Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant:	**Stonington Behavioral Health, Inc. d/b/a Stonington Institute**
Docket Number:	**04-30361-CON**
Project Title:	**Establish and Operate a Hospital for Mentally Persons in Ledyard**
Statutory Reference:	**Sections 19a-638 and 19a-639 of the Connecticut General Statutes**
Filing Date:	**November 30, 2005**
Hearing Date:	**January 5, 2006**
Presiding Officer:	**Cristine A. Vogel, Commissioner**
Decision Date:	**March 10, 2006**
Default Date:	**March 15, 2006 (including 15-day review period extension)**
Staff Assigned:	**Laurie K. Greci and Annie Jacob**

Project Description: Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Stonington" or "Applicant") proposes to establish and operate a Hospital for Mentally Ill Persons in Ledyard, at a total capital expenditure of $3,131,388.

Nature of Proceedings: On November 30, 2005, the Office of Health Care Access ("OHCA") received the proposal of Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Stonington" or "Applicant") to establish and operate a Hospital for Mentally Ill Persons in Ledyard, at a total capital expenditure of $3,131,388. The Applicant is a health care facility or institution as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

On September 24, 2004, a notice to the public regarding OHCA's receipt of the Applicant's Letter of Intent to file its CON application was published in *The Day* (New London) pursuant to Sections 19a-638 and 19a-639, C.G.S. OHCA received several responses from the public requesting that a hearing be held on Stonington's CON application.

Pursuant to Sections 19a-638 and 19a-639, C.G.S., a public hearing regarding the CON application was held on January 5, 2006. On December 6, 2005, the Applicant was notified of the date, time and place of the hearing. On December 9, 2005, a notice to the public was published in *The Day* (New London). Commissioner Cristine A. Vogel served as Presiding Officer for this case. The public hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

By petition dated December 30, 2005, Natchaug Hospital requested Party status or, in the alternative, Intervenor status with full rights of cross-examination regarding Stonington's CON application. The Presiding Officer denied the request of Natchaug Hospital for Party status and granted Intervenor status with full rights of cross-examination.

By petition dated December 30, 2005, Hartford Hospital and Rushford Center, Inc., collectively, requested and was granted Intervenor status with full rights of cross-examination by the Presiding Officer regarding Stonington's CON application.

By petitions dated December 29, 2005, Waterford Country School, Inc. and United Services, Inc. each requested Intervenor status regarding Stonington's CON application. The Presiding Officer granted the requests of Waterford Country School, Inc. and United Services, Inc. and designated each as an Intervenor with limited rights of participation.

By petitions dated December 30, 2005, the State of Connecticut's Department of Children and Families and the Office of the Child Advocate, the Connecticut Association of Nonprofits, Windham Hospital, and Lawrence & Memorial Hospital each requested Intervenor Status regarding Stonington's CON application. The Presiding Officer granted the requests and designated each as an Intervenor with limited rights of participation.

The Presiding Officer heard testimony from the Applicant's and the Intervenors' witnesses, in rendering this decision, considered the entire record of the proceeding. OHCA's authority to review and approve, modify or deny the CON application is established by Sections 19a-638 and 19a-639, C.G.S. The provisions of these sections, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need
Impact of the Proposal on the Applicant's Current Utilization Statistics
Proposal's Contribution to the Quality and Accessibility of Health Care Delivery in the Region

1. Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Stonington" or "Applicant") is a for-profit corporation licensed by the State of Connecticut Department of Public Health, the Department of Children and Families, and the Department of Education to operate the following:
   - A 45-bed Child Care Facility to provide Residential Treatment Center ("RTC") Services located on its North Stonington campus at 75 Swantown Hill Road, North Stonington, CT;
   - A Hospital for Mentally Ill Persons that provides a 4-bed adolescent psychiatric subacute unit for females on its North Stonington campus;
   - A 63-bed Facility for the Care or Treatment of Substance Abusive or Dependent Persons and a Mental Health Day Treatment Facility on the North Stonington campus;
   - An outpatient Facility for the Care or Treatment of Substance Abusive or Dependent Persons and a Mental Health Day Treatment Facility located at 333 Long Hill Road, Groton, CT;
   - An outpatient Facility for the Care or Treatment of Substance Abusive or Dependent Persons and a Mental Health Day Treatment Facility located at 428 Long Hill Road in Groton, CT;
   - An outpatient Facility for the Care or Treatment of Substance Abusive or Dependent Persons located at 83 Boston Post Road in Waterford, CT; and
   - An outpatient Facility for the Care or Treatment of Substance Abusive or Dependent Persons and a Mental Health Day Treatment Facility located at 86 Boston Post Road, Waterford.

   (January 19, 2005, Initial CON Submission, page 4 and Exhibit 8)

2. Stonington also operates a private special education school, the Stonington Institute School, for students in grades 9-12 at 428 Long Hill Road in Groton. The school is accredited by the Connecticut State Department of Education. *(January 19, 2005, Initial CON Submission, page 4)*

3. On September 13, 2005, under Docket 05-30362-CON, OHCA authorized Stonington to add a 10-bed Residential Treatment Center program for adolescents 12 to 18 who have a diagnosis of a significant developmental disability and a co-occurring substance abuse or psychiatric disability on the North Stonington campus. *(September 13, 2005, Final Decision for Docket 05-30362-CON)*

4. Stonington is accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and is a credentialed provider under the state Medical Assistance Program ("Medicaid") and the Department of Mental Health & Addiction Services General Assistance Behavioral Health Program. *(January 19, 2005, Initial CON Submission, page 4)*

5. The following towns are considered within the primary service area of Stonington Institute:

Bozrah	Groton	Montville	Preston
Colchester	Lebanon	New London	Salem
East Lyme	Ledyard	North Stonington	Sprague
Franklin	Lisbon	Norwich	Stonington
Griswold	Lyme	Old Lyme	Voluntown
			Waterford

(January 19, 2005, Initial CON Submission, page 40)

6. Stonington Behavioral Health, Inc. is a wholly owned subsidiary of Universal Health Services, Inc. ("UHS"), a corporation formed under Delaware law in 1979. UHS has its principal executive offices in King of Prussia, PA. *(January 19, 2005, Initial CON Submission, Attachment 3)*

7. Stonington proposes to augment its adolescent residential services by establishing a Hospital for Mentally Ill Persons ("HMIP") at 45 King's Highway in Ledyard. The Ledyard location was chosen because of its centrality within New London County and the location is within a local zoning district that allows for the operation of a hospital as a permitted use. *(August 20, 2004, Letter of Intent, page 2 and November 15, 2005, CON Completeness Response, page 15)*

8. The Applicant's proposal is for a 36-bed acute/subacute inpatient psychiatric facility for adolescents.[1] The initial ratio of beds is 4 acute beds and 32 subacute beds. The mix of beds will be based upon demand for services at any given point in time. The focus will be primarily on the subacute level of care. *(November 15, 2005, CON Completeness Response, pages 2, 3, and 12)*

9. The Applicant will provide diagnostic assessment services and treatment to acute disturbed adolescents, ages 12 to 18, who have emotional, behavioral, or combined medical/psychiatric problems and who can benefit from inpatient stabilization, assessment, and disposition services. *(November 15, 2005, CON Completeness Response, pages 3 and 5)*

10. Services will include individual, group and family therapy, parent counseling, and intensive aftercare planning services. *(November 15, 2005, CON Completeness Response, pages 3 and 6)*

[1] Unless specifically stated otherwise, children are those youth aged 11 years or younger; adolescents are those aged 12 to 17; and youth are those aged 17 and under.

11. Patients admitted to the facility will also have access to the services available within the Applicant's continuum of care, either during the admission or as a step-down level of care. *(November 15, 2005, CON Completeness Response, page 6)*

12. Patients and families will have access to the services of the Stonington Institute Transportation Department for transportation services for program-related activities. *(November 15, 2005, CON Completeness Response, page 14)*

13. Medical staffing will include 2.4 full time equivalents ("FTE") of board certified or board eligible child and adolescent psychiatrists to maintain a 1:18 psychiatrist to staff ratio and adequate on-call coverage. Additional on-call coverage will be contracted for as needed. Nursing staff includes 8.4 FTE of registered nurses with mental health experience. The total FTE count will be 63 FTEs, including Certified Nurses Aides, clinical staff and mental health workers. *(November 15, 2005, CON Completeness Response, pages 13 and 14)*

14. Stonington supported the need for its proposal by citing the report from the Governor's Blue Ribbon Commission from July 2000 ("Blue Ribbon Report"). The Blue Ribbon Report stated that national estimates[2] indicate that between 14 and 20 percent of all children and adolescents have some type of emotional or behavioral disturbance. The Blue Ribbon Report identified a clear lack of sufficient acute level services for youth in the State of Connecticut and stated that the lack of capacity leads to longer emergency and general hospital stays. *(January 19, 2005, Initial CON Submission, pages 22 and 23)*

15. The Applicant stated that, according to the United States Census Bureau[3] ("Census Bureau") and the State of Connecticut Department of Public Health ("DPH"), the estimated population of the State of Connecticut using Census 2000, as of July 1, 2003, was 3,483,309 persons; the estimated population of New London County was 264,007, with 64,418 being under the age of 18. *(January 19, 2005, Initial CON Submission, page 22)*

16. The population of Region 3[4] in 2000 was 26,552 children aged 0 to 4 and 65,863 aged 5 to 17 for a total of 92,415 of children and adolescents. *(United States Census Bureau, Census 2000)*

17. The Blue Ribbon Report applied the national estimates to the Connecticut population and stated that 87,500 to 125,000 children and adolescents have a diagnosable mental health condition. Excluding children under the age of five, the Applicant estimated that between 6,316 and 9,305 children and adolescents living in New London County

[2] Brandenburg, NA, Friedman, RM, Silver, SE. (1990). The epidemiology of childhood psychiatric disorders: prevalence findings from recent studies. Journal of the American Academy of Child and Adolescent Psychiatric, 29,1,76-83.
[3] Based on the United States Census 2000
[4] Pursuant to Section 17a-478, C.G.S, Connecticut has five designated mental health regions identified as Regions 1, 2, 3, 4, and 5. Eastern Connecticut is designated as Region 3 and includes the towns in the New London and Windham Counties, as well as several towns from Tolland County.

have a diagnosable mental health condition. *(January 19, 2005, Initial CON Submission, page 22)*

18. The Applicant stated that there are no dedicated inpatient beds for acute care for children or adolescents in New London County. *(January 19, 2005, Initial CON Submission, page 26)*

19. The Applicant stated that since its 4-bed subacute unit opened in January 2005 and through November 8, 2005, it has had 33 admissions to the unit. Sixty-eight adolescents who met the criteria for admission could not be admitted due to lack of an available bed. *(November 15, 2005, CON Completeness Response, page 9)*

20. The Applicant reported that the statewide average of youth accessing acute care inpatient psychiatric services from State FY 2000 to State FY 2004 was 2.7 discharges per 1,000 youth.[5] The rates by region of the state are reported in the following table:

Table 1: Utilization Rate per 1,000 Youth by Region of State

Region	Utilization Rate (Discharges per 1,000 Children)
1	1.5
2	3.9
3	1.9
4	3.3
5	2.3
Statewide	2.7

(November 15, 2005, CON Completeness Response, page 105)

21. The Applicant used the following methodology to calculate the number of beds needed to meet the need for child and adolescent inpatient psychiatric services:

$$\frac{\text{(Population x Utilization Rate x Average Length of Stay)}}{\text{(days/year x occupancy rate)}} = \text{Number of Beds}$$

Application of the above formula to New London County provided an estimate of the number of beds needed:

$$\frac{\text{(64,418}^{6}\text{ children and adolescents x 2.7/1000 x 84 days)}}{\text{(365 x 0.85)}} = 47 \text{ beds}$$

(November 15, 2005, CON Completeness Response, page 31)

[5] CT Acute Care Pediatric Inpatient Psychiatric Services Utilization (under age 18), OHCA Presentation, September 16, 2005.
[6] The number of children and adolescents in New London County as reported in Finding of Fact # 15.

22. Current providers in Connecticut of psychiatric acute care beds for adolescents are listed in the following table:

Table 2: Providers of Psychiatric Acute Care Beds for Adolescents

License	Provider Name	Number of Acute Care Beds Available for Adolescents	Town
HMIP*	Natchaug Hospital	15	Mansfield
HMIP	Riverview Hospital for Children	45**	Middletown
HMIP	Hall-Brooke Behavioral Health Services	26	Bridgeport
HMIP	Silver Hill Hospital	10	New Canaan
ACGH^	Hartford Hospital/Institute of Living	13	Hartford
ACGH	Saint Francis Hospital and Medical Center	8	Hartford
ACGH	Yale-New Haven Hospital	14	New Haven
ACGH	Hospital of Saint Raphael	10	New Haven
ACGH	Manchester Hospital	10	Manchester
ACGH	Waterbury Hospital	5	Waterbury
Maximum Number of Acute Care Beds:		**196**	

*Hospital for Mentally Ill Persons
^Acute Care General Hospital.
**Facility has a total of 85 beds that are shared with children 0 to 12 years of age

(January 3, 2006, Prefiled Testimony of Stephen Larcen, Ph.D., page 11)

23. Connecticut Community KidCare ("KidCare") is a statewide effort to reform the way behavioral health services for youth are coordinated, financed, and delivered to the youth and their families. KidCare is based on the principles that: youth with behavioral health needs should receive services in their community whenever possible; parents and families are an integral part of the planning and decision making process; and services need to be provided in a linguistically and culturally competent fashion. The following group of youth and families are eligible to receive KidCare services: youth and families insured under the HUSKY[7] program; all youth committed to the Department of Children and Families[8] ("DCF"), including Juvenile Justice Children; and youth and families who meet criteria for the DCF Voluntary Services program. *(November 15, 2005, CON Completeness Response, pages 184 and 185)*

[7] HUSKY (Healthcare for Uninsured Kids and Youth) is Connecticut's public health insurance program for children and teenagers under 19.

[8] The Department of Children and Families ("DCF") is the state agency that has statutory responsibility for the mental health services of children and adolescents.

24. KidCare has allowed for the funding of psychiatric residential treatment facilities ("PTRF"). PRTFs are inpatient psychiatric facilities that provide supervised 24 hour residential care to adolescents that no longer require treatment in a hospital setting. The PRTs are a true "step-down" from hospital care. *(January 3, 2006, Prefiled Testimony of Stephen Larcen, Ph.D. page 12)*

25. Karen Snyder, Chief of Operations for DCF, stated that Connecticut is in the process of initiating a major reform regarding child and adolescent behavioral health services. During the 2005 legislative session the Connecticut General Assembly passed Public Act 05-280 that establishes the Behavioral Health Partnership between DCF and the Department of Social Services ("DSS"). The two agencies will jointly direct an Administrative Services Organization ("ASO") that will manage and coordinate behavioral health services for youth. *(January 3, 2006, Prefiled Testimony, Karen Snyder, pages 1 and 2)*

26. Diane Manning, President and Chief Executive Officer of United Services, Inc. ("United Services") stated that United Services provided crisis evaluations at community sites for almost 400 children and adolescents in the past year. In the experience of United Services, fewer than twenty of the adolescents seen required acute psychiatric hospitalization due to a danger to themselves or others. *(January 3, 2006, Prefiled Testimony, Diane Manning, page 2)*

27. The following table reports the number of adolescents admitted to a Connecticut acute care hospital and the average length of stay for FYs 2002, 2003, 2004, and the first two quarters of FY 2005. Adolescents included in the table were assigned a mental health Diagnoses Related Group ("DRG") code from 424 to 432, inclusive, and 424 to 432, inclusive, or a substance abuse DRG code from 433 to 437, inclusive, and 521, 522, or 523. The overall average length of stay for the reported years was eleven days.

Table 3: Number Admitted and Average Length of Stay of Adolescents Ages 12 to 17 Admitted to an Acute Care Hospital

	New London County			State of CT		
Fiscal Year	Patient Days	Number of Discharges	Average Length of Stay, in days	Patient Days	Number of Discharges	Average Length of Stay, in days
2002	423	70	6.0	17,767	1,824	9.7
2003	841	79	10.6	21,367	1,918	11.1
2004	712	71	10.0	19,564	1,811	10.8
2005*	473	46	10.3	10,940	964	11.3

* Includes the first two quarters of FY 2005 only.

(OHCA Acute Care Discharge Database, FYs 2002, 2003, 2004 and 1st quarter of 2005)

28. The following table reports, by number and percentage of adolescents aged 12 to 17, the destination of adolescents upon discharge from an acute care hospital located within the State of Connecticut. Adolescents included in the table were assigned a mental health Diagnoses Related Group ("DRG") code between and including 424 and 432, or a substance abuse DRG code between and including 433 and 437, and 521, 522, or 523.

Table 4: Destination of Adolescents Discharged from an Acute Care Hospital

Number of Discharges In FY	Discharged to Home		Transferred to Another Facility		Other	
	Count	Percent (%)	Count	Percent (%)	Count	Percent (%)
2002	1,491	81.4	273	15.3	60	3.3
2003	1,640	85.5	253	13.2	25	1.3
2004	1,527	84.3	261	14.4	23	1.3
2005*	800	83.2	151	15.5	13	1.2

* Includes the first two quarters of FY 2005 only.

(OHCA Acute Care Discharge Database, FYs 2002, 2003, 2004 and 1st quarter of 2005)

29. Projected admissions for the proposal for FYs 2006 through 2008 are given in the following table:

Table 5: Projected Admissions by Service Level

Year	Acute Admissions	Subacute Admissions
2006	25	249
2007	25	292
2008	25	292

(November 15, 2005, CON Completeness Response, page 5 and November 29, 2005, Electronic Mail, page 1)

30. The expected average lengths of stay are 50 days for acute admissions and 34 days for subacute admissions. The total of 84 days represents the average length of stay for adolescents in the Applicant's existing four-bed subacute care program. The average of 50 days includes days spent in acute care programs prior to accessing the subacute services at Stonington. *(November 15, 2005, CON Completeness Response, page 7)*

31. William Aniskovich, Chief Operating Officer for Stonington, stated in his prefiled testimony that:
    - Stonington's four-bed subacute unit for adolescent girls opened in January 2005 and has been operating at ninety-nine percent capacity since March 2005;
    - As of mid-November 2005 Stonington turned away sixty-eight adolescent girls and forty-three adolescent boys in need of treatment.

- Stonington maintains a wait-list for its four-bed subacute unit. Those adolescents on the list are in need of subacute services and are not receiving the services in their current placements.
- Since opening, the four-bed unit has placed forty-nine adolescents on the wait-list. Adolescents who were admitted from, or remain on, the wait-list spent, on average, 26 days awaiting placement.

(December 29, 2005, Prefiled Testimony of William Aniskovich, page 3)

32. Stephen Larcen, Ph.D., Chief Executive Officer for Natchaug Hospital ("Natchaug'), testified at the hearing on behalf of Natchaug Hospital, Hartford Hospital, and Rushford Center, Inc. Dr. Larcen stated that in FY 2000, twenty-one of the children and adolescents, of the 278 that were admitted to the hospital, had stays over 50 days. These twenty-one youth used 64% of the occupied beds. In FY 2005, sixteen children and adolescents with stays over 50 days used only 19% of the occupied beds, and Natchaug was able to admit 539 children and adolescents. *(January 3, 2006, Prefiled Testimony, Stephen Larcen, Ph.D. page 17)*

33. Dr. Larcen stated that with Natchaug's single occupancy design that allows for admissions regardless of patient age or sex, allows for the most efficient utilization of the available beds. Lawrence & Memorial Hospital and William W. Backus Hospital are Natchaug's largest referral sources for children and adolescents. Natchaug also serves as a back-up facility to respond to the high levels of demand for inpatient admissions at Connecticut Children's Medical Center. *(January 3, 2006, Prefiled Testimony, Stephen Larcen, Ph.D. page 26)*

34. Dr. Larcen provided the following information concerning length of stay at three facilities in the most recent fiscal year:

Table 6: Length of Stay ("LOS") at Three Freestanding Acute Care Facilities

Facility	Number of Admissions	Number of Admissions with LOS > than 50 days	Percent (%) of Admissions with LOS > 50 days
Natchaug Hospital	425	11	2.6%
Institute of Living	297	17	5.7%
Hall-Brooke	403	26	6.4%

(January 3, 2006, Prefiled Testimony, Dr. Stephen Larcen, page 13)

35. Dr. Larcen stated that Natchaug is satisfying 83% of the demand for admissions from New London County, having admitted 129 adolescents of the 155 adolescents that were admitted to Natchaug, the Institute of Living, Hall-Brooke Behavioral Health Services, or other facilities to which the acute care hospitals in New London County made referrals. *(January 5, 2006, Hearing Testimony, Dr. Stephen Larcen)*

36. Dr. Larcen stated that Natchaug's length of stay averages 11.3 days, the length of stay actually experienced by adolescents from Eastern Connecticut, and is consistent with the average 9 day length of stay for acute care hospitals and 12 days for freestanding

hospitals without the inclusion of Stonington's patient days. Five percent (5%) of the adolescents hospitalized stayed 50 days or more, indicating that these youth required a different level, or type of, care. *(January 5, 2006, Hearing Testimony, Dr. Stephen Larcen)*

37. Mark Schaefer, Ph.D., the Director Medical Policy for the State of Connecticut, Department of Social Services, provided information that summarized the characteristics of the reinsurance population from March 2005 was provided. The reinsurance information reported by Dr. Schaefer included only HUSKY youth under age 19 years of age who stayed for more than 15 days. Thirty-two percent (32%) of the HUSKY children and adolescents with a discharge status were awaiting home or residential placement. Proposed discharge status for "home" may include birth or adoptive home, regular foster care, group home, a professional parent home, or therapeutic foster care. *(January 3, 2006, Prefiled Testimony, Dr. Stephen Larcen, pages 38A and 38D)*

38. Rushford Center, Inc. ("Rushford") provides services for children and adolescents in Regions 2, 3, and 4. Rushford provides emergency mobile psychiatric services, extended day treatment, therapeutic shelter, partial hospital, intensive outpatient, and residential treatment services. Community Health Resources, Inc. ("CHR") provides emergency mobile psychiatric services, care coordination, small group homes, therapeutic shelter, outpatient care, treatment foster care, family support teams, intensive family reunification, intensive in-home services, enhanced care coordination, and comprehensive global assessment for large portions of Regions 3 and 4. Rushford and CHR are lead providers of services for DCF. *(January 3, 2006, Prefiled Testimony, Jeffrey Walter, President of Rushford, and Heather Gates, President of CHR, pages 57 and 59)*

39. Mr. Walter and Ms. Gates stated in their prefiled testimony that during the past several years KidCare has focused its efforts on the implementation of treatment services designed to help youth remain in the community and to stay with the family. The CTBHP was "created to marshal the state's financial resources toward the KidCare approach to providing the most effective system of behavioral health care possible for children and families." Its goals include the reduction in the unnecessary use of institutional and residential services for children and adolescents. The CTBHP is mandated to "provide on-site assistance to Connecticut hospitals in the expeditious placement of hospitalized children in appropriate care in the community." *(January 3, 2006, Prefiled Testimony, Jeffrey Walter, President of Rushford and Heather Gates, President of CHR, pages 57 and 59)*

40. J. Kevin Kinsella, Vice President of Hartford Hospital, stated that at the Institute of Living, on any day, "four or five of the 23 beds are occupied by youth who are waiting for community placement. These waits can be anywhere from 30 days to one year. These children have finished their acute care and sit waiting for a DCF placement." *(January 3, 2006, Prefiled Testimony, J. Kevin Kinsella, page 68)*

41. Mr. Kinsella testified at the hearing that there is overcrowding in hospital emergency departments ("ED"). Hartford Hospital and The Institute of Living provide psychiatric

services to the CCMC ED. Youth that come to the CCMC ED fall into three categories: one-third goes home or back to the community after a brief evaluation; a second third could be stabilized within one to three days and then returned to another setting; and the last third need inpatient psychiatric hospitalization. The IOL operates 23 beds for children and adolescents. There are two youth in the IOL that have been there over 100 days. If they could have been moved after a ten-to- fifteen day stay that would have allowed for fourteen additional admissions. Additional community facilities are needed to accept children and adolescents who no longer need to be in an inpatient unit. *(January 5, 2006, J. Kevin Kinsella, Hearing Testimony)*

42. Karen Snyder testified that the DCF has engaged in a policy direction that is comprehensive and intended to provide a quality set of services for the youth and families in Connecticut. There are fifty-one group homes scheduled to open; eleven have opened; two are behind schedule. The others are at different stages of planned development. By June 2007, there will be two hundred places for children and adolescents to reside. There are four group homes scheduled for the Eastern District. Keeping more youth in their communities and their homes, these youngsters require shorter stays in hospitals. Through these initiatives the number of youngsters waiting for admission to the state-run hospital and the amount of time they wait has been reduced. In the context of the development of the care system, the exit plan of the Juan F. Consent Decree required reduction in the utilization of the residential care[9]; DCF is very close to achieving the outcome. *(January 5, 2006, Karen Snyder, Hearing Testimony)*

43. DCF reported that there are 294 youth placed in residential treatment facilities located out-of-state; 110 of those children or adolescents would be suitable to receive treatment in Connecticut if a placement were available. *(January 30, 2006, Response to Completeness Questions concerning DCF Late Files, pages 3 and 4)*

44. Karen Snyder stated that "the addition of inpatient subacute beds is not anticipated to have any significant impact on expediting placement into residential treatment centers nor would [DCF] anticipate that such an addition would expedite the return of children currently placed in out-of-state residentials back to Connecticut." *(January 30, 2006, Response to Completeness Questions concerning DCF Late Files, Transmittal Letter, page 2)*

[9] The Exit Plan for the Juan F. Consent Decree requires that the number of DCF children placed in privately operated residential treatment care not exceed 11% of the total number of children in DCF out-of-home care. State operated facilities, stand alone group homes, Safe Homes, and juvenile justice 24 hour facilities are not included in the measure.

Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Financial Feasibility of the Proposal and its Impact on the Applicant's Rates and Financial Condition
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

45. Stonington's proposed total capital expenditure of $3,131,388 consists of the following capital cost components for the construction and renovation costs:

Table 8: Proposed Total Capital Expenditure for Renovation/Construction

Description	New Construction	Renovation	Total Cost
Total Building Work Costs	$ 0	$2,145,485	$2,145,485
Total Site Work Costs	380,839	0	380,839
Total Architectural and Engineering Costs	0	150,000	150,000
Other: Furniture/IS	0	455,064	455,064
Total Construction / Renovation Cost	**$380,839**	**$2,750,549**	**$3,131,388**

(November 15, 2005 CON Completeness Response, page17)

46. Stonington's projected incremental revenue from operations, total operating expense and gain from operations associated with the CON proposal are as follows:

Table 9: Stonington's Incremental Financial Projections for FY 2006, FY 2007, and FY 2008

Description	FY 2006	FY 2007	FY 2008
Revenue from Operations	$5,482,414	$6,273,503	$6,318,477
Total Operating Expense	$5,633,641	$6,193,825	$6,233,183
Gains from Operations	**($151,227)**	**$79,678**	**$85,294**

(November 15, 2005 CON Completeness Response, page 292)

47. Stonington's incremental revenue from operations are based on a projection of 23.227 sub-acute clients per day at a rate of $550 per day and a projection of 3.4 acute clients per day at a rate of $700 per day in FY 2006. The projection for the subsequent years such as FY 2007 and FY 2008 were 27.2 sub-acute clients per day and 3.4 acute clients per day at the same rate projected for FY 2006. *(November 15, 2005, Completeness Response, page 292, Exhibit 24)*

48. The proposal's capital expenditure will be funded by the Applicant's equity operating funds. *(January 19, 2005, CON Application, page 9)*

49. Stonington's projected payer mix during the first three years of operation is as follows:

Table 10: Three-Year Projected Payer Mix with the CON Proposal

Payer Mix	**FY 2006**	**FY 2007**	**FY 2008**
Education	0%	0%	0%
Medicaid	76%	76%	76%
Contract Revenues	0%	0%	0%
Total Government	**76%**	**76%**	**76%**
Commercial Insurers	22%	22%	22%
Self Pay	2%	2%	2%
Workers Compensation	0%	0%	0%
Total Non-Government	**23.5%**	**23.5%**	**23.5%**
Uncompensated	**0.5%**	**0.5%**	**0.5%**
Total Payer Mix	**100%**	**100%**	**100%**

(November 15, 2005, CON Completeness Response, page 291)

50. There is no State Health Plan in existence at this time. *(January 19, 2005, Initial CON Submission, page 4)*

51. The Applicant has adduced evidence that this proposal is consistent with their long-range plans. *(January 19, 2005, Initial CON Submission, page 5 and Exhibit 1)*

52. The Applicant's proposal will not result in a change to any teaching or research responsibilities. *(January 19, 2005, Initial CON Submission, page 9)*

53. There are no distinguishing characteristics of the client/physician mix of the Applicant. *(January 19, 2005, Initial CON Submission, page 9)*

54. The Applicant has the technical, financial and managerial competence to provide efficient and adequate service to the public. *(January 19, 2005, Initial CON Submission, Exhibit 7)*

55. The Applicant's rates are sufficient to cover its capital and operating costs. *(November 15, 2005, CON Completeness Response, page 9)*

56. The Applicant has improved productivity and contained costs through group purchasing and the application of technology. *(January 19, 2005, Initial CON Submission, page 8)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Stonington Behavioral Health, Inc., d/b/a Stonington Institute ("Stonington" or "Applicant") proposes to establish a Hospital for Mentally Ill Persons in Ledyard ("Hospital"). The program is specifically for the treatment of adolescents. Stonington proposes to renovate an existing building located at 45 King's Highway in Ledyard to accommodate the proposed program. The estimated total capital expenditure to renovate the building and purchase equipment is $3,131,388.

The Applicant based the need for the proposed Hospital on information obtained from a report released six years ago, the Governor's Blue Ribbon Commission Report of July 2000 ("Blue Ribbon Report"). In the several years since the issuance of the Blue Ribbon Report the State of Connecticut Department of Children and Families has initiated its Connecticut Community KidCare program ("KidCare"). Under Public Act 05-280 Connecticut Behavioral Health Partnership ("CTBHP") will manage the patients subject to DCF authorization for care, including services provided by acute-care hospitals, freestanding hospitals, residential treatment centers, and group homes. It is expected that management of behavioral health services by CTBHP will help move children and adolescents through a continuum of care in a timely manner, freeing up beds for more timely movement from one service level to another.

The capacity of an inpatient service provider is dependent on the expected length of stay, in days, of patients. Stonington reported that the expected length of stay for the acute level is 50 days and for the subacute level it is 34 days. Stonington based the length of stay on its existing four-bed subacute adolescent unit. Natchaug also provided information that the average length of stay for the acute level of care provided by freestanding service providers, not including Stonington, in Connecticut; the length of stay was reported to be twelve days. OHCA is unable to verify the data submitted by either Stonington or the Intervenors. OHCA determined from the Acute Care Discharge Database that the average length of stay for adolescents that received behavioral health treatment in acute care hospitals in the state of Connecticut during the past few years was eleven days. Applying the average length of stay of eleven days, as verified by OHCA when compared to the average length of stay reported by the Applicant, to the overall population of children and adolescents in Region 3 the estimated bed capacity is five beds[1] at the acute care level. Natchaug currently operates 15 acute care beds. Although there are no acute care beds in

[1] (92,415 * (2.7/1000) * 11 days divided by (365 * .85) = 5 beds

New London County specifically, there appears to be an adequate number of acute care beds within Region 3. Stonington has not demonstrated the need for the acute level of service.

Stonington currently operates a four-bed subacute care unit for adolescent girls. OHCA does not consider the length of stay information for that unit to be adequate evidence of the need for a facility that is proposed to contain eight times the number of beds. The Applicant provided no evidence that would support the number of subacute beds needed in Connecticut or in the Applicant's proposed service area. OHCA has concluded that Stonington has not demonstrated the need for the subacute level of care.

Hartford Hospital and The Institute of Living provided testimony that youth who cannot be placed in the next appropriate level of care cannot be discharged. DSS also reported that many children and adolescents do not require continued hospitalization, but remain in hospitals longer than necessary because there is no group home or residential placement available. The beds occupied by these patients then are not available to the next children or adolescents who need them. OHCA determined from the Acute Care Discharge Database that statewide over 80% of adolescents are discharged to home, or conversely, less than 20% of the adolescents that required acute care were discharged to another level of care. Through KidCare and the CTBHP, DCF is in the process of establishing group homes in the state. In addition, psychiatric residential treatment facilities are being offered in the state to add another level of care for children and adolescents. There was no supporting documentation in Stonington's application that would allow for the determination of the numbers, or percentages of, children and adolescents that need the various levels of care, but it is important to provide them with a continuum of care. The Applicant, as well as the Intervenors, failed to provide documentation as to the appropriate level of care for youth in the current system. OHCA does recognize that the expansion of community-based services will increase the accessibility of services for children and adolescents.

OHCA is concerned that the proposal is financially dependent on a single payer. Stonington estimates that 76% of its payer mix will be through Medicaid. The financial success of the proposal will depend on DCF authorizing placement of adolescents into the new facility. However, the Exit Plan for the Juan F. Consent Decree requires that DCF lower the number of adolescents that it places into facilities such as the one Stonington is proposing to establish. DCF is in the process of establishing group homes in the state in order to place children and adolescents into the community. As shown by the information provided by DCF as part of the testimony, the children and adolescents placed out-of-state are receiving services at the residential treatment facility level of care, a lower level of care than acute or subacute hospitalization. These youth will not be brought back to Connecticut to receive care in an acute care setting, but rather when a program at the same level or care, or lower, has the space and services available to treat them. Therefore, OHCA cannot determine the financial feasibility of Stonington's proposal.

Based on the foregoing Findings and Rationale, the Certificate of Need application of Stonington Behavioral Health d/b/a Stonington Institute to establish a Hospital for Mentally Ill Persons in Ledyard is hereby DENIED.

Order

The proposal of Stonington Behavioral Health, Inc. d/b/a Stonington Institute to establish and operate a Hospital for Mentally Ill Person at 45 King's Highway in Ledyard, Connecticut, at an associated capital expenditure of $3,131,388 is hereby DENIED.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Office of Health Care Access

Date Signed:
March 10, 2006

Signed by:
Cristine A. Vogel
Commissioner

CAV:lkg