Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant:	**MidState Medical Center**
Docket Number:	**07-30964-CON**
Project Title:	**Facility Building Project including Expansion of the Emergency Department, Termination of Inpatient Psychiatric Services, Addition of 30 Licensed Medical Surgical Beds and Other Facility Improvements**
Statutory Reference:	**Sections 19a-638 & 19a-639 of the Connecticut General Statutes**
Filing Date:	**August 27, 2007**
Hearing Date:	**October 17, 2007**
Presiding Officer:	**Commissioner Cristine A. Vogel**
Decision Date:	**March 4, 2008**
Staff Assigned:	**Jack A. Huber**

Project Description: MidState Medical Center proposes to undertake a facility building project, which includes the expansion of the Emergency Department, the termination of inpatient psychiatric services, the addition of 30 licensed medical-surgical beds and the completion of other facility improvements, at a proposed total capital expenditure of $45,089,500.

Nature of Proceedings: On August 27, 2007, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application of MidState Medical Center ("Hospital") seeking authorization to undertake a facility building project, which includes the expansion of the Emergency Department, the termination of inpatient

psychiatric services, the addition of 30 licensed medical-surgical beds and the completion of other facility improvements, at a proposed total capital expenditure of $45,089,500. The Hospital is a health care facility or institution as defined in Section 19a-630 of the Connecticut General Statutes.

A notice to the public concerning OHCA's receipt of the Hospital's initial CON submission was published in *The Record Journal* of Meriden on June 3, 2007, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes ("C.G.S.").

A public hearing regarding the CON application was held on October 17, 2007, pursuant to Section 19a-639, C.G.S. On September 20, 2007, the Hospital was notified of the date, time and place of the hearing. A notice to the public was published in *The Record Journal* of Meriden on September 24, 2007. 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 Sections 19a-638 and 19a-639, C.G.S. The public hearing regarding the CON application was closed on November 29, 2007.

Richard Anderson, M.D., Paul Horton, M.D. and The Hospital of Central Connecticut petitioned for intervenor status with full procedural rights in the proceeding, including the right to present evidence and argument as well as the right to cross-examine witnesses. The Presiding Officer denied each of the requests for intervenor status with full procedural rights and granted each requestor intervenor status with limited rights of participation.

In addition, the following individual and entities petitioned for intervenor status in the proceeding with limited rights to participate: Michele Jones, R.N.; Mental Health Association of Connecticut, Inc.; Connecticut Legal Rights Project, Inc.; National Alliance on Mental Illness of Connecticut, Inc.; and Advocacy Unlimited, Inc. The Hearing Officer granted intervenor status with limited rights to participate to Michele Jones, R.N.; Mental Health Association of Connecticut, Inc.; Connecticut Legal Rights Project, Inc.; National Alliance on Mental Illness of Connecticut, Inc.; and Advocacy Unlimited, Inc.

The Presiding Officer heard testimony from witnesses representing the Hospital, Intervenors, and other informal participants. In rendering this decision, the Presiding Officer 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 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. MidState Medical Center ("Hospital") is a non-profit, acute care hospital located at 435 Lewis Avenue in Meriden, Connecticut. *(May 4, 2007, Letter of Intent, page 1)*

2. The Hospital's parent corporation is Hartford Healthcare Corporation ("HHC"). Other HHC subsidiaries include Hartford Hospital and the Institute of Living. *(May 4, 2007, Letter of Intent, page 1)*

3. The Hospital is proposing to undertake a facility building project ("project" or "proposal"), which represents the next major step in the implementation of the Hospital's master facility plan. *(July 6, 2007, Initial CON application submission, page 4 and August 6, 2007, Hospital's first completeness letter response, page 1 and Attachment I, page 27)*

4. The project encompasses construction of a new four-story pavilion measuring approximately 100,000 square feet ("SF") and renovation of approximately 5,000 SF. The proposal includes the following major service/facility objectives:

    a) Expansion of the existing Emergency Department into the first floor of the new pavilion. The expansion will result in a 30,000 increase in the departmental square footage ("SF") from 10,000 to 40,000 SF, an increase of 24 treatment beds from 30 to 54 beds, and the establishment of an imaging suite a closed behavioral health unit consisting of 9 treatment beds and a 12 bed assessment unit;

    b) Termination of inpatient psychiatric services and the conversion of 6 existing psychiatric inpatient beds to the medical-surgical inpatient service;

    c) Addition of 30 new licensed medical-surgical inpatient beds on the third floor of the pavilion;

    d) Construction of shelled space for future inpatient, outpatient and/or medical office use on the pavilion's second floor;

    e) Construction of shelled space for future inpatient use on the pavilion's fourth floor; and

    f) Completion of other facility improvements including:
        1) Creation of a covered main entrance, lobby and patient drop-off area;
        2) Expansion of the facility's central utility plant;
        3) Expansion of on-campus parking;

4) Circulation changes to improve ambulance and vehicular traffic patterns; and
5) Relocation of the Hospital's helipad.

(July 6, 2007, Initial CON application submission, pages 4 through 10 and 18 through 20 and August 6, 2007, Hospital's first completeness letter response, pages 17 through 20)

5. The Hospital is not requesting the implementation of any new programs or services to its existing complement of programs and services. *(July 6, 2007, Initial CON application submission, page 4)*

6. The Hospital states that the proposal is intended to serve individuals residing in its existing primary and secondary service areas. The towns comprising each service area are as follows:
   a) Primary service area ("PSA"): Cheshire, Meriden, Southington and Wallingford.
   b) Secondary service area ("SSA"): Berlin, Durham, Middlefield and Middletown.
   (July 6, 2007, Initial CON application submission, page 5)

7. The Hospital is currently licensed for 130 general hospital beds and 12 bassinets. The Hospital's overall licensed occupancy rate, excluding newborn, was 88.2% in fiscal year ("FY") 2007. The Hospital's medical-surgical licensed occupancy rate was 96.4% in FY 2007. (*Connecticut Office of Health Care Access Inpatient Discharge Database and the Hospital Budget System Schedule 500 for MidState Medical Center for FY 2007)*

8. The Hospital staffs 124 general hospital beds and 12 bassinets. In FY 2007, the Hospital's overall staffed bed occupancy rate, excluding newborn, was 92.4%. The Hospital's medical-surgical staffed occupancy rate was 96.4% in FY 2007. (*Connecticut Office of Health Care Access Inpatient Discharge Database and the Hospital Budget System Schedule 500 for MidState Medical Center for FY 2007)*

9. The proposal seeks to increase the number of licensed general hospital beds by 30 from 130 to 160 beds. The number of licensed newborn bassinets will remain unchanged from its current level of twelve ("12") bassinets. *(August 3, 2007, Hospital's second completeness letter response, page 8)*

Emergency Department Expansion

10. The Hospital indicates that physical constraints have hampered the Emergency Department ("ED" or "department") in its ability to provide high quality and appropriate emergency services. The Hospital identifies the following departmental constraints:
    a) Inadequacy in the physical size of the ED; and
    b) Inadequacy in the number of treatment beds.
    (July 6, 2007, Initial CON application submission, pages 7, 8 and 28 and August 6, 2007, Hospital's first completeness letter response, page 16)

11. The ED opened in September of 1998 with a 24 treatment bed complement. It was designed to serve 26,000 patient visits annually. The Hospital added 6 additional treatment beds in 2002 to bring the complement to 30 treatment beds. *(July 6, 2007, Initial CON application submission, page 7)*

12. The Hospital has implemented a number of initiatives over the past three years. The Hospital established a multi-disciplinary task force that has evaluated key factors affecting ED operations. A patient throughput action committee initiated new approaches to address capacity constraints that resulted in positive outcomes in the following areas:
    a) Ancillary testing turn-around time;
    b) Environmental services room turn-around time;
    c) Delay in inpatient discharges;
    d) ED admitting processes; and
    e) Waiting time to be seen by an ED physician.
    (August 6, 2007, Hospital's first completeness letter response, pages 6 and 7)

13. The Hospital proposes to add 24 private ED treatment beds. The number of existing and proposed treatment beds by service type is as follows:

Table 1: ED Treatment Beds by Service Type

Description	Current	Proposed	Variance
Main ED	14	33	+19
Observation Unit	6	0	-6
Minor Care	6	0	-6
Behavior Health Care	4	9	+5
Assessment Unit	0	12	+12
Total Number of Treatment Beds	**30**	**54**	**+24**

(August 6, 2007, Hospital's first completeness letter response, Attachment IX, page 75)

14. ED patient visits have increased by approximately 37% since department's opening. *(August 6, 2007, Hospital's first completeness letter response, page 6)*

15. The Hospital reports the following number of ED patient visits, treated and admitted and treated and discharged, from FY 1998 through 2006 and projected-actual for FY 2007 as follows:

Table 2: Actual ED Service Volumes

Description	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
ED Treated & Admitted	4,632	4,755	4,922	4,784	4,784
ED Treated & Discharged	30,194	33,225	36,077	40,510	40,661
Total	34,826	37,980	40,999	45,636	45,445
% Variance	-	9.1%	7.9%	11.3%	-0.4%

Description	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007*
ED Treated & Admitted	4,838	5,087	5,922	5,913	-
ED Treated & Discharged	40,423	39,255	40,211	41,519	-
Total	45,261	44,342	46,133	47,432	47,669
% Variance	-0.4%	-2.0%	4.0%	2.8%	0.5%

Notes: *Annualized data for FY 2007 based on 7 months of actual data.
(August 6, 2007, Hospital's first completeness letter response, page 6 and October 10, 2007, Prefile testimony of Karen Goyette, page 3)

16. The Hospital projects ED patient visits of 50,371 in FY 2012 and 53,608 in FY 2017, based on an analysis of historical department service volume, service area population trends and Hospital market share trends. *(October 10, 2007, Prefile testimony of Karen Goyette, page 3)*

17. The expanded ED is being designed to accommodate approximately 60,000 patient visits annually. *(August 27, 2007, Hospital's second completeness letter response, page 8 and October 10, 2007, Prefile testimony of Karen Goyette, page 3)*

18. Disaster preparedness and response provisions have been incorporated into the ED design. The key components include:
    a) Ability to lock-down the entire ED;
    b) Increased the number of isolation rooms and negative pressure rooms;
    c) Satellite security station situated within the department; and
    d) Dedicated emergency medical services and decontamination areas within the ED.
    (August 27, 2007, Hospital's second completeness letter response, page 2)

19. The Hospital proposes the inclusion of the following services within the proposed department:

    a) Imaging Suite – with projected volumes above 50,000 patient visits per year the Hospital asserts the department will benefit from direct access to a dedicated computed tomography ("CT") scanning unit and an equipped digital imaging room;

    b) Behavioral Health Module – the creation of a closed 9 treatment bed unit was recommended by the Hospital's architect based on a 99% psychiatric ED bed availability, an 18 hour ED turnaround time and the number of projected ED patient visits.

    c) Assessment Unit – the unit employs a concept of rapid triage, assessment, treatment and discharge of the patient, when possible, from the department. Open and closed patient treatment spaces placed close to the ambulance entrance will allow a team of clinicians to treat patients before they enter the ED proper. The unit is designed to reduce the time from "door to doctor" as well as minimize non-urgent patient cases from utilizing space within the ED core areas.
    (July 6, 2007, Initial CON application submission, page 29; August 6, 2007, Hospital's first completeness response, page 20; August 27, 2007, Hospital's second completeness letter response, page 2 and October 31, 2007, Late File Exhibit 3, pages 19 and 20)

20. The proposed imaging suite will include one relocated CT scanner from the Radiology Department and the construction of two digital radiology rooms. One of the radiology rooms will be fully equipped and the second room of 185 square feet is to be shelled-in space for use at a later date. The imaging suite will serve other Hospital departments during evening and night hours and will be easily accessible from the inpatient units. *(August 6, 2007, Hospital's first completeness letter response, page 20)*

21. The behavioral health module will be located in a locked, secured area of the department and will offer reduced stimuli for patients. The unit will be staffed by dedicated psychiatric nurses, crisis clinicians and psychiatric social workers. *(August 27, 2007, Hospital's second completeness letter response, page 2 and October 31, 2007, Late File Exhibit 3, pages 19 and 20)*

22. The behavioral health module will be proximate to the ambulance entrance, as the Hospital finds approximately 95% of psychiatric patients that are disruptive or agitated arrive via ambulance transport. The unit will include dedicated bathrooms and shower facilities, private consultation offices for community physicians, and a multi-purpose room that can be utilized by staff for group meetings and consultations involving larger groups. *(October 31, 2007, Late File Exhibit 3, pages 19 and 20)*

Psychiatric Inpatient Service Termination

23. The Hospital provides psychiatric inpatient services for adults in a 10 bed "swing unit" *(July 6, 2007, Initial CON application submission, page 10)*

24. The Hospital does not provide psychiatric inpatient services for children and adolescents. *(August 27, 2007, Hospital's second completeness letter response, pages 12 and 13)*

25. In a Certificate of Need authorization under Docket Number: 92-567, the Hospital was required to establish a 10 bed "swing unit" with the following parameters:
    a) At least 6 beds were to be considered and staffed as "Flex" beds to be used for either adult psychiatric or adult medical-surgical patients;
    b) The 4 other remaining beds were to be designated for use as psychiatric inpatient beds; and
    c) Psychiatric patients requiring stays longer that 4 to 8 days, specialty treatment due to age, or who have refractory clinical symptoms or complicating medical conditions for whom treatment is not available in the community, were to be transferred to other hospitals providing psychiatric inpatient services, including the Institute of Living.

    (October 31, 2007, Late File 1, Exhibit A, page 11)

26. The Hospital proposes the following plan with regard to its complement of psychiatric services:
    a) Terminating its psychiatric inpatient service;
    b) Transferring patients that present to the Hospital requiring psychiatric inpatient care to IOL or other psychiatric facilities that have the capacity to serve this population;
    c) Converting the psychiatric inpatient beds to the medical-surgical inpatient service; and
    d) Increasing the number of dedicated psychiatric treatment beds in the ED from 4 to 9 beds. *(August 27, 2007, Hospital's second completeness letter response, page 12 and October 10, 2007, Prefile testimony of Fred Tilden, MD, ED Medical Director of MidState Medical Center, page 6)*

27. The Hospital asserts the following with respect to the operation of the "swing unit":

    a) Due to ongoing medical-surgical inpatient occupancy constraints, the psychiatric inpatient service has operated a 6 bed unit for the past year with an average daily census of 4 patients;

    b) The Hospital cannot offer the same level of expertise required to provide special needs patients with inpatient psychiatric care that a larger more specialized psychiatric hospital can provide;

    c) As the Hospital's psychiatric unit is small in bed size and serves a diverse inpatient psychiatric population (i.e. substance abuse, anorexia, depression, etc.), the Hospital established a relationship with the Institute of Living ("IOL"), an affiliate of HHC; and

    d) The relationship has allowed the Hospital to stabilize and transfer psychiatric patients to IOL's inpatient service; and

    e) A memorandum of understanding ("MOU") regarding the arrangement was signed by the Hospital and IOL in May of 2006. *(July 6, 2007, Initial CON application submission, page 10; August 27, 2007, Hospital's second completeness letter response, page 13 and October 10, 2007, Prefile testimony of Lucille Janatka, President & CEO of MidState Medical Center, pages 2 through 4)*

28. Prior to the execution of the MOU, the Hospital worked with area psychiatric inpatient facilities to identify the most appropriate level of care for their patients. (*August 27, 2007, Hospital's second completeness letter response, page 13)*

29. Since the execution of the MOU, the Hospital indicates that it has worked with the IOL to meet the community need for acute inpatient psychiatric services. ED clinicians evaluate each psychiatric patient that presents to the department. ED clinicians prepare a plan for care and, if required, contact the IOL assessment center for acute inpatient placement. (*August 27, 2007, Hospital's second completeness letter response, page 13)*

30. In the event that IOL is unable to accept a psychiatric transfer from the Hospital, the Hospital works with other area inpatient providers to find appropriate placement. (*August 27, 2007, Hospital's second completeness letter response, page 15)*

31. There have been instances since the execution of the MOU, where IOL has been unable to accept Hospital psychiatric patients requiring inpatient services. The frequency of this type of occurrence was not quantified by the Hospital. (*August 27, 2007, Hospital's second completeness letter response, page 15)*

32. The Hospital's psychiatric inpatient utilization for FYs 2004 through 2007 are presented in the following table:

Table 3: Actual Psychiatric Inpatient Service Volumes*

Description	FY 2004	FY 2005	FY 2006	FY 2007
# Licensed Beds	10	10	10	10
# Staffed Beds	10	10	10	6
Ave. Census	9	9	7	5
# Discharges	322	382	317	262
# Patient Days	3,341	3,275	2,629	1,918
ALOS	10.38	8.75	8.29	7.32
Licensed Occupancy	91.5%	89.7%	72.0%	52.5%
Staffed Occupancy	91.5%	89.7%	72.0%	87.6%

**Source: Connecticut Office of Health Care Access Inpatient Discharge Database and the Hospital Budget System Schedule 500 for MidState Medical Center for the respective fiscal years cited*

33. Richard H. Anderson, M.D., Department Chief of Psychiatry at MidState Medical Center offered the following comments during his testimony at the public hearing:

a) The proposal would deprive the Meriden/Wallingford community of any local inpatient psychiatric service;
b) The plan would necessitate, in many cases, long trips by family members who may be unaccustomed to leaving the area and/or may experience transportation problems getting to other hospital psychiatric inpatient programs;
c) The Hospital's ED will be crowded with dual diagnosed, uninsured and chronically ill psychiatric patients who could not be easily placed at any other facility;
d) Psychiatrists faced with the task of performing consultations would be constantly faced with similar placement problems;
e) Patients with concurrent medical problems, such as those that necessitate the original hospitalization, are in many cases not accepted on other psychiatric inpatient units; and
f) The concept of local care for psychiatric patients would be severely compromised.

(Testimony offered by Richard H. Anderson, at the October 17, 2007 public hearing, submitted as Intervenor Exhibit 1)

Medical-Surgical Inpatient Services

34. The proposal seeks to construct a new 30 bed medical-surgical ("M/S"), unit resulting in the following:
    a) An increase in the number of licensed hospital beds from 130 to 160 beds; and
    b) An increase in the number of M/S inpatient beds from 99 to 138 beds.

    (July 6, 2007, Initial CON application submission, page 10; August 27, 2007, Hospital's second completeness letter response, page 10 and Connecticut Office of Health Care Access Inpatient Discharge Database and the Hospital Budget System Schedule 500 for MidState Medical Center)

35. The Hospital is seeking to increase its number of licensed medical-surgical ("M/S") inpatient beds based upon the following factors:
    a) Increasing M/S patient days;
    b) Increasing licensed and staffed occupancy rates for M/S inpatient services;
    c) Continued increase in the proportion of the population that is 65 years of age and older; and
    d) Increasing complexity of illness for those individuals receiving M/S inpatient care.

    (July 6, 2007, Initial CON application submission, pages 8 and 9 and August 27, 2007, Hospital's second completeness letter response, page 1 and Attachment 1a, pages 20 through 22)

36. The total number of medical-surgical inpatient discharges, patient days, average daily census, and average length of stay excluding newborns for FYs 2004 through 2007 are as follows:

Table 4: Actual M/S Service Volumes*

Description	FY 2004	FY 2005	FY 2006	FY 2007
# Discharges	5,690	6,558	6,495	6,502
# Patient Days	30,178	32,370	33,326	34,851
ADC**	83	89	91	95
ALOS**	5.30	4.94	5.13	5.36

** Source: Connecticut Office of Health Care Access Inpatient Discharge Database and the Hospital Budget System Schedule 500 for MidState Medical Center for the respective fiscal years cited.*

** ADC means average daily census; ALOS means average length of stay.

37. The actual medical-surgical bed counts and occupancy rates for FYs 2004 through 2007 are as follows:

Table 5: M/S Bed Count and Corresponding Occupancy Percentages*

Fiscal Year	M/S Bed Count		Occupancy %	
	Staffed	Licensed	Staffed	Licensed
FY 2004	95	99	87.0%	83.5%
FY 2005	95	99	93.4%	89.6%
FY 2006	95	99	96.1%	92.2%
FY 2007	99	99	96.4%	96.4%

** Source: Connecticut Office of Health Care Access Inpatient Discharge Database and the Hospital Budget System Schedule 500 for MidState Medical Center for the respective fiscal years cited.*

38. Employing a use rate methodology, the Hospital projected the number of medical-surgical beds it would need annually to serve its existing service area population through FY 2015. *(August 6, 2007, Hospital's first completeness letter response, pages 9 through 12 and August 27, 2007, Hospital's second completeness letter response, page 1 and Attachment 1a, pages 20 through 22)*

39. Based on a 90% medical-surgical occupancy rate, the Hospital is projecting the need for 146 medical-surgical beds to meet FY 2015 inpatient demand. Due to the number of variables and factors used in the projections, the Hospital is not requesting

additional medical-surgical beds be included at this time (i.e. 146 projected M/S beds vs. a requested M/S total to 138 beds pursuant to this proposal). *(August 6, 2007, Hospital's first completeness letter response, pages 9 through 12 and August 27, 2007, Hospital's second completeness letter response, page 1 and Attachment 1a, pages 20 through 22)*

40. The Hospital's bed need analysis incorporates a variety of factors, which the Hospital indicates is based on historical trends or industry standards. The following are the Hospital's key assumptions used in its bed need analysis and calculation:

    a. Service area population growth equals an increase of approximately 1% annually to 279,000 by FY 2015 using CERC figures as its source;
    b. Medical-surgical discharges per 1,000 population equivalent to an increase of nearly 2% annually to 104 discharges per year by 2015, whereby the Hospital assumes that 50% of the average annual change from the last 10 years will be realized;
    c. Market share to remain constant at FY 2006 volume levels using CHIME data;
    d. M/S average length of stay ("ALOS") will remain constant at 4.93 days with initiatives in place to insure that ALOS will remain within appropriate guidelines;
    e. Out-of-service area draw to remain constant at 6% based on CHIME data; and Targeted licensed bed need occupancy at 90%. *(August 6, 2007, Hospital's first completeness letter response, pages 9 through 12 and August 27, 2007, Hospital's second completeness letter response, page 1 and Attachment 1a, pages 20 through 22)*

41. The Hospital's projected M/S service volume is presented in the following table for FYs 2008 through 2015:

Table 6: Projected Medical-Surgical Service Volumes*

Description	FY 2008	FY 2009	FY 2010	FY 2011
# Discharges	7,601	7,864	8,036	8,319
# Patient Days	37,629	38,951	39,809	41,231
Ave. Daily Census	103	107	109	113

Description	FY 2012	FY 2013	FY 2014	FY 2015
# Discharges	8,620	8,936	9,273	9,628
# Patient Days	42,741	44,332	46,022	47,806
Ave. Daily Census	117	121	126	131

**Source: August 27, 2007, Hospital's second completeness letter response, Hospital's CON Bed Need Analysis, Attachment 1a, pages 20 through 22.*

42. The number of M/S bed needed in the fiscal years following the completion of the proposed project, based on the Hospital's bed need calculations is presented in the following table:

Table 7: Projected Medical-Surgical Bed Need*

Description	FY 2008	FY 2009	FY 2010	FY 2011
# M/S Bed Needed	114	119	121	126
Variance**	5	10	-18	-13
% Occupancy	93%	97%	78%	82%

Description	FY 2012	FY 2013	FY 2014	FY 2015
# M/S Bed Needed	130	135	140	146
Variance**	-9	-4	1	7
% Occupancy	85%	88%	91%	95%

**Source: August 27, 2007, Hospital's second completeness letter response, Hospital's CON Bed Need Analysis, Attachment 1a, pages 20 through 22)*

**Variance assumes Hospital staffed beds to be 139 for the years fiscal years cited.

43. The Hospital indicated that its bed need projections were completed without considering the impact that other Hospital services, such as surgical services, would have on the demand for medical-surgical inpatient services. *(October 10, 2007, Testimony of Karen Goyette at the public hearing)*

44. The Hospital indicated that in the month of October 2007, the average length of time an ED patient waited for medical-surgical bed placement was 4.3 hours. *(October 31, 2007, Late File 3, Section f., page 23)*

Other Facility Improvements

45. The new pavilion is to be built at the south end of the existing campus between the Emergency Department and Pavilion D. *(July 6, 2007, Initial CON application submission, page 18)*

46. The medical office entrance currently serves as the Hospital's main entrance. This entrance is utilized by patients of the medical offices, surgi-center drop-off and pick-up, as well as visitors to the Hospital. *(August 6, 2007, Hospital's first completeness letter response, pages 17 and 18)*

47. The proposal calls for the establishment of a dedicated main entrance that will allow for access to a covered drop off area. The proposed area will alleviate current congestion of individuals and vehicles at the medical office entrance. *(August 6, 2007, Hospital's first completeness letter response, pages 17 and 18)*

48. Expansion to the Hospital's central utility plant will include an additional boiler, emergency generator and electric chiller to fulfill the requirement presented by the new construction. *(July 6, 2007, Initial CON application submission, page 24 and August 6, 2007, Hospital's first completeness letter response, page 18)*

49. The Hospital conducted a parking and traffic study as part of its planning process to determine the most cost effective manner to enhance access and parking at the facility. The survey reflects the need for 150 additional parking spaces, which will

be devoted for patient and staff use. *(August 6, 2007, Hospital's first completeness letter response, page 18)*

50. The Hospital will relocate the current Emergency Department ambulance and walk-in entrances as part of the project. The relocation will allow controlled traffic and accessible parking for ambulances and walk-in patients. Currently, ambulance and walk-in patient traffic is combined with general Hospital traffic. Each component was evaluated as part of the parking and traffic study. *(August 6, 2007, Hospital's first completeness letter response, page 18)*

51. The proposal's shelled-in square footage ("SF") by pavilion floor is as follows:
    a. 1st Floor: Future radiology, pharmacy or surgery center use equals approximately 5000 SF and
       Future ED digital radiology room space equals approximately 185 SF;
    b. 2nd Floor: Future inpatient, outpatient and/or medical office space use equals approximately 16,000 SF
    c. 4th Floor: Future inpatient or ambulatory service space use equals approximately 22,000 SF.

    (August 6, 2007, Hospital's first completeness response, page 19)

Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on the Rates and Financial Condition of the Hospital
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

52. The project's total capital expenditure is $45,089,500 and is itemized as follows:

Table 8: Project Cost Itemization

Description	Component Cost
Building Work	$32,662,500
Medical Equipment	$2,795,972
Non-Medical Equipment	$2,249,028
Architect & Engineering Fees	$2,972,000
"Other" Costs*	$4,410,000
Total Capital Expenditure	**$45,089,500**

Note: *"Other" Costs include contingency, consulting fees, legal fees and permits.
(July 6, 2007, Initial CON application submission, page 18 and August 6, 2007, First Completeness Response Letter, page 15)

53. The project's building costs are itemized as follows:

Table 9: Building Cost Itemization

Description of Costs	New Construction	Renovation	Total Costs
Building Work	$29,300,000	$1,200,000	$30,500,000
Site Work	$2,000,000	$0	$2,000,000
Other Building Costs	$162,500	$0	$162,500
Total Building Costs	**$31,480,000**	**$1,200,000**	**$32,662,500**

(July 6, 2007, Initial CON application submission, page 28)

54. The project schedule is as follows:

Table 10: Project Schedule

Description	Date
Building Work Commencement Date	December, 2007
Building Work Completion Date	December, 2009
Licensure Date	December, 2009
Commencement of Operations Date	December, 2009

Note: DPH= Connecticut Department of Public Health
(July 6, 2007, Initial CON application submission, page 30 and August 6, 2007, Hospital's first completeness response, page 20 and Attachment XIX, pages 122 through 127)

55. The project has been designed in a manner which will allow for Hospital services to be provided in an uninterrupted fashion. *(October 10, 2007, Prefile testimony of Karen Goyette, page 10)*

56. An itemization of the proposal's 105,000 gross square feet is as follows:

Table 11: Building Space Itemization

Category Description	Sq. Ft. Allocation	Percentage Allocation
1st Floor – ED expansion including mechanical space and 5,000 square feet of unfinished shell space	35,000	33.3%
2nd Floor – unfinished shell space	16,000	15.2%
3rd Floor – M/S unit with 30 private rooms	21,000	20.0%
4th Floor - unfinished shell space	21,000	20.0%
Central Utility Plant	7,000	6.7%
ED Renovation – for materials management functions	5,000	4.8%
Total Proposed New Building Space	**105,000**	**100.0%**

(July 6, 2007, Initial CON application submission, pages 18 and 19 and August 6, 2007, Hospital's first completeness letter response, page 18)

57. The Hospital anticipates financing the proposal through the following sources:
    a) Connecticut Health and Educational Facilities Authority – which has provided the Hospital with a letter of interest for $30,000,000 in financing the majority of the proposed project; and
    b) Hospital operating funds of $15,589,500.
    (July 6, 2007, Initial CON application submission, pages 30 and 31)

58. The Hospital projects the following staffing additions/deletions in full-time equivalents ("FTE") by category attributable to the building project:

Table 12: Incremental Staffing Attributable to the Project

FTEs by Area	FY 2010	FY 2011	FY 2012
Nursing Care	20.1	25.0	30.0
Emergency Department	10.0	12.5	15.0
Patient Care	8.8	8.8	8.8
Indirect Staffing	15.8	15.8	15.8
Inpatient Psychiatric Care	-17.8	-17.8	-17.8
Total FTEs	**36.9**	**44.2**	**51.8**

Notes: Nursing Care includes a Nursing Director, RNs, LPNs, an APRN and Clinical Care and Info. Associates
ED includes a Physician, RNs, Patient Care Techs, and a Clinical Information Associate
Patient Care includes Pharmacist, Social Worker, Resource Mgr., Respir. Therp., Food Service, etc.
Indirect staffing includes Environmental Techs, Security Guards, Radiology & Med Techs., Transport, etc.
Inpatient Psych. includes Mgr., RNs, Admin., Clinical Care and Info. Associates and Occ. Therapist.
*(*August *27, 2007, Hospital's second completeness letter response, page 18)*

59. The Hospital projects incremental revenue from operations, total operating expense and (loss)/gain from operations associated for the initial first three full fiscal years of operating the expanded facility as follows:

Table 13: Incremental Financial Projections with the Project

Description	FY 2010	FY 2011	FY 2012
Incremental Revenue from Operations	$1,391,826	$6,807,924	$13,677,538
Incremental Total Operating Expense	$7,364,975	$10,178,046	$13,599,349
Incremental (Loss)/Gain from Operations	**($5,973,149)**	**($3,370,122)**	**$78,188**

(October 31, 2007, Hospital Late File Submission, Exhibit G, pages 42 and 43)

60. The projected incremental losses from operations in FYs 2010 and 2011 are due to increased salary and fringe benefit expenses, depreciation and interest expenses and other operating expenses associated with the implementation of the project. *(October 31, 2007, Hospital Late File Submission, Exhibit G, pages 42 and 43)*

61. The Hospital projects overall revenue from operations, total operating expense and (loss)/gain from operations associated for the initial first three full fiscal years of operating the expanded facility as follows:

Table 14: Hospital Overall Financial Projections with the Project

Description	FY 2010	FY 2011	FY 2012
Revenue from Operations	$174,720,742	$185,930,313	$198,847,650
Total Operating Expense	$178,119,011	$186,108,876	$197,350,028
(Loss)/Gain from Operations	**($3,398,269)**	**($1,178,563)**	**$1,497,622**

(October 31, 2007, Hospital Late File Submission, Exhibit G, pages 42 and 43)

62. The current and projected payer mix percentages for the first three years of operating the expanded facility are as follows:

Table 15: Hospital's Current and Three-Year Projected Payer Mix

Description	Current	Year 1	Year 2	Year 3
Medicare	37.7%	37.8%	38.2%	38.7%
Medicaid	6.7%	6.0%	5.8%	5.6%
TriCare (CHAMPUS)	0%	0%	0%	0%
Total Government	**44.4%**	**43.8%**	**44.0%**	**44.3%**
Commercial Insurers	54.4%	50.8%	50.6%	50.2%
Uninsured	5.2%	5.4%	5.4%	5.5%
Workers Compensation	0%	0%	0%	0%
Total Non-Government	**55.6%**	**56.2%**	**56.0%**	**55.7%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

(July 6, 2007, Initial CON application submission, page 32)

63. There is no State Health Plan in existence at this time. *(July 6, 2007, Initial CON application submission, page 4)*

64. The project is consistent with the Hospital's Long Range Plan and its Revised Master Facility Plan. *(July 6, 2007, Initial CON application submission, page 4)*

65. The Hospital has improved productivity and contained costs by undertaking energy conservation measures and employing group purchasing practices in its procurement of supplies and equipment. *(July 6, 2007, Initial CON application submission, pages 14 and 15)*

66. The proposal will not result in any change to the Hospital's teaching and research responsibilities. *(July 6, 2007, Initial CON application submission, page 16)*

67. The Hospital's current patient/physician mix is similar to that of other acute care hospitals in the region. The proposal is not expected to result in any change to this mix. *(July 6, 2007, Initial CON application submission, pages 16 and 17)*

68. The Hospital has sufficient technical, financial and managerial competence and expertise to provide efficient and adequate service to the public. *(July 6, 2007, Initial CON application submission, pages 12 and 13)*

69. The Hospital's rates are sufficient to cover the proposed capital expenditure and operating costs associated with the proposal. *(October 31, 2007, Hospital Late File Submission, Exhibit G, pages 42 and 43)*

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.

MidState Medical Center ("Hospital") is a non-profit, acute care hospital, whose campus is located at 435 Lewis Avenue in Meriden, Connecticut. The Hospital's parent corporation is Hartford Healthcare Corporation ("HHC"). Other HHC subsidiaries include Hartford Hospital and the Institute of Living. The Hospital proposes to undertake a facility building project ("project" or "proposal"), which represents the next major step in the implementation of the Hospital's master facility plan.

The major components of the project include: expansion of the Emergency Department, termination of psychiatric inpatient services, addition of 30 licensed medical-surgical inpatient beds and completion of other facility improvements. The project encompasses the construction of a four-story pavilion measuring approximately 100,000 square feet of new facility space and renovations to existing facility space measuring approximately 5,000 square feet. The Hospital proposes to shell-in approximately 43,000 square feet of new pavilion space. While OHCA appreciates the space constraints experienced by the Hospital, it remains concerned that approximately 40% of the newly constructed pavilion will be non-occupied, shell space. OHCA recognizes, however, that it is more cost-effective for the Hospital to invest in its long-term facility development today so that it may be in a better position to address health delivery system changes in the future. The project is scheduled to be completed in December 2009 and has been designed in a manner that will allow for Hospital services to be provided in an uninterrupted fashion.

Emergency Department Expansion

The Emergency Department ("ED") was originally designed to serve approximately 26,000 patient visits annually when it first opened in 1998. The department is now considered to be inappropriately sized in its square footage and number of treatment beds. Further, it is considered to be inappropriately designed to meet current and future demand for emergency services. The Hospital indicates that while it has been successful in implementing a number of initiatives to improve ED operations, physical constraints have hampered the department's ability to provide high quality and appropriate emergency services. Consequently, the Hospital is proposing a major expansion and redesign of the department.

In fiscal year ("FY") 2006 the ED provided approximately 47,500 patient visits, an increase of approximately 49% in the number of visits experienced since FY 1998. The 10,000 square foot ED will expand by 30,000 square feet to operate in a proposed 40,000 square foot department. Renovation work will total approximately 5,000 square feet of existing

space for materials management functions. The ED currently operates with 30 treatment beds. The Hospital's proposal calls for an increase of 24 treatment beds, resulting in a complement of 54 treatment beds. The proposed ED capacity is based on providing 60,000 visits annually.

The expansion plan incorporates other improvements as follows: improved circulation patterns; the latest in technology and disaster response provisions; and the establishment of an imaging suite, behavioral health module and assessment unit. The imaging suite will assist the Hospital in improving ED patient throughput by directly providing computed tomography and digital radiology services for patients treated in the ED. The behavioral health module will offer improved patient safety and privacy in a closed 9 bed unit. The module will also offer skilled clinicians to treat the special health care needs of this population. Lastly, the establishment of a 12 bed assessment unit, employing a concept of rapid triage and assessment, will reduce the time a patient waits to be seen by an ED physician and will minimize the use of core ED areas in the handling of non-emergent patient cases.

Although the proposed ED service expansion will improve accessibility to high quality emergency department services, OHCA finds the proposed size of the ED with its attendant overhead costs may lead to financial challenges for the Hospital. While the projected service volumes may be reasonable, the Hospital did not provide strong evidence that such ED demand can be sustained over the long term. OHCA does realize, however, that departmental space and floor design are critical elements in the operation of an efficient ED operation. Consequently, OHCA concludes that the proposed expansion is necessary for improving accessibility to ED services and maintaining a high level of quality ED services for individuals residing in the Hospital's service area.

Inpatient Psychiatric Service Termination

The Hospital seeks to terminate its psychiatric inpatient services. The plan includes transferring patients that present to the Hospital requiring inpatient psychiatric care primarily to the Institute of Living ("IOL") in Hartford, Connecticut or in some cases to other area psychiatric inpatient facilities that have the capacity to serve this population. As addressed earlier, the proposal further seeks to create a behavioral health module that will increase the number of dedicated psychiatric ED treatment beds from 4 to 9. In May of 2006, the Hospital established a formal relationship with the IOL through the signing a memorandum of understanding ("MOU"), which allows the Hospital to transfer stabilized psychiatric patients to IOL's inpatient service. Since its opening in 1998, the Hospital's psychiatric inpatient service has been operating within the framework of a 10 bed "swing unit". The unit primarily serves adult psychiatric patients and occasionally serves adult medical-surgical patients. The Hospital seeks to terminate the service due to ongoing medical-surgical occupancy constraints and difficulties it says it has experienced in adequately treating a diverse inpatient psychiatric population. The Hospital asserts that it cannot offer the same level of expertise required to provide special needs patients with care that a larger more specialized psychiatric hospital can provide.

A careful examination of the Hospital's psychiatric inpatient utilization for FYs 2004 through 2007 reveals that prior to the signing of the MOU with IOL, the unit's average daily census ("ADC") was 9 patients for FYs 2004 and 2005. Fiscal year 2006, the transition year where the MOU became effective in the last third of the fiscal year, exhibited a slight reduction in the unit's ADC to 7 patients. Even in FY 2007, the first full fiscal year the unit operated with the MOU in place, the unit's ADC was 5 patients. The number of annual discharges from the inpatient unit over the same time period, FYs 2004 through 2007, was 322, 382, 317 and 262, respectively.

OHCA finds that the average daily census and the number of annual discharges have remained consistently strong with or without the transfer memorandum in place. Consequently, OHCA believes that the Hospital has not provided any evidence to support that its psychiatric inpatient service needs for the area served by the Hospital have materially decreased. Additionally, the Hospital has not provided any evidence that existing providers have the willingness and ability to completely provide such services to this population. In fact, all the data examined by OHCA provides strong evidence to support the need for an inpatient psychiatric unit at the Hospital. In addition, OHCA believes that an individual requiring routine inpatient psychiatric care will be better served by receiving their treatment closer to home, where matters pertaining to patient support from family members and the establishment of appropriate aftercare treatment can be better achieved. Those individuals who require a higher level of psychiatric inpatient care may still be referred to the specialized hospitals that provide special needs psychiatric care. OHCA commends the Hospital in it efforts to develop beneficial working relationships with specialized psychiatric hospitals. The needs persist, however, for the adequate provisions of routine psychiatric inpatient services in the Hospital's service area. Finally, OHCA believes that the inpatient psychiatric unit will be supported by the creation of the 9 treatment bed behavioral health module in the ED. With improved medical management developing between the ED behavioral health module and the psychiatric inpatient unit, there may even be a point in the future when the relative demand for inpatient services may decline. Based on the above, OHCA concludes the Hospital's request to terminate its psychiatric inpatient services is denied. Additionally, as the demand for psychiatric inpatient services remains strong, the Hospital shall maintain a psychiatric inpatient service consisting of no less than 8 licensed beds.

Medical-Surgical Inpatient Beds

The Hospital seeks to construct a new 30 bed medical-surgical ("M/S") unit on the third floor of the proposed pavilion. The unit's 30 beds would increase the Hospital's complement of M/S inpatient beds to 138. In the aggregate the proposal increases the total number of licensed beds for all inpatient services from 130 to 160. The Hospital indicates its request is predicated on the following anticipated trends: an increasing number of annual M/S patient days; increasing M/S occupancy rates; continued increases in the proportion of the population that is 65 years of age and older; and increasing complexity of illness for those individuals receiving M/S inpatient care. The Hospital employed a use rate methodology to predict the anticipated number of required medical-

surgical inpatient beds to serve its existing service area population. Medical-surgical bed need was calculated for each fiscal year up to and including FY 2015. Based on a targeted 90% medical-surgical occupancy rate, the Hospital is projecting the need for 146 medical-surgical beds to meet its FY 2015 service demand. The Hospital indicated that due to the number of variables and factors used in calculating bed need, it is not seeking additional medical-surgical beds beyond the 138 M/S beds requested in this project.

The Hospital did not provide strong evidence that the demand for medical-surgical inpatient services would increase significantly, as the rate of increase as measured by the medical-surgical discharges per 1,000 population is equivalent to 2% annually. In fact, the Hospital projects the increased need for M/S beds without demonstrating the impact that other Hospital services, such as surgical services, could potentially have on the demand for medical-surgical inpatient services. Consequently, OHCA questions the thoroughness of the needs assessment conducted by the Hospital in considering the future requirements for medical-surgical inpatient beds as well as other various inpatient and outpatient health services that should have been considered within the context of the Hospital's long-term strategic planning process.

The Hospital solely relied on a relatively weak population growth projection and no increase in market share. OHCA recognizes that the Hospital does experience occasions when there are delays in placing an individual in a M/S bed. Although there may be several occurrences within a given week when a patient must wait for an M/S bed to become available, the Hospital did present evidence to show that on average the wait time to be admitted to an inpatient bed from the Emergency Department is 4.3 hours.

Consequently, OHCA is concerned that the Hospital's proposed M/S bed addition is based on projections that may not be realized. While this may be the case, OHCA also realizes that the Hospital's space constraints are impeding the Hospital's ability to provide efficient clinical care. OHCA concludes that the Hospital's complement of licensed medical-surgical beds should be increased to a level that is reflective of the Hospital's anticipated average daily census for FY 2011, the first full fiscal year after completion of the facility building project. An increase of 14 licensed medical-surgical beds will allow the Hospital flexibility in accommodating patients into its M/S service at times of peak admissions. Therefore, OHCA concludes that the Hospital's request to add 30 licensed medical-surgical inpatient beds is modified. The Hospital shall be approved to increase its complement of licensed medical-surgical inpatient beds by 14, from 99 to 113 beds.

Other Facility Improvements

Lastly, the Hospital's proposal seeks the following improvements to the its general facilities and physical plant: a dedicated main entrance that will allow for access to a covered drop-off area to alleviate the current congestion of individuals and vehicles at the medical office entrance; one-hundred-fifty (150) additional parking spaces that will be devoted for patient and staff use; relocation of the ED ambulance and walk-in entrances that will provide for greater traffic control and accessible parking for ambulances and walk-in patients; relocation of the Hospital's helipad; and central utility plant expansion that will provide for an additional boiler, emergency generator and electric chiller necessary to satisfy future plant requirements. OHCA finds the improvements to be reasonable and appropriate as the enhancements will improve travel logistics for patients, visitors and receiving ambulances and will be needed, in part, to satisfy additional physical plant requirements born by the project.

Order

Based upon the foregoing Findings and Rationale, the Certificate of Need application of MidState Medical Center ("Hospital") to undertake a facility building project, which includes the expansion of the Emergency Department, the termination of psychiatric inpatient services, the addition of 30 licensed medical-surgical beds and the completion of other facility improvements, at a proposed total capital expenditure of $45,089,500, is hereby modified and is subject to the following conditions:

1. The Hospital's request to undertake a facility building project, which encompasses the construction of a four-story pavilion measuring approximately one-hundred thousand (100,000) square feet of new facility space and renovations measuring approximately five thousand (5,000) square feet to existing facility space, is approved.

2. This authorization shall expire on July 1, 2012. Should the Hospital's building project not be completed by that date, the Hospital must seek further approval from the Office of Health Care Access ("OHCA") to complete the project beyond that date.

3. The Hospital shall not exceed the approved capital expenditure of $45,089,500. In the event that the Hospital learns of potential cost increases or expects that the final project costs will exceed those approved, the Hospital shall notify OHCA immediately.

4. The Hospital's request to expand its Emergency Department ("ED") into the first floor of the new pavilion is approved. The expansion will result in the following ED improvements:

    a) The addition of twenty-four (24) ED treatment beds, thereby, increasing the number of private treatment beds from thirty (30) to fifty-four (54) treatment beds;
    b) The establishment of an imaging suite, which will include one relocated computed tomography scanner from the Hospital's Radiology Department and the construction of two digital radiology rooms, the first room to be fully equipped and the second room to be shelled-in space for use at a later date;
    c) The creation of a separate behavioral health module consisting of 9 treatment beds within the closed unit; and
    d) The establishment of a 12 bed assessment unit that will be utilized to triage and treat non-emergent patient cases outside of the core areas of the department.

5. The Hospital's request to terminate its psychiatric inpatient services is denied. The Hospital shall continue to operate its psychiatric inpatient services with a complement of eight (8) licensed psychiatric inpatient beds.

6. The Hospital's request to add 30 licensed medical-surgical inpatient beds is modified. The Hospital is approved to increase its complement of licensed medical-surgical

inpatient beds by fourteen (14), from ninety-nine (99) to one-hundred and thirteen (113) licensed medical-surgical inpatient beds.

7. The building project will increase the Hospital's overall number of licensed general hospital beds by fourteen (14), from the current level of one hundred and thirty (130) beds to a resulting complement of one hundred and forty-four (144) licensed general hospital beds. The number of licensed newborn bassinets will remain unchanged from its current level of 12 bassinets.

8. The following facility improvements are approved:

    a) Creation of a covered main entrance, lobby and patient drop-off area;
    b) Expansion of on-campus parking;
    c) Expansion of the facility's central utility plant;
    d) Circulation changes to improve ambulance and vehicular traffic patterns; and
    e) Relocation of the Hospital's helipad.

9. The Hospital's proposed shelled-in space is approved. The Hospital shall be required to file with OHCA a request for approval to complete the approved shelled-in space. The quantification of shelled-in square footage ("SF") by pavilion floor is identified as follows:

    a) 1st Floor: Future radiology, pharmacy or surgery center space equaling approximately 5,000 SF and
    Future ED digital radiology room space equaling approximately 185 SF;
    b) 2nd Floor: Future inpatient, outpatient and/or medical office space equaling approximately 16,000 SF
    c) 4th Floor: Future inpatient or ambulatory service space equaling approximately 22,000 SF

10. Should the Hospital propose any change in the array of health care services offered and/or any change in its complement of existing major medical or imaging equipment, the Hospital shall file with OHCA appropriate documentation regarding its change, including either a Certificate of Need Determination Request or a Certificate of Need Letter of Intent.

Should the Hospital fail to comply with any of the aforementioned conditions, OHCA reserves the right to take additional actions as authorized by law.

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

Signed by Commissioner Vogel on March 4, 2008

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Date Cristine A. Vogel
Commissioner

CAV:jah