STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 15, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to General Statutes § 19a-638, as amended by Public Act 10-179, by:	Notice of Final Decision Office of Health Care Access Docket Number: 10-31643-CON
John Dempsey Hospital & Connecticut Children's Medical Center	**Establishment of 10 Additional Licensed Beds at John Dempsey Hospital and 40 Additional Licensed Beds for Connecticut Children's Medical Center as a Result of John Dempsey Hospital Transferring Operational Control of its 40-bed Neonatal Intensive Care Unit (NICU) to Connecticut Children's Medical Center**

To:

Cato T. Laurencin, M.D., Ph.D
Dean of University of Connecticut
School of Medicine
John Dempsey Hospital
263 Farmington Avenue
Farmington, CT 06030

Martin J. Gavin
President & Chief Executive Officer
Connecticut Children's Medical Center
282 Washington Street
Hartford, CT 06106

Dear Dr. Laurencin and Mr. Gavin:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter. On December 15, 2010, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

KRM: agf
Enclosure

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **John Dempsey Hospital &**
Connecticut Children's Medical Center

Docket Number: **10-31643-CON**

Project Title: **Establishment of 10 Additional Licensed Beds at John Dempsey Hospital and 40 Additional Licensed Beds for Connecticut Children's Medical Center as a Result of John Dempsey Hospital Transferring Operational Control of its 40-bed Neonatal Intensive Care Unit (NICU) to Connecticut Children's Medical Center**

Project Description: John Dempsey Hospital of the University of Connecticut Health Center ("JDH") & Connecticut Children's Medical Center ("CCMC") (together, "Applicants") are proposing to establish 10 additional licensed beds at JDH and 40 additional licensed beds for CCMC as a result of JDH transferring operational control of its 40-bed Neonatal Intensive Care Unit ("NICU") to CCMC. The project's total associated capital expenditure is $350,000.

Procedural History: In May 2010, the Connecticut General Assembly amended General Statutes § 10-109b (b) in passing Public Act 10-104 ("the Act"), creating the University of Connecticut Health Network. The Act provides, in relevant part, for the construction of a new bed tower at JDH, the renovation of academic, clinical and research space at the University of Connecticut Health Center, the increase in adult medical surgical beds at JDH and transfer of operational control of the NICU to CCMC.

Consistent with P.A. 10-104, on November 5, 2010, the Office of Health Care Access ("OHCA") received the Applicants' Certificate of Need ("CON") application. On October 14, 15, and 16, 2010, public notice of the Applicants' intent to file their application was published in *The Hartford Courant.* On November 12, 2010, OHCA deemed the application complete. A notice to the public was posted on OHCA's website on November 12, 2010, and was sent to the Secretary of State on November 19, 2010. The Applicants are health care facilities or institutions as defined by General Statutes § 19a-630, as amended by Public Act 10-179.

A public hearing regarding the CON application was held on November 30, 2010. On November 10, 2010, the Applicants were provided notice of the hearing. On November 13, 2010, notice was published in *The Hartford Courant.* Deputy Commissioner Norma D. Gyle served as Presiding

Officer. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act, General Statutes § 4-166 et seq. and § 19a-639a, as amended by Public Act 10-179. The Presiding Officer considered the entire record in reaching this decision.

Findings of Fact

1. CCMC is a licensed children's hospital located at 282 Washington Street, Hartford, with satellites at Hartford Hospital and St. Mary's Hospital. Ex. E, p. 2019.

2. JDH is a licensed general hospital located at 263 Farmington Avenue, Farmington. Ex. E, p. 2020.

3. With the proposal, CCMC will operate a separate NICU within the JDH building ("Connecticut Children's Unit") and JDH will no longer provide neonatal intensive care services. Ex. E, p. 141.

4. With the proposal, CCMC's licensed bed capacity will increase from 147 to 187, and JDH's licensed bed capacity will increase from 224 to 234.

Table 1: Current and Proposed Beds

	Current		Proposed	
	JDH	**CCMC**	**JDH**	**CCMC**
Licensed	224 Total (40 NICU)	147 Total (32 NICU)	234 Total (0 NICU)	187 Total (72 NICU)
Staffed	224 Total (40 NICU)	142 Total (32 NICU)	234 Total (0 NICU)	182 Total (72 NICU)

Ex. E, p. 26.

5. The Applicants anticipate that changes to their licenses can be made by February 2011. Testimony of Theresa Hendricksen, Executive Vice President and Chief Operating Officer, CCMC, November 30, 2011.

6. The new bed tower[1] at JDH will house the additional medical/surgical beds associated with this proposal. Ex. E, p. 5.

7. The Applicants' primary and secondary service area towns ("PSA" and "SSA," respectively) are based on historical utilization patterns. The service area towns for the Connecticut Children's Unit will be the same service area towns served currently by CCMC. JDH will continue to serve its historical service area towns for adult medical/surgical services under the proposal. Ex. E, pp. 13, 35, and 136.

8. With the proposed transfer of NICU beds from JDH to CCMC, the number of NICU beds in Connecticut will not change but the size of CCMC's NICU will more than double, from 32 beds to 72 beds. Ex. E, p. 26.

[1] As of October 1, 2010, there is no longer a capital expenditure threshold that requires CON approval. Thus, the bed tower construction is not a part of this decision. General Statutes § 19a-638, as amended by Public Act 10-179.

9. Research shows that larger and higher-level NICUs are associated with lower mortality and length of stay compared to smaller and lower-level NICUs. Ex. E, pp. 1086-1117.

10. By hiring physicians as a larger, single unit with an enhanced reputation, CCMC's Neonatology Premier Program will avoid duplication in recruitment efforts and increase the breadth and depth of clinical expertise available on staff. CCMC will also act as a regionalized training center for physicians and other allied health professionals at community hospitals with smaller and less intensive neonatal programs. Ex. E, pp. 10, 12, 21, and 24.

11. Research programs at CCMC will benefit from a multi-site program with a larger volume of infants available for scientifically valid clinical studies and CCMC will be able to conduct neonatal clinical and translational research on a scale very few other NICUs in the country can match. Ex. E, p. 11.

12. The ability to balance volume between the two NICU sites will provide CCMC greater predictability of staffing requirements, as each individual unit will be less subject to severe peaks and valleys in patient census.

Table 2: NICU Occupancy Rate and Variability in Census

		Historical			YTD	Projected		
	NICU Site	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**
Occupancy rate	JDH	86%	93%	73%	68%	68%	68%	68%
	CCMC	88%	94%	88%	88%	88%	88%	88%
High daily census	JDH	47	46	42	35	35	33	33
	CCMC	34	35	36	36	32	32	32
Low daily census	JDH	24	24	18	14	18	20	20
	CCMC	21	21	18	14	18	20	20

Ex. E, p. 12; Ex. L, p. 1.

13. The four-year average of NICU inpatient days (FYs 2007 through 2010) is 10,443 for CCMC and 11,660 for JDH. Assuming a target of 85% occupancy for NICU beds, the combined 22,102 average of inpatient days for JDH and CCMC requires 71.24 NICU beds. Ex. E, pp. 36 and 38.

14. CCMC anticipates capturing an estimated 300 to 400 additional NICU patients due to its acquisition of extracorporeal membrane oxygenation ("ECMO") technology in fiscal year 2011. Previously, children in need of this service sought treatments in out-of-state hospitals. Ex. E, pp. 36.

15. Many factors influence demand for NICU beds, and the Applicants identified additional potential sources of both increased and decreased NICU demand over the next five years; because there is no predominance of either positive or negative trends, the Applicants chose to assume that demand will remain level, projecting 20,092 patient days in FYs 2011, 2012, and 2013. Ex. E, pp. 37-38. Ex. L, p. 1.

16. Based on the Applicants' analysis of current and projected demand, the 72 NICU beds that would be licensed to CCMC under the proposal are sufficient for the service area population for the next five years.

Table 3: Demand for NICU Beds

Demand	**Scenario**	**Beds**
Current demand	2007 to Present	71.24
Additional immediate demand	+ ECMO	1.1
Additional long term demand	+/- Other factors	Unknown
Projected demand through 2016	**Total**	**72.34**
Proposed CCMC-licensed NICU beds	Total proposed	72

Ex. E, p. 38.

17. JDH's physical plant is aging and has not undergone any substantial renovation since it began operation in 1975. There is inadequate capacity to accommodate new technologies and patient/provider expectations in a number of areas throughout the hospital including operating rooms, inpatient rooms, outpatient treatment areas, and support spaces. Ex. E, p. 3.

18. In 2007, the legislature directed the Connecticut Academy of Science and Engineering ("CASE") to conduct an analysis of JDH. The CASE Report concluded that both the size of JDH and the condition of its facilities limit JDH's ability to develop clinical and translational research programs, to properly support medical education, or to attract students, clinicians, faculty and researchers in fulfillment of the mission of the University of Connecticut School of Medicine ("SOM"). Ex. E, pp. 3-4.

19. JDH has limited capacity to accommodate a gradual increase in patient volume over the next few years. Testimony of Cato T. Laurencin, M.D., Vice President for Health Affairs at the University of Connecticut and Dean of the SOM, November 30, 2011.

20. Nearly half of JDH's licensed beds (105) are dedicated to specialty services such as NICU, psychiatry, maternity, and Department of Corrections. As a result, JDH does not have the ability to flex additional medical/surgical beds into service to address capacity issues, and medical students and residents have limited access to patients with the wide range of health conditions necessary for their training. By increasing JDH's complement of medical/surgical beds from 119 to 169 (40 converted NICU beds and 10 new licensed beds) this proposal will establish sufficient bed capacity to support the varied mix of patient care programs, subspecialties, clinical trials, and basic research required of a successful academic medical center. Ex. E, pp. 3 and 5; Testimony of Dr. Laurencin and Mike Harold Summerer, M.D., Hospital Director, JDH, November 30, 2011.

21. Given the number of semi-private beds at JDH, it becomes difficult to move patients when occupancy rises above 80-82% due to gender and infection control issues. Testimony of Dr. Summerer, November 30, 2011.

22. Utilizing the Hartford Region defined in the CASE Report, the area hospitals, their total staffed medical/surgical beds, and their share of area beds, are as follows:

Table 4: Greater Hartford Staffed Medical/Surgical Beds

	Staffed Adult Med/Surg Beds	Share of Total Beds
Hartford Hospital	376	31.5%
St. Francis Hospital and Medical Center	374	31.3%
The Hospital of Central Connecticut	222	18.6%
JDH	91*	7.6%
Bristol Hospital	78	6.5%
The Charlotte Hungerford Hospital	52	4.4%
CCMC	0	0.0%
Total	**1,193**	**100%**

* For consistency between hospitals, this table utilizes 2009 data from OHCA Report 400. Because the reporting methodology for Report 400 differs from JDH's internal methodology for determining occupancy of staffed beds, and because of a 2009 conversion of beds at JDH, 119 adult medical/surgical beds are reported elsewhere in this application. Ex. E, p. 35; Ex. K, pp. 2-3.

23. JDH's medical/surgical discharges calculated as a share of the total number of discharges for JDH's PSA and SSA is within one half of one percent of the Applicants' share of total beds calculation.

24. JDH expects to have the new bed tower with additional medical/surgical beds available by July 1, 2015. Following are historical and projected utilization measures showing the impact of this proposal.

Table 5: Medical/Surgical Utilization, JDH

	Historical			YTD	Projected		
	FY 2008	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2016**	**FY 2017**	**FY 2018**
Occupancy rate	72.4%	76.2%	69.6%	63.0%	62.8%	69.7%	78.7%
Admissions	6,569	6,806	6,830	551	8,071	8,952	10,120
Average daily census ("ADC")	78.2	82.3	80.8	75	106	118	133
Variability in census	49-101	62-107	44-114	62-97	75-130	80-145	95-160
Patient Days	28,627	30,041	29,507	2,325	38,741	42,970	48,576

Note: The FY 2010 drop in occupancy was due in part to an increase in available medical/surgical beds at JDH, from 108 to 119. Ex. K, p. 2.

25. The Applicants utilized two methodologies to conclude that an additional 50 medical/surgical beds (40 converted NICU beds and 10 new licensed beds) were needed at JDH. The first analysis focused on the sustainability of the SOM through recruitment of new faculty, while the second was based upon service area population. Ex. E, p. 26.

26. The SOM has developed a clinical faculty recruitment plan to fill current vacancies, build depth of service, expand research capability, and allow for a modest increase in class size over the next five years. It is anticipated that all hires will be completed by the end of academic year 2015, and that the full impact of these hires will be felt by FY 2018. The table below details this plan and its impact on bed need at JDH.

Table 6: SOM Clinical Faculty Recruitment Plan

	Incremental Clinical FTEs	Annual Admits/FTE	Incremental Admissions	Incremental Patient Days
Cardiovascular Signature Program	5.5	73.64	405	1,984.5
Musculoskeletal Signature Program	7	53.6	375	1,837.5
Cancer Care Signature Program	4	55	220	1,078
Primary Care/Medical Specialty	15	61	915	3,013.5
Surgical Specialty	9	68.3	615	3,013.5
New Physicians Building Practices*	--	--	420	2,058
Total	**40.5**	**--**	**2,950**	**14,455**
Increase in ADC (patient days/365)	**40**			
Incremental Bed Need at 80% Occupancy	**50**			

* Fourteen recently recruited faculty who are building practices at JDH and whose impact will be incremental to the 2010 baseline. The analysis assumes 30 incremental admissions per physician.
Note: Admits per FTE are based on actual experience at JDH. This analysis assumes that ALOS will remain constant at the current 4.9 days. Ex. E, pp. 26-27.

27. JDH's greatest service area population growth is occurring in the age bands with the heaviest utilization of medical/surgical inpatient services. The combination of high utilization rates for those aged 65+ and the projected increase in population for this same group indicate increased demand for adult medical/surgical beds in the JDH service area.

Table 7: Connecticut Adult Medical/Surgical Hospital Utilization & JDH Service Area Adult Population Growth

Age Group	2009, CT Discharges per 1,000 Population	% Pop Change 2009 to 2020
18 to 44	36.9	-11%
45 to 64	89.8	36%
65 to 84	261.1	28%
85+	520.1	50%
Total Population	**104.3**	**7%**

Ex. E, pp. 28-30.

28. The Applicants project that 42 to 50 additional medical/surgical beds will be needed by JDH between 2016 and 2020 using a population-based methodology summarized in the following table.

Table 8: JDH Medical/Surgical Bed Need

	2016	2017	2018	2020
Total service area discharges age 18+	103,772	105,309	106,879	110,125
ADC, service area	1,393	1,414	1,435	1,478
Bed need, 80% Occupancy	1,741	1,767	1,794	1,848
Service area Bed Shortage	(548)	(574)	(601)	(655)
JDH share of bed shortage	**42**	**44**	**46**	**50**

Notes: The Applicants calculated total service area discharges age 18+ using population and discharge data by age band. To arrive at ADC, the Applicants divided total discharges by 365 days and multiplied by ALOS of 4.9 days. The service area bed shortage was calculated by subtracting 1,193 (current actual staffed med/surg beds in the service area) from the projected bed need; JDH's share of the bed shortage was calculated assuming 7.6% market share for the area (see Table 4). Ex. E, pp. 31-35.

29. The Applicants have demonstrated that additional medical surgical beds are needed at JDH to meet the demand between 2015 and 2020.

30. The proposal involves a capital expenditure of $350,000 for purchase of a security system and renovation of the NICU; this will be funded through CCMC's operating funds. Ex. E, p. 47.

31. JDH will enter into a lease with CCMC for sufficient space, fixtures, and equipment in the JDH building for operation of the Connecticut Children's Unit. The Applicants have also drafted a Master Service Agreement that outlines the services that will be furnished by JDH to CCMC associated with operation of the unit. Ex. E, pp. 141, 148, and 164.

32. Clinical and ancillary staff associated with the NICU will remain JDH employees and will be leased to CCMC through a shared service agreement. They will remain state employees. Physicians associated with the JDH NICU will have the option of remaining state employees or becoming part of the CCMC practice plan. Regardless, physicians will have privileges at both hospitals. Ex. E, p. 141; Testimony of Ms. Hendricksen, Dr. Laurencin, and Paul Dworkin, M.D., Physician-in-Chief, JDH, November 30, 2011.

33. No changes in the patient population mix are assumed to result from this proposal other than the transfer of NICU patients.

Table 9: Patient Population Mix

	JDH		CCMC	
Payer Description	**Current FY 2010**	**Projected FYs 2016-18**	**Current FY 2010**	**Projected FY 2012-14**
Medicare *	40.3%	42.3%	0.0%	0.0%
Medicaid *	19.4%	18.0%	51.9%	51.5%
CHAMPUS & TriCare	0.9%	0.8%	0.6%	0.7%
Department of Corrections	3.5%	3.7%	0.0%	0.0%
Total Government	**64.1%**	**64.8%**	**52.5%**	**52.3%**
Commercial Insurers *	32.9%	32.0%	43.2%	43.7%
Uninsured	0.9%	0.9%	4.3%	4.0%
Workers Compensation	0.7%	0.8%	0.0%	0.0%
Other	1.4%	1.5%	0.0%	0.0%
Total Non-Government	**35.9%**	**35.2%**	**47.5%**	**47.7%**
TOTAL	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity. Ex. E, p. 48.

34. The proposal does not change the teaching and research responsibilities of either Applicant, but rather enhances each Applicant's ability to conduct these activities more effectively. Ex. E, p. 53.

35. CCMC projects an incremental gain from operations in each of the first three years of the proposal. This gain offsets a projected loss without the proposal and by FY 2013, CCMC projects an overall gain of more than $5.7 million.

Table 10: Projected Gains with Proposal: CCMC

	FY 2011	FY 2012	FY 2013
Revenue from Operations	$228,012	$242,989	$250,519
Total Operating Expense	$223,170	$237,182	$246,326
Gain/(Loss) from Operations	**$4,842**	**$5,807**	**4,194**
Non-Operating Revenue	$1,521	$1,521	$1,521
Revenue Over Expense	**$6,363**	**$7,328**	**$5,715**

Note: Amounts are in thousands. Ex. E, p. 2023.

36. JDH projects an incremental gain from operations in each of the first three years of the proposal. In FYs 2016 and 2017, this gain offsets JDH's projected loss without the proposal and by FY 2018, JDH projects an overall gain of more than $10 million.

Table 11: Projected Gains/(Losses) with Proposal: JDH

	FY 2016	FY 2017	FY 2018
Revenue from Operations	$344,709	$$380,129	$426,083
Total Operating Expense	$351,845	$380,188	$415,367
Gain/(Loss) from Operations	**($7,136)**	**(59)**	**$10,716**
Non-Operating Revenue	$63	$63	$63
Revenue Over/(Under) Expense	**($7,073)**	**$4**	**$10,779**

Note: Amounts are in thousands. Ex. E, p. 2022.

37. The proposal is consistent with JDH's long-range strategic plan to correct structural deficits and institutional inefficiencies at JDH in order to transform JDH and the SOM into a leading and nationally recognized academic, medical and research center. Ex. E, p. 53.

38. The proposal is consistent with CCMC's 2008-2012 strategic plan that includes priorities such as growth, financial strength, and clinical quality. Ex. E, p. 53.

39. The proposal is cost effective in that it creates a coherent and efficient way to increase the financial viability of each institution. Ex. E, p. 52.

DISCUSSION

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639 (a), as amended by Public Act 10-179, and the Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services,* 288 Conn. 790 (2008); *Swiller v. Commissioner of Public Health*, No. CV 95-0705601 (Sup. Court, J.D. Hartford/New Britain at Hartford, October 10, 1995); *Bridgeport Ambulance Serv. v. Connecticut Dept. of Health Serv.*, No. CV 88-0349673-S (Sup. Court, J.D. Hartford/New Britain at Hartford, July 6, 1989); *Steadman v. SEC*, 450 U.S. 91, 101 S.Ct. 999, *reh'g den.*, 451 U.S. 933 (1981); *Bender v. Clark*, 744 F.2d 1424 (10th Cir. 1984); *Sea Island Broadcasting Corp. v. FCC*, 627 F.2d 240, 243 (D.C. Cir. 1980).

JDH and CCMC seek approval for two interrelated projects. JDH proposes to increase its current licensed bed capacity by 10 beds and to repurpose 40 NICU beds transferred to CCMC as adult medical/surgical beds. CCMC proposes to operate a NICU within the JDH building and to increase its licensed bed capacity by the 40 NICU beds currently held by JDH at that location.

The proposed NICU transfer will not change the total number of NICU beds in Connecticut, but will substantially increase the size of CCMC's NICU to 72 beds. FF 8. This will have a positive impact on many aspects of clinical operations, patient care, research programs, and physician recruitment. Research shows that larger and higher-level NICUs are associated with lower mortality and length of stay compared to smaller and lower-level NICUs. FF 9. With a larger unit, CCMC will also be able to more effectively mitigate fluctuations in patient volume between the two units. FF 12. CCMC anticipates that the new, expanded NICU will improve sub-specialty recruiting and training opportunities for practitioners at community hospitals in Connecticut. FF 10. Finally, a larger patient population will allow CCMC to increase the number and scale of neonatal clinical and translational research projects. FF 11. The Applicants have demonstrated that the proposed NICU transfer will improve the quality of patient care for newborns throughout the state.

CCMC verified the need for 72 NICU beds in the area by using the combined four-year average of NICU inpatient days (FYs 2007 through 2010) for CCMC and JDH; assuming a target occupancy of 85%, the 22,102 average inpatient days require 71.24 NICU beds. FF 13. The Applicants presented evidence that NICU volume may increase due to CCMC's acquisition of ECMO technology, but also that the many positive and negative potential trends in NICU demand and utilization make projecting growth rate difficult. FF 14-15. As such, the Applicants assumed that besides the 300-400 additional patients due to ECMO, volumes at CCMC would remain stable in the near term and CCMC would need approximately 72.34 NICU beds. FF 16. CCMC's proposed 72 licensed NICU beds are sufficient to meet the needs of the service area population for the next five years.

The proposal will address both capacity and facility issues at JDH and the SOM. JDH's physical plant is outdated and unable to accommodate the clinical, research, and educational activities important to its mission. FF 17-18. Currently, JDH has limited capacity to accommodate increases in patient volume. FF 19. Nearly half of JDH's licensed beds (105 of 224) are dedicated to specialty services and therefore JDH cannot flex additional medical/surgical beds into service as needed. FF 20. This is exacerbated by the number of semi-private beds at JDH which limit the movement of patients due to gender and infection control issues. FF 21. This environment not only constrains patient care, it also impacts the experience of medical students and residents at the SOM. The Applicants have demonstrated a range of limitations associated with JDH's current size and bed distribution, and have shown that development of additional medical/surgical beds will improve access to high quality inpatient care for adult patients in the region.

The Applicants used two distinct methodologies to determine the need for an additional 50 medical/surgical beds (40 converted NICU beds and 10 new licensed beds) at JDH. First, to address JDH's need for expanded research capability and depth of service, the SOM plans to recruit more than 40 clinical FTEs in a range of specialties over the next five years. Together with the incremental impact of 14 recently recruited faculty who are in the process of building practices, the Applicants demonstrated that these new hires have the potential to generate 2,950 incremental admissions and 14,455 incremental patient days at JDH, resulting in demand for 50

additional medical/surgical beds by FY 2018. FF 26. Next, the Applicants based their projections on estimated adult population growth and current utilization patterns by age group in the Hartford region, estimating that the Hartford region will have an overall shortage of 655 medical/surgical beds by the year 2020. If JDH maintains its current share of these beds in the region (7.6%), it will need an additional 50 adult medical/surgical beds by 2020 in order to accommodate patient volume. FF 27-28. The Applicants' utilization projections for JDH appear to be reasonable. The evidence is sufficient to establish the need for additional medical/surgical inpatient beds at JDH within the next ten years, and that the proposed 10 new licensed beds, along with the 40 converted NICU beds, is sufficient to meet this need.

The proposal will incur capital expenditures totaling $350,000, which will be funded through CCMC's operating funds. FF 30. With the proposal, CCMC projects total patient days of 20,092 in FYs 2011 through 2013. FF 15. CCMC projects an incremental gain from operations in each of these years, which offsets a projected loss without the proposal. By FY 2013, CCMC projects an overall gain of more than $5.7 million. FF 35. Given the Applicants' conservative approach to projecting NICU demand, the financial projections and the visit volumes upon which they are based are reasonable and achievable. The Applicants have demonstrated that the additional volume resulting from the NICU transfer will provide for the financial stability of CCMC, and that this proposal is financially feasible.

JDH projects total medical/surgical admissions of 8,801 in FY 2016, 8,952 in FY 2017, and 10,120 in FY 2018. FF 24. In each of these years, JDH projects that the proposal will result in an incremental gain from operations. In FYs 2016 and 2017, this incremental gain offsets some of JDH's losses projected without the proposal. By FY 2018, the impact of the proposal is sufficient to result in an overall gain at JDH of more than $10 million. FF 36. Given the many factors presented by JDH such as the Hartford Region's projected population growth, Connecticut's age-banded utilization rates, and JDH's proposed recruitment efforts, the financial projections and the visit volumes upon which they are based are reasonable and achievable. The Applicants have demonstrated that this proposal is financially feasible and has the potential to ensure the continued viability of JDH and the SOM.

ORDER

Based upon the foregoing Findings and Discussion, the Certificate of Need application of JDH & CCMC for the establishment of 10 additional licensed beds for JDH and 40 additional licensed beds for CCMC as a result of JDH transferring operational control of its 40-bed NICU to CCMC, is hereby **APPROVED**, and as provided by Public Act 10-104, subject to the following conditions:

1. CCMC is authorized by OHCA to increase its licensed bed capacity, from 147 licensed beds to 187 licensed beds, an addition of 40 beds. These 40 beds can only be staffed and utilized at the Connecticut Children's Unit at JDH and cannot be staffed at any other facility unless CCMC files with OHCA appropriate documentation and receives OHCA approval.

2. JDH is authorized by OHCA to increase its licensed bed capacity, from 224 licensed beds to 234 licensed beds, an addition of 10 beds. These 10 beds can only be staffed and utilized at JDH and cannot be staffed at any other facility unless JDH files with OHCA appropriate documentation and receives OHCA approval.

3. CCMC shall report to OHCA, the date of the opening of the Connecticut Children's Unit at JDH, no later than 30 calendar days following said opening.

4. JDH shall report to OHCA, the date of the commencement of operations of JDH's additional medical/surgical beds, no later than 30 calendar days following said commencement. If the initial use of the beds is to be staggered, JDH shall report to OHCA each date upon which additional beds are brought online.

5. The Applicants shall meet with OHCA concerning activities associated with the increase in licensed beds by both CCMC and JDH. The first meeting shall occur in September, 2011; subsequent meetings shall occur annually thereafter; and the meetings shall continue until after two full years of operations of JDH's additional medical/surgical beds. Unless otherwise notified in writing by OHCA, the meetings will focus on progress implementing the proposal, physician recruitment, clinical and translational research activities, patient volumes, and clinical quality.

6. JDH shall submit a report on physician recruitment related to the proposal, 14 calendar days prior to each annual meeting. Such report shall include completion of the following table, and shall discuss any barriers to implementing the clinical faculty recruitment plan as presented in this proposal.

Clinical Faculty Recruitment Plan

	Incremental Clinical FTEs	**Annual Admits/FTE**	**Incremental Admissions**	**Incremental Patient Days**
Cardiovascular Signature Program				
Musculoskeletal Signature Program				
Cancer Care Signature Program				
Primary Care/Medical Specialty				
Surgical Specialty				
New Physicians Building Practices				
Total				
Increase in ADC (patient days/365)				
Incremental Bed Need at 80% Occupancy				

7. CCMC shall submit reports of data regarding NICU volume at its main campus in Hartford and at the Connecticut Children's Unit at JDH. The first report shall be due 30 calendar days after the end of the first six months of operation, with reports continuing every six months thereafter. Such reports shall include the aggregate number of NICU discharges and the number of NICU patient days for each location. Data submissions shall continue until OHCA releases a written statement which terminates the continued data submissions.

8. JDH shall submit reports of data regarding medical/surgical volume at JDH. The first report shall be due 30 calendar days after the end of the first six months of operation, with reports continuing every six months thereafter. Such reports shall include the aggregate number of medical/surgical discharges and the number of medical/surgical patient days. Data submissions shall continue until OHCA releases a written statement which terminates the continued data submissions.

Should JDH & CCMC fail to comply with any of the aforementioned conditions, OHCA reserves the right to take additional action as authorized by law. All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of

12.15.10
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner
Office of Health Care Access

NG:af