Office Of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	**Hartford Hospital and Connecticut Children's Medical Center**
Docket Number:	**07-30918-CON**
Project Title:	**Establish and Operate a Child and Adolescent Rapid Emergency Stabilization (CARES) Program for the Greater Hartford Area**
Statutory Reference:	**Section 19a-638 of the Connecticut General Statutes**
Filing Date:	**May 4, 2007**
Hearing Date:	**May 30, 2007**
Presiding Officer:	**Cristine A. Vogel, Commissioner**
Decision Date:	**June 21, 2007**
Default Date:	**August 2, 2007**
Staff Assigned:	**Laurie K. Greci**

Project Description: Hartford Hospital and Connecticut Children's Medical Center ("Applicants") propose to establish and operate a Child and Adolescent Rapid Emergency Stabilization ("CARES") program for the Greater Hartford area at Hartford Hospital's Institute of Living campus, at a total capital expenditure of $700,000.

Nature of Proceedings: On May 4, 2007, the Office of Health Care Access received a completed Certificate of Need ("CON") application from the Applicants to establish and operate a Child and Adolescent Rapid Emergency Stabilization ("CARES") program for the Greater Hartford area at Hartford Hospital's Institute of Living campus, at a total capital expenditure of $700,000. The Applicants are health care facilities or institutions as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public regarding OHCA's receipt of the Applicants' Letter of Intent to file its CON Application was published on February 12, 2007, in the Hartford Courant. OHCA received no responses from the public concerning the Applicants' proposal.

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on May 30, 2007. On May 11, 2007, the Applicants were notified of the date, time, and place of the hearing. On May 15, 2007, a notice to the public announcing the hearing was published in The Hartford Courant. Commissioner Cristine A. Vogel served as Presiding Officer. The 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 May 16, 2007, the State of Connecticut Office of the Child Advocate requested Intervenor status regarding the Applicants' CON application. The Presiding Officer designated the Office of the Child Advocate as an Intervenor with limited rights of participation. Designated representatives from the State of Connecticut Department of Children and Families and the Department of Social Services also participated in the hearing.

OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-638, C.G.S. The provisions of this section 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 Hospital's Current Utilization Statistics
Proposal's Contribution to the Quality of Health Care Delivery in the Region
Proposal's Contribution to the Accessibility of Health Care Delivery in the Region

1. Hartford Hospital ("Hospital") is an acute care general hospital in Hartford, Connecticut. Its main campus is located at 80 Seymour Street and the campus for the Institute of Living ("IOL"), the Hospital's center for the treatment of behavioral, psychiatric, and addiction disorders, is located at 200 Retreat Avenue. The Hospital's total licensed bed capacity of 867 beds and bassinets includes 819 licensed beds and 48 licensed bassinets. At the IOL, 150 beds of the Hospital's 819 licensed beds are defined as psychiatric beds. *(February 2, 2007, Letter of Intent, page 11 and Attachment 1)*

2. Connecticut Children's Medical Center ("CCMC") is a children's hospital located at 282 Washington Street, Hartford. The CCMC has a licensed bed capacity of 135 beds. The CCMC is located adjacent to the main campus of the Hospital. *(February 2, 2007, Letter of Intent, page 11)*

3. The Hospital and CCMC ("Applicants") have an ongoing contractual relationship and collaboration regarding the provision of mental health services for children[1] who present for care in the CCMC's Emergency Department ("ED") and those that have been hospitalized for medical/surgical conditions at CCMC. *(April 12, 2007, Initial CON Submission, Attachment 5)*

4. The Applicants are proposing to establish a new behavioral health service program for children at the Hospital's IOL that will help to address the overcrowding in the CCMC's emergency department ("ED") where the number of children requiring mental health evaluations has increased from 566 in 2000 to 1,608 in 2006. The increase in the number of children requiring mental health evaluations has contributed to the number of children who spend one or more nights at the ED waiting for an inpatient bed or being held until community services can be arranged and accessed. *(April 12, 2007, Initial CON Submission, page 2)*

5. The new program, identified as the Children and Adolescent Rapid Emergency Services ("CARES") program, will be a collaborative effort between the Hospital and CCMC and has been designed to:
   a. Provide diversion from inpatient care to those that can be rapidly stabilized;
   b. Serve children and adolescents, ages 5 to 17, who are in psychiatric crisis;
   c. Triage children that present to the CCMC's ED with behavioral or psychiatric problems;
   d. Alleviate ED overcrowding;
   e. Accept referrals from schools, residential services, shelters, medical doctors and medical clinics;
   f. Be available to other hospital EDs;
   g. Provide psychiatric evaluations to children covered under Medicaid psychiatric evaluations as these children face particular difficulties accessing this level of care; and
   h. Address transportation and the culturally specific needs of the children and their families.

   (April 12, 2007, Initial CON Submission, pages 2, 3, and 4)

6. The CARES program staff will work collaboratively with representatives of the Connecticut Behavioral Health Partnership[2] ("CTBHP"), local systems of care, the State of Connecticut Department of Children and Families ("DCF") and Emergency Mobile Psychiatric Services[3] ("EMPS") teams to provide access to aftercare needs for patients discharged from the CARES unit. For some children, these community systems will provide a bridge until the family can access and connect to traditional outpatient care. *(May 4, 2007, Completeness Response, page 5)*

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[1] Includes children aged 5 to 17 years.

[2] The State of Connecticut Department of Social Services ("DSS") and DCF formed the CTBHP under a Request for Proposal issued in 2004 to plan and implement an integrated public behavioral health services system for children and families to provide access to community-based behavioral health services.

[3] Community EMPS teams provides emergency services, including mobile response, psychiatric assessment, medication consultation, assessment, and short-term medication management, and behavioral management services. EMPS teams deliver a range of crisis response and crisis stabilization services to children, youth, their families and caregivers including children residing in relative, adoptive, and foster care homes.

7. The IOL currently provides the following services:
   - The Child Guidance Clinic –outpatient psychiatric treatment to children, the majority of who meet DCF-involved criteria.
   - Extended Day Program –for children ages 11 to 14 operating through a DCF grant; has 12 slots, eight of which are reserved for DCF-involved children.
   - Partial Hospital and Intensive Outpatient Services – group-based programs that include family therapy and multi-family group services.
   - Inpatient Services – Short-term hospitalization with 14 beds for adolescents and 8 beds for children.

   (April 12, 2007, Initial CON Submission, pages 3 and 4)

8. The proposed primary service area includes the towns of Avon, Bloomfield, East Hartford, Farmington, Glastonbury, Hartford, Manchester, Bolton, New Britain Newington, Rocky Hill, Simsbury, South Windsor, West Hartford, Wethersfield, and Windsor. The secondary service area includes an additional forty-seven towns that are contiguous, or near, to a primary service area town. The Applicants established the services areas from data collected on all children who present to the CCMC's ED for mental health evaluations and dispositions. *(April 12, 2007, Initial CON Submission, pages 5 and 6)*

9. The Applicants propose to develop a six-bed unit that will be located in the Donnelly Building on the IOL campus that will be staffed twenty-four hours a day, seven days a week. The unit will be adjacent to the IOL Inpatient Child Psychiatric Unit. *(April 12, 2007, Initial CON Submission, pages 7 and 8)*

10. The six-bed unit for the CARES program was based on the average number of children held overnight at CCMC's ED in 2005 and adjusted for 2006 numbers. In addition, the number of children coming from other EDs was considered. *(May 4, 2007, Completeness Submission, page 3)*

11. The CARES program will be provided under the State of Connecticut Department of Public Health regulations (Section 19-13-D3) that requires:
    a. Psychiatric exam of patients be completed with seven days of admission;
    b. One registered nurse will be on duty at all times; and
    c. Licensed social work or psychologist and at least one additional staff person will be available at all times to assess and develop care plan interventions.

    (April 12, 2007, Initial CON Submission, page 11)

12. Each child that presents to the CCMC's ED for mental health problems will be triaged to determined if an acute level of care is needed, i.e. an inpatient psychiatric bed. If the child can obtain access to the psychiatric bed within six hours, the child will be held in the ED and will be directly transferred to an inpatient unit at the IOL or another hospital. Children, who upon triage and assessment in the CCMC's ED, are able to return home or go to a residential facility within six hours will also be discharged directly from the ED. *(April 12, 2007, Initial CON Submission, pages 25 and 26)*

13. Children placed in an appropriate program or returned to the home within the six-hour window will be transferred to the CARES program. CARES staff will provide an

intensive psychiatric assessment, stabilization, and intensive case management in order to link the child to community services. If it is determined that a child needs an inpatient level of care, the child will be transferred to an inpatient unit as soon as a bed is available. *(April 12, 2007, Initial CON Submission, page 26)*

14. In 2006, the discharge status for children that presented to the CCMC's ED for mental health evaluations is presented in the following table:

Table 1: Discharge Status for Children that Required a Mental Health Evaluation at the CCMC's ED in 2006

Discharge Status	Percent of Children
Inpatient Bed	41.4%
Partial Hospital Program or Intensive Outpatient Program	14.4%
Outpatient	36.2%
Shelter or Residential	2.6%
Home	0.9%
Other Providers	4.5%
Total	**100%**

(April 12. 2007, Initial CON Submission, page 26)

15. The Applicants reported the following utilization measures of the CCMC's ED:

Table 2: CCMC's ED Utilization for Calendar Years 2002 to 2006

	Calendar Year				
	2002	**2003**	**2004**	**2005***	**2006****
Presented to ED (number)	1,102	1,248	1,502	1,640	1,617
Stayed in ED Overnight (number)	470	555	649	747	-
Admitted as Inpatient	470	506	596	690	673
Mean Time from Presentation to Discharge (hours)	6.6	8.95	8.52	9.99	-

* Annualized; based on 8 months of data.
** Number admitted and the hours to discharge were not available.

(May 11, 2007, Supplemental Data Submission)

16. In March 2007, the CCMC reported that children with mental health issues filled 18 of the 23 beds in the ED. Many families who were seeking acute medical care for their sick children left without receiving such care. *(May 30, 2007, Jeanne Milstein, Office of the Child Advocate, Hearing Testimony)*

17. Backlogs for access to child psychiatrists in the proposed service area have contributed to a crisis in the availability of rapid response to a child's need for psychiatric stabilization. The current waiting time for an intake appointment in a Hartford-area clinic or private practice is between four months and six months. The Hospital's IOL Child and Adolescent Professional Practice is currently scheduling new intakes for four months in

advance. The waiting time for children needing residential care and are being held on inpatient units is over 90 days. The waiting time for children being held in an ED who need access to Riverview Hospital ("Riverview") for Children and Youth, the state's only public child psychiatric hospital, averages five days. *(May 4, 2007, Completeness Response, page 5)*

18. Brian Mattiello, former Acting Commissioner of the State of Connecticut's Department of Children and Families ("DCF"), the state agency with the statutory authority to provide for children's mental health services testified that:
    a. DCF operates Riverview as well as other facilities and group homes;
    b. DCF has signed 43 contracts for the creation of new group homes and has plans to establish an additional eight group homes; and
    c. DCF also provides funding for behavioral health services in the community. *(May 30, 2007, Brian Mattiello, DCF, Hearing Testimony)*

19. Mr. Mattiello testified that:
    a. Riverview treats children with some of the most complicated histories and presentations;
    b. The three most frequently treated diagnoses are post-traumatic stress disorder, mood disorder, and oppositional defiant disorder;
    c. The number of referrals to Riverview exceeds the number of available beds;
    d. During calendar year 2006, there were 264 referrals and during the same time period, admissions per month averaged 15.25 for a total of 183 for the year; and
    e. Riverview has a total bed capacity of 84 with plans to add an additional four when the necessary space improvements are complete.

    (May 30, 2007, Brian Mattiello, DCF, Hearing Testimony)

20. DCF supports the Applicants' proposal. Currently, DCF and the Connecticut Behavioral Health Partnership[4] ("CTBHP") manage a continuum of behavioral health services for children, youth, and families. The continuum includes grant-based services under contract to DCF and services reimbursed through the CTBHP on a fee-for-service basis. *(May 30, 2007, Brian Mattiello, DCF, Hearing Testimony)*

21. DCF and the CTBHP are taking a number of measures to reduce system gridlock and facilitate improved access to care, including:
    a. Adding residential treatment beds;
    b. Developing and enhancing group home settings;
    c. Preparing Riverview to admit appropriate referrals from the CARES program;
    d. Providing special consideration to children boarded in an ED who meet Riverview's level of care criteria; and
    e. Assigning an Intensive Care Manager by CTBHP to work with the CARES program on discharge and disposition issues.

    (May 30, 2007, Brian Mattiello, DCF, Hearing Testimony)

[4] The State of Connecticut Department of Social Services ("DSS") and DCF formed the CTBHP to plan ad implement an integrated public behavioral health services system for children and families to provide access to community-based behavioral health services.

22. The Applicants project the following units for service for FY 2007, 2008, and 2009:

Table 3: Proposed Units of Service:

	FY 2007*	FY 2008	FY 2009
Number of Children to be Evaluated	155	933	1,026
Number of Children Evaluated that will stay overnight**	135	808	808
Average Length of Stay	1.8	1.8	1.8
Patients days	246	1,476	1,476

* Assuming a start date of 8/1/2007 and represents 2 months in FY 2007.

** Assumes 85% of children require an overnight stay due to clinical presentation and experience of children in the CCMC ED.

(May 4, 2007, Completeness Response, pages 1 and 2)

23. With the establishment of a collaborative relationship between the Applicants and the EMPS teams, by year 3 some children will come directly to CARES and not to an ED first. The number of overnight stays, i.e. patient days, is not expected to increase in the same proportion, as these children will be referred to CARES from outpatient and community services and not from a hospital ED. *(April 12, 2007, Initial CON Submission, page 17)*

24. A new cost center will be created within the IOL to track costs and revenue. *(April 12, 2007, Initial CON Submission, page 17)*

25. J. Kevin Kinsella, Vice President of Hartford Hospital testified that:
    a. The success of the Applicant's proposal is dependent upon the community, the EMPS teams, and other providers;
    b. It is dependent upon the Department of Social Services ("DSS"), which not only provides funding, but also is the linkage to the CTBHP, and DCF, which is the payer of last resort for many patients;
    c. Many of the children that come into the ED are seen and then evaluated by the CARES program. Those that do not need that level of care are discharged to go home. Unfortunately, many do not have a home. DCF needs to help with moving those children out of the CCMC's ED and the CARES program;
    d. Currently, on any day, on the IOL's inpatient unit there are four to five children waiting for placement in a community program or in Riverview. These children are taking beds out-of-service and being boarded by the IOL; and
    e. The projected average length of stay for a child in the CARES program is 1.8 to 2 days and not being able to move children out will cause the system to back up.

    (May 30, 2007, Kevin Kinsella, Hearing Testimony)

26. Dr. Paul Dworkin from the CCMC testified that:
    a. The CARES program is unique and not simply an allocation of six beds;
    b. The program is modeled after a program provided by New York Presbyterian Hospital in New York City;
    c. CCMC has a unique responsibility to provide care to children regardless of their presenting problems;
    d. When patients present with behavioral health crises, it creates enormous challenges to maintain their safety and the safety of the other patients in the ED;
    e. In 2007, the CCMC anticipates 1,750 children from over 90 towns to come to the ED in behavioral health crisis and 166 of these will have an overnight stay representing over 1,137 nights spent in the ED;
    f. The CCMC's ED has 23 beds, four are dedicated to children in acute crisis;
    g. When these children become stockpiled in the ED, they overwhelm the ability of the ED to care for them and keep them safe as well as the ability to provide the emergency medical services to them and the other children; and
    h. The CCMC's ED average turnaround time is 6 hours, and the ED strives for 4 hours.

    (May 30, 2007, Paul Dworkin, MD, CCMC, Hearing Testimony)

27. The CARES program will function in the following way:
    a. When a child in acute behavioral health crisis presents to the CCMC's ED, the child is immediately triaged to a safe ED room;
    b. First the child is evaluated and cleared from a medical perspective;
    c. The child is then assessed by mental health providers accessed through the contractual arrangement that is in place with the IOL and backed up by child psychiatrists from the IOL;
    d. Some are returned to the community, especially with cooperation from the EMPS and the CTBHP;
    e. Those requiring inpatient care and that can be transferred within 6 hours will be discharged to the appropriate inpatient program;
    f. Those that cannot be discharged within 6 hours and require ongoing assessment and stabilization will be transferred to the CARES program until they can be transferred to the appropriate program;
    g. Medical issues continue to be monitored by the CCMC's ED; and
    h. There is no ability to expand CCMC's ED due to the footprint of the building.

    (May 30, 2007, Paul Dworkin, MD, CCMC, Hearing Testimony)

28. Dr. Schwartz, the Chief of Psychiatry at the IOL testified that:
    a. The CARES program will address some deficiencies in the care continuum;
    b. All children entering the CCMC's ED with a primary psychiatric diagnosis will be entered into the program;
    c. The program starts the moment the child is identified as being in the ED for a psychiatric issue and each child will receive a comprehensive psychiatric evaluation;
    d. The children will be transferred to the CARES program unit located in the Donnelly building on the IOL campus;

e. Though the program will be using licensed beds, the program is considered to be differentiated from an inpatient unit and will provide rapid emergency stabilization which is not a regulatory-designated level of care;
f. The high level of physician and other professional staffing will assure the goals of a rapid and thorough assessment, intensive intervention, and rapid disposition;
g. The focus of the program is to provide care while awaiting transfer to an acute inpatient or residential level of care; and
h. By discharge, it is possible that the child will need a lower level of care after a short stay in the CARES program, i.e. a residential level rather than inpatient.

(May 30, 2007, Harold Schwartz, MD, IOL, Hearing Testimony)

29. Michael Starkowski, Commissioner of the State of Connecticut, Department of Social Services ("DSS") testified that:
    a. During state budget negotiations in 2006, $395,000 was appropriated to the CARES program with a starting date of April 2007;
    b. A financial arrangement has been made with the Hospital that will provide for the financial stability of the program;
    c. The reimbursement provided to the Hospital will be reviewed and adjusted based on the actual costs of maintaining the program;
    d. An additional meeting is required to finalize the financial arrangement;
    e. The Hospital will also need to develop affiliation agreements with community service providers in order to support its commitment to increase diversions back to the community among children who present to the CCMC's ED or directly to the CARES program;
    f. The Hospital has also committed to reduce the rate of admission to general and psychiatric hospital inpatient care;
    g. DSS is prepared, along with DCF, to provide the full measure of CTBHP resources to support the timely disposition of the children in the CARES program, so that the program does not become an alternative boarding site for hard-to-place children; and
    h. DSS will work with the Hospital to measure the impact of the CARES program and particularly on its ability to reduce reliance on traditional inpatient psychiatric services.

    (May 30, 2007, Commissioner Starkowski, DSS, Hearing Testimony)

30. Dr. Mark Schaefer, Policy Director at DSS, testified that:
    a. DSS is in the process of soliciting approval from the State of Connecticut Office of Policy and Management ("OPM") for a sole source contract (or Personal Service Agreement) with the Hospital to use the funds for a portion of the capital cost for the Hospital and an additional $95,000 to support an increase in the Hospital's clinical assessment services that are provided in the CCMC's ED as well as the CARES program;
    b. The Secretary of OPM approved carryover of the funds to be expended in the State's next fiscal year, i.e., 2008; and
    c. There may be need for the CARES program to be offered in other areas of the state.

d. One of the goals of rate setting is to assure access to those children that DSS insures through the non-managed care Medicaid/Medicare fee-for-service program or the CTBHP;
e. Most children that will be admitted to the CARES program are covered by CTBHP;
f. The CTBHP rates are set collaboratively under the memorandum of understanding with DCF;
g. To date, CCMC bills for the emergency room evaluation only as the psychiatric evaluation is provided by the Hospital;
h. DSS will not pay for duplication of services by the ED and CARES;
i. Children seen at the CCMC's ED and discharged from the CCMC's ED will be reimbursed the same at it is currently by the CTBHP;
j. For children going to the CARES program for evaluation, the Hospital will receive $405 for the comprehensive evaluation;
k. For children admitted to the CARES program overnight the per diem will be $1,100 for up to a three day stay;
l. DSS will revisit the adequacy of the rates at approximately one year after the program has begun operations to determine how the rate needs to be adjusted, either up or down where the cap on the evaluation fee will be $450, and $1,175 for the per diem;
m. Many children requiring care do not need to be in Riverview or sent out-of –state for specialized expertise, but could be accommodated in the existing network of inpatient services if the reason for the inability to have them admitted can be determined; and
n. DSS and DCF will meet with the providers of inpatient services to identify why some children were not admitted to determine what services or special challenges are not addressed in the current programs.

(May 30, 2007, Dr. Mark Schaefer, DSS, Hearing Testimony)

31. When children are transferred from the CCMC's ED to the CARES program, parents are responsible for their child that is under 16 years of age. For 16 and 17 year olds, it may vary since their admission to CARES program may be considered involuntary if the child does not want to be admitted. *(May 30, 2007, Annetta Caplinger, IOL, Hearing Testimony)*

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

32. The total renovation capital expenditure of $700,000 includes the following:

Table 4: Construction and Renovation Capital Expenditures

Description	Amount
Renovations	$450,000
Beds and Furnishings	90,000
Architectural and Engineering Costs	15,000
Contingency Costs	145,000
Total Capital Expenditures	**$700,000**

(April 12. 2007, Initial CON Submission, pages 18 and 19)

33. The total capital expenditure for the CON proposal of $700,000 will be funded with a $300,000 grant from the State of Connecticut, and $200,000 of funded depreciation from each Applicant. *(May 4, 2007, Completeness Response, page 20)*

34. The Hospital will divide an existing inpatient unit located on Donnelly I South on the IOL campus. The adolescent patients that currently occupy that unit will be moved to Donnelly II North. Donnelly I South will be renovated to create a separate unit to house the six-bed CARES program. The other part of Donnelly I South will house the eight-bed children's unit. Renovations will include the refurbishment of the common areas on the second floor to accommodate a 14-bed adolescent unit. *(April 12, 2007, Initial CON Submission, page 19)*

35. The CARES unit will have six private rooms needed for the diversity of ages. The private rooms will also allow for a better and more private atmosphere for the patients, as well as the ability to admit to a more optimal and consistent census. *(April 12, 2007, Initial CON Submission, page 19)*

36. The Hospital projects incremental revenue from operations, total operating expense and losses from operations associated with the CON proposal as follows:

Table 5: Hospital's Incremental Financial Projections by Fiscal Year

Description	FY 2007	FY 2008	FY 2009
Incremental Revenue from Operations	$334,809	$2,069,824	$2,106,529
Incremental Total Operating Expense	244,413	2,036,611	2,075,231
Incremental Gain from Operations	**$ 99,396**	**$ 33,213**	**$ 31,298**

(May 4, 2007, Completeness Response, Attachment 1)

37. CCMC will not realize any incremental revenue or gain from operations with the proposal. However, CCMC will incur a one-time operating expense of $200,000 for its contribution to the capital expenditure. *(May 4, 2007, Completeness Response, Attachment 5)*

38. The Hospital presented the following staffing requirements for the CARES program:

Table 6: Proposed Staffing for CARES Program

Staff	Full Time Equivalent (FTE)
Unit Secretary	1.0
Registered Nurses	4.83
Psychiatric Technicians	7.60
Social Workers	3.20
MD, Child Psychiatrist	0.5
Administrative Manager	0.13
Total Staff Required	**17.26**

(April 12. 2007, Initial CON Submission, page 25)

39. The Hospital reported the following payer mix for the proposal based on net patient revenues. The current payer mix is reported for the IOL as a whole; the payer mixes for FYs 2007 to 2009 are reported for the CARES program only.

Table 7: Payer Mix by Fiscal Year

Program	IOL	CARES Program		
Payer	Current (%)	FY 2007 (%)	FY 2008 (%)	FY 2009 (%)
Medicare	43.8	0	0	0
Medicaid	10.5	71.0	71.0	71.0
CHAMPUS, TriCare and VA federal patients	0.5	0	0	0
Total Government	**54.8**	**71.0**	**71.0**	**71.0**
Commercial (including Workers Compensation)	39.3	29	28.9	28.8
Uninsured	5.9	0	0	0
Total Non-Government	**45.2**	**29.0**	**28.9**	**28.8**
Total	**100**	**100**	**100**	**100**

(May 4, 2007, Completeness Response, Attachment 2)

40. The Applicants have initiated dialogues with the commercial payers to incorporate the CARES program within the contracts as a special service to cover the premium costs that the CARES program incurs. *(May 30, 2007, Dr. Stephen Larcen, Hartford Hospital, Hearing Testimony)*

41. Commercial insurance, Medicaid, and HUSKY cover ambulance service. When other sources do not pay for the service, the Hospital has a fund that is part of its operating budget to cover the cost. *(May 30, 2007, J. Kevin Kinsella, Hartford Hospital, Hearing Testimony)*

42. There is no State Health Plan in existence at this time. *(April 12, 2007, Initial CON Submission, page 4)*

43. The Hospital has adduced evidence that the proposal is consistent with the Hospital's long-range plan. *(April 12, 2007, Initial CON Submission, page 4)*

44. The Hospital has improved productivity and contained costs by undertaking energy conservation, group-purchasing activities, application of technology, and reengineering. *(April 12, 2007, Initial CON Submission, page 15)*

45. As the Hospital is a teaching and research hospital that provides training to mental health professionals, the CARES program offers the potential for training psychiatry fellows and other mental health professionals in a model that employs intensive evaluation, rapid symptom, stabilization, and coordination of community supports. *(April 12, 2007, Initial CON Submission, page 15)*

46. The professional staff that has demonstrated competency in the care of children will distinguish the CARES program. The IOL currently employs nine child psychiatrists and six child psychiatry fellows in its programs and services. *(April 12, 2007, Initial CON Submission, page 16)*

47. The Hospital has sufficient technical, financial, and managerial competence and expertise to provide efficient and adequate service to the public. *(April 12, 2007, Initial CON Submission, Attachment 2)*

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.

Hartford Hospital ("Hospital") is an acute care general hospital in Hartford, Connecticut. The Institute of Living ("IOL"), the Hospital's center for the treatment of behavioral, psychiatric, and addiction disorders and the Connecticut Children's Medical Center ("CCMC") are located adjacent to the Hospital. The Hospital and CCMC ("Applicants") have an ongoing contractual relationship and collaboration regarding mental health services to children[1] who present for care in the CCMC's Emergency Department ("ED") and for those children that have been hospitalized for a medical or surgical conditions at the CCMC.

Since 2000, the number of children presenting at the CCMC's ED requiring mental health evaluations has increased from 566 to 1,608 in 2006. In 2006, 41% of the children that presented to the CCMC's ED for mental health evaluations were discharged to an inpatient bed. When these children accumulate in the ED, they overwhelm the ability of the ED to care for them and keep them safe. They also overwhelm the ability of the staff to provide the emergency medical services to them and the other children. Many times these children spend one or more nights at the ED waiting for an inpatient bed or being held until community services can be arranged and accessed. In March 2007, the CCMC reported that children with mental health issues filled 18 of its 23 beds in the ED.

The Hospital and the CCMC are proposing to establish a new behavioral health service program for children identified as the Child and Adolescent Rapid Emergency Services ("CARES") program. The CARES program will be located at the Hospital's IOL and will help address long waits in the CCMC's ED as well as overcrowding in general. The IOL location was selected because the CCMC's ED cannot expand its treatment areas due to lack of available space. In addition, the IOL currently has programs in place to treat children and, with minimal renovations, can provide the bed space needed. The Applicants propose to develop a six-bed unit in the IOL's Donnelly Building that will be staffed 24 hours a day, 7 days a week. The unit will be adjacent to the IOL's Inpatient Child Psychiatric Unit.

The primary purpose of the CARES program will be to provide an alternative level of care to children who are in a psychiatric crisis and that can be rapidly stabilized. Each child that presents to the CCMC's ED for mental health problems will be triaged to determined if an acute level of care is needed, i.e. an inpatient psychiatric bed, residential care or a group home. If the child can be placed in a psychiatric bed within six hours, the child will be held in the ED and will be directly transferred to an inpatient unit at the IOL or another hospital. Children,

[1] Includes children aged 5 to 17 years.

who upon triage and assessment in the CCMC's ED, are able to return home or go to a residential facility within six hours, will also be discharged directly from the ED. Otherwise, the children will be sent to the CARES program for a comprehensive evaluation and admission as appropriate. The Hospital stated that the projected average length of stay for a child in the CARES program would be approximately two days.

The Connecticut Behavioral Health Partnership ("CTBHP") is an integrated public behavioral health services system that will cover most of the children to be admitted to the CARES program. The State of Connecticut Department of Social Services ("DSS") and the Department of Children and Families ("DCF") formed the CTBHP to provide an integrated public behavioral health services system and access to community-based behavioral health services for children and families. Currently, DCF and CTBHP manage a continuum of behavioral health services, including grant-based services under contract to DCF and services reimbursed through the CTBHP on a fee-for-service basis. DCF and the CTBHP are taking a number of measures to reduce system gridlock and facilitate improved access to care, including the addition of more residential treatment beds and group homes. DCF will prepare Riverview to admit appropriate referrals from the CARES program at the same priority level as children being referred from other EDs that meet Riverview's level of care criteria. CTBHP will assign an Intensive Care Manager to work with the CARES program on discharge issues. DSS and DCF testified that both agencies are prepared to provide the full measure of CTBHP resources to support the timely disposition of the children in the CARES program, so that the program does not become an alternative boarding site for hard-to-place children.

DSS is also the agency that determines the rates and funding for the behavioral health programs and will do so for the CARES program. DSS will review and adjust rates based on the actual costs of maintaining the program. DSS testified that it will work with the Hospital to measure the impact of the CARES program and particularly on its ability to reduce reliance on traditional inpatient psychiatric services. The success of the CARES program is contingent on the funding and continuing support from DCF and DSS. With no additional reimbursement to be provided when inpatient care exceeds three days in the CARES program, the challenge for the Hospital, DCF, and DSS will be to prevent children from being boarded at the CARES program instead of an ED. In addition, adequate support will be required from existing providers, the community, the Emergency Mobile Psychiatric Service ("EMPS") teams and others to provide the required level of care to children. However, if the program operates as successfully as the model of care under which it was designed, the program's benefit will be better care for all patients and improved access to care.

The CON proposal's total capital expenditure of $700,000 will be funded with a grant of $300,000 from the State of Connecticut and equity contributions of $200,000 from each Applicant. The Hospital projects incremental gains from operations of $99,396, $33,213, and $31,298 in Fiscal Years 2007, 2008, and 2009, respectively, with the CON proposal. Although the CCMC will not see a gain from operations from the CARES program, the proposal will improve access by alleviating backlogs and enable the CCMC's ED to provide timely quality care to children with medical needs. The Hospital's financial agreement with DSS will, at a minimum, provide adequate revenue to cover the cost of the program. Although OHCA cannot

draw any conclusions, the Hospital's volume and financial projections upon which they are based appear to be reasonable and achievable.

Order

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Hartford Hospital ("Hospital") and Connecticut Children's Medical Center ("CCMC") to establish a Child and Adolescent Rapid Emergency Stabilization program on the campus of the Institute of Living, at a total capital expenditure of $700,000, is hereby GRANTED, subject to conditions:

1. This authorization shall expire on June 21, 2008. If the CARES program is not in operation by that date, the Hospital and CCMC must seek further approval from OHCA to complete the project beyond that date.

2. The Hospital and CCMC shall not exceed the approved total capital expenditure of $700,000. In the event that the Hospital and CCMC learn of potential cost increases or expects that final project costs will exceed those approved, the Hospital and CCMC shall notify OHCA immediately.

3. The Hospital and CCMC must report the commencement date of the CARES program within two weeks of the commencement date.

4. The Office of Health Care Access ("OHCA") requires that the Hospital and CCMC contact OHCA to schedule quarterly meetings with OHCA upon commencement of the CARES program. Attendees to the meetings shall include designated representatives from the Hospital, CCMC, the Department of Children and Families and the Department of Social Services. It will be at the discretion of OHCA to determine the number of meetings to be held and the data that must be submitted. Unless otherwise notified in writing by OHCA, at each meeting, the Hospital and CCMC shall submit to OHCA the following information for the CARES program and the CCMC's Emergency Department ("ED"):

   a) Utilization Data
      - Number of children[1] presenting to CCMC's ED that required a psychiatric evaluation;
      - Number of children required to stay in CCMC's ED overnight and the average length of stay;
      - Number of children evaluated at CCMC's ED by CARES or IOL staff;
      - Number of children transferred to CARES program and method of transportation, (e.g. ambulance, a parent or legal guardian) from CCMC's ED;
      - Number of children that received a psychiatric evaluation at CARES;
      - Number of children admitted to CARES and average length of stay;
      - For non-admits, the mean average length of time from presentation at CCMC's ED to discharge and discharge referral (e.g., home, outpatient, etc) and names of providers;

[1] Includes children aged 5 to 17 years.

- Disposition of children discharged from CARES and the discharge referral;
- Number of children discharged from CARES requiring an acute care inpatient stay and the admitting hospital;
- Issues related to delays in discharge from CARES (i.e., waiting for bed, etc.)

b) Report on Community Resources
- List outpatient services and referrals made to each of these programs; and
- Delays in CARES discharge due to outpatient services not available.

c) Operational Issues/Barriers that are limiting the CARES program from stabilizing and discharge patients according to the model of care, i.e., 72 hours.

d) Funding issues
- The ready availability of the $95,000 for staffing and an accounting of the funds;
- The ready availability of the $300,000 grant to the Applicants to prepare the CARES program's physical space at the IOL and an accounting of the funds;
- Report on the rates of reimbursement; and
- Any other relevant funding issues.

Should the Hospital and 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 the
Office of Health Care Access

June 21, 2007

Signed by Cristine A. Vogel
Commissioner

CAV: lkg