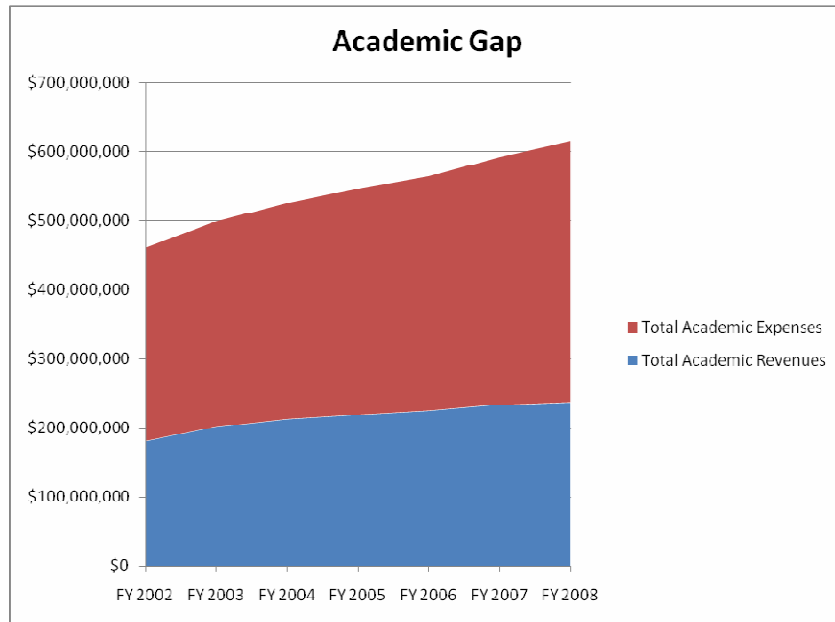
To understand why a partnership between UCHC and a surrounding hospital, namely Hartford Hospital, is so necessary, it is imperative to understand the current state of UCHC. In my discussion with Dr. "Monty" MacNeil, current Dean of the School of Dental Medicine, I began to understand how the UCHC operates much like a family, whose family members each contribute to the overall success or demise of the entire unit. In this "family," there are four major members: teaching, research, clinical care at John Dempsey Hospital, and the administrative infrastructure of the actual UCHC facility. Academics have remained consistently strong, with increasingly diverse, more involved, and astute students and faculty. Research at the UCHC has continued to progress, with the addition of an Academic Research Building (ARB) and expanded research faculty. Research dollars have grown significantly. Yet, the physical facility has become outdated, and the original building plan prevents the renovation needed to

equip John Dempsey Hospital (JDH) with the resources it needs to effectively compete on a technological scale with other regional hospitals. Most pressing, the financial struggles of JDH are of immediate concern to the vitality of the entire enterprise. It is important to note that the root causes of these struggles, which will be discussed hereafter, are not, in my opinion, the result of poor leadership and management, as so often is alleged, but rather a set of external conditions and labor agreements not negotiated by UCHC administration that make maintaining a financially successful delivery system impossible.

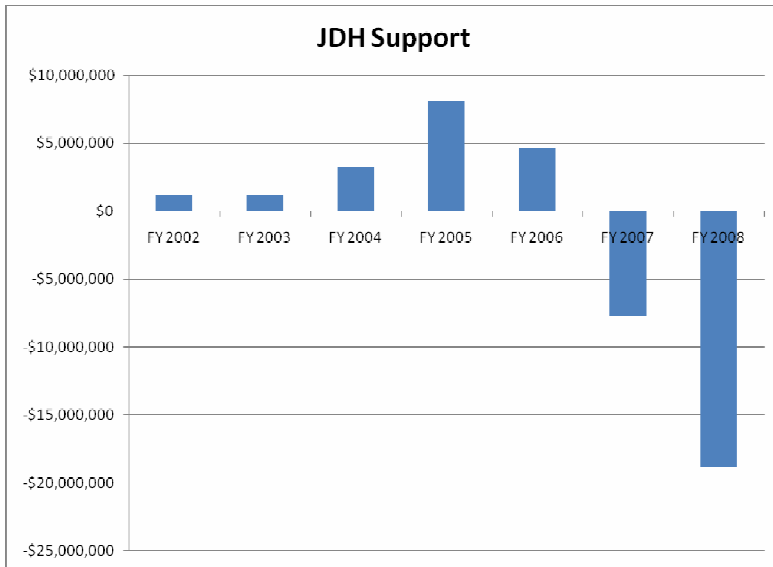
A. Finances

A sound institution must be financially viable. In assessing the financial state of the UCHC, I have seen that several sectors of the business model are unable to generate sufficient revenue to cover the operating and indirect costs of running a large-scale medical facility. To effectively understand UCHC financial structure, I relied on information presented to the UCHC Board of Directors at their quarterly meeting on June 8, 2009. As the UCHC budget projections were being reconstructed, the State's own budget had not yet been decided; there existed significant differences in funding for UCHC (to the tune of about \$28 million for the John Dempsey Hospital alone) between the projected UCHC budget and potential budgets proposed by Governor M. Jodi Rell and the Connecticut General Assembly. For the purpose of understanding the potential impact of a large-scale hospital merger, we will focus upon the budget for the John Dempsey Hospital and the faculty practice groups, the UConn Medical Group (UMG), in this analysis – both of which, as clinical entities, receive no general fund state support. Such support is exclusively used yearly academic projects of the schools and administration of UCHC itself.

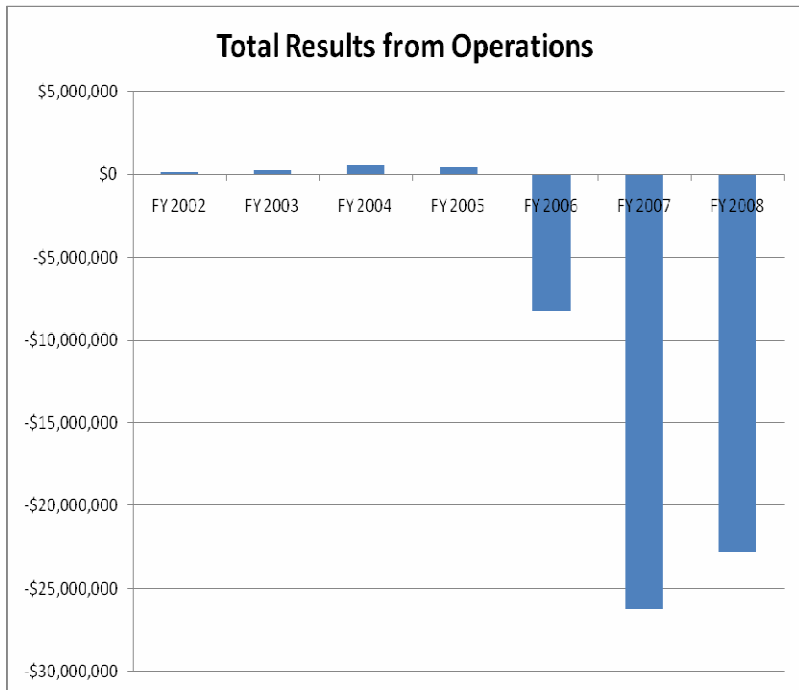
A broad, trending view of UCHC finances is best illustrated by examining the academic gap, the difference between academic revenue and expenses of the School of Medicine. A view of the academic gap is seen in the following graph from FY2002-FY2008:



This figure illustrates how UCHC has trended toward an increasing academic gap. Academic revenues are derived from such items as tuition, Graduate Medical Education payouts for residents, and research revenues as well as other investment and endowment funding sources. Academic expenses are incurred by the Schools of Medicine and Dental Medicine and the research enterprise to run their respective operations. The increasing gap between revenues and expenses poses a difficult problem and a pressing question; how does UCHC eliminate this problem? Part of the gap is reconciled by direct and indirect dollars from the state General Fund, which totaled over \$136 M in FY2008 (UConn Health Center, 2007). This General Fund account will be discussed in detail later; still, UCHC cannot cover its expenses. The only potential additional source of revenue is the clinical operation at John Dempsey Hospital. JDH’s contribution and overall UCHC performance can be seen in the following graphs:



As evidenced by the graphs, JDH was formerly a profitable entity for UCHC, bailing out the academic gap with revenues from 2002-2006. Yet, in 2007, as a result of a hospital that became too small and outdated, JDH operations began to contribute drastically to the overall **deficiency** in



operations that followed in FY2007-2008. As a state institution, the net loss for UCHC is covered through a deficiency budget appropriated by the General Assembly at the end of every fiscal year. Given uncontrolled increasing health care expenses and restricted clinical reimbursements, this pattern is predicted to worsen in the years to come. It would be foolish of the State not to seek a long term solution to yearly deficiency appropriations.

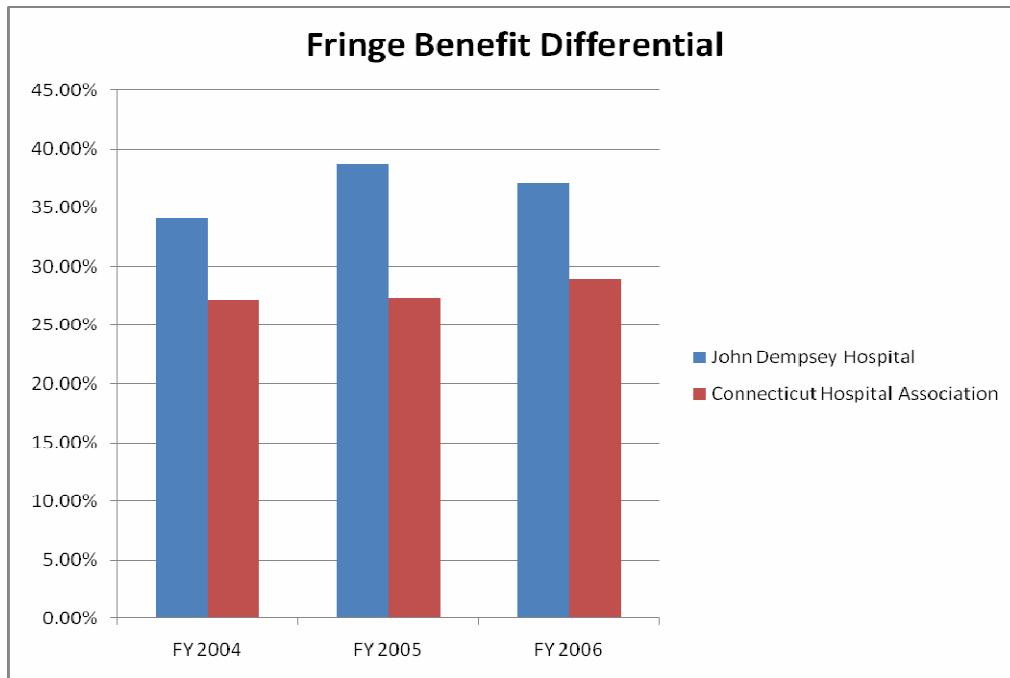
Simply put, the financial picture of UCHC has become bleak in recent years. There are fundamentally three possibilities that can explain the current financial state. First, the financial operation could have been stalled by poor management, and in turn failure to control excess expenses that would even prevent high patient revenue, if such existed, from being profit-generating. Secondly, a fringe benefit differential could cripple the JDH, putting it at a considerable comparative disadvantage to private hospitals in the Hartford region. Thirdly, the lack of profitable beds at JDH could contribute to its lack of profitability. The proposed affiliation agreement focuses on the latter two causes and how they can be rectified.

Before we delve into the concept of the fringe benefit differential as it applies to UCHC, we must take a moment to reflect on how the Schools of Medicine and Dental Medicine along with the research enterprise are the beneficiaries of a very generous General Fund appropriation. This fund, provided by the state for education and research, totaled over \$136 million in FY 2008. At a modest 4% return on investment, it is equivalent to having a stable \$3.4 billion endowment. UCHC is extremely fortunate that the state invests so highly in medical and dental education for its future physicians, dentists, and scientists. Such investments are rarely seen in other public institutions. While the general fund has not increased yearly at the same rate as inflation in the state, it still represents a considerable state commitment to UCHC that must be both noted and appreciated.

B. The Fringe Benefit Differential

Perhaps the most central and controversial issue for UCHC is the fact of fringe benefits. Provided to employees as a form of additional compensation, fringe benefits can include, at the least, generous health and dental benefits. In most Connecticut state agencies, the state covers the fringe benefits of their employees **in full**. Yet, in times when the healthcare sector was

booming, it was decided that the fringe benefits for JDH employees would not be covered by the state, but rather incurred as an additional cost to the hospital. Although this posed few problems in these times of high reimbursement and profitable payer mix, it has now become a significant concern in light of JDH's financial struggles. To compound the problem, the required state fringe benefit rates are drastically higher for JDH and UMG than those observed in the private healthcare sector. The rates for FY2004-2006 are shown below; the JDH rates rose to 41% in FY 2008 (UConn Health Center, 2008).



In dollar terms, the difference between JDH and market rates was estimated to cost the hospital \$9.7 M in FY2007 and \$11 M in FY2008. The figure is rising, making up a large portion of the UCHC deficit (UConn Health Center, 2008). With no commitment from the state to cover the fringe benefits, the hospital and the medical practice (UMG) must include this as an additional cost in their operating budget. John Dempsey Hospital currently serves as the only agency in the State of Connecticut that must bear the full fringe benefit cost of all its employees.

It makes competing with regional hospitals a near impossibility, and has sparked initiatives to enact corrective legislation. The current legislation calls for state coverage of the “fringe benefit differential,” the difference between the average market rate paid by other regional hospitals and the one assumed by JDH for its employees. This would be an important change to ensure that JDH and UCHC can remain financially stable and successful in the future.

The Connecticut Academy of Science and Engineering (CASE) Report and Proposed Affiliation

With this financial uncertainty as background, we now move to the most recent proposal that would make Dr. Massey’s age-old vision a reality. The necessity for immediate change is driven by many factors that currently made the health center financially unsustainable. As discussed previously, the UCHC has a higher than market, but contractually determined fringe benefit rate, putting it at a comparative disadvantage with local private hospitals. JDH, an already small hospital, must also deal with an adverse payer/service mix. Of the 224 beds available at John Dempsey Hospital, only 108 are traditional medical/surgical beds. The other 116 beds are low reimbursement beds, including specialty beds used for the Neonatal Intensive Care Unit (NICU), newborn, high-risk maternity, psychiatry, and a Department of Corrections locked unit. The small size of the hospital prevents it from having the economies of scale necessary to reduce the cost per bed per day. Perhaps the most urgent concern is the continuing deficit generated on a year-to-year basis, causing the health center to seek a deficiency appropriation from the state legislature. Such a cycle is projected to continue and likely increase in the years to come and the deficiency appropriation annually represents a crude, short term, approach to supporting the state’s own medical center. The need for a stable, long- term solution drove the Connecticut General Assembly to commission the Connecticut Academy of Science

and Engineering (CASE) to provide a comprehensive analysis of possible long-term sustainability plans.

The CASE study submitted the “Needs-Based Analysis of the University of Connecticut Health Center Facilities Plan” to the general assembly. The study was conducted in two consecutive phases. Phase one identified the impediments that UCHC was currently facing and also proposed major restructuring processes. As part of the first phase, CASE recommended that UCHC develop a set of guiding principles that would form the framework for whatever course of action was taken. Such a vision should be represented in the Solicitation of Interest document, the focus of Phase II, also recommended by the CASE Study.

Not surprisingly, the guiding principles of the health center were focused on the university’s academic goal of educating young professionals. In the context of the UCHC’s role in the larger community, the Schools of Medicine, Dental Medicine, and Graduate Biomedical Sciences serve as points of educational access to many of Connecticut’s future physicians, dentists, and scientists. In addition, the research enterprise is a vital economic driver in the State. The CASE study reported that the research enterprise of UCHC underperformed as compared to other academic medical centers. Therefore, in seeking a clinical affiliate, the University should concentrate on expanding research opportunities. It should seek additional NIH funding to investigate novel ideas in disease prevention, structural biology, and molecular medicine. The final member of the UCHC family is its patient care programs. These include John Dempsey Hospital, clinical teaching affiliates, and community clinics. The most striking of the CASE study findings were specific to John Dempsey Hospital, the focus of restructuring plans. The study’s recommendations are seen in part in UCHC’s vision statement to be a top-tier academic medical center:

“Without a) significant additional investment in JDH with debt guarantees by the State or another system, and b) fundamental change in the position of JDH in the health care delivery system of the Hartford region, it is unlikely that JDH will be able to continue to serve in a stable role as the primary teaching hospital for the facility, and as a stable work environment for the JDH employees” (The Connecticut Academy of Science and Engineering, January 2009).

The CASE report, particularly a line stating that “the continuation of the status quo ... jeopardizes the General Assembly’s goal of UCHC achieving excellence in academic medicine and is not in best interests of the state,” underscores the immense opportunity available to UCHC at this time. It is an opportunity for UCHC to expand the clinical enterprise available at UCHC and to redesign and remake an already novel and nationally modeled medical education curriculum. It is further an opportunity to improve the biomedical research platform and boost the Connecticut economy, addressing the fact that UCHC’s impact on economic impact has not increased from 2000 to 2007. (The Connecticut Academy of Science and Engineering, January 2009). In an era when public educational institutions, particularly academic medical centers, lead economic growth and diversification, collaboration is needed to ensure such is true for the State of Connecticut. It is with this sense of opportunity that CASE recommended UCHC develop a solicitation of interest (SOI) for a clinical and academic partner.

The SOI was unambiguous in its expectation for relationships within the proposed affiliation. Any agreement should contain three fundamental characteristics. First, there should be a full integration of income and expense statements between JDH and the affiliated partner through a lease/joint operating agreement. Secondly, there should be collaboration/merging of the UConn Medical Group and the other group practice organizations of affiliates. Thirdly, there should be a large academic commitment to the School of Medicine from the affiliated health system. The primary goal of this affiliation should be the enhancement of medical education and

research at the UConn Health Center. Therefore, the study of the academic impact of such an affiliation is a central and appropriate topic for this thesis. In enhancing the academic mission of the health center, UCHC has identified three sub-objectives of the proposed affiliation:

1. Establishment and growth of a large clinical faculty in the School of Medicine and Dental Medicine.
2. Financial support of the academic programs of the School of Medicine and Dental Medicine.
3. Provision for a stable in-patient faculty highly supportive of clinical education and clinical research.

The integrated new facility and faculty practice should service a diverse patient base with ample opportunities for clinical research for faculty and students. With these criteria in mind, UCHC put out a solicitation of interest and received proposals from neighboring hospitals. After careful consideration, the proposal submitted by Hartford Healthcare and the Hospital of Central Connecticut (HOCC) was selected as the only proposal responsive to and representative of the UCHC vision.

The Hartford Healthcare-UCHC Affiliation

The Hartford Healthcare-UCHC affiliation is comprehensive in that it proposes a plan to enhance the academic, research, and clinical missions. The crux of the agreement is that the Hartford Healthcare Corporation (HHCC) assumes responsibility for the operation and finances of JDH. Therefore, state appropriations for education and research, and associated administration, totaling now almost \$150 million per year, to the Schools of Medicine and Dental Medicine would still remain intact, but the hospital would, if in a deficiency, operate on funds from HHCC. HHCC would also be responsible for maintaining direct commitment to medical education and research, investing a total of \$100 million over the first five years of the

partnership to enhance its research enterprise. It would complement and expand the School of Medicine's faculty by integrating its dynamic medical and surgical with the University's. With HHCC responsible for any deficits generated by JDH, UCHC would not need to seek deficit appropriations from the State each year, reaching a long-term solution to an ever-growing problem. In addition, in a separate legislative ruling, State coverage of the fringe benefit differential would put considerably less strain on JDH and HHCC. The plan would transform the Hartford region into a prime medical care destination, one that can effectively compete with the medical centers of excellence in New York and Boston. The shared vision would finally create one university hospital on two campuses.

The original plan called for the creation of a new, state of the art hospital on the UCHC campus in Farmington, CT, one that would be able to house the technological and medical resources needed to be at the cutting edge of biotechnology. This hospital would be merged with Hartford Hospital, which would be further renovated to serve as the inner city part of the academic medical center. This new University Hospital would have a total of over 1,000 beds, making it one of the top ten biggest academic medical centers in the country, an impressive transformation from the second smallest as JDH now stands. The resources available at Hartford Hospital would immediately provide tertiary and quaternary services such as the region's only Level 1 Trauma Center, LifeStar, Interventional Neuroradiology, and transplant services. Merging the hospitals into one single University Hospital will also be further complemented by integration of the fulltime faculties of each institution into a single medical staff, creating a highly-dedicated workforce and enriched medical environment needed to recruit, in the future, additional world-class physicians committed to education and clinical care.

As of January 30, 2009, when CASE released its final report entitled *Independent Monitor Report: Implementation of the UCHC Study Recommendations*, the entire integration agreement between UCHC and HHCC was projected by some to be 95% complete. The agreement for the new University Hospital allowed HHCC to be the parent of the two licensed affiliates. One would be entitled University Hospital – Hartford Campus, Inc., which would be owned and operated by HHCC. The second licensed affiliate would be University Hospital – Farmington Campus, Inc. Under such an agreement, HHCC would essentially lease and operate JDH from UConn. Employees of the State of Connecticut would retain their employment status and be eligible for any state benefits but new employees would be hired by the University Hospital under the direction of HHCC.

A. Faculty Practice Plan

The new faculty practice plan, combining full-time faculty of Hartford Healthcare and the UConn Medical Group (UMG), would be called University Physicians, Inc. Such a plan would require much collaboration. The faculty in the new University Physicians would have the option to be dually employed, by the School of Medicine for their academic duties and by University Physicians for their clinical duties, on either the Hartford or Farmington campuses, or both.

B. Governance

The agreement also specified a detailed governance structure for both the University Hospitals and the University Physicians faculty practice group. In terms of the University Hospital, there would be a cross-representation on the respective boards for UConn and HHCC. For example, UConn would have two appointees to the HHCC Board of Directors, and vice versa. A new board would be created for the University Hospital, with voting members including the HHCC President and CEO, HHCC appointee, UConn President and UConn Dean

of the School of Medicine. Therefore, the governance for the University Hospital would represent an equal distribution of power between the two entities. A similar strategy was taken with the governance of the faculty practice plan, University Physicians. The Board of Directors would contain the University Hospital President and COO, Dean of the School of Medicine, and other members from each entity.

Coupled with cross-representation on the Board of Directors are precise responsibilities and powers granted to the senior leadership. The University Hospital President and CEO would retain reserve power over any major clinical enterprise decisions. He or she would be able to appoint and discharge medical directors as well as monitor the productivity and compensation of clinical faculty. Since the hospital and the faculty practice plan are intimately connected, the Hospital President and CEO would also be responsible for the operating costs for the University Physicians. On the other hand, the School of Medicine Dean would be responsible for all academic and research priorities for the new system. The Dean would make all academic appointments and monitor clinical education and research productivity and compensation standards for the faculty. As in the current structure, the Dean would also be responsible for the educational and research operation and quality standards.

C. Financial Matters

Financial matters are also specified in the affiliation agreement. The critical change is that HHCC would assume the financial risk for the combined enterprise. It would also be responsible for \$100 million dollars invested toward enriching the academic experience at the UConn School of Medicine and Dental Medicine. Funding for further growth and transformation would be assumed by HHCC. A new bed tower project in Hartford would be funded and supervised by HHCC. Additions to the clinical faculty and new biotechnological

investments would also be decided upon and funded by HHCC under the direction of the HHCC President and CEO. Overall, the affiliation agreement represents a transition in the financial risk/reward from the UConn Health Center, and ultimately the State of Connecticut, to HHCC. While the State's financial responsibilities to the health center will certainly be diminished, the State would continue to fund the School of Medicine and Dental Medicine's Academic and administrative needs at the current rate, with an adjustment for inflation each year. Since these monies are used exclusively for academics, they represent appropriations to the State's own medical education institution. In addition, the state would be responsible for funding the replacement hospital for JDH in Farmington. While projected costs for the replacement hospital have increased to over \$500 million, the State would appropriate this money on a year-to-year basis. For example, the first appropriations would be about \$25-50 million, the total cost of the planning and design projects necessary before building can begin. The State commitment should also contain coverage of the fringe differential. This coverage would accomplish two tasks for HHCC and the University Hospital enterprise. First, it relieves a considerable financial strain on HHCC, while allowing state employees to retain their state benefits. Secondly, it allows the University Hospital to be competitive in terms of overall fringe cost compared to regional hospitals. Therefore, competition between hospitals will occur on the quality and effectiveness of care and consumers should receive more appropriate, affordable, high quality care.

D. Employee Matters

Finally, the agreement between UCHC and HHCC specifies employee matters. The situation becomes complicated because UCHC's state institution status conflicts with the private nature of HHCC. In addition, much of the UCHC support staff are unionized workers while employees at HHCC are not. This said, the agreement seems to reach a happy medium by

allowing employees to retain their current employment status. First, the agreement specifies a distinction between teaching, research and clinical care. For teaching and research responsibilities, faculty will be considered state employees, paid by the School of Medicine. For clinical care, faculty will be employed by University Physicians. Faculty members conducting academic teaching, research, and clinical care will be paid via both entities, in proportion to the amount of time they spend in each area, designated by a percentages of a full-time equivalent (FTE). For current support staff, non-unionized employees have the option to become State employees or be employed directly by the University Hospital. New staff will not have this option and will be exclusively employed by the University Hospital outside of union representation. Staff currently in the union would also be able to retain their union and state employment status.

Implications of an Affiliation

The above describes the current situation and proposed affiliation for the UConn Health Center. As previously stated, there is tremendous opportunity for the full-scale transformation of the academic health center to make it on par with leading centers of excellence around the country. In light of other failed attempts to expand the clinical enterprise of UCHC, time is running out to make JDH viable and able to meet the needs of growing medical and dental school classes. In a system with eager, high quality medical students and an invested clinical staff, it is certain that change is needed to ensure long-term sustainability. The previous section of this paper is intended to provide an understanding of the complexity of issues that surround UCHC. It should help the reader understand the unstable financial situation at JDH, which will soon paralyze the health center as a whole. It elucidates the details of a very viable affiliation

agreement, from governance structure to support staff matters. I worry that, as in the past, political smoke and mirrors, and, most of all, lack of political courage, will derail it.

We now shift our attention from the present to the future, examining the possible implications the merger or maintenance of the status quo. It is my hope, that in this analysis, the reader will appreciate the challenges inherent in such a transformation, as well as the possible short and long term benefits and losses that might pertain. With this said, it is important to revisit the history of UCHC. At the heart of the matter, the health center was created for one central purpose: to provide an outstanding School of Medicine, and School of Dental Medicine, to thereby educate physicians and dentists of the State of Connecticut of tomorrow. UCHC has undergone tremendous growth and transformation in its history, yet the core mission of an exceptional medical education has never wavered. In this light, I will focus on the academic implications of the affiliation agreement, or lack thereof. While a successful affiliation or maintenance of the status quo will each have its own set of financial, political, and clinical consequences, we will focus on those which affect the status and attainability of the school's **academic** mission. As an undergraduate student at the University of Connecticut seeking a professional medical education, the situation at the UCHC is personal. It has made me consider what issues potential students like myself should investigate as they choose the correct setting for their medical studies. It has shown me the immense political negotiations, often self-serving, that underlie any decision in a state-run educational facility. Finally, it has illustrated how dedicated clinicians and tireless researchers can mold an exceptional educational experience for students.

Much of the analysis provided below is the outcome of an enriching internship experience I was privileged to have in the summer of 2009. As a part of the Summer Research

Fellowship Program at the UConn School of Medicine, I worked alongside senior UCHC leadership members for a ten-week period. That summer was an exciting time to be at the UCHC, as the affiliation agreement was crafted and presented to the Connecticut Legislature during my time there. Over the course of these ten weeks, I was able to gain an understanding of how the entire system works, including how the hospital and dental clinics, medical and dental schools, and research laboratories are integrated to provide a medical experience unique to academic health centers. In my conversations, I heard the fears of many of the employees, the challenges they felt would hinder a successful partnership. I also came to understand the financial woes associated with the hospital's current situation. I was constantly fascinated by the complexities of operating such a multi-disciplinary service enterprise. My experience has served as the impetus for this paper. Below follows my analysis of the academic implications and challenges involved in structuring and implementing the HHCC-UCHC affiliation.

As a student pursuing a medical degree, I first looked to determine the characteristics that produce a superb medical education. I have identified three factors which are the standard that distinguish top academic health centers:

Standards of Excellence

- A.** A large, highly invested, world-class, even internationally renowned, faculty embracing all specialties.
- B.** A large, diverse patient base, allowing medical students to experience and treat a wide variety of medical conditions
- C.** Ample opportunities for student involvement in basic science, clinical, and translational research

In an era where curricula around the country have adopted Problem Based Learning (PBL), and other innovative educational approaches, these three factors serve as the crucial but variable parts

of a medical education. In the following analysis, I hope to explain how the presence or absence of an affiliation agreement with a similarly dedicated hospital system will affect these crucial factors.

A. Building a World-Class Teaching Faculty

The need for a highly dedicated teaching and clinical faculty is integral to providing excellent medical education. The faculty serves as teachers, role models, and mentors for the medical school class. Like all good teachers, the medical faculty must be highly invested in their students, genuinely wanting to aid in their success. A dedicated faculty is important because faculty members, as mentioned, serve as mentors for aspiring medical professionals, guiding them in both personal and career decisions. Therefore, a faculty member often takes on the role of a friend as well as advisor.

While the need for an *invested* medical faculty is apparent, there is also a need for a *large* medical faculty. A large faculty affords students with the opportunity to engage many different physicians from various specialties and sub-specialties, seek a variety of opinions in clinical and general matters, and, thereby, students eventually make the most educated choices. It allows students to work in dynamic group environment in which they receive input from various physicians on clinical conditions that reach across disciplines. This being said, how does an academic medical center produce a large, highly invested medical faculty? Perhaps the simplest way would be to have a large university hospital on the health center campus, a hospital that employs a large faculty that are intimately tied to the School of Medicine and Dental Medicine. In terms of the UCHC, expansion of the current JDH has been attempted at many points in the past, only to be thwarted each time in the Connecticut Legislature in response to competitive political pressures from other hospitals, most notably St. Francis Hospital.

If the addition of a larger hospital built on the Farmington campus is stalled, the next alternative to expanding the breadth of the medical faculty is an affiliation/partnership with a surrounding hospital(s). A partnership exhibits many benefits in terms of faculty expansion. It provides a simple, affordable way to develop a large clinical faculty. Since the clinical faculties at Hartford Hospital are experienced and have worked in the medical landscape of the region, there is little needed for aggressive recruitment and training of new, young faculty members. A partnership, especially the merging of the UConn Medical Group and Hartford Healthcare into a new faculty practice plan called University Physicians, Inc., would instantly expand UConn's medical faculty. Hartford Healthcare currently has an active medical staff of over 1,000 physicians, instantly tripling the existing medical faculty. The physicians that would become part of the School of Medicine faculty would come from a highly respected tertiary/quaternary care facility, easing any doubts about the quality of care and its expertise. In addition, with Hartford Healthcare responsible for the operating and capital budgets of the University Physicians, Inc., the expansion of the faculty would come at little cost to the School of Medicine and the UCHC. Overall, the partnership agreement provides a cost-effective way of tripling the medical faculty available to the University of Connecticut School of Medicine.

Though the partnership effectively increases the size of the faculty, there are many challenges to ensure that new faculty members are deeply committed to medical education. In my discussions with UCHC staff and faculty, the most consistent concern was that the emergence of the new University Physicians faculty practice plan would serve to dilute the academic focus of the medical school faculty. Despite many full-time hospital based HHCC physicians, such concerns are appropriate because Hartford Hospital currently is and will remain a largely private entity. A large majority of the physicians that work at the hospital are in private

practice, not employed directly by Hartford Healthcare. Unlike UCHC physicians, who are salaried and expected to provide meaningful academic contributions in the classroom and at the bedside, private practice physicians generate income almost solely from clinical care. In a typical fee-for-service system, financial incentives are aligned in such a way today for these physicians to be efficient, purely clinical employees, instead of clinical educators. While these physicians may provide quick turnaround times and service a high volume of patients, a way to cause these excellent clinicians to be dedicated to the academic mission of the School of Medicine must be found.

It is clear that the structuring of the new faculty practice plan cannot be just a simple combination of Hartford Healthcare and UCHC faculties. It must address the issues inherent in combining a faculty experienced in an academic medical center environment with one trained to expedite the speed at which care is delivered in the private setting. It must in some way realign financial incentives to ensure that the academic mission will not be lost during faculty expansion and consolidation. If done successfully, this could become a national model. In my opinion, the UCHC already uses a system that can be built upon to address these needs. First of all, for the 150 faculty members employed directly by Hartford Healthcare, the integration should be a simple task. Like UCHC faculty, these salaried employees are highly involved in a more diverse set of responsibilities, including research, resident and medical student education.

For the remaining faculty, modification of the new CREATE profiles, replacing older CREAM profiles, could provide the necessary incentive structure to ensure that affiliation provides a faculty committed to educating the next generation of medical professionals. The CREATE profiles are currently used, as one faculty member described it, as an accounting mechanism. Since an employee's overall salary comes from many separate budgets within

UCHC and HHCC, the profiles maintain an accurate account of how an individual is paid. The profiles are divided by their funding source: C for clinical, R for research, E for education, A for administration, For example, a current faculty member may receive seventy percent of his pay from the School of Medicine budget for his medical teaching and the other thirty percent from the UConn Medical Group for his clinical duties. Currently, the private practice Hartford Hospital physicians, who would be absorbed under the University Physicians umbrella, often spend 100% of their time on clinical care. Yet, if clinical education was incentivized, namely through additional payment for taking on educational roles within the new University Hospital system, the problem of integrating two vastly different faculties could be resolved. Private practice physicians would not be so pressured to see a high volume of patients to meet their financial goals and would be able to spend time educating medical students while being financially rewarded. Physicians wanting to continue to provide purely clinical care could do so, thus remaining a profit-generating entity for the new University Hospital as a whole. New faculty recruitment with an educational focus will help to supplement the clinical faculty.

It is important to note that the faculty expansion, including private practice and group practice physicians, provides a huge financial benefit for both Hartford Healthcare and UCHC. Private practice physicians in specialty practices receive many of their new patients directly from primary care physician (PCP) referrals. Therefore, to maintain a financially sustainable patient base, these physicians must actively seek out PCPs that agree to refer to them. Such a system is extremely beneficial in an affiliation because the UCHC will now be able to benefit from an increased network of PCPs who agree to refer their patients to the total integrated University Hospital. Currently at UCHC, there is little incentive for salaried physicians to engage in such behavior because there is no financial reward for doing so. Currently, there is a small

department at UCHC tasked to convince PCPs to refer patients to JDH. In an affiliation, each private practice physician at Hartford Hospital essentially becomes an ambassador, or marketing agent, for the new University Hospital. It is a prime example of what Adam Smith dubbed “the invisible hand.” As these physicians seek out PCPs to support their own private practices, they also provide a broader network of patients that will be referred to the new University Hospital. By its very nature, the affiliation agreement allows the hospital to market itself through its faculty, with no additional investment or time expenditure. The possible benefits of a combined clinical faculty are immense, provided that such a new faculty practice plan can be monitored so as to retain and strengthen the University’s academic missions and create a fair reward system.

B. Exposure to a Diverse Case Mix

The art of medical education has changed drastically in recent years. The recognition that physicians must not only be extremely knowledgeable scientists but also exceptional clinicians has altered medical curricula around the country. The emergence of new educational techniques shows a strong shift to an emphasis on clinical skills. Medical students now often begin seeing patients in their first year of medical school and learn in active, patient-driven environments. To provide an unparalleled education experience, student must be able to see, diagnose, and discuss a wide variety of clinical cases. Such a goal can only be realized if the medical school’s clinical affiliates provide a large, diverse patient base.

Apart from the direct relationship between a diverse patient base and clinical education, the financial benefits of a large clinical enterprise also bode well for building a world-class medical education program. A large hospital provides the necessary economies of scale to be financially successful. Fixed costs remain the same, but the cost on a per-paying-patient basis decreases as volume increases. With the excess capacity available, the hospital will be able to

efficiently add or take away beds to meet seasonal and emergency demands. Most importantly, a larger hospital grants the University and Hartford Healthcare negotiation power with insurance companies for reimbursement. The Hospital will be able to provide insurance companies with a large patient population and a greater number of faculties accepting a particular insurance. In this sense, as a UCHC senior leadership member once said, “The University Hospital will be together what neither of the hospitals could be individually.” Negotiating these new rates allows the hospital to increase profit. These profits should then be used to enhance technological expertise and advance the educational experience, which can be done in numerous ways. For example, such monies could be recycled into the University Hospital itself to directly purchase new biotechnology. This will not only enhance quality of care, but also allow students and residents to learn ground-breaking procedures that will likely become commonplace in the years to come. Profits could be used to provide a more affordable education for medical students or formulate opportunities to learn how medicine is practiced in other parts of the world. Each of these options requires financial support, ideally from a large, successful clinical enterprise that eliminates the academic gap UCHC now experiences. The focus will be on enriching the medical educational experience and building exceptional clinicians that distinguish a top-tier medical facility.

In the current JDH, the presence of only 108 medical/surgical beds makes it difficult to negotiate with insurance companies. Combined with a low census likely fueled by the media perception of JDH as an outdated, deteriorating facility, the hospital is essentially at the mercy of insurance companies. The Hartford region, rich with insurance companies, already creates a difficult market for hospitals to prosper. It is an environment in which hospitals compete to win contracts with insurance companies, much different than one in which many insurers compete for

membership with a single large hospital. Such an affiliation would be an important step in helping strike a balance of power between providers and insurers.

While the expansion of the clinical enterprise presents a huge financial opportunity that can be used to fund clinical education, it also presents many important challenges. Like many other challenges involved in making this merger a reality, they stem from the philosophical differences between the state-supported UCHC and private Hartford Healthcare, two institutions with very different missions. UCHC is intimately tied to providing State needs.. Because it is State supported, it not does experience the same “bottom line” pressures that a private institution would. Hartford Hospital, as a private institution, has one fundamental goal: provide great care that allows the hospital to generate a profit. Therefore, in a private hospital, programs and services that are not generally profit-generating are cut, downsized, or replaced by ones that are. This may present a fundamental problem if an affiliation were to occur. Under the agreement, Hartford Healthcare takes full financial responsibility for the operating and capital budgets of the University Hospital. Therefore, they would also expect to have jurisdiction over any decisions that directly affect the hospital, as they bear full financial risks for the hospital’s performance.

Currently, JDH provides many services because they are necessary for the State to meet its societal responsibilities. For example, all inmates in the State’s Department of Corrections receive their most serious medical care at UCHC. The current Department of Corrections contract occupies an entire floor on an already small JDH. If these beds were available for general medical/surgical cases, they would generate additional profit. They cannot do so now as they are now reimbursed. This is also the case for the large Department of Psychiatry that is currently at JDH. It is plausible that Hartford Healthcare would want to see these departments diminished and replaced by additional medical/surgical beds for two fundamental reasons. First,

the state's reimbursement level for the corrections contract is lower than the average reimbursement of privately insured patients. Similarly, psychiatry has a high proportion of patients insured by Medicaid, where reimbursements are so low that the Hospital actually loses money per patient. If a majority of the corrections or psychiatry beds were converted into medical/surgical beds with a better payer mix, the hospital would be able to generate additional revenue. Secondly, such patients currently in the system have an average greater length of stay than those typical of medical/surgical beds. The longer a patient is kept in the hospital, the less profitable he or she becomes as additional resources are used daily.

The danger of Hartford Healthcare abandoning these departments is evident for academic reasons. First of all, we must not forget that the State of Connecticut funds the School of Medicine to a considerable degree. Therefore, the medical school has the obligation to serve the needs of State, not only by training the next generation of medical professionals, but also by providing services that others are unwilling to provide. If the University Hospital does not facilitate the Department of Corrections contract, who will? The Department of Psychiatry is important in that it allows medical students to gain exposure to a wide range of psychiatric conditions. A severe reduction in this department would be detrimental to the learning and training experience for both medical students and residents. Overall, while the finances may determine many of the decisions that Hartford Healthcare makes, there could be real potentially negative impacts on the breadth of medical education and fulfillment of the State's needs.

There is a delicate interplay between the profit generating nature of Hartford Healthcare and the State servitude model of UCHC and its medical school. In reconciling these differences, it is important that the School of Medicine have veto power over any decisions of Hartford Healthcare that they believe would adversely affect the level of clinical education available to

students and residents. Currently, the School of Medicine would only hold this power if a decision was made to terminate an entire contract or department. In my estimation, to protect the academic nature of the UCHC, this power should be extended to any changes in the size or range of services offered by a department. It is important that Hartford Healthcare is reminded that the University Hospital is an integral part of the UCHC, and therefore also a part of the State of Connecticut. Academic considerations and State needs must take the front seat in any decisions made regarding the University Hospital.

C. Expanding Research Opportunity and Funding

Finally, an exceptional medical education must contain a strong research program. Research is vital to building successful academic medical centers for a number of reasons. First, a large, well-funded research program allows students to be involved in new, ground-breaking discoveries. Students are attracted to places where they will have ample opportunities to engage in basic science, clinical, and translational research. The top medical students have likely already engaged in some research activities during their undergraduate years and seek to extend those experiences. Therefore, the strengthening of the research program is an essential recruitment step for the School of Medicine. Currently, the UCHC is ranked 63rd of 123 medical schools that receive NIH funding. In a simple comparison between this ranking and the overall medical school rankings, generated by the *U.S. News and World Report*, we find that the UConn School of Medicine ranked 56th in 2009. Therefore, the research sector underperforming to some degree compared to national standards, but also an opportunity for improvement exists.

While a strong NIH funding record is directly beneficial to students, it is also essential in terms of faculty recruitment to the School of Medicine. High quality, resource-demanding faculty are attracted to schools with the financial support to fund their ideas. They want to be

surrounded by similarly-minded faculty members to collaborate with and from whom they can learn. Therefore, increasing total NIH funding for the UCHC should be a top priority moving forward for, at the least, exceptional student and faculty recruitment. In my conversation with a senior medical school administrator, I realized that the greatest model for medical education is one in which those that are teaching students are also discovering new knowledge. Here, we see how medical education and research are intimately connected. It is principally for this reason that the concept of an academic medical center, devoted to great care based on research and education, has been adopted by so many schools of medicine nationally. This being said, it is important that the affiliation create a plan to strengthen and integrate research across the two institutions.

Future Courses of Action and Possible Implications

In the process of completing this research, we received word that the proposed affiliation had been pulled from discussion. *The Hartford Courant* reported on November 21, 2009, citing that “University of Connecticut leaders have scrapped a proposal to merge the UConn Health Center with Hartford Hospital, determining that the latest plan...could not win enough support [in the Connecticut legislature] to succeed,” a tragic but expected outcome (Becker, 2009). While this affiliation may be considered dead at the current time, a similar agreement should resurface in the years to come, as it is comprehensive, with many of the same characteristics. Therefore, this research is still applicable in the context of how the academic medical education process must be improved and/or expanded at UCHC. Following the announcement, for my purposes, the situation has reverted back to 2006, when senior UCHC executives first spoke to the Connecticut Governor about the need for a larger hospital that could be financially viable. In light of the current circumstances, I have included in this analysis how future courses of action

will impact the makeup of UCHC and ultimately determine whether bright, young, talented minds choose UCHC as a place where they feel they can have an exceptional educational experience. I have also included the possible challenges associated with each course of action and their feasibilities. I will focus on three major courses of action:

- A. Maintain the Status Quo
- B. Adopt a Distributed or Harvard Model
- C. Construct a New, Larger Hospital on the UCHC Campus

A. Maintain the Status Quo

It is evident that any affiliation agreement or restructuring plan for UCHC must include and support the three standards of excellence: the creation of a large, highly dedicated clinical and teaching faculty; access to a constant, large diverse patient base; and a commitment to strengthening research opportunities for students and faculty. In reaction to the current proposed UCHC-HHCC agreement, there has been much discussion about how this plan is unique and represents a significant change from the UCHC's current situation. Critics have pointed to the fact that students and residents already rotate at the surrounding hospitals, including Hartford Hospital. Interestingly, Hartford Hospital received more residents (247) than JDH, which only received 133 (Value of DGME and IME Residents, 2006). Residents are paid for the most part by the federal government through Graduate Medical Education (GME) funds; therefore, having a larger number of residents increases hospital revenue significantly.

While it is true that students and residents currently have access to a large patient base at community hospitals including Hartford Hospital, there are two fundamental academic differences between the status quo and what would be achieved in the proposed affiliation. First, the affiliation calls for the merging of the faculty practice. This plays an important role in the

recruitment and retention of physicians. New faculty will see the integrated entity as primarily academically focused, and University Physicians will be able to attract top clinical talent with an interest in educating. This is vastly different from the recruitment currently undertaken at Hartford Hospital and other private facilities, which strive almost solely for efficient, quality clinical care in order to maintain a positive bottom line. The emergence of a large, academically focused clinical faculty can only be done in a setting that is intimately tied to the School of Medicine, not one loosely tied only through resident training. In any loose cooperation private hospitals will continue to seek pure clinicians to teach residents, who aid their practices daily, a very different breed of physicians than those currently practicing at academic medical centers around the country. Therefore, the affiliation would provide the necessary framework to attract highly qualified academic physicians to the University of Connecticut School of Medicine.

Secondly, the affiliation accomplishes a binding between Hartford Hospital and research and education expenditures. In the current system, UCHC must provide the labor and money needed to expand the educational and research facilities and services. In a new agreement, Hartford Healthcare will be required to invest over \$100 million to expand its own research capabilities on behalf of the combined academic experience between the affiliates. This requirement is important because it represents a change in vision to a more academic focus. In the current situation, Hartford Hospital remains as a community hospital; its mission continues to be to provide access to clinical care for the citizens of the region. Therefore, in hard economic times, their first expenditure cuts will likely come from research and education, which currently serve as supplementary goals for the institution. Such budget cuts are detrimental for academic facilities because they stall the continuity of education and research needed to build world-class programs. With this affiliation, the financials of UCHC and HHCC would be tied together.

Consequently, research and education would no longer remain as merely supplementary goals for Hartford Hospital; in fact, they would instantly become priorities, as the hospital transforms into a major educational facility. It is for these two principal reasons that the status quo is not a sustainable option for the health center.

For talented students, maintenance of the status quo serves to dismiss any attraction that the UCHC provides. Students will watch as key, high quality faculty members seek other, more stable medical centers as their places for teaching and practice. Therefore, UCHC must look to recruit other highly talented physicians to fill these positions. Yet, the recruitment process is also stifled. High quality physicians searching for new opportunities seek robust, dynamic programs in which to practice medicine. Since it is unlikely that a debt-ridden UCHC with only 108 medical/surgical beds will fit this vision, these physicians will likely choose other environments for their place of work. This combination is detrimental for UCHC, and talented students around the State of Connecticut will see a depleted faculty, and thus be likely to choose other institutions to continue their medical education. The maintenance of the status quo would result in a bleak view of the quality of academics and the caliber of students receiving their degrees at UCHC.

B. Adopt a Distributed or “Harvard Model”

Recently, there has been much talk about the adoption of the so-called “Harvard or distributed model.” In a *Hartford Courant* Opinion piece entitled “Outsourcing the Hospital,” Dr. Robert Rosson, for years a private practice gastroenterologist at Hartford Hospital, describes this model as one in which “a university medical school has neither a hospital it owns nor with whom it is intimately aligned, but rather uses various hospitals...for teaching students, residents, and fellows, and for patient care and research by its faculty.” Such a model is seen in the

Harvard medical system, which maintains this arrangement with many of the surrounding hospitals, including Massachusetts General Hospital, Brigham and Women's Hospital, and the Beth Israel Deaconess Medical Center. The model represents a creative approach to broaden the scope of UCHC and push it toward the nation's elite programs" (Rosson, 2009).

However, there is one major requirement in this model that makes its implementation a near impossibility in the Hartford region: the model is only successful when the faculty employed at the affiliated hospitals are principally *teaching* faculty, not only *clinical* faculty. This is the only way to ensure that medical education is not sacrificed in these institutions. The Dean of the Harvard Medical School approves every single faculty appointment to any of its affiliates. Currently, I doubt that the surrounding Hartford regional hospitals would be willing to grant such power to the UCHC Deans and thereby relinquish their ability to hire faculty at their own discretion. The model is successful at Harvard because the medical school is in a unique situation. It represents the long recognized, world-wide pinnacle of medical excellence, and therefore provides immense prestige to its affiliates. Essentially, the surrounding hospitals would not be what they are today without Harvard Medical School and vice versa. Such dependence on a large university medical school does not exist in the Hartford region, and regional hospitals have little desire to align with UCHC in an arrangement like this. Without the ability to determine the characteristics of the clinical faculty, UCHC would not have any power to ensure that a strong academic focus is established at the community hospitals. The distributed model would thus lose much of its desired effect. Essentially, the closing of JDH, which could accompany the implementation of the distributed model, would in fact hurt clinical education in the long run and diminish the stature of UCHC in the region. If such a model could be successfully implemented, it would likely be incorporated into a number of medical universities,

instead of the handful that it currently is operative in. The bottom line is that medical schools like Harvard carry a much greater power and dependence than UCHC is currently capable of carrying in the Hartford region, given its short history.

Without the power to appoint clinical faculty, UCHC would again be at a comparative disadvantage in terms of recruiting intelligent young students from the State. While prospective students will see a large clinical faculty, they will also see one that is more interested in delivering patient care rather than in providing medical education. These students will likely choose other medical education institutions, ones that have large University hospitals with full-time faculty whose passion is teaching AND clinical education. They will understandably seek to learn from physicians more interested in taking the time to review and discuss cases with them rather than those rushing to see a high volume of patients they can see in a given day for the sake of reimbursement. Students will want to work not only with those who deliver care but those who create new approaches to care and love to teach it. Again, the stature of clinical education at UCHC will undoubtedly be compromised without a solid clinical faculty prioritizing medical education above expediting patient care delivery.

C. Construct a New, Larger Hospital on the UCHC Campus

In 2006, senior leadership at UCHC met with the State Governor to discuss the possibility of building a new, 250-bed hospital equipped with more profitable medical/surgical beds to replace John Dempsey Hospital.. Unable to win enough support in the Connecticut Legislature, this original plan was scrapped in favor of implementing the CASE recommendations, which suggested an affiliation agreement with a surrounding hospital. With the failure of the affiliation agreement, we have come “full circle,” where again building a new hospital is a potential future course of action, and may be the only surviving one.

The construction of an adequate sized new University Hospital on the UCHC campus would be the ideal situation to attract the nation's top students to the UConn School of Medicine. The hospital would be equipped with state-of-the art equipment that would let students learn using the most advanced biomedical technology. They would be able to train in a facility outfitted to meet the changing healthcare needs of the population. Perhaps, most importantly, a new, larger university hospital would ensure that medical and dental students are taught by an exceptional, high quality, educationally devoted faculty. The effect would be both immediate and long-term. Faculty currently viewing UCHC's condition as precarious and unstable would welcome the new hospital as bringing stability and financial viability to UCHC. This would encourage retention of current key faculty at UCHC who provide excellent teaching and are committed to discovering new medicine. Long term, faculty recruitment would be substantially increased. To build a world-class program, the medical center must attract world-class medical talent by creating an atmosphere where such faculty can thrive. A larger hospital equipped with more medical/surgical beds will allow clinical faculty to develop a more diverse and challenging patient base, perform more complex procedures and market UCHC as an outstanding place of work. Also, the larger hospital will give newly recruited department heads and other administrators the flexibility to bring other talented physicians along with them. Under the current system, the hospital does not have the patient volume to significantly expand the faculty and keep them active. Therefore, recruits are often sought only to replace vacated positions and departments have little room to grow. Overall, there is a tremendous upside in terms of building and retaining a world class faculty to educate potential students if a new, larger University Hospital is created on the UCHC campus.

A new hospital will also impact medical education through research. The vacated halls of the old John Dempsey Hospital will provide the needed space and infrastructure to build new research laboratories engaging in the frontiers of biomedical research. A stronger clinical faculty eager to discover new medicine, combined with increased research space, is a powerful attraction for talented students interested in both the world of basic research and delivering clinical care. The new hospital would undoubtedly generate a larger patient base, expanding the ability for clinical and translational research at UCHC, two areas which will continue to grow in the years to come.

It is clear that the construction of a new hospital would be a powerful step toward transforming UCHC into one of the nation's elite university medical centers. It would bring a sense of financial stability to the clinical care operation and help reduce the stigma of UCHC as an underperforming, debt-ridden medical center. It would retain the health center's best faculty talent, while providing an opportunity to recruit new, outstanding faculty with the resources needed in order to let them thrive, possibly the most important characteristic of a world-class program. It would expand the research arm of the health center, and allow for increased basic science, clinical, and translational research to occur on campus. These factors would attract the state's top prospective medical students, instilling in them the belief that they will receive an educational experience at UCHC that few other universities can match, most notably at such an affordable price. All this would distinguish UCHC as standard-bearer in medical education, its hospital as a top destination to receive medical care, and its design as one that other universities and medical schools would seek to emulate.

The feasibility of such a plan, costing upwards or in excess of \$500 million, is unlikely in the current economic circumstances. Nevertheless, it provides the most comprehensive reform to

achieve the goal that Dr. Massey envisioned decades back. Perhaps in better economic times such a plan will come to fruition and the UCHC will assert itself as a leading setting for students to receive a medical education.

Conclusion

The School of Medicine, School of Dental Medicine, School of Graduate Biomedical Sciences and the UConn Health Center have grown tremendously in the 64 years since the Board of Trustees first met to discuss the possibility of a medical education curriculum at the University. In its short history, the School of Medicine has grown to attract considerable quality talent from in the state and around the nation and to provide superb preparation for students pursuing graduate medical education. The curriculum is robust and dynamic, allowing it to reflect the needs of a changing global healthcare landscape. Students are taught to become not only exceptional clinicians, but also exceptional communicators and humanists, and the curriculum captures the essence of learning both the science and art of medicine. Research has expanded tremendously, and the faculty continues to discover new medicine. This has provided expanded enrichment to an already special student experience.

That said, the current situation, one in which the future course of action is uncertain, is unsustainable for UCHC as an educational institution. In a hospital that is too small to attract a diverse range and complexity of clinical cases, medical students will not be able to learn in a premiere clinical environment. Without financial stability, the nation's best clinical educators will not join the faculty and those present will seek other opportunities. Facing increasing pressure from managed care organizations, clinicians will naturally respond by sacrificing medical student clinical education for graduate medical education in the name of clinical efficiency and profitability. With this recipe, UCHC cannot achieve the excellence that Dr.

Massey, and so many others after him, sought; it cannot even achieve a sustained mediocrity. Long term, perhaps even short term, without sufficient resources, the quality of the clinical faculty will diminish, as will clinical education. In such a scenario, ultimately, talented students will no longer consider the UConn Health Center as a top destination for medical or dental education and the health center's age-old mission will be crippled.

Today, we – UCHC employees, state policy makers, exceptionally talented students, and ultimately all Connecticut citizens – stand at a crossroads. We can watch the degree of medical education wane in the years to come because it is aligned with a hospital that is too small and inadequately funded to succeed. We can watch as key, high quality faculty leave the UCHC for other, more stable opportunities and new faculty recruitment becomes increasingly difficult. We can watch as outstanding Connecticut students seek other institutions for their medical education. We can watch as the school's academic triumphs are slowly eroded in the years to come. Or we can drive change, a change that would propel UCHC and the UConn School of Medicine to becoming the nation's elite. To do so the bed capacity to make the health center both financially secure and viable must be available. This fact is seminal and cannot be ignored. If accomplished soon, we can attract that nation's top medical and clinical talent to teach the State's most eager and able minds. We can enrich the medical student experience in a way with which few others can compare. We can build a highly integrated faculty capable of marketing itself to other talented educators. We can legitimately advertize the UConn Health Center as an elite destination to receive clinical care and receive a medical education. After all, this is our hospital, our health center, our university. Why would a legislative or executive branch want to be party to anything but the very best for its citizens?

Special Thanks

I would like to extend a special thanks to Dr. Peter Deckers, who has served as my mentor and thesis advisor throughout the entire process of the research and writing of this thesis. Dr. Deckers has been instrumental in helping me establish a firm understanding of the past and current issues facing the UConn Health Center. He has been always willing to help me seek the knowledge I need to answer the questions I wish to explore in this thesis. His expertise in this matter has served as an invaluable resource. Thank you for your constant willingness to push me to discover the truth, coach me in the art of developing sound arguments, and provide me with a profound educational experience.

As previously mentioned, I had the unique opportunity of working with senior administration members in a 10-week Summer Research Fellowship Program in Summer 2009. Much of the information gathered in the thesis was derived from the interactions I engaged in during these months. I would like to thank the following individuals for their willingness to speak to me in an open manner and educate me on the workings of medical and dental administration:

Peter Albertsen, M.D.
John M. Biancamano
Anthony Borda
David Gillon
Bruce Koeppen, M.D., Ph.D.
Kevin Larsen
Cato T. Laurencin, M.D., Ph.D.
Ellen Leone, R.N., M.S.N.
Joanne Lombardo
R. Lamont “Monty” MacNeil, D.D.S., M.Dent.Sc.
Richard Simon, M.D.
Mike H. Summerer, M.D., F.A.C.P.E.
Marie A. Whalen, MBA

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