

Greer, Leslie

From: Martone, Kim
Sent: Thursday, September 03, 2015 1:25 PM
To: Hansted, Kevin
Cc: Olejarz, Barbara; Greer, Leslie; Riggott, Kaila; Roberts, Karen
Subject: FW: Letter of Determination
Attachments: Windham Form 2020 FINAL 9.3.2015.pdf

From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, September 03, 2015 12:55 PM
To: Martone, Kim
Subject: Letter of Determination

Ms. Martone:

Please find attached a Certificate of Need Determination Form, Form 2020, detailing Windham Hospital's proposal for the alignment of its critical care unit as a progressive care unit.

The original copy is following via FedEx.

Sincerely,

Janette Edwards

This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, or an employee or agent responsible for delivering the message to the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message, including any attachments.

September 3, 2015

Ms. Kimberly Martone
Director, Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capital Avenue, MS#13 HCA
Hartford, CT 06106

Dear Ms. Martone:

Please find enclosed a Certificate of Need Determination Form, Form 2020 detailing Windham Community Memorial Hospital's proposal for the alignment of its Critical Care Unit as a Progressive Care Unit.

Please don't hesitate to contact me for if you require further information.

Sincerely,


Janette Edwards

Director, Planning & Business Development



State of Connecticut Office of Health Care Access CON Determination Form Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner
Full Legal Name	Windham Community Memorial Hospital
Doing Business As	Windham Hospital
Name of Parent Corporation	Hartford HealthCare Corporation
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	112 Mansfield Avenue, Windham, CT 06226
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP
Contact Person at Facility , including Title/Position: This Individual at the facility will be the	Janette Edwards, Director Planning & Business Development

Petitioner's Designee to receive all correspondence in this matter.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	112 Mansfield Avenue, Windham, CT 06226
Contact Person's Telephone Number	860-456-6800
Contact Person's Fax Number	860-456-6838
Contact Person's e-mail Address	Janette.edwards@hhchealth.org

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Alignment of Critical Care Unit as a Progressive Care Unit
- b. Estimated Total Project Cost: \$0
- c. Location of proposal, identifying Street Address, Town and Zip Code:
Windham Hospital, 112 Mansfield Avenue, Windham, CT 06226
- d. List each town this project is intended to serve:
Existing service area (no changes in communities currently served).
- e. Estimated starting date for the project: Upon OHCA's approval of this determination request.

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and the target population to be served.

The mission of Windham Community Memorial Hospital (“Windham”) is “to enhance the lives and well being of people in the communities we serve by providing quality health care.” In furtherance of its mission, Windham is committed to providing access to the right care, in the right location, and at the right time. To achieve this goal, Windham is proposing to provide services to patients who have historically received care in its critical care unit (“CCU”) in a new progressive care unit (“PCU”) without changing the clinical care provided to these patients.

Windham is a 130 bed hospital and currently delivers inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23- bed medical-surgical unit, and a 12-bed unit historically referred to as the CCU.

The average daily census at Windham for FY 2015 through July is 35 patients for the entire hospital. The following generally describes the types of patients cared for in the CCU during this period:

- Average daily census for critical care patients was 2.06 or 17% of total patients treated on the CCU with a 1.9 day average length of stay (these patients can be treated in PCU);
- Average daily census for intermediate level of care (“ILC”) patients in the CCU was 1.5 or 12.5% of total patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Average daily census for uncomplicated medical surgical patients was 5.16 or 43% of patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Overall, the CCU operates at 72.5% occupancy with only 17% needing CCU/PCU services.

Windham experienced a decline in critical care patient volume and length of stay for patients cared for in its CCU in recent years and these patients could be cared for in a PCU:

- 2013: 365, average length of stay 3.13 days
- 2014: 366, average length of stay 2.6 days
- 2015: 332 through July, average length of stay 1.9 days

Based on historical utilization and patient acuity to date, Windham proposes to address the clinical needs of its patients currently cared for in its CCU by transitioning the current 12-bed CCU to a 4-bed PCU. The proposed PCU will serve the same Windham patients who were previously treated in its CCU. Patients who will be admitted to the PCU will continue to be patients who require medical and nursing care beyond general inpatient level of services.

According to the American Association of Critical Care Nurses, progressive care is part of the continuum of critical care. The following may be applicable to PCU level patients:

- The patient has a persistent unstable status requiring continuous bedside cardiac and/or respiratory monitoring with frequent blood pressure monitoring as outlined in the PCU;
- The patient requires acute and/or complex medical monitoring as outlined in the PCU;

- The patient requires complex nursing treatment regimen; and
- The patient requires medication therapy requiring a higher level of assessment and intervention.¹

PCU patients typically include patients that have a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability and an increased ability to participate in their care.² In the last five years, patients who have been treated in the Windham CCU have met the definition for PCU level of care. The patients requiring progressive care will be managed with the same technology and staff competency levels that currently exist in the CCU. The only change will be that there will no longer be a dedicated physical space with 12 beds, which is clearly not needed based upon census for the last three years. Accordingly, this proposal will not change the clinical care provided to patients after the transition to the proposed PCU.

Should Windham patients cared for in the PCU require tertiary care services not available at Windham, these patients would continue to be transferred like they are from the CCU today. For example, Hartford Hospital is available to receive these patients and currently does receive these patients. The Windham Paramedic Program is readily available for necessary transport of these patients if the need arises during an inpatient stay. All full-time paramedics employed by the Windham Paramedic Program are critical care transport certified, or are in the process of receiving certification as a CCEMT-P or FP-C³. This is unique among paramedic transport services, and it ensures the highest level of care is available to Windham's patients during transport.

While the level of services currently provided to patients in the CCU will not change as a result of the transition to the PCU, it will allow space that is currently being underutilized to be utilized more efficiently and more responsively to the clinical needs of the community.

The services provided in the CCU will continue to be provided in the PCU. Please see Exhibit 1 for a list of the services currently provided to patients in the CCU, which will remain after the transition to a PCU.

There is no proposed change to the Windham license, attached as Exhibit 2.

Based upon the foregoing, Windham Hospital respectfully requests confirmation that the alignment of its Critical Care Unit to a Progressive Care Unit will not require a CON.

¹ CriticalCareNurse Vol 31, No. 3, JUNE 2011

² CriticalCareNurse Vol 31, No. 3, JUNE 2011

³ In the case of those paramedics who are also on the LifeStar flight crew. These certifications are granted by The Board for Critical Care Transport Certification.

Exhibit 1

Services provided at Windham CCU will continue at the PCU and will include:

- Management of sudden acute event on admitted medical surgical patient;
- Short term ventilator support (post anesthetic or otherwise);
- Hemodynamic instability due to hypovolemia, hemorrhage, sepsis, or other cause;
- Central nervous system depression that threatens to compromise airway and protective reflexes;
- Management of renal or electrolyte abnormalities;
- Extended intra-operative time and vigorous fluid resuscitation with the probability of fluid shifts and massive third spacing;
- Patients with delirium tremens requiring continuous sedative infusions without respiratory failure requiring intubation;
- Patients requiring continuous observation and pulse oximetry due to upper airway disease;
- Monitoring possible intra-operative cardiac events (i.e. ST changes, arrhythmias, etc.) which are asymptomatic and patient is hemodynamically stable;
- Arrhythmias that are hemodynamically stable (IE. atrial fibrillation/flutter, supra ventricular tachycardia);
- Angina pectoris that is hemodynamically stable but requires intravenous nitroglycerin for prophylaxis of the angina;
- Mild to moderate congestive heart failure without signs/symptoms of shock;
- Hypertensive conditions without evidence of end-organ damage;
- Patients requiring initiation of and maintenance intravenous infusions of anti-arrhythmics, and vasoactive inotropic medications;
- Patients with a tracheostomy tubes requiring aggressive pulmonary toileting or requiring arterial blood gases;
- Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or continuous positive airway pressure;
- Post-op patients after being fully recovered in PACU and meeting all other CSD criteria; and
- Patients requiring monitoring for seizure activity or obstructive sleep apnea.

WINDHAM LICENSE

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0061

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Windham Community Memorial Hospital, Inc. of Willimantic, CT d/b/a Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is hereby licensed to maintain and operate a General Hospital.

Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is located at 112 Mansfield Avenue, Willimantic, CT 06226.

The maximum number of beds shall not exceed at any time:

14 Bassinets
130 General Hospital Beds

This license expires **September 30, 2015** and may be revoked for cause at any time.

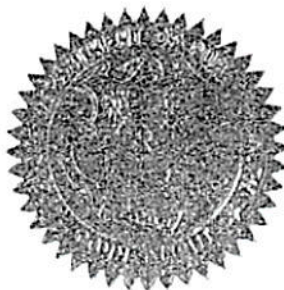
Dated at Hartford, Connecticut, October 1, 2013.

Satellites:

Windham Middle School Health Center, 123 Quarry Street, Willimantic, CT
Windham High School Wellness Center, 355 High Street, Willimantic, CT
*Charles Barrows STEM Academy School-Based Health Center, 141 Tuckie Road, N. Windham, CT

License revised to reflect:

*Added (1) Satellite effective 8/26/13



Handwritten signature of Jewel Mullen in cursive.

Jewel Mullen, MD, MPH, MPA
Commissioner

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Windham Community Memorial Hospital

Project Title: Alignment of Critical Care Unit as a Progressive Care Unit

I, David A. Whitehead, President of Windham Community Memorial Hospital, being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.

David A. Whitehead 09/03/15
Signature Date

Subscribed and sworn to before me on 9/3/15

Mary E. Vega
Notary Public/Commissioner of Superior Court

My commission expires: 4/30/16

Greer, Leslie

From: Hansted, Kevin
Sent: Wednesday, September 09, 2015 9:57 AM
To: Greer, Leslie
Subject: FW: Determination #15-32026-DTR

Leslie, please add the below to the record.

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, September 03, 2015 4:27 PM
To: Hansted, Kevin
Subject: RE: Determination #15-32026-DTR

Attorney Hansted,

I am confirming that the services currently provided to patients on the CCU will not change as a result of the transition to a PCU.

Please let me know if you require any further information.

Janette Edwards

From: Hansted, Kevin [<mailto:Kevin.Hansted@ct.gov>]
Sent: Thursday, September 03, 2015 1:49 PM

To: Edwards, Janette
Subject: Determination #15-32026-DTR

Dear Ms. Edwards,

I am in receipt of your determination request regarding the alignment of the Critical Care Unit (“CCU”) as a Progressive Care Unit (“PCU”) at Windham Hospital. Can you confirm for me that all of the services that are currently offered in the CCU will be offered in the PCU?

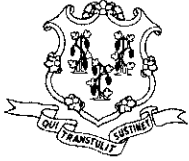
Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 9, 2015

Janette Edwards
Director Planning & Business Development
Windham Community Memorial Hospital
112 Mansfield Avenue
Windham, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital


Dear Ms. Edwards:

On September 4, 2015, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Windham Community Memorial Hospital ("Petitioner") with respect to the alignment of clinical services at Windham Hospital.

Windham Hospital is a licensed nonprofit hospital and part of Hartford HealthCare Corporation. Windham Hospital currently provides inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23-bed medical-surgical unit, and a 12-bed critical care unit ("CCU"). The Petitioner is proposing to implement a progressive care unit ("PCU") in place of its CCU and reduce the number of beds in the PCU to four (4). The medical services currently provided in the CCU will continue to be provided in the new PCU to the same patient population. Also, there is no proposed change to the Petitioner's license.

Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), a certificate of need is required for the "termination of inpatient or outpatient services offered by a hospital..." The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a **CON is not required** for the Petitioner's proposal.

Sincerely,


Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

* * * COMMUNICATION RESULT REPORT (SEP. 9. 2015 2:22PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FILE MODE	SEP. 9. 2015 2:21PM OPTION	ADDRESS	RESULT	PAGE
270 MEMORY TX		98604566838	OK	2/2

REASON FOR ERROR
 E-1) HANG UP OR LINE FAIL
 E-3) NO ANSWER

E-2) BUSY
 NO FACSIMILE CONNECTION



**STATE OF CONNECTICUT
 DEPARTMENT OF PUBLIC HEALTH
 OFFICE OF HEALTH CARE ACCESS**

FAX SHEET

TO: JANETTE EDWARDS

FAX: 860 456 6838

AGENCY: WINDHAM COMMUNITY MEMORIAL HOSPITAL

FROM: OHCA

DATE: 9/9/15 **Time:** _____

NUMBER OF PAGES: 2
(including transmittal sheet)

Comments: Attached is the determination regarding Report Number 15-32026-DTR Regarding Alignment of Clinical Services at Windham Hospital

PLEASE PHONE Barbara K. Olejarsz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 Fax: (860) 418-7053

**410 Capitol Ave., MS#13HCA
 P.O.Box 340308
 Hartford, CT 06134**

Attorney Dennis O'Brien

120 Bolivia Street, Willimantic, Connecticut 06226 Tel (860) 423-2860 Fax (860) 423-1533

September 25, 2015

Ms. Kimberly R. Martone
Director of Operations
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308



**Re: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital**

Dear Ms. Martone:

I am writing pursuant to Connecticut General Statutes (C.G.S.) section 19a-638(22)(c)(1), authorizing any "person" who is unsure whether a certificate of need is required under section 19a-638 to send a letter to your office asking that you make a determination as to whether a certificate of need is required. It is my understanding that if a determination is made that a certificate of need is required, an extensive review process will be undertaken with opportunity for public input pursuant to C.G.S. sections 19a-639 and 19a-639a.

With all due respect, I believe your office's prior determination that no certificate of need is required in the above-entitled matter should be reconsidered and that the processes set forth in sections 19a-639 and 19a-639a should be undertaken in the interests of due process of law and all of the many persons certain to be negatively impacted by the transformation of the Windham Hospital critical care unit (CCU) to what Hartford Health Care (HHC) is calling a progressive care unit (PCU).

I have continuously resided in Willimantic, CT for more than forty years, a mile or two from Windham Community Memorial Hospital (WCMH). I have been a member of the bar of this state for forty-three years. From 1980 to 1995, I was chief counsel and deputy director of Connecticut Legal Services, our statewide legal aid organization. In 1995, I entered the private practice of law, and I later served as judge of probate for the District of Windham from January 1, 1999, until I retired from that position on January 5, 2011.

For the final four years of my judgeship, I served as the first administrative judge of the Northeast Regional Children's Probate Court at 90 South Park Street, Willimantic, covering child protection cases from most of two of the eight counties in Connecticut. I continue to be town attorney for three area towns, Andover, Ashford, and Chaplin, CT. Today, I am writing to you only in my capacity as an individual "person."

To: Ms. Kimberly R. Martone
Office of Health Care Access
September 25, 2015
Page Two

According to the 2020 form filed earlier this month by the president of Windham Hospital, an employee of HHC, the hospital plans "to address the clinical needs of its patients currently cared for in its CCU by transitioning the current 12-bed CCU to a 4-bed PCU." Previously, it was widely publicized by HHC that it planned to eliminate 119 jobs at Windham Hospital. It is impossible for this layperson and experienced public law lawyer to imagine how these changes will not result in the level of "termination of inpatient or outpatient services offered by a hospital," sufficient to require a CON per C.G.S. section 19a-638(a)(5), and due process of law protections for affected persons provided in C.G.S. sections 19a-639 and 19a-639a.

There have been at least two well attended public forums here in Willimantic to address this proposed termination of vital health care services by HHC at WCMH. The latest, led by our local legislative delegation, was held at the Windham Middle School on Monday, September 21, 2015. Among the 200 attendees were speakers who are area medical professionals, including doctors and nurses. One physician stated that the WCMH "division of medicine" voted that the ICU should not be terminated in favor of a PCU.

Ever since this very controversial proposal publicly surfaced, I have heard local physicians say that the replacement/termination of the ICU and loss of critical care personnel and on site capacity 24/7 at WCMH will have a ripple effect, causing loss of physician confidence in the emergency care component of the hospital and further diminishing patient care and numbers, which will lead to additional cuts in service to this community, and possibly to the ultimate demise, literally or figuratively, of WCMH..

As a former legal aid lawyer and children's court judge here in town, I am very familiar with the large low income community here. Our school population is predominantly low income, a great many of whom are English Language learners.

Thousands here lack practical access to motor vehicles. Public transportation service in this urban enclave situated in the most rural county in our state is extremely limited and inadequate. The loss of our ICU at WCMH and lack of transportation will surely lead to unavailability of health care services to those in need and dire consequences for some, perhaps many. In my view this would constitute a termination of services.

The likely consequences of the cutbacks proposed by HHC for WCMH in its 2020 form are of great magnitude and warrant much more input by citizens, patients and medical professionals to the OHCA than the HHC provided in its 2020 filing. Again, with all due respect, the OCHA's September 9, 2015 determination in this hugely important situation affecting thousands of people here was made only on the basis of what appears to be a self-serving form 2020 sworn to by an HHC administrator apparently lacking a

To: Ms. Kimberly R. Martone
Office of Health Care Access
September 25, 2015
Page Three

strong background in health care, rather than by the hospital chief of staff or another locally experienced physician. As an experienced litigator, I doubt that this affiant would qualify as an expert witness on the question addressed in his affidavit as to whether the proposed change would be a termination of service necessitating a CON.

At the very beginning of its form 2020 narrative, HHC/WCMH states that "The mission of Windham Community Memorial Hospital ('Windham') is **to enhance the lives and well being of people in the communities we serve by providing quality health care.** In furtherance of its mission, Windham is committed to providing access to the right care, in the right location, at the right time."

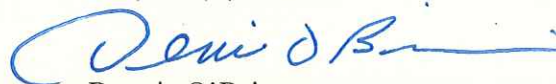
Given what many local professional health care providers are saying about the likely effects of what HHC/WCMH is proposing to do, among many other claims of the hospital, this rather curious introductory portion of the hospital's form 2020 in combination with the entirety of HHC's proposal should be subjected to close additional scrutiny by the OHCA in a transparent open ended due process proceeding per state law.

Not that it is expressly required by law, though it certainly should be, the HHC/WCMH form 2020 was filed without notice to the public, press or legislators. When HHC announced the September 9, 2015 determination based only on the 2020, everyone here with the possible exception of HHC/WCMH administration, was shocked. All things considered, the magnitude of this situation calls for much more in the way of due process, and that process is provided for in General Statutes sections 19a-639 and 639a.

On my own behalf, as a "person" within the meaning of C.G.S. sections 19a-638(22)(c)(1) and 19a-630(14), I therefore respectfully but firmly ask that the OHCA reconsider the September 9, 2015 determination based only on the HHC/WCMH form 2020, and conclude that a certificate of need is in fact required in this case, and that all CON procedures set forth in the applicable statutes and regulations, including a public hearing, be implemented before any changes in health care service proposed by HHC/WCMH may be undertaken.

Thank you for your anticipated attention to my letter and request. Please contact me at 860-208-2345, if you would like additional information from me.

Very truly yours,



Dennis O'Brien
Attorney at Law



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 30, 2015

Dennis O'Brien, Esq.
120 Bolivia Street
Willimantic, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Attorney O'Brien:

Thank you for your letter of September 25, 2015 regarding the determination issued by the Office of Health Care Access ("OHCA") under Docket Number 15-32026-DTR.

OHCA understands and appreciates your concerns. In making its determination OHCA's jurisdiction is limited by Conn. Gen. Stat. § 19a-638; specifically § 19a-638(a)(5) in this matter. § 19a-638(a)(5) mandates that a certificate of need be filed when a hospital is proposing to terminate inpatient or outpatient services offered by the hospital. The information provided by Windham Hospital in its 2020 form, and further confirmed via written communications between OHCA and Windham Hospital, the services currently being offered in the critical care unit will continue to be offered in the new progressive care unit. While Windham Hospital may be reducing the extent to which services are being offered, it is not terminating any services. OHCA's jurisdiction does not extend to reductions in the hours a particular service is offered or the number of beds used to offer that service.¹ Therefore, OHCA has no legal basis upon which it can require Windham Hospital to file a certificate of need application.

At your convenience, the complete record of this matter can be viewed on OHCA's website at <http://www.ct.gov/dph/ohca>.

Sincerely,

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

¹ Conn. Gen. Stat. § 19a-638(a)(12) requires a certificate of need for an increase in the licensed bed capacity of a health care facility. However, Windham Hospital is not seeking an increase in its licensed bed capacity.

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

Greer, Leslie

From: Martone, Kim
Sent: Thursday, October 01, 2015 1:53 PM
To: Hansted, Kevin
Cc: Greer, Leslie; Riggott, Kaila; Roberts, Karen
Subject: FW: Emailing - Final letter sent to OHCA for reconsideration regarding CON.pdf
Attachments: Final letter sent to OHCA for reconsideration regarding CON.pdf

From: Gregory Kotecki [<mailto:GKotecki@aftct.org>]
Sent: Thursday, October 01, 2015 1:26 PM
To: Martone, Kim
Subject: FW: Emailing - Final letter sent to OHCA for reconsideration regarding CON.pdf

Dr. Mullen and Commissioner Martone:

Please accept the attached letter. A hard US mailed version will follow.

Greg Kotecki
AFT Connecticut
AFLCIO, CLC



AFT Connecticut
AFT, AFL-CIO

Teachers
PSRP
Higher Education
Public Employees
Nurses and Health
Professionals

35 Marshall Road
Rocky Hill, CT 06067
860/257-9782
Fax: 860/257-8214
Toll Free: 888/398-3373
www.aftct.org

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SECRETARY-TREASURER

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Harry Rodriguez
Jim Romano
Kathy Sanner
Martha Shoemaker
Mary Symkowicz

October 2, 2015

Dr. Jewel Mullen
Commissioner, Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Ms. Kimberly Martone
Director, Office of Health Care Access
410 Capitol Avenue
MS#13HCA
Hartford, CT 06134-0308

**RE: Request for reconsideration CON 15-32026-DTR form 2020
determination for Windham Hospital Alignment of Services as a
Progressive Care Unit**

Dear Dr. Mullen/Ms. Martone:

My name is Greg Kotecki, and I am a Field Representative for the AFT Connecticut, a Labor Union that represents the registered nurses' Union at Windham Hospital. In addition, AFT Connecticut represents the Windham United Union, which is the Union that represents all of the non-nurse direct care givers at Windham Hospital.

Pursuant to 19a-638 of the Connecticut General Statutes, I am requesting reconsideration regarding your agency's decision to not require a CON for the changes that have taken place at Windham Hospital.

I make my request for a CON reconsideration based on the following omissions/misrepresentations contained in the Hospital's form 2020 submission:



Objection 1

1. Section I Windham Hospital's clear omission and lack of authority and standing.

In accordance with the original integration agreement (CON Docket Number: 08-31178-CON see attached) that resulted in the integration of *Windham Community Memorial Hospital* (herein referred to as WCMH) into *Hartford Hospital Care Corporation* (herein referred to as HHCC), this newly created and OHCA approved integrated agreement clearly outlined HHCC's control over Windham Hospital.

In the original CON that integrated the two entities together, the following was stated under the *Finding of Fact* section 4 (page 3 of 13):

Under the proposed integration WCMH will become a wholly-owned subsidiary of HHCC similar to Hartford Hospital and MidState Medical Center. (June 2, 2008, Letter of Intent)

Also, under the *Findings of Fact* subsection 12 (page 5 of 13), it stated:

HHCC shall have the following powers and rights as set forth in Section 1.3 of Schedule 1.2:

(a) *The sole power to elect and remove, with or without cause members of the WCMH Board.*

(b) *Review and approve, disapprove, or modify annual operating and capital budgets; significant proposed programs and expenditures, the purchase of significant operating or capital assets not contemplated in an approved budget or plan; and the borrowing of any sum in excess of \$1,000,000 with a stated ten of greater than one year.*

(c) **Approve, disapprove, modify or direct the implementation of strategic plans, programmatic plans; health care standards of care; utilization review; and program coordination with other entities or persons in HHCC's health care system. (emphasis's added)**

(d) **Approve or disapprove any voluntary dissolution, merger or consolidation of WCMH** or the sale, pledging, leasing or transfer of any substantial amount of WCMH's assets or the creation or acquisition of any significant subsidiary or affiliate corporation, significant contracts which WCMH in its discretion may refer to HHCC for review or approval; the selection of certified public accountants for WCMH; the filing of any Certificate of Need application for an expenditure or program outside of WCMH's ordinary business. **(emphasis's added)**

(e) Approve or establish guidelines or parameters for governing WCMH's participation in managed care contracts. (September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of HHCC and WCMH Integration Agreement, page 4).

The original CON also mandated the following in subsection 18 a & b:

18. The Applicants stated that:

(a). The day to day operations of WCMH will remain the responsibility of the WCMH Board of Directors, the Chief Executive Office and administrative staff,

(b) The reserve powers of the agreement require WCMH to get approval from HHCC for certain fundamental decisions that will be subject to HHCC's or the members approval (e.g., annual budgets, major capital purchases exceeding certain capital thresholds, and Certificate of Need projects), (Emphasis added)

Therefore, WCMH clearly lacked the authority and standing to request a determination as a single entity. Both HHCC and WCMH should have sought the desired determination. Form 2020 clearly contemplated such a circumstance as the form allowed for joint filing in section 1

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table. (Emphasis added)

Objection 2

2. **WCMH's failure to apply for a CON when it changed its Critical Care Unit (herein referred to as CCU) designation to a Progressive Care Unit (herein referred to as a PCU).**

In section IV Proposal Description of the submitted 2020 form, WCMH stated:

Windham experienced a decline in critical care patient volume and length of stay for patients cared for in its CCU in recent years and these patients could be cared for in a PCU:

- 2013: 365. average length of stay 3.13 days
- 2014: 366, average length of stay 2.6 days
- 2015: 332 through July, average length of stay 1.9 days

*Based on historical utilization and patient acuity to date, Windham proposes to address the clinical needs of its patients currently cared for in its CCU by transitioning the current 12-bed CCU to a 4-bed PCU. **The proposed PCU will serve the same Windburn patients who were previously treated in its CCU, Patients who will be admitted to the PC1.1 will continue to be patients who require medical and nursing care beyond general inpatient level of services.** (Emphasis added)*

The Hospital also made certain representations at the bargaining table¹ with the Union that the current CCU has, for some time, served as both a recovery room for Post-Anesthesia Care Unit (herein referred to as PACU) patients as well as a PCU patients.

Based on this omission both by way of the 2020 form, as well as practice and disclosure to the Union at the bargaining table, WCMH should have requested a CON, and OHCA should have demanded one be filed when it changed the level of care in the CCU to its current PCU configuration.

Precedent for this “Retro CON” request can be found in: *Certificate need report # 13-31829-DTR Operational Status of certain outpatient services at or by Lawrence and Memorial Hospital*² (herein referred to as L&M). In a letter dated April 2, 2013, your agency stated the following:

Based upon a review of the matter outlined above, OHCA determines the following:

- a. *Lawrence and Memorial Hospital is required to file a Certificate of Need request for the termination of its Outpatient Behavioral Medicine Counseling Services, Obstetrics Clinic Services in March 2008.*
- b. *Associated Specialists of Southeastern Connecticut, Inc., an affiliate of the Hospital and a health care facility, is required to file a Certificate of Need request for the establishment of Outpatient Behavioral Medicine Counseling Services, Obstetric Clinic Services and HIV/AIDS Clinic Services in April of 2008.*

¹ The two Unions and the Hospital are currently engaged in decisional bargaining over the closure of the CCU and the transformation of the CCU into a Progressive Care Unit. Minutes of such negotiations shall be made available upon request from OHCA.

² See attached determination

Clearly OHCA has exercised such authority and should in this case as well. In the L&M case cited, your agency force L&M to file a CON **five years after L&M failed to timely and properly file in the case cited above.**

Objection 3

WCMH is currently violating its own CCU Admission/Transfer Orders Policy, and it does not have any PCU policies in effect at this time

WCMH is currently in violation of its current policies regarding care in the current CCU. In WCMH's own CCU policy titled *Admission/Transfer Orders Policy* (see attached), it clearly states that "All patients admitted to the CCU require specific CCU orders, written by attending or covering physician. Orders must be written prior to patient arriving on the unit." With WCMH freely admitting that it cares for non-CCU patients in CCU, it violates its own policy while at the same time does not have any PCU policies in effect nor did it offer any such policies when it sought OHCA approval of a PCU designated Unit.

Objection 4

WCMH failed to disclose that it lacks the necessary transportation for its critical care unit trained Paramedics.

Should Windham patients cared for in the PCU require tertiary care services not available at Windham, these patients would continue to be transferred like they are from the CCU today. For example, Hartford Hospital is available to receive these patients and currently does receive these patients. The Windham Paramedic Program is readily available for necessary transport of these patients if the need arises during an inpatient stay. All full-time paramedics employed by the Windham Paramedic Program are critical care transport certified, or are in the process of receiving certification as a CCEMT-P or PP-0¹. This is unique among paramedic transport services, and it ensures the highest level of care is available to Windham's patients during transport.

Although there is no dispute that WCMH's Paramedics have the required certification for the transportation of critical care patients, **WCMH failed to disclose that it does not have the required transportation vehicles to actually transport critical care patients.** WCMH currently uses SUV-type vehicles only. It does not have the required Ambulances necessary to transport critically ill patients. WCMH relies on local government owned and operated ambulances to transport patients to other facilities. WCMH Paramedics rarely ride the entire transport route when

transporting patients. Therefore, patients cannot possibly benefit from WCMH's critical care transport certified Paramedics.

OHCA should also note that Marc Scrivener, Chief for the town of Willimantic Fire Department, stated at public hearing³ that this proposal "will increase transport times and have a chilling effect on recruiting volunteer EMS/paramedics."

Objection 5

WCMH misrepresented the facts regarding providing the same level of services Section IV Proposal description.

In *Section IV Proposal Description* of the 2020 form, the Hospital made certain misrepresentations describing the level of services that would be provided when the Hospital converts its CCU to a PCU:

While the level of services currently provided to patients in the CCU will not change as a result of the transition to the PCU, it will allow space that is currently being underutilized to be utilized more efficiently and more responsively to the clinical needs of the community.

The services provided in the CCU will continue to be provided in the PCU. Please see Exhibit 1 for a list of the services currently provided to patients in the CCU, which will remain after the transition to a PCU,

What the Hospital failed to mention is that by changing the level of care from a CCU model of care to a PCU model of care, the nurse-to-patient ratio will change from CCU level of care of 1:2 to PCU level of care of 1:4. This is clearly a change that will severely impact care at WCMH.

In addition, one of the main concerns that exists is in the event that a patient "crashes," meaning their condition declines in a very short period of time, the Hospital does not currently have a plan regarding how that patient will be treated. We also believe that such a plan would require OHCA's approval since the level of care would be changed.

³ See attached YouTube video <https://www.youtube.com/watch?v=YnsZ3lnMguk>

Objection 6

All of the changes described above constitutes a violation of the original order that integrated the two entities together: *Docket Number: 08-31178-CON*, which stated:

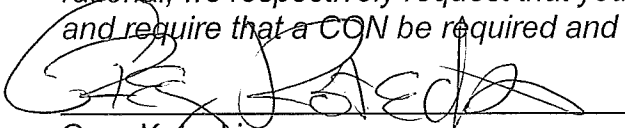
ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Windham Community Memorial Hospital ("WCMH" or "Hospital") and Hartford Health Care

Corporation, Inc. ("HHCC") (together referred to as "Applicants") for the integration of WCMH into HHCC with no associated capital expenditure, is hereby Approved, subject to the following conditions:

- 1. This authorization expires on January 31, 2010. Should the Applicants proposal not be completed (i.e. final agreement are executed) by that date, the Applicants must seek further approval from OHCA to complete the project beyond that date.*
- 2. Within 60 days of the completion of the integration of WCMH into HHCC, the Applicants shall file with OHCA; a full copy of any and all signed, dated and completed final integration agreements including attachments indicating the integration of WCMH into HHCC has occurred.*
- 3. If in the future there is any change in the ownership structure of WCMH or its affiliates or any change in control of WCMH, the Applicants shall file a CON Determination Form with OHCA.*
- 4. If in the future there is any change in WCMH service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA. (Emphasis added)***
- 5. As there is no associated capital expenditure with this proposal, in the event that the Applicants learn of potential costs associated with this proposal, the Applicants shall notify OHCA immediately.*

Based on the foregoing, including all the supplied information, documents and rational, we respectfully request that your agency immediately reopen this case and require that a CON be required and applied.



Greg Kotecki
Field Representative
AFT Connecticut
AFL-CIO CLC

Date

10/2/15

Windham
Hospital
Connect to healthier.

September 3, 2015

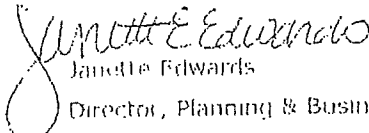
Ms. Kimberly Martone
Director, Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capital Avenue, MS # 13 HCA
Hartford, CT 06106

Dear Ms. Martone:

Please find enclosed a Certificate of Need Determination Form, Form 2020 detailing Windham Community Memorial Hospital's proposal for the alignment of its Critical Care Unit as a Progressive Care Unit.

Please don't hesitate to contact me for if you require further information.

Sincerely,


Janette Edwards

Director, Planning & Business Development



**State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020**

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner
Full Legal Name	Windham Community Memorial Hospital
Doing Business As	Windham Hospital
Name of Parent Corporation	Hartford HealthCare Corporation
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	112 Mansfield Avenue, Windham, CT 06226
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP
Contact Person at Facility, including Title/Position: This Individual at the facility will be the	Janette Edwards, Director Planning & Business Development

Petitioner's Designee to receive all correspondence in this matter.

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail 112 Mansfield Avenue, Windham, CT 06226

Contact Person's Telephone Number 860-456-6800

Contact Person's Fax Number 860-456-6838

Contact Person's e-mail Address Janette.edwards@hhchealth.org

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Alignment of Critical Care Unit as a Progressive Care Unit
- b. Estimated Total Project Cost: \$0
- c. Location of proposal, identifying Street Address, Town and Zip Code:
Windham Hospital, 112 Mansfield Avenue, Windham, CT 06226
- d. List each town this project is intended to serve:
Existing service area (no changes in communities currently served).
- e. Estimated starting date for the project: Upon OHCA's approval of this determination request.

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and the target population to be served.

The mission of Windham Community Memorial Hospital ("Windham") is "to enhance the lives and well being of people in the communities we serve by providing quality health care." In furtherance of its mission, Windham is committed to providing access to the right care, in the right location, and at the right time. To achieve this goal, Windham is proposing to provide services to patients who have historically received care in its critical care unit ("CCU") in a new progressive care unit ("PCU") without changing the clinical care provided to these patients.

Windham is a 130 bed hospital and currently delivers inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23- bed medical-surgical unit, and a 12-bed unit historically referred to as the CCU.

The average daily census at Windham for FY 2015 through July is 35 patients for the entire hospital. The following generally describes the types of patients cared for in the CCU during this period:

- Average daily census for critical care patients was 2.06 or 17% of total patients treated on the CCU with a 1.9 day average length of stay (these patients can be treated in PCU);
- Average daily census for intermediate level of care ("ILC") patients in the CCU was 1.5 or 12.5% of total patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Average daily census for uncomplicated medical surgical patients was 5.16 or 43% of patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Overall, the CCU operates at 72.5% occupancy with only 17% needing CCU/PCU services.

Windham experienced a decline in critical care patient volume and length of stay for patients cared for in its CCU in recent years and these patients could be cared for in a PCU;

- 2013: 365, average length of stay 3.13 days
- 2014: 366, average length of stay 2.6 days
- 2015: 332 through July, average length of stay 1.9 days

Based on historical utilization and patient acuity to date, Windham proposes to address the clinical needs of its patients currently cared for in its CCU by transitioning the current 12-bed CCU to a 4-bed PCU. The proposed PCU will serve the same Windham patients who were previously treated in its CCU. Patients who will be admitted to the PCU will continue to be patients who require medical and nursing care beyond general inpatient level of services.

According to the American Association of Critical Care Nurses, progressive care is part of the continuum of critical care. The following may be applicable to PCU level patients:

- The patient has a persistent unstable status requiring continuous bedside cardiac and/or respiratory monitoring with frequent blood pressure monitoring as outlined in the PCU;
- The patient requires acute and/or complex medical monitoring as outlined in the PCU;

- The patient requires complex nursing treatment regimen; and
- The patient requires medication therapy requiring a higher level of assessment and intervention.¹

PCU patients typically include patients that have a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability and an increased ability to participate in their care.² In the last five years, patients who have been treated in the Windham CCU have met the definition for PCU level of care. The patients requiring progressive care will be managed with the same technology and staff competency levels that currently exist in the CCU. The only change will be that there will no longer be a dedicated physical space with 12 beds, which is clearly not needed based upon census for the last three years. Accordingly, this proposal will not change the clinical care provided to patients after the transition to the proposed PCU.

Should Windham patients cared for in the PCU require tertiary care services not available at Windham, these patients would continue to be transferred like they are from the CCU today. For example, Hartford Hospital is available to receive these patients and currently does receive these patients. The Windham Paramedic Program is readily available for necessary transport of these patients if the need arises during an inpatient stay. All full-time paramedics employed by the Windham Paramedic Program are critical care transport certified, or are in the process of receiving certification as a CCEMT-P or FP-C³. This is unique among paramedic transport services, and it ensures the highest level of care is available to Windham's patients during transport.

While the level of services currently provided to patients in the CCU will not change as a result of the transition to the PCU, it will allow space that is currently being underutilized to be utilized more efficiently and more responsively to the clinical needs of the community.

The services provided in the CCU will continue to be provided in the PCU. Please see Exhibit 1 for a list of the services currently provided to patients in the CCU, which will remain after the transition to a PCU.

There is no proposed change to the Windham license, attached as Exhibit 2.

Based upon the foregoing, Windham Hospital respectfully requests confirmation that the alignment of its Critical Care Unit to a Progressive Care Unit will not require a CON.

¹ CriticalCareNurse Vol 31, No. 3, JUNE 2011

² CriticalCareNurse Vol 31, No. 3, JUNE 2011

³ In the case of those paramedics who are also on the LifeStar flight crew. These certifications are granted by The Board for Critical Care Transport Certification.

Exhibit I

Services provided at Windham CCU will continue at the PCU and will include:

- Management of sudden acute event on admitted medical surgical patient;
- Short term ventilator support (post anesthetic or otherwise);
- Hemodynamic instability due to hypovolemia, hemorrhage, sepsis, or other cause;
- Central nervous system depression that threatens to compromise airway and protective reflexes;
- Management of renal or electrolyte abnormalities;
- Extended intra-operative time and vigorous fluid resuscitation with the probability of fluid shifts and massive third spacing;
- Patients with delirium tremens requiring continuous sedative infusions without respiratory failure requiring intubation;
- Patients requiring continuous observation and pulse oximetry due to upper airway disease;
- Monitoring possible intra-operative cardiac events (i.e. ST changes, arrhythmias, etc.) which are asymptomatic and patient is hemodynamically stable;
- Arrhythmias that are hemodynamically stable (i.e. atrial fibrillation/flutter, supra ventricular tachycardia);
- Angina pectoris that is hemodynamically stable but requires intravenous nitroglycerin for prophylaxis of the angina;
- Mild to moderate congestive heart failure without signs/symptoms of shock;
- Hypertensive conditions without evidence of end-organ damage;
- Patients requiring initiation of and maintenance intravenous infusions of anti-arrhythmics, and vasoactive inotropic medications;
- Patients with a tracheostomy tubes requiring aggressive pulmonary toileting or requiring arterial blood gases;
- Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or continuous positive airway pressure;
- Post-op patients after being fully recovered in PACU and meeting all other CSD criteria; and
- Patients requiring monitoring for seizure activity or obstructive sleep apnea.

WINDHAM LICENSE

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0061

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-593

Windham Community Memorial Hospital, Inc. of Willimantic, CT d/b/a Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is hereby licensed to maintain and operate a General Hospital

Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is located at 112 Mansfield Avenue, Willimantic, CT 06226.

The maximum number of beds shall not exceed at any time:

14 Bassinets
130 General Hospital Beds

This license expires September 30, 2015 and may be revoked for cause at any time

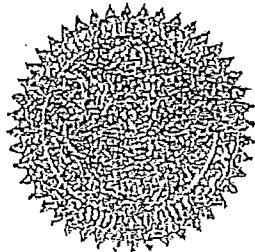
Dated at Hartford, Connecticut, October 1, 2013

Satellites:

Windham Middle School Health Center, 121 Quarry Street, Willimantic, CT
Windham High School Wellness Center, 355 High Street, Willimantic, CT
*Charles Barrows STEM Academy School-Based Health Center, 141 Tuckie Road, N. Windham, CT

License revised to reflect

*Added (1) Satellite effective 8/26/13



A handwritten signature in cursive script, appearing to read "Jewel Millien".

Jewel Millien, MD, MPH, MPA
Commissioner

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Windham Community Memorial Hospital

Project Title: Alignment of Critical Care Unit as a Progressive Care Unit

I, David A. Whitehead, President of Windham Community Memorial Hospital, being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.

David A. Whitehead 09/03/15
Signature Date

Subscribed and sworn to before me on 9/3/15

Mary E. Vega
Notary Public/Commissioner of Superior Court

My commission expires: 4/30/16

Greer, Leslie

From: Hansted, Kevin
Sent: Wednesday, September 09, 2015 9:57 AM
To: Greer, Leslie
Subject: FW: Determination #15-32026-DTR

Leslie, please add the below to the record.

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, September 03, 2015 4:27 PM
To: Hansted, Kevin
Subject: RE: Determination #15-32026-DTR

Attorney Hansted,

I am confirming that the services currently provided to patients on the CCU will not change as a result of the transition to a PCU.

Please let me know if you require any further information.

Janette Edwards

From: Hansted, Kevin [<mailto:Kevin.Hansted@ct.gov>]
Sent: Thursday, September 03, 2015 1:49 PM

To: Edwards, Janette
Subject: Determination #15-32026-DTR

Dear Ms. Edwards,

I am in receipt of your determination request regarding the alignment of the Critical Care Unit ("CCU") as a Progressive Care Unit ("PCU") at Windham Hospital. Can you confirm for me that all of the services that are currently offered in the CCU will be offered in the PCU?

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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Office of Health Care Access Certificate of Need Application

Final Decision

Applicants: Windham Community Memorial Hospital,
Inc. and Hartford Health Care
Corporation, Inc.

Docket Number: 08-31178-CON

Project Title: Integration of Windham Community
Memorial Hospital, Inc. into Hartford
Health Care Corporation, Inc.

Statutory Reference: Sections 19a-638, C.G.S.

Filing Date: November 3, 2008

Public Hearing Date: January 6, 2009

Decision Date: January 29, 2009

Default Date: February 1, 2009

Staff: Tillman Foster
Steven W. Lazarus
Sharon Malinowski

Project Description: Windham Community Memorial Hospital, Inc. (“WCMH” or “Hospital”) and Hartford Health Care Corporation, Inc. (“HHCC”) propose the integration of WCMH into HHCC, with no associated capital expenditure.

Nature of Proceedings: On November 3, 2008, the Office of Health Care Access (“OHCA”) received the completed Certificate of Need (“CON”) Application of WCMH and HHCC for the integration of WCMH into HHCC, with no associated capital expenditure. WCMH and HHCC

(collectively known as the "Applicants") are considered to be health care facilities or institutions for purposes of this CON as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on January 6, 2008. On December 8, 2008, the Applicants were notified of the date, time, and place of the hearing. On December 6, 2008, notices to the public announcing the hearing were published in *The Hartford Courant* and on December 8, 2008, in *The Chronicle*.

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., the Presiding Officer heard testimony from the Applicants and their witnesses.

OHCA's authority to review and approve, modify or deny this proposal 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

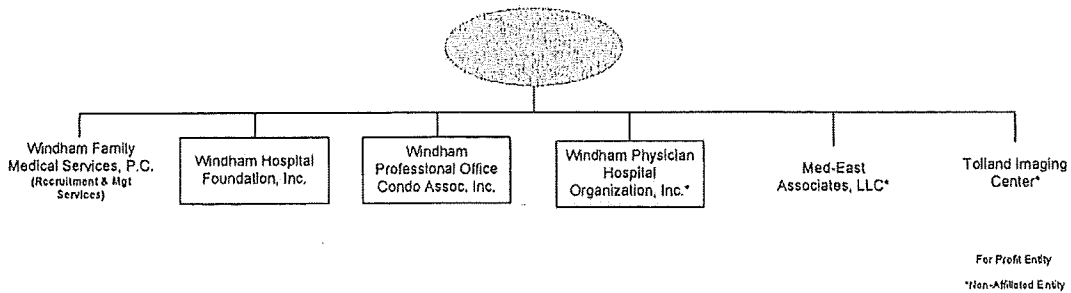
Clear Public Need

Impact on the Applicants' Current Utilization Statistics Contribution of the Proposal to the Accessibility and Quality of Health Care Delivery in the Region

1. Windham Community Memorial Hospital, Inc. ("WCMH" or "Hospital") is a Connecticut corporation located at 112 Mansfield Avenue, Willimantic, Connecticut and operates a 144 licensed bed acute care hospital. (*CON Application, 08-31178-CON, HHCC and WCMH Integration Agreement, Appendix B, and Office of Health Care Access, Hospital Reporting System, FY 2007, Report 400*)
2. Hartford Health Care Corporation ("HHCC") located at 80 Seymour Street, Hartford, Connecticut, is the parent corporation of Hartford Hospital, in Hartford and MidState Medical Center in Meriden. (*November 3, 2008, CON Application, page 1 and Office of Health Care Access, Hospital Reporting System, FY 2007, Report 400*)

3. WCMH and HHCC (“Applicants”) are proposing the integration of WCMH into HHCC, with no associated capital expenditure. *(June 2, 2008, Letter of Intent and November 3, 2008, CON Application, pages 1-8)*
4. Under the proposed integration WCMH will become a wholly-owned subsidiary of HHCC similar to Hartford Hospital and MidState Medical Center. *(June 2, 2008, Letter of Intent)*
5. The organization chart of WCMH and its affiliates before integration with HHCC is as follows:

Chart One: WCMH Organization Chart Prior to Integration into HHCC:



Source: CON Application DN 08-31178-CON, Proposed Integration Agreement, Schedule 2.2

6. The following table lists affiliated and non-affiliated entities currently under WCMH (prior to the proposed the integration):

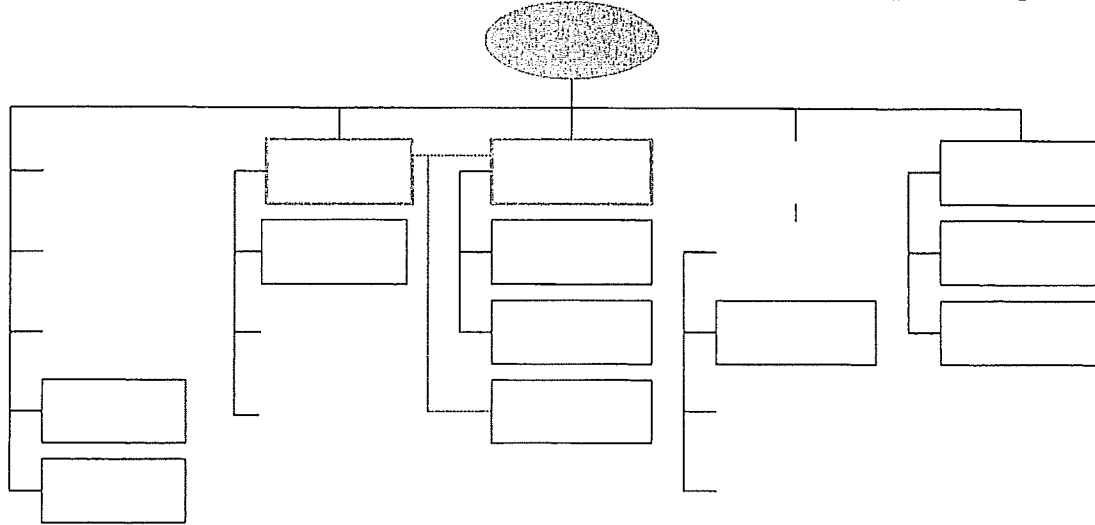
Table 1: Affiliated and Non-Affiliated WCMH Entities

Affiliated Entities		
Entity		WCMH Ownership Percentage
Windham Family Medical Services, P.C.		One Hundred Percent
Windham Hospital Foundation, Inc.		One Hundred Percent
Windham Professional Office Condominium Association, Inc.		One Hundred Percent
Non-Affiliated Entities		
Windham Physician – Hospital Organization, Inc.		Fifty Percent
Med-East Associates, LLC		Fifty Percent
Tolland Imaging Center, LLC		Fifteen Percent
Health Connecticut, LLC (Connecticut Hospital Association Entity)		WCMH one of 18 Hospital owners

Note: “Affiliated” entities are describe as having greater than 50% WCMH ownership;
 “Non-Affiliated” are described as having 50% or less WCMH ownership
(CON Application, 08-31178-CON, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008 Prefile Testimony, Response to OHCA Interrogatories, page 127 and January 6, 2009, Applicants Public Hearing Testimony)

7. The organization chart of HHCC before integration with WCMH is as follows:

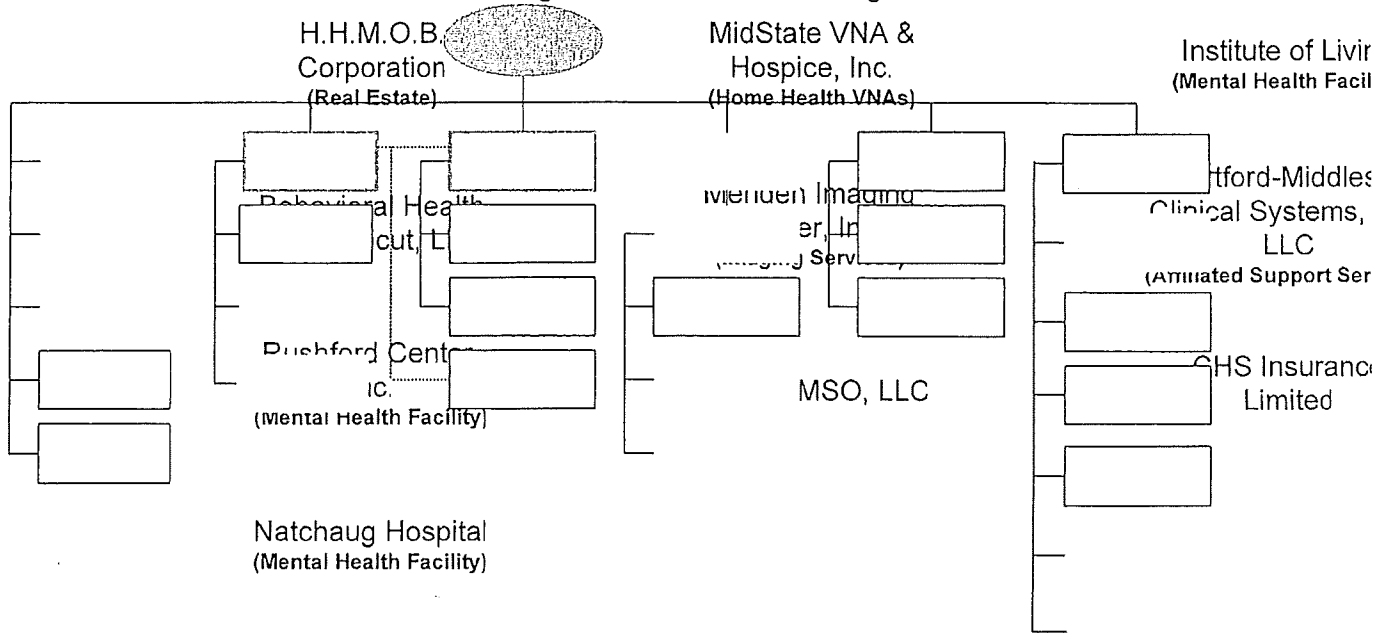
Chart Two: HHCC Organization Chart prior to the proposed Integration:



Source: Hartford Hospital, Docket Number 07-005AR, FY 2007 Annual Reporting

8. The proposed organization chart of WCMH and its affiliates after integration into HHCC as Hartford Hospital follows:

Chart Three: WCMH Organization Chart After Integration into HHCC:



Sources: CON Application DN 08-31178-CON, Proposed Integration Agreement, Schedule 2.2 and Hartford Hospital, Docket Number 07-005AR, FY 2007 Annual Reporting

9. As of Integration Agreement's closing date, the Board of Directors of WCMH will consist of eighteen (18) individuals, three (3) of which are ex-officio, serving on the WCMH Board of Directors as set forth in Schedule 1.3 of the Integration Agreement. *(CON Application, 08-31178-CON, December 30, 2008, Prefile Testimony and Response to OHCA Interrogatories, HHCC and WCMH Integration Agreement, page 126)*
10. Section 3.1 of the Pre-Closing Amended and Restated Bylaws (or Schedule 1.2 of Integration Agreement) sets forth that the WCMH Board shall not consist of any more than 18 directors, and only HHCC shall have the exclusive right to elect directors or fill any vacancy on WCMH's Board. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of HHCC and WCMH Integration Agreement, page 4)*
11. Under Article V of the Pre-Closing Amended and Restated Certificate of Incorporation WCMH shall operate under the management of its Board of Directors having all the necessary corporate power and authority to own, lease and use its properties and to operate its businesses as now being conducted as set forth in Clause 2.2 of the Integration Agreement. *(September 18, 2008, Initial Certificate of Need Application, 08-31178-CON, Pre-Closing Amended and Restated Certificate of Incorporation or Schedule 1.1 of HHCC and WCMH Integration Agreement, Article V)*
12. HHCC shall have the following powers and rights as set forth in Section 1.3 of Schedule 1.2:
 - (a) The sole power to elect and remove, with or without cause members of the WCMH Board.
 - (b) Review and approve, disapprove, or modify annual operating and capital budgets; significant proposed programs and expenditures, the purchase of significant operating or capital assets not contemplated in an approved budget or plan; and the borrowing of any sum in excess of \$1,000,000 with a stated term of greater than one year.
 - (c) Approve, disapprove, modify or direct the implementation of strategic plans, programmatic plans; health care standards of care; utilization review; and program coordination with other entities or persons in HHCC's health care system.
 - (d) Approve or disapprove any voluntary dissolution, merger or consolidation of WCMH or the sale, pledging, leasing or transfer of any substantial amount of WCMH's assets or the creation or acquisition of any significant subsidiary or affiliate corporation, significant contracts which WCMH in its discretion may refer to HHCC for review or approval; the selection of certified public accountants for WCMH; the filing of any Certificate of Need application for an expenditure or program outside of WCMH's ordinary business.
 - (e) Approve or establish guidelines or parameters for governing WCMH's participation in managed care contracts. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of HHCC and WCMH Integration Agreement, page 4)*
13. When WCMH is integrated into HHCC there will be no change in ownership of WCMH's affiliated entities except that HHCC will become the sole member of WCMH as set forth Section 1.2 of Schedule 1.2 and the affiliated entities will remain unchanged as listed in Schedule 2.2 of the Integration Agreement. *(September 18, 2008, Initial Certificate of Need Application, Schedule 1.2 of the*

Integration Agreement, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008, Prefile Testimony and Response to OHCA Interrogatories)

14. WCMH shall maintain its Board of Corporators (“Corporators”) consisting of no more than 150 members who are adults who either work or reside in the towns listed in Section 2.4 of Schedule 1.2, but it will serve only in an advisory capacity to WCMH’s Board. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of the HHCC and WCMH Integration Agreement, page 4)*
15. The Independent Practice Association which owns fifty percent of Windham Physician-Hospital Organization, Inc., supports the proposed Integration of WCMH into HHCC. *(September 18, 2008, Initial Certificate of Need Application, Testimony of Windham Community Memorial Hospital, January 6, 2009, Public Hearing)*
16. The Applicants state that historically, WCMH has had a close relationship with Hartford Hospital and with respect to medical staff referrals for tertiary level services as well as for other programmatic collaboration. This relationship has included successful clinical efforts in oncology, cardiology and emergency medicine. It has also assisted in allowing WCMH to participate in National Institutes of Health (“NIH”) clinical research trials and other research projects. *(September 18, 2008, Initial Certificate of Need Application, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, page 5)*
17. According to the Applicants:
 - (a). In spring 2006, a strategic partnership agreement was signed by the Boards of both organizations,
 - (b). In January 2007, the leadership of WCMH, including the Board, Administration and Medical Staff embarked upon a comprehensive strategic planning process. Principles for affiliation were identified and given the longstanding relationship of both institutions, formal discussions were pursued with HHCC. Concurrently with the formal adoption of the revised strategic plan in early summer 2007, actions were implemented by both administrations and boards to develop an agreement. These agreements were approved in August of 2007,
 - (c). Formal votes of WCMH were taken in the spring of 2008 and the Corporators of WCMH took a vote in June 2008, approving this affiliation and the documents necessary for implementation. *(September 18, 2008, Initial Certificate of Need Application, pages 2-3)*
18. The Applicants stated that:
 - (a). The day to day operations of WCMH will remain the responsibility of the WCMH Board of Directors, the Chief Executive Office and administrative staff,
 - (b) The reserve powers of the agreement require WMCH to get approval from HHCC for certain fundamental decisions that will be subject to HHCC’s or the members approval (e.g., annual budgets, major capital purchases exceeding certain capital thresholds, and Certificate of Need projects), and
 - (c) No consolidation of services are planned at this time. However, it is possible in accordance with further development of the HHCC integrated Health Care delivery system

that certain services will not be duplicated at each member entity. It is also anticipated that certain administrative, management and technical services may be consolidated more immediately in order to achieve economies of scale and enhanced quality of service.
(November 3, 2008, Responses to OHCA's Completeness Letter, page 3)

19. According to the Applicants, WCMH will be integral to HHCC plan to advance the quality of Health Care delivered to residents in the region served by WCMH. *(November 3, 2008, Responses to OHCA's Completeness Letter, page 4)*
20. As set forth in Section 8.3 of the Integration Agreement, the HHCC Board of Directors will continue to be the principal policy making and decision making body for the System. Accordingly, WCMH management will have system accountability together with internal reporting relationships. *(September 18, 2008, Initial Certificate of Need Application, Section 8.3 of the Integration Agreement, page 21)*
21. The following utilization data is related to WCMH, as reported in the Patient Census Report of September 2008:

	2008	2007
Total WCMH Admissions	5,744	5,742
Medical-Surgical Service	4,724	4,651
Emergency Dept. Visits	29,054	26,822

(Patient Census Report, September, 2008)

22. WCMH stated that through the proposed integration, it will be better able to recruit primary care physicians and to explore development of primary care group sites in key locations throughout WCMH's service area. *(December 30, 2008, Prefile Testimony of Mr. Richard A. Brvenik, President and Chief Executive Officer of WCMH, pages 5-6)*
23. The Applicants state that the direct benefits of the integration to HHCC include the following opportunities:
- (a). Additional opportunities for Clinical research,
 - (b). Teaching,
 - (c) Implementation of quality initiatives,
 - (d) Shared best practices,
 - (e) Volume purchasing,
 - (f) Consolidation of certain administrative services,
 - (g) Deployment of expensive technologies throughout the system,
 - (h) Spreading of risk, and
 - (i) Recruitment of medical talent by virtue of system size and coordinated efforts.
- (November 3, 2008, Responses to OHCA's Completeness Letter, page 2)*

24. According to the Applicants, benefits of the integration to be derived by WCMH include the following opportunities:

- (a) Improved ability to recruit physicians,
- (b) Increase market share in secondary service area communities,
- (c) Access managed care contracting expertise,
- (d) Purchase select clinical and administrative services,
- (e) Achieve economies of scale,
- (f) Improve the balance sheet by refinancing existing debt,
- (g) Increase the services and technology offered locally,
- (h) Decrease the out-migration of patients,
- (i) Improved ability to access capital at a lower cost, and
- (j) Reduce operating costs by being able to utilize the purchasing power of HHCC.
(September 18, 2008, Initial Certificate of Need Application, page 4)

**Financial Feasibility 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 Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines**

25. The projected three-year incremental revenue from operations, total operating expense and losses/gains from operations associated with the proposed integration are presented in the table below:

Table 3: WCMH's Incremental Financial Projections

Description	FY 2009	FY 2010	FY 2011
Incremental Revenue from Operations	\$0	\$0	\$0
Incremental Total Operating Expense	\$(600,000)	\$(600,000)	\$(600,000)
Incremental Gain from Operations	\$600,000	\$600,000	\$600,000
Revenue Over/(Under) Expenses	\$600,000	\$600,000	\$600,000

(September 18, 2008, Initial Certificate of Need Application, Financial Attach. I, number 12.C (i))

26. At a minimum is projected to save WCMH \$600,000 annually for FYs 2009-2011. The annual savings is primarily due to better financial terms attributable to WCMH's new affiliation with HHCC. *(CON Application, 08-31178-CON, Pro Forma Attachment I, Appendix M and Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, Public Hearing, page 5)*

27. HHCC's current payer mix and projected with the CON proposal is as follows:

Table 4: Current and Three-Year Projected Payer Mix with the CON Proposal

<i>Total HHCC</i>	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare	40%	40%	40%	40%
Medicaid (includes other medical assistance)	12%	12%	12%	12%
TRICARE and CHAMPUS	3%	3%	3%	3%
Total Government	55%	55%	55%	55%
Commercial Insurers*	45%	45%	45%	45%
Uninsured (1)				
Workers Compensation (1)				
Total Non-Government	45%	45%	45%	45%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity

(1) Included in Commercial Insurers

(September 18, 2008, Initial Certificate of Need Application, page 17)

28. WCMH's current payer mix and projected payer mix with the CON proposal is as follows:

Table 5: Current and Three-Year Projected Payer Mix with the CON Proposal

<i>Total WCMH</i>	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	58%	58%	58%	58%
Medicaid *(includes other medical assistance)	20%	20%	20%	20%
TRICARE and CHAMPUS				
Total Government	78%	78%	78%	78%
Commercial Insurers*	21%	21%	21%	21%
Uninsured	1%	1%	1%	1%
Workers Compensation				
Total Non-Government	22%	22%	22%	22%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity

(1) Included in Commercial Insurers

Based on hospital discharges

(September 18, 2008, Initial Certificate of Need Application, page 17)

29. WCMH stated that the most recent data indicate the payer mix for WCMH as a percent of gross revenue is: Medicare 39%, Medicaid 17%, commercial insurance 40% and self-pay 4%, which is significantly less positive than that of the average Connecticut acute care hospital. (December 30, 2008, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital)

30. WCMH stated given the demographics of its patients, financial analyses and forecasts showed that as a free-standing hospital, WCMH would be hard pressed to achieve an operating gains of even 1% in future years, accordingly financial analysts seek operating margins in the range of 4-5% to

assure future viability and institutional financial health. *(December 30, 2008, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital)*

31. WCMH stated that it is a safety net provider for the region it serves. In order to sustain this role WCMH felt it needed to strengthen its long-term financial stability. Consequently becoming a part of HHCC was viewed as critical to its long-term financial stability. *(CON Application, 08-31178-CON, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008, Response to OHCA Interrogatories, pages 1 & 2)*

32. Richard A. Brevnik, President and Chief Executive Officer of WCMH, stated that in order to achieve its institutional goals, WCMH required an estimated \$43 million dollars in capital over five year period covering, FY 2007 through 2012. The required capital would be earmarked for the following purposes:
 - a. Refinancing of WCMH's pension fund;
 - b. Refinancing of WCMH's Long-Term Debt;
 - c. Physician recruitment;
 - d. Facility upgrades; and
 - e. Acquiring other medical technologies.*(CON Application, 08-31178-CON, Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, Public Hearing)*

33. There is no State Health Plan in existence at this time. *(September 18, 2008, Initial Certificate of Need Application, page 2)*

34. The Applicants stated that this proposal is consistent with each of their respective long-range plans. *(September 18, 2008, Initial Certificate of Need Application, page 2)*

35. The Applicants have improved productivity and contained costs in the past year through the application of new technology, undertaking energy conservation measures and employing group purchasing methods. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

36. The proposal will not result in any change to the Applicants' teaching or research responsibilities. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

37. There are no distinguishing characteristics of the Applicants' patient/physician mix that makes the proposal unique. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

38. The Applicants have sufficient technical and managerial competence and expertise to provide efficient and adequate service to the public. *(September 18, 2008, Initial Certificate of Need Application, pages 10-11 and Appendix D)*

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.

Windham Community Memorial Hospital, Inc. (WCMH”) and Hartford Health Care Corporation, Inc. (“HHCC”) propose the integration of WCMH into HHCC, thereby, making WCMH a wholly owned subsidiary of HHCC, similar to Hartford Hospital and MidState Medical Center. WCMH has historically had a close relationship with Hartford Hospital (a subsidiary of HHCC) and its medical staff for referral for tertiary level services, as well as for other programmatic collaboration. Even though the Applicants are not planning any consolidation of service at this time, further development of HHCC integrated Health Care delivery system in the future will lead to certain services not being duplicated at each member entity of HHCC.

This partnership between the Applicants has been in place since January of 2007 and was formalized in June of 2008. As a result of this proposed integration, there will be no change in ownership of WCMH’s affiliated entities, as they will continue to operate under WCMH. HHCC will become the sole member of WCMH as set forth in the written agreements provided to this agency. The day to day operations of WCMH will remain the responsibility of the WCMH Board of Directors, the Chief Executive Officer and Administrative Staff; however, the reserve powers of the agreement between the Applicants require WCMH to get approval from HHCC for certain fundamental decisions which will be subject to HHCC’s or the members approval.

This proposal will improve the quality of health care delivered to patients in the region. This proposal will allow WCMH to improve its ability to recruit physicians, improve its managed care contracts, refinance its existing debt, access to capital at lower cost and reduce its overall operating costs. HHCC will intern have opportunities for additional clinical research, shared best practices and deploy expensive technologies through the system. It appears to OHCA that this proposal is mutually beneficial for both Applicants. WCMH’s utilization has stayed steady or increased between FY 2007 and 2008 for total admissions, medical surgical services and emergency department, leading OHCA to believe that the financial challenges appear to be more related to the patient mix. WCMH will be an integral part of HHCC’s plan to advance the quality of health care delivery to its patients in the region and the Applicants testified that they will improve access to primary care services. The Applicants also stated that currently they will not be terminating any services; however, OHCA realizes that in the future the reduction of duplicative services may be necessary to further strengthen the financial viability of the system.

WCMH projects gains from operations, incremental to the proposal of \$600,000 for FYs 2009-2011, the first three years of the proposal, which is a result of WCMH’s relationship with HHCC which aided in restructuring of WCMH’s existing debt. This proposal provides longer term financial viability to the system of care. HHCC is projecting gains from operations, incremental to the proposal of

\$1,850,960, \$1,942,000 and \$1,238,000, for FYs 2009-2010. WCMH and HHCC's financial projections and volumes upon which they are based appear to be reasonable and achievable.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Windham Community Memorial Hospital ("WCMH" or "Hospital") and Hartford Health Care Corporation, Inc. ("HHCC") (together referred to as "Applicants") for the integration of WCMH into HHCC with no associated capital expenditure, is hereby **Approved**, subject to the following conditions:

1. This authorization expires on January 31, 2010. Should the Applicants proposal not be completed (i.e. final agreement are executed) by that date, the Applicants must seek further approval from OHCA to complete the project beyond that date.
2. Within 60 days of the completion of the integration of WCMH into HHCC, the Applicants shall file with OHCA; a full copy of any and all signed, dated and completed final integration agreements including attachments indicating the integration of WCMH into HHCC has occurred.
3. If in the future there is any change in the ownership structure of WCMH or its affiliates or any change in control of WCMH, the Applicants shall file a CON Determination Form with OHCA.
4. If in the future there is any change in WCMH service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.
5. As there is no associated capital expenditure with this proposal, in the event that the Applicants learn of potential costs associated with this proposal, the Applicants shall notify OHCA immediately

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

Signed by Commissioner Vogel on January 29, 2009

Date

Cristine A. Vogel
Commissioner



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

April 2, 2013

Pamela J. Kane, Vice President
Physician Practice Management
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

RE: Certificate of Need Determination; Report Number 13-31829-DTR
Operational Status of certain outpatient services at or by Lawrence & Memorial Hospital

Dear Ms. Kane:

On January 4, 2013, the Office of Health Care Access ("OHCA") initiated an inquiry regarding the operational status of certain outpatient services at or by Lawrence & Memorial Hospital, namely Outpatient Behavioral Medicine Counseling Services, Obstetrics Clinic Services and HIV/AIDS Clinic Services. On January 17, 2013 and March 11, 2013, OHCA received information from the Hospital in response to OHCA questions. OHCA's determination issued herein is based on the following information:

1. Lawrence & Memorial Hospital, Inc. ("Hospital") is a general hospital licensed by the Department of Public Health under Connecticut General Statutes Chapter 368v and is a health care facility for purposes of Connecticut General Statutes Chapter 368z.
2. Associated Specialists of Southeastern Connecticut, Inc. is an active, non-stock corporation affiliated with the Hospital. It is described by the Hospital as a captive physician practice entity. The following information is found in the notes of the Hospital's FY 2008 audited financial statements regarding this affiliated entity:

"Effective January 1, 2008, Associated Specialists of Southeastern Connecticut, Inc. (Associated Specialists) was established. On April 1, 2008, Associated Specialists began billing under their own provider numbers. This is a wholly owned entity of the Hospital."
3. The term Health Care Facility as defined in Connecticut General Statutes Chapter 368z includes "any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility or institution."

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

10. The HIV/AIDS Clinic Services continue to be provided by and billed for by Associated Specialists and remain in the same location.
11. The Hospital remains the provider of Intensive Outpatient Therapy and Inpatient Psychiatric Unit Care; these services were not transferred to Associated Specialists or to L&M Physician Association.
12. Connecticut General Statutes §19a-638(a)(2) stated the following at the time of the transfer of services which occurred as of April 1, 2008: "Each health care facility or institution or institution or state health care facility or institution, including any inpatient rehabilitation facility, which intends to introduce any additional function or service into its program of health care shall submit to the office, prior to the proposed date of the institution of such function or service, a request for permission to undertake such function or service."
13. Connecticut General Statutes §19a-638(a)(3) stated the following at the time of the transfer of services which occurred as of April 1, 2008: "Each health care facility or institution or state health care facility or institution which intends to terminate a health service offered by such facility or institution or reduce substantially its total bed capacity, shall submit to the office, prior to the proposed date of such termination or decrease, a request to undertake such termination or decrease."
14. The current wording of Connecticut General Statutes §19a-638 (4) requires a Certificate of Need for the termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care hospital or children's hospital of inpatient and outpatient mental health and substance abuse services.

Based upon a review of the matter outlined above, OHCA determines the following:

- a. Lawrence & Memorial Hospital is required to file a Certificate of Need request for the termination of its Outpatient Behavioral Medicine Counseling Services, Obstetrics Clinic Services and HIV/AIDS Clinic Services in March of 2008.
- b. Associated Specialists of Southeastern Connecticut, Inc., an affiliate of the Hospital and a health care facility, is required to file a Certificate of Need request for the establishment of Outpatient Behavioral Medicine Counseling Services, Obstetrics Clinic Services and HIV/AIDS Clinic Services in April of 2008.

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.		Page 1 of 1
TITLE: Admission/Transfer Orders Policy		SCOPE: Critical Care Unit Staff
EFFECTIVE: 7/87	REVIEWED: Triennially	AUTHORED BY: CCU Nurse Manager
REVIEWED BY: Critical Care Committee		APPROVED BY: CCU Committee
REVIEWED: 6/88, 5/89, 4/90, 9/91, 5/92, 5/97, 2/02, 8/03, 2/05, 6/07, 11/10		REVISED & APPROVED: 5/93, 4/96, 1/98, 4/02, 01/11

POLICY:

ADMISSION TO CCU: All patients admitted to the Critical Care Unit (CCU) required specific CCU orders, written by attending or covering physician. Orders must be written prior to patient arriving on the unit.

Exception is during a code/emergency situation

TRANSFERS:

When a patient is being down graded and transferred out of the CCU, the physician is responsible for rewriting orders for the receiving unit. Telephone orders may be provided to facilitate the transfer process.

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.			PAGE: 1 OF: 1
TITLE: Critical Care Unit Admission, Transfer, and Discharge Criteria Policy (combined policies)		SCOPE: Hospital - Clinical	
EFFECTIVE: 6/07	REVIEW: Triennially	REVIEWED: 7/2010	REVISED: 11/07, 11/09
REVIEWED BY: Critical Care Unit Committee		APPROVED BY: Medical Director, Critical Care Unit	

PURPOSE: To establish Admission, Transfer and Discharge criteria and timeliness of orders for the Critical Care Unit

POLICY:

1. CRITERIA

- a. Admission - Patients are admitted to the CCU based on their need for medical and nursing care beyond conventional services, and the need for select acute and/or complex medical diagnostic or treatment regimens. Examples include:
 - i. Acute Myocardial Infarction (AMI), Life threatening arrhythmias
 - ii. Continuous drug infusion for anti-arrhythmic and/or vasopressor intervention
 - iii. Acute Pulmonary Edema, Respiratory Failure requiring invasive Mechanical Ventilation
 - iv. Acute/Potential evolving System(s) Failure
 - v. Diabetic Ketoacidosis (DKA) with DKA insulin drip
 - vi. Invasive Hemodynamic Monitoring
 - b. Transfer and/or Discharge - Patient no longer requires the scope of services provided in the CCU. Examples include:
 - i. Myocardial Infarction is ruled out and cardiovascular status is stable
 - ii. Angina, Congestive Heart Failure (CHF), arrhythmias are stable or resolved
 - iii. Extubated, ABGs within normal limits, Respiratory Failure resolved.
 - iv. System(s) Failure resolved
 - v. DKA resolved and DKA insulin drip discontinued
 - vi. No invasive hemodynamic monitoring required for assessment/diagnostic parameters
 - vii. Renal function improved, no longer requiring acute interventions
 - viii. Patient/Family requesting no further acute interventions
 - ix. Services required are not available at WCMH
2. There are no direct admissions to the CCU. All patients must be evaluated in the Emergency Department.
 3. Any patient with a critical illness, who requires admission or transfer to the CCU, must be evaluated by the Attending Physician within 2 hours, with appropriate orders written.
 4. It is the responsibility of the attending or covering physician to assess the patient and write complete transfer orders into and out of the CCU.

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.		Page 1 of 1
TITLE: Discharge and Transfer Policy		SCOPE: Clinical
EFFECTIVE: 4/93	REVIEWED: Triennially	AUTHORED BY: Manager Surgical Services
REVIEWED BY: Nurse Executive Committee & Department of Anesthesiology		APPROVED BY: Department of Anesthesiology
REVIEWED: 3/95, 5/96, 7/97, 10/99, 3/99, 11/00, 12/07, 12/10, 12/13		REVISED & APPROVED: 4/02, 8/03, 11/04, 1/05, 6/06

POLICY:

1. One-day surgery patients assigned to PACU/CCU/OB for their initial recovery may begin phase 2 recovery or be transferred to the ACU for continued recovery upon meeting the following criteria or upon approval of their anesthesia provider.
2. All Same Day Surgery and Inpatients assigned to PACU/CCU/OB for their post-operative recovery will remain in the Recovery area until their condition is deemed stable by the PACU/CCU/OB RN utilizing the following criteria:
 - a. Aldrete score system of 8 or at least baseline.
 - b. Post-Anesthesia discharge criteria.
 - Movement and sensation in lower extremities and/or return of movement and sensation following spinal or epidural anesthesia.
 - Post-op dressing/bleeding - within normal limits
 - Pain management achieved
 - Mental status alert and oriented or returned to baseline level of consciousness
 - c. Patent/stable airway
 - d. Stable vital signs X 30 minutes
 - e. Temperature greater than 96.8.

*Movement is defined as being able to wiggle toes.

*Notify Anesthesiologist if further evaluation or assessment is required.

3. Same Day Surgery and in-patients discharged from PACU/CCU/OB will be transported on a stretcher/bed and be accompanied by a Transport Aide unless the patient is transferred to the Telemetry Unit or The Critical Care Unit. In the case of the latter, a Registered Nurse will accompany the patient. (A one-day surgery patient may be transported by wheelchair, recliner chair or stretcher, as patient condition dictates).
4. Patients may be transferred by the anesthesiologist/CRNA to the CCU and OB/GYN Recovery room for recovery when PACU is closed.
5. Patients who have been deemed by the Anesthesiologist and/or the Surgeon to require more extensive nursing care will be transferred to the Critical Care Unit or other appropriate special care units for recovery and nursing care.
6. It is the responsibility of an anesthesiologist to assess the SDS/Inpatients and document discharge prior to patient's discharge from PACU.

PROCEDURE:

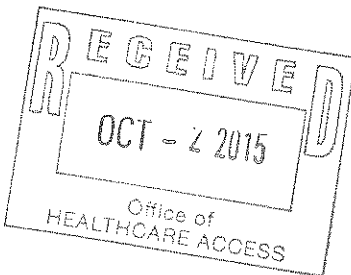
1. The Anesthesiologist and/or operating practitioner will document orders for patient transfer to Specialty Care Unit.
2. The Post Anesthesia Care Unit Registered Nurse will:
 - a. Notify Administrative Coordinator/Director/Manager
 - b. Notify Specialty Care Unit of transfer
 - c. Notify Admitting Office for observation admits



GENERATIONS

FAMILY HEALTH CENTER

October 2, 2015



VIA FIRST CLASS MAIL AND FACSIMILE

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Determination Report 12-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone:

I am writing on behalf of the staff, physicians and patients of Generations Family Health Center ("Generations"), the Federally Qualified Health Center ("FQHC") serving Eastern Connecticut, regarding the determination that a Certificate of Need ("CON") is not required for Windham Community Memorial Hospital ("Petitioner" or "Hospital") to close its critical care unit ("CCU") and develop a 4-bed progressive care unit ("PCU"). In the above referenced determination, OHCA writes:

"The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a **CON is not required** for the Petitioner's proposal."

It appears that the above finding is inconsistent with facts in this matter as well as information provided to OHCA in the Petitioner's submission to OHCA on September 3, 2015. First, Petitioner acknowledges in its Proposal Description that it does indeed provide critical care services in the CCU and that at least 2 critically ill patients are in that unit on a daily basis. However, Petitioner goes on to state that these patients can be cared for in a PCU which is factually incorrect. Both the Society of Critical Care Medicine and the American Association of Critical-Care Nurses ("AACM") regard CCU and PCU as distinct levels of care with specifically delineated admission criteria and staff competencies.

Progressive Care is a term used by AACM to collectively refer to patient care settings also known as Intermediate Care, Step-Down Care, Telemetry, Direct Observation or Transitional Care (**Exhibit I**). Further, the Society of Critical Care Medicine Guidelines for ICU Admission, Discharge, and Triage as well as the Guidelines on Admission and Discharge for Adult

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Intermediate Care Units clearly distinguish the two levels of care (Exhibit 2). Petitioner's statement that CCU patients can be treated in a PCU does not comport with published guidelines.

On the second page of the Proposal Description, Petitioner states:

"In the last five years, patients who have been treated in the Windham CCU have met the definition for PCU level of care."

This statement is false. The Hospital's CCU treats hemodynamically unstable patients as well as patients with acute respiratory distress and/or failure requiring intubation and mechanical ventilation. These patients do not meet published admitting criteria for PCU level of care (Exhibit 2). It is also false to state that CCU and PCU staff competencies are the same. For years, AACM has recognized the two nursing practices as distinct and offers unique credentialing and certification for PCU and CCU (Exhibit 3).

And while Petitioner claims to have paramedic transport available to transfer patients to Hartford Hospital, Petitioner fails to disclose the increasing demand for these services, that it does not own an ambulance and the municipality service is BLS only, and without increasing services is therefore not equipped to deal with the timely transfer of critically ill patients. The Society of Critical Care Medicine has published specific guidelines regarding inter-hospital transfers of critically ill patients (Exhibit 4). Because adequate and appropriate ambulance inter-hospital transportation does not exist in the rural service area, Life Star is routinely deployed to transfer patients that can be cared for at the Hospital.

Lastly, Petitioner Exhibit 1 lists services that Petitioner proposes to provide in the PCU. Several of these services are appropriate only to a CCU and are inconsistent with published guidelines (Exhibit 2).

Generations is concerned that OHCA relied on inaccurate representations in making its decision that a service is not being terminated. CCU care and PCU care are not interchangeable. Either Petitioner is terminating critical care services or it is proposing to provide critical care in an inappropriate setting. We believe the former to be true and respectfully request that OHCA reconsider its determination.

Very truly yours,



Arvind Shaw
Chief Executive Officer

cc.

Generations Family Health Center
October 2, 2015

EXHIBIT 1: AACN Progressive Care Fact Sheet

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

Progressive Care Fact Sheet

Background

In the early 1970s, major medical center recruiters placed advertisements for both critical care and progressive care nurses in *Heart and Lung*. Initially, progressive care units housed post myocardial infarction patients requiring cardiac monitoring, but not requiring intensive care and observation. With the changing healthcare environment, the acuity of patients admitted to hospitals steadily increased and caused an increase in the demand for critical care beds. With the increased demand and decreased availability of critical care beds, patients were often transferred from critical care units while still requiring an increased level of nursing care and vigilance. Patients admitted to critical care units five to ten years ago are now routinely admitted to progressive care.

Progressive care is the term the American Association of Critical-Care Nurses (AACN) uses to collectively describe areas that are also referred to as Intermediate Care Units, Direct Observation Units, Step-down Units, Telemetry Units, or Transitional Care Units as well as to define a specific level of patient care. AACN recognizes the need to define and identify the special needs of progressive care nurses. In 2008, the Certification Corporation convened a progressive care nursing study of practice. The study of practice determined the scope of practice, populations served, the core competencies and basic knowledge and skill requirements of progressive care nurses and provided a foundation for development of certification exams. Progressive care nurses across the country participated in the study of practice.

Definition

The American Association of Critical-Care Nurses recognizes progressive care as part of the continuum of critical care. AACN is dedicated to creating a healthcare system driven by the needs of patients and families where critical care nurses make their optimal contribution. The AACN Synergy Model for Patient Care is the conceptual framework that actualizes the vision. It defines nursing practice based on the needs of the patient and the characteristics of the nurse to attain optimal patient outcomes.

Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care. Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

Progressive Care Patient Location

AACN's Synergy Model assists in defining the progressive care patient. The Synergy Model identifies patients based on the characteristics and needs that they present and not on the location of the bed they occupy. As in critical care, the geographic domain of progressive care is expanding. Care provided to progressive care patients is not limited by geography but is based on the needs and required interventions of the patient. While specific progressive care units can be identified, patients requiring progressive care nursing can be located throughout the hospital.

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

According to the Synergy Model, stability, complexity, vulnerability, resiliency, predictability, resource availability, participation in care and participation in decision making are the patient characteristics that describe patient function. The nurse characteristics that typically represent comprehensive nursing practice include clinical judgment, advocacy, caring practices, collaboration, systems thinking, response to diversity, clinical inquiry and learning facilitation. The framework, therefore, takes into account the unpredictability of the progressive care patient and, based on the patient's and family's needs, the competencies of the progressive care nurse. Progressive care can be very specialized, with care focused on a specific system such as cardiac, or more generalized, as in the care of patients with multi-system problems.

Educational Requirements

Progressive care nursing has expanded beyond the basic cardiac telemetry that marked its beginning and now encompasses many of the same technologies and therapies that were once limited to critical care units. To meet the changing needs of the patient, nurses caring for progressive care patients must demonstrate competencies that are influenced by ever changing technology. Progressive care nurses must demonstrate the following core competencies:

- Cardiac monitoring techniques and lead placement.
- Basic & advanced life support.
- Basic dysrhythmia interpretation and treatment, including ST segment and QTc interpretation.
- Drug dosage calculation, continuous medication infusion administration, and patient monitoring for medication effects.
- Titration of selected vasoactive medications such as nitroglycerin.
- Monitoring patients using standardized procedures for pre, intra, and post procedures (i.e., cardioversion, TEE, cardiac catheterization with PCI, bronchoscopy, EGD, PEG placement, chest tube insertion)
- Invasive arterial pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Non-Invasive hemodynamic pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Recognition of the signs and symptoms of cardiopulmonary emergencies and initiate standardized interventions to stabilize the patient awaiting transfer to critical care including cardioversion, defibrillation and transcutaneous pacing. Seek assistance as needed.
- Monitoring normal and abnormal diagnostic test results.
- Interpretation of ABGs and communicating findings.
- Recognition of indications for and management of patients requiring non-invasive O2 delivery systems including oral airways, blpap, and nasal CPAP
- Assessment of the ventilated patient to assure delivery of the prescribed treatment and patient response including tracheostomy care, and continuous and intermittent SpO₂ monitoring.

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- Managing patients with chest tubes.
- Assisting with thoracentesis and chest tube insertion.
- Administering medications for procedural sedation and monitor patient's response.
- Assessing, monitoring and managing patients with stroke, seizure disorders and intracranial hemorrhage.
- Managing and titrating insulin infusions.
- Recognition of indications for and complications of enteral and parental nutrition
- Assessing, monitoring and managing patients requiring renal therapeutic interventions; e.g. hemodialysis, peritoneal dialysis, stents, continuous bladder irrigation, and urostomies
- Management of patients with complex wounds with fistulas, drains, and vacuum-assisted closure devices.
- Recognition of signs and symptoms of behavioral emergencies (e.g. delirium and dementia, mood disorders and substance abuse).
- Evaluating the family's need for enhanced involvement in care to facilitate the transition from hospital to home.

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Generations Family Health Center
October 2, 2015

EXHIBIT 2: Society of Critical Care Medicine Guidelines for CCU and PCU

Guidelines for ICU Admission, Discharge, and Triage



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These guidelines can also be found in the March 1999 issue of *Critical Care Medicine* --
Crit Care Med 1999 Mar; 27(3):633-638

Society of Critical Care Medicine
701 Lee Street
Suite 200
Des Plaines, IL 60016
Phone: 847/827-6869

Society of Critical Care Medicine

Guidelines for ICU Admission, Discharge, and Triage

American College of Critical Care Medicine
of the Society of Critical Care Medicine

ABSTRACT

Appropriate utilization of Intensive Care Unit (ICU) resources is an important issue as the nation struggles to contain health care expenditures. The guidelines proposed here provide models which ICUs may use in formulating admission, discharge and triage criteria. A process for implementation, monitoring and performance review of policies and procedures is also included.

INTRODUCTION

The ICU concept prevalent today proliferated in the 60's (1-3). The first Consensus Conference on Critical Care Medicine led by the National Institutes of Health (NIH) in 1983 pointed out that clinical practice has led to expanded indications for admissions to critical care units (4). Most physicians are of the opinion that the benefits of ICU care are unmeasured rather than uncertain (5). Because of the utilization of expensive resources, ICUs should, in general, be reserved for those patients with reversible medical conditions who have a "reasonable prospect of substantial recovery" (4-6). With recent changes in the health care environment, efficient use of ICUs has become a priority. Unfortunately, few studies have examined the indications for and the outcome of ICU care (7-10). Those that have suggest that we may not be categorizing patients accurately. For example, Kraiss, et al. evaluated 196 patients undergoing carotid endarterectomy over a two-year period. There was no difference in outcome or complications between the group admitted to intensive care and those admitted to a general ward (8).

The Ethics Committee of the Society of Critical Care Medicine has previously published a consensus statement on triage (11). Guidelines for developing admission and discharge criteria were also proposed (12). The current document is a compilation and revision of the previously published guidelines.

Individual ICUs, using the guidelines presented below, should create policies specific to their unit. Criteria for ICU admission and discharge should be explicitly described. In addition, each ICU should define the scope of services it provides, and the patient population it serves, as approved by the professional staff. Specific circumstances under which the patients are admitted should also be defined (12-14). Guidelines and implementation policy should be written by a multiprofessional team. While the composition of the ICU Committee may vary, it should assure an adequate voice for those who regularly provide service to ICU patients, including respiratory care practitioners, nurses, physicians, and social workers.

The ICU Committee should review the policies of the intensive and intermediate care units. The Committee should also help educate the staff on admission/discharge/triage criteria, and efficient resource consumption.

Policies written for admission, discharge, and triage should be reviewed on a regular basis and revised as needed. Revisions should be based on objective data. Compliance with the policy should be monitored in an appropriate forum, which in most institutions would be the ICU Committee. A policy should be in place for accommodating admissions when unit capacity is reached. Options may include limiting elective surgery or re-routing critical care admissions from the emergency department. Increasing the functional capacity of the ICU by boarding patients in other advanced care areas (assuming appropriate personnel and technological resources are available) may be an alternative to limiting services.

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The admission, discharge, and triage criteria should also recognize patient autonomy, including advance directives, living wills, or durable powers of attorney for health care decisions. It also should indicate who can admit patients to the ICU. Specific credentialing procedures should be in place.

Levels of Recommendations for the Intensive Care Unit

The Intensive Care Unit serves as a place for monitoring and care of patients with potentially severe physiological instability requiring technical and/or artificial life support. The level of care in an ICU is greater than that available on the floor or Intermediate Care Unit.

Rating System

Level 1: Convincingly justifiable on scientific evidence alone

Level 2: Reasonably justifiable by available scientific evidence and strongly supported by expert critical care opinion

Level 3: Adequate scientific evidence is lacking but widely supported by available data and critical care expert opinion

1. (Level 3) The Intensive Care Unit should have designated medical and nursing directors who are responsible for assuring appropriate patient triage through enforcement of patient admission and discharge criteria. This triage must consider the needs of the patient and institution.
2. (Level 3) The physician and nurse directors should determine the limits of care, telemetry, mechanical ventilation and types of intravenous medications.
3. (Level 3) Intensive Care Unit Committee - A multiprofessional committee should be involved in developing and implementing the admission and discharge criteria.
4. (Level 2) The provision of intensive care improves the outcome of critically ill patients.
5. (Level 2) An intensivist-led multiprofessional team improves the outcomes of critically ill patients as measured by mortality, length of stay, and resource consumption. (15, 16)

ADMISSION CRITERIA

ICU admission criteria should select patients who are likely to benefit from ICU care (2). Griner identified two conditions in which ICU care was of no greater benefit than conventional care (10). Situations involved patients who were at the two extremes of the risk of death spectrum; relatively low risk of death and exceedingly high risk of death. These groups can be referred to as "too well to benefit" and "too sick to benefit" from critical care services. ICU care has been demonstrated to improve outcome in severely ill, unstable patient populations (17, 18). Defining the "too well to benefit" and "too sick to benefit" population may be difficult solely based on diagnosis (7, 19-24). For example, drug overdose patients are commonly admitted to an ICU. However, Brett et al. (19), demonstrated that patients without clinically determined high risk criteria never required ICU interventions. Nonetheless, 70% of these low risk patients were admitted to an ICU for observation.

In addition to difficulties in determining the patient population who are too well or too sick to benefit, the specific criteria defining "substantial benefit" are subject to interpretation. For example, Paz, et al, examined admissions to the medical ICU following bone marrow transplantation. Bone marrow transplantation patients undergoing

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mechanical ventilation had an ICU discharge rate of only 3.8% compared to a discharge rate of 81.3% for those patients not requiring this therapy (21). Previous published reports documented similar poor survival rates for ventilator-requiring bone marrow transplantation patients (2.5% to 7.0%) (22-24). Whether a 2.5% to 7% discharge rate of bone marrow transplantation patients requiring mechanical ventilation is substantial or not may depend on the institution. These interpretations will lead to differences in admission criteria between institutions and physicians.

Thus, it is recommended that ICU practitioners understand tools for assessing severity of illness and prognosis of critically ill patients. These instruments in conjunction with clinical judgement represent the best tools currently available to determine prognosis (11, 25-27). It should be noted, however, that in general, these predictive instruments have only been applied to patients already admitted to an ICU and have not been tested as preadmission screening tools.

The ICU admission decision may be based on several models utilizing prioritization, diagnosis, and objective parameters models. We wish to emphasize that these models are presented as guidelines and individual institutions must create specific criteria to meet their special requirements.

Prioritization Model

This system defines those that will benefit most from the ICU (Priority 1) to those that will not benefit at all (Priority 4) from ICU admission.

Priority 1: These are critically ill, unstable patients in need of intensive treatment and monitoring that cannot be provided outside of the ICU. Usually, these treatments include ventilator support, continuous vasoactive drug infusions, etc. Priority 1 patients generally have no limits placed on the extent of therapy they are to receive. Examples of these patients may include post-operative or acute respiratory failure patients requiring mechanical ventilatory support and shock or hemodynamically unstable patients receiving invasive monitoring and/or vasoactive drugs.

Priority 2: These patients require intensive monitoring and may potentially need immediate intervention. No therapeutic limits are generally stipulated for these patients. Examples include patients with chronic comorbid conditions who develop acute severe medical or surgical illness.

Priority 3: These unstable patients are critically ill but have a reduced likelihood of recovery because of underlying disease or nature of their acute illness. Priority 3 patients may receive intensive treatment to relieve acute illness but limits on therapeutic efforts may be set such as no intubation or cardiopulmonary resuscitation. Examples include patients with metastatic malignancy complicated by infection, cardiac tamponade, or airway obstruction.

Priority 4: These are patients who are generally not appropriate for ICU admission. Admission of these patients should be on an individual basis, under unusual circumstances and at the discretion of the ICU Director. These patients can be placed in the following categories:

- A. Little or no anticipated benefit from ICU care based on low risk of active intervention that could not safely be administered in a non-ICU setting (too well to benefit from ICU care). Examples include patients with peripheral vascular surgery, hemodynamically stable diabetic ketoacidosis, mild congestive heart failure, conscious drug overdose, etc.
- B. Patients with terminal and irreversible illness facing imminent death (too sick to benefit from ICU care). For example: severe irreversible brain damage, irreversible multi-organ system failure, metastatic cancer unresponsive to chemotherapy and/or radiation therapy (unless the patient is on a specific treatment protocol), patients with decision-making capacity who decline intensive care and/or invasive monitoring and who receive comfort care only, brain dead non-organ donors, patients in a persistent vegetative state, patients who are permanently unconscious, etc.

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Diagnosis Model

This model uses specific conditions or diseases to determine appropriateness of ICU admission.

A. Cardiac System

1. Acute myocardial infarction with complications
2. Cardiogenic shock
3. Complex arrhythmias requiring close monitoring and intervention
4. Acute congestive heart failure with respiratory failure and/or requiring hemodynamic support
5. Hypertensive emergencies
6. Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain
7. S/P cardiac arrest
8. Cardiac tamponade or constriction with hemodynamic instability
9. Dissecting aortic aneurysms
10. Complete heart block

B. Pulmonary System

1. Acute respiratory failure requiring ventilatory support
2. Pulmonary emboli with hemodynamic instability
3. Patients in an intermediate care unit who are demonstrating respiratory deterioration
4. Need for nursing/respiratory care not available in lesser care areas such as floor or intermediate care unit
5. Massive hemoptysis
6. Respiratory failure with imminent intubation

C. Neurologic Disorders

1. Acute stroke with altered mental status
2. Coma: metabolic, toxic, or anoxic
3. Intracranial hemorrhage with potential for herniation
4. Acute subarachnoid hemorrhage
5. Meningitis with altered mental status or respiratory compromise
6. Central nervous system or neuromuscular disorders with deteriorating neurologic or pulmonary function
7. Status epilepticus
8. Brain dead or potentially brain dead patients who are being aggressively managed while determining organ donation status
9. Vasospasm
10. Severe head injured patients

D. Drug Ingestion and Drug Overdose

1. Hemodynamically unstable drug ingestion
2. Drug ingestion with significantly altered mental status with inadequate airway protection
3. Seizures following drug ingestion

E. Gastrointestinal Disorders

1. Life threatening gastrointestinal bleeding including hypotension, angina, continued bleeding, or with comorbid conditions
2. Fulminant hepatic failure
3. Severe pancreatitis
4. Esophageal perforation with or without mediastinitis

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F. Endocrine

1. Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis
2. Thyroid storm or myxedema coma with hemodynamic instability
3. Hyperosmolar state with coma and/or hemodynamic instability
4. Other endocrine problems such as adrenal crises with hemodynamic instability
5. Severe hypercalcemia with altered mental status, requiring hemodynamic monitoring
6. Hypo or hypernatremia with seizures, altered mental status
7. Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias
8. Hypo or hyperkalemia with dysrhythmias or muscular weakness
9. Hypophosphatemia with muscular weakness

G. Surgical

1. Post-operative patients requiring hemodynamic monitoring/ventilatory support or extensive nursing care

H. Miscellaneous

1. Septic shock with hemodynamic instability
2. Hemodynamic monitoring
3. Clinical conditions requiring ICU level nursing care
4. Environmental injuries (lightning, near drowning, hypo/hyperthermia)
5. New/experimental therapies with potential for complications

Objective Parameters Model

Objective criteria have been requested, expected and reviewed from individual hospitals as part of the Joint Commission on Accreditation of Healthcare Organizations' review process of special care units in the past. While the review process has recently been changed (13), it is understandable that hospitals would continue to incorporate objective parameters as part of the admitting criteria. **The criteria listed, while arrived at by consensus, are by necessity arbitrary.** They may be modified based on local circumstances. Data demonstrating improved outcome using specific criteria levels are not available.

Vital Signs

- * Pulse < 40 or > 150 beats/minute
- * Systolic arterial pressure < 80 mm Hg or 20 mm Hg below the patient's usual pressure
- * Mean arterial pressure < 60 mm Hg
- * Diastolic arterial pressure > 120 mm Hg
- * Respiratory rate > 35 breaths/minute

Laboratory Values (newly discovered)

- * Serum sodium < 110 mEq/L or > 170 mEq/L
- * Serum potassium < 2.0 mEq/L or > 7.0 mEq/L
- * PaO₂ < 50 mm Hg
- * pH < 7.1 or > 7.7
- * Serum glucose > 800 mg/dl
- * Serum calcium > 15 mg/dl
- * Toxic level of drug or other chemical substance in a hemodynamically or neurologically compromised patient

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Radiography/Ultrasonography/Tomography (newly discovered)

- * Cerebral vascular hemorrhage, contusion or subarachnoid hemorrhage with altered mental status or focal neurological signs
- * Ruptured viscera, bladder, liver, esophageal varices or uterus with hemodynamic instability
- * Dissecting aortic aneurysm

Electrocardiogram

- * Myocardial infarction with complex arrhythmias, hemodynamic instability or congestive heart failure
- * Sustained ventricular tachycardia or ventricular fibrillation
- * Complete heart block with hemodynamic instability

Physical Findings (acute onset)

- * Unequal pupils in an unconscious patient
- * Burns covering > 10% BSA
- * Anuria
- * Airway obstruction
- * Coma
- * Continuous seizures
- * Cyanosis
- * Cardiac tamponade

DISCHARGE CRITERIA

The status of patients admitted to an ICU should be revised continuously to identify patients who may no longer need ICU care.

- A. When a patient's physiologic status has stabilized and the need for ICU monitoring and care is no longer necessary
- B. When a patient's physiological status has deteriorated and active interventions are no longer planned, discharge to a lower level of care is appropriate

Discharge criteria from Critical Care Units should be similar to the admitting criteria for the next level of care such as intermediate care where available. However, not all patients require intermediate care after ICU discharge.

TRIAGE

Under ideal conditions patients would be admitted or discharged strictly on their potential to benefit from ICU care. Unfortunately, in many instances the number of potential ICU patients exceeds the available beds. A method of prioritizing or triaging patients is necessary (11, 29). Initial triage of patients may follow the guidelines given in the prioritization model for admissions. In an environment where ICU admissions are rigorously screened for benefit, and discharge is ongoing and continuous, the need for triage is minimized.

When all ICUs and step-down units are filled, the ICU/Critical Care Director should have access to all of these units and have the responsibility and authority to admit/discharge patients from these units. Triage policies for an institution should be written in advance. Triage decisions should be made explicitly, and without bias. Ethnic origin, race, sex, social status, sexual preference or financial status should never be considered in triage decisions. Triage decisions may be made without patient or surrogate consent, and can be made despite an anticipated untoward outcome. Religious or moral convictions may be the basis for providing treatment "if the costs are not borne by the general society and the provision of such services does not foreclose the treatment of other patients who

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would benefit from critical care" (30). The topic of triage of critically ill patients has been recently reviewed by the Society of Critical Care Medicine Ethics Committee (11). The reader is referred to this document for a more in-depth discussion of this topic.

PERFORMANCE REVIEW

The performance evaluation and review of an ICU should include its admission/discharge/triage policy. A multiprofessional team should review performance at least annually. In order to adequately review performance as it relates to admission, outcome, and the decision-making process, a database able to track these and other variables would be extremely useful. Severity adjusted outcomes should be utilized whenever possible in order to minimize the effect of severity of illness on raw mortality data, independent of policy or care standards. As guidelines to limit these types of admissions are instituted, care must be taken to track the patients sent to other areas to assure equivalency of outcome, length of stay, etc. A mechanism to review requested admissions that were denied should be in place to assure appropriateness of both the policy and the decision-making process. Conflicts over discharges should be reviewed so that possible improvements in the discharge policy can be identified and incorporated. Readmissions to the ICU for a similar problem should be monitored closely as they may directly relate to the quality of the discharge process (31-33). The quality and efficiency of an ICU should be continually examined and improved through this process. Studies examining objective criteria for admission and benefit of admission to ICUs should be encouraged in order to better define appropriate utilization of this important and expensive resource.

Administrative Recommendations to Facilitate Appropriate Admissions, Discharges and Delivery of Intensive Care Units

A. Personnel

1. A Physician Director must be appointed who, on the basis of training, interest, type of practice, and availability can give clinical, administrative and educational direction to the Intensive Care Unit. The Physician Director should meet "Guidelines for the definition of an intensivist and the practice of critical care medicine" published by the Society of Critical Care Medicine (34). Collaboration with nursing and ancillary staff should be emphasized. The Director should assume responsibility for assuring the quality, safety, and appropriateness of care in the Intensive Care Unit. The Director must work collaboratively with the Directors of other areas in the institution so that patient care, triage, and patient flow are effective and efficient.

The ultimate authority for ICU admission, discharge, and triage rests with the ICU Director.

2. An ICU Director has the responsibility to ensure that the patients meet ICU admission and discharge criteria. Formal recognition of the role of the ICU Director should occur through established hospital pathways. A knowledge of the various prognostic models is required of the ICU Director (11). A clearly written procedure for conflict resolution as it relates to admission and discharge of patients must be in place.
3. The multiprofessional team of professionals should meet on a regular basis to identify and solve problems through quality assurance and continuous quality improvement activities.

SUMMARY

The Intensive Care Unit can provide efficient and effective care to the critically ill patients by implementing well thought out admission, discharge, and triage policies and procedures.

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The Task Force members who participated in the review and revision of this document include: Andrew B. Egol, DO, FCCM; Robert E. Fromm, MD, FCCM; Kalpalatha K. Guntupalli, MD, FCCM; Melissa A. Fitzpatrick, RN, MSN, CCRN; David A. Kaufman, MD; Stanley A. Nasraway, MD, FCCM; David L. Ryon, MD; and Jack E. Zimmerman, MD, FCCM

Approved by the Council of the Society of Critical Care Medicine in May 1998. To be revised in 2002.

Guidelines on Admission and Discharge for Adult Intermediate Care Units



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These guidelines can also be found in the March 1998 issue of *Critical Care Medicine* --
Crit Care Med 1998 Mar; 26(3):607-610

Society of Critical Care Medicine
701 Lee Street
Suite 200
Des Plaines, IL 60016
Phone: 847/827-6869

Society of Critical Care Medicine

Guidelines on Admission and Discharge for Adult Intermediate Care Units

American College of Critical Care Medicine
of the Society of Critical Care Medicine

INTRODUCTION

In acute care hospitals, one can identify a patient population that does not require intensive care but needs more care than that provided on a general ward. These patients may require frequent monitoring of vital signs and/or nursing interventions, but usually do not require invasive monitoring. In a study of 706 surgical and medical ICU patients, this patient population accounted for approximately 22% of all ICU bed days (1). In a more recent study of 17,440 ICU admissions, 6,180 patients were admitted strictly for intensive monitoring, though they had a less than 10% risk for requiring active treatment based on this monitoring (2). As a consequence, intermediate care has been proposed as a more appropriate means of resource utilization for these patients (2-6). Intermediate care areas can be represented as multipurpose "progressive care units" or as single-organ subspecialty floors such as cardiac telemetry, surgical (thoracic, vascular, etc.), neurosurgical/neurological monitoring areas, or chronic ventilator respiratory care units (7-11). In light of the recent emphasis on cost containment, the intermediate care unit concept is suggested as a strategy that promotes greater flexibility in patient triage, increases accessibility to limited intensive care and provides a cost-effective alternative to critical care unit admission, particularly for patients with a low risk of, but potential for, major complications and who have been admitted for routine monitoring (7, 11-16). Moreover, patient satisfaction may be increased since an intermediate care environment is less noisy and may have more liberal family visitation policies (17).

There are few reports demonstrating the efficacy of intermediate care as a graded option between conventional ward care and intensive care. Most studies are retrospective or uncontrolled observational series (13). There is only one randomized, controlled study demonstrating reduced costs without a negative impact on outcome (16). Franklin and colleagues observed a decrease in the case fatality rate of a large urban medical service after the introduction of an intermediate care unit, noting an important reduction in the number of "low risk monitoring" admissions to their intensive care unit; this unit effectively increased the ready availability of critical care services to those patients most urgently in need, streamlining the ICU admission process, and attenuating unnecessary ICU stays or delays in transfer (7). In addition, these changes were associated with fewer ward cardiac arrests, presumably because of more timely and appropriate levels of observation.

Byrick et al. compared the initial impact on ICU utilization of opening an intermediate care unit, followed by closure of that unit (6,12). The intermediate care unit led to earlier extubation and discharge from the ICU, and shortened overall length of stay with no change in outcome. The availability of intermediate care increased ICU bed availability and freed the operating room schedule from being ICU-dependent. Nine years after opening, the intermediate care unit was dismantled due to hospital budgetary constraints. This closure led to a four-fold increase in ICU admissions with a lower severity of illness. The lack of stepdown resources caused a reduction in triage flexibility, which negatively impacted on ICU discharge planning and required longer ICU stays for "sicker" patients. Based on this comparison, intermediate care was reinstated (12).

Intermediate care reduces hospital costs by decreasing staffing to coincide with the need of the patients (2,3). Since personnel costs may comprise up to 80% of total ICU expenses, the savings afforded by a reduction in staffing necessary for patients with intermediate severities of illness can be substantial (14-18). These savings may be overstated if the reduction in nursing staff is partially offset by the need for additional healthcare team members (i.e., respiratory therapy). Similarly, there may not be a large difference in supplies and capital expenditures if the reduced use of invasive monitoring is counterbalanced by implementation of any of an increasing array of noninvasive monitoring equipment (3). However, there may be real and substantial savings from the change in protocol practice that occurs with transfer out of an ICU. Douglas et al. (16) established a stepdown facility for the

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"chronically critically ill" (ICU length of stay >7 days, hemodynamically stable). This study is the only prospective, randomized trial to triage patients to an intermediate care unit who qualified based on pre-established criteria (16). The role of house officers was eliminated and the number of routine diagnostic laboratory tests and radiographs was sharply reduced. This change in protocol practice translated into "hidden" but substantial savings (16).

The investigation by Franklin et al. found a decrease in mortality with intermediate care, but further research is needed in this area (7). Sophisticated designs for the study of intermediate care should include concurrent, randomized controls rather than using sequential prospective study periods. Little attempt has been made to quantify the impact of intermediate care on reducing ICU readmissions ("bouncesbacks"), i.e., patients who are discharged from the ICU and require urgent return within 48 to 72 hours (19, 20). The costs of different levels of care must also be studied, with methods that control for diagnosis, comorbidities and severity of illness (13). These kinds of studies are needed before the benefits and limitations of intermediate care can be fully appreciated. Research that evaluates these guidelines will promote their standardization and improvement, and this may improve patient outcome.

RECOMMENDATIONS

The American College of Critical Care Medicine developed by consensus the following recommendations to promote safe triage of patients to intermediate care units.

Rating System

Level 1: Convincingly justifiable on scientific evidence alone.

Level 2: Reasonably justifiable by available scientific evidence and strongly supported by expert critical care opinion.

Level 3: Adequate scientific evidence is lacking but widely supported by available data and expert critical care opinion.

1. (Level 2) The intermediate care unit serves as a place for the monitoring and care of patients with moderate or potentially severe physiologic instability, requiring technical support but not necessarily artificial life support. The Intermediate Care Unit is reserved for those patients requiring less care than standard intensive care but more than that which is available from ward care.
2. (Level 1) The intermediate care unit reduces costs, reduces ICU length of stay without increasing hospital length of stay, does not impact negatively on patient outcome and improves patient/family satisfaction* by providing a physical environment that is quieter and calmer than the ICU.
3. (Level 3) The intermediate care unit should have designated Physician and Nurse Directors who can be responsible for assuring appropriate patient triage through enforcement of the admission and discharge criteria. This triage must involve personnel from the general wards, the ICU, the post-anesthesia care unit (i.e., recovery room), and others so that a system is developed which meets the needs of the patient and the institution efficiently and economically.

*Shown for pediatric but not adult ICUs

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4. (Level 3) The Physician and Nurse Directors should determine the limits of care that can be rendered in the intermediate care unit, based on institutional needs, staff qualifications and unit resources. This assessment includes the extent of invasive monitoring, telemetry, mechanical ventilation and types of intravenous medications.
5. (Level 3) Each intermediate care unit should develop specific admission and discharge policies and procedures, patient care standards, and outcome criteria for quality assessment (continuous quality improvement). Tools should be developed to monitor outcomes and other performance measures. Compliance with admission and discharge policies should be monitored and deviations reported to the hospital quality improvement section for action.

Listed below are admission and discharge guidelines with some examples of specific conditions or diseases that could qualify for intermediate care.

I. Admission Criteria

A. Cardiac System

1. Low-probability myocardial infarction; rule out myocardial infarction.
2. Hemodynamically stable myocardial infarction.
3. Any hemodynamically stable dysrhythmia.
4. Any hemodynamically stable patient without evidence of myocardial infarction but requiring temporary or permanent pacemaker.
5. Mild-to-moderate congestive heart failure without shock (Killip Class I, II).
6. Hypertensive urgency without evidence of end-organ damage.

B. Pulmonary System

1. Medically stable ventilator patients for weaning and chronic care.
2. Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or nasal continuous positive airway pressure.
3. Patients who require frequent vital signs or aggressive pulmonary physiotherapy.

C. Neurologic Disorders

1. Patients with established, stable stroke who require frequent neurologic assessments or frequent suctioning or turning.
2. Acute traumatic brain injury patients who have a Glasgow Coma Scale above 9 but require frequent monitoring for signs of neurologic deterioration.
3. Stable severe traumatic brain injury patients who require frequent positioning and pulmonary toilet.
4. Subarachnoid hemorrhage patients post-aneurysm clipping who require observation for signs of vasospasm or hydrocephalus.
5. Stable neurosurgical patients who require a lumbar drain for treatment of cerebrospinal fluid leak.
6. Stable cervical spinal cord injured patients.
7. Patients with chronic but stable neurologic disorders, such as neuromuscular disorders, who required frequent nursing interventions.
8. Grade I-II subarachnoid hemorrhage patients awaiting surgery.
9. Patients with ventriculostomies who are awake and alert awaiting ventriculo-peritoneal (V-P) shunt.

D. Drug Ingestion and Drug Overdose

1. Any patient requiring frequent neurologic, pulmonary, or cardiac monitoring for a drug ingestion or overdose who is hemodynamically stable.

E. Gastrointestinal (GI) Disorders

1. GI bleeding with minimal orthostatic hypotension responsive to fluid therapy.
2. Variceal bleeding without evidence of bright red blood by gastric aspirate and stable vital signs.
3. Acute liver failure with stable vital signs.

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- F. Endocrine
1. Diabetic ketoacidosis patients requiring constant intravenous infusion of insulin, or frequent injections of regular insulin during the early regulation phase after recovery from diabetes ketoacidosis.
 2. Hyperosmolar state with resolution of coma.
 3. Thyrotoxicosis, hypothyroid state requiring frequent monitoring.
- G. Surgical
1. The postoperative patient who, following major surgery, is hemodynamically stable but may require fluid resuscitation and transfusion due to major fluid shifts.
 2. The postoperative patient who requires close nurse monitoring during the first 24 hrs. Examples include but are not limited to carotid endarterectomy; peripheral vascular reconstruction; the neurosurgical patient requiring frequent neurological exams; V-P shunt revision, renal transplant, etc.
- H. Miscellaneous
1. Appropriately treated and resolving early sepsis without evidence of shock or secondary organ failure.
 2. Patients requiring closely titrated fluid management.
 3. Obstetrical patients admitted at any point in their pregnancy and postpartum period for treatment of pre-eclampsia/eclampsia or other medical problems.
 4. Any patient requiring frequent nursing observation or extensive time requirement for wound management who does not fall under the above categories may be considered for admission (example: Addison's disease, renal failure, delirium tremens, hypercalcemia).
- II. Patients who are usually *NOT* appropriate for admission to Intermediate Care include:
- A. Complicated acute myocardial infarction with temporary pacemaker, angina, hemodynamic instability, significant pulmonary edema or significant ventricular dysrhythmias.
 - B. Patients requiring heavy nursing loads and titrated patient care of 12 to 24 hrs/day.
 - C. Patients with acute respiratory failure who are recently intubated or at imminent risk of requiring intubation.
 - D. Patients requiring invasive hemodynamic monitoring with a pulmonary artery or left atrial catheter, or an intracranial pressure monitor.
 - E. Patients in status epilepticus.
 - F. Patients with catastrophic brain illness or injury who are not to be resuscitated and are not candidates for organ donation.
 - G. Patients from whom aggressive modalities of care are being withheld or have been withdrawn, such that they are receiving only comfort measures.
- III. Discharge Criteria:
- Discharge of patients from an intermediate care unit shall take place:
- A. When a patient's physiologic status has stabilized and the need for intensive patient monitoring is no longer necessary and the patient can be cared for on a general unit.
 - B. When a patient's physiological status has deteriorated and active life support is required or highly likely, the patient will be transferred to a critical care unit per unit-specific protocol.
- IV. Administrative Recommendations to Facilitate Appropriate Admissions, Discharges and Delivery of Intermediate Care.
- A. Personnel
1. A physician director must be appointed who, on the basis of training, interests, type of practice, and availability can give clinical, administrative and educational direction to the Intermediate Care Unit. The Physician Director should meet "Guidelines for the definition of an intensivist and the practice of critical care medicine," published by the Society of Critical Care Medicine (21). Collaboration with nursing and ancillary staff should be emphasized. The Director should assume responsibility for assuring the quality, safety, and appropriateness of care in the intermediate care unit. The Director

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- must work collaboratively with the Directors of other areas in the institution so that patient care, triage, and patient flow are effective and efficient.
2. A nursing director should be appointed in order to establish precise lines of authority, responsibility, and accountability for delivery of high-quality, safe and appropriate nursing care. The Nurse Director should be an RN with a BSN degree and should have had at least 3 yrs experience working in an ICU. In major teaching institutions the Nurse Director should have a graduate degree (i.e., MS, MSN) with at least 5 yrs of experience in critical care nursing. The Nursing Director shares responsibility with the Physician Director for quality of care and patient safety, and ensures ongoing continuing education and professional development of the nursing staff.
 3. The exact nurse-to-patient ratio should be based on patient acuity of illness.
 4. Available ancillary staffing should include professionals from respiratory therapy, clinical pharmacy, nutritional support, social work, and rehabilitation services. These staff members should be integrated into a multidisciplinary intermediate care unit team. They must interact with the ICU, post-anaesthesia care unit, and other unit staffs.
 5. The multidisciplinary team of professionals should meet on a regular basis to identify and solve problems through quality assurance and continuous quality improvement activities.

SUMMARY

The intermediate care unit promotes efficient and effective care by increasing the flexibility of patient triage, utilizing personnel efficiently, and providing cost-effective care.

Society of Critical Care Medicine

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The Task Force members who participated in the preparation of this document include: Stanley A. Nasraway, MD, FCCM; Ian L. Cohen, MD, FCCM; Richard C. Dennis, MD, FCCM; Michelle A. Howenstein, MS, RN, CCRN; Diana K. Nikas, RN, MN, FCCM; Jonathan Warren, MD, FCCM; and Suzanne K. Wedel, MD, FCCM

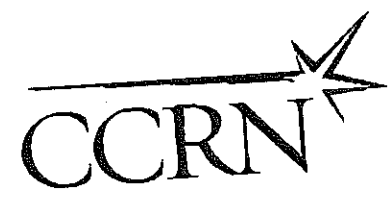
Approved by the Council of the Society of Critical Care Medicine in May 1997. To be revised in 2002.

Generations Family Health Center
October 2, 2015

EXHIBIT 3: AACN CCRN and PCCN Certification

Exam

CCRN Exam Handbook (Adult • Pediatric • Neonatal)



Acute/Critical Care
Nursing Certification



AACN
CERTIFICATION
CORPORATION

Certification Organization for the American Association of Critical-Care Nurses

MISSION

AACN Certification Corporation contributes to consumer health and safety through comprehensive credentialing of nurses to ensure their practice is consistent with established standards of excellence in caring for acutely and critically ill patients and their families.

VISION

As the undisputed leader in credentialing nurses, AACN Certification Corporation has demonstrated that certification contributes to achieving optimal outcomes that are consistent with the goals and values of acutely and critically ill patients and their families.

VALUES

As the Corporation works to advance its mission and vision and fulfill its purpose and inherent obligation to ensure the health and well-being of patients experiencing acute and critical illness, the Corporation is guided by a set of deeply rooted values.

- Providing **leadership** to bring all stakeholders together to create and foster cultures of excellence and innovation.
- Acting with **integrity** and upholding ethical values and principles in all relationships and in the provision of sound, fair and defensible credentialing programs.
- Committing to **excellence** in credentialing programs by striving to exceed industry standards and expectations.
- Promoting **leading edge, research-based** credentialing programs that reach diverse certificants.
- Demonstrating **stewardship** through fair and responsible management of resources and cost-effective business processes.

ETHICS

AACN and AACN Certification Corporation consider the American Nurses Association (ANA) Code of Ethics for Nurses foundational for nursing practice, providing a framework for making ethical decisions and fulfilling responsibilities to the public, colleagues and the profession. AACN Certification Corporation's mission of public protection supports a standard of excellence that certified nurses have a responsibility to read, understand and act in a manner congruent with the ANA Code of Ethics for Nurses.

The following AACN Certification Corporation programs have been accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence (ICE):



CCRN[®] (Adult)
 CCRN[®] (Pediatric)
 CCRN[®] (Neonatal)
 CCRN-E[™] (Adult)

PCCN[®]
 CMC[®]
 CSC[®]

ACNPC-AG[®]
 ACCNS-AG[®]
 ACCNS-P[®]
 ACCNS-N[®]

Our advanced practice certification programs, ACCNS-AG, ACCNS-P, ACCNS-N and ACNPC-AG, meet the National Council of State Boards of Nursing (NCSBN) criteria for APRN certification programs.

**AACN
CERTIFICATION
CORPORATION**

Certification Organization for the American Association of Critical-Care Nurses

CCRN EXAM HANDBOOK

Acute/Critical Care Nursing Certification - Adult, Pediatric, Neonatal

As healthcare becomes increasingly complex and challenging, certification has emerged as a mark of excellence showing patients, employers and the public that a nurse is qualified and competent, and has met the rigorous requirements to achieve specialty and/or subspecialty certification.

AACN Certification Corporation programs were created to protect healthcare consumers by validating the knowledge of nurses who care for the acutely and critically ill. We are pleased to provide you with this handbook with information about our programs and how to apply for and take the CCRN certification exams.

Today, more than 93,000 practicing nurses hold one or more of these certifications from AACN Certification Corporation:

Specialty Certifications

CCRN® is for nurses providing direct bedside care to acutely/critically ill adult, pediatric or neonatal patients.

CCRN-E™ is for nurses working in a tele-ICU monitoring acutely/critically ill adult patients from a remote location.

CCRN-K™ is for nurses whose non-bedside practice influences patients, nurses and/or organizations to have a positive impact on the care delivered to acutely/critically ill adult, pediatric or neonatal patients.

PCCN® is for progressive care nurses providing direct bedside care to acutely ill adult patients.

CNML is for nurse managers and leaders; offered in partnership with AONE (American Organization of Nurse Executives) Credentialing Center.

Subspecialty Certifications

CMC® is for certified nurses providing direct bedside care to acutely and/or critically ill adult cardiac patients.

CSC® is for certified nurses providing direct bedside care to acutely and/or critically ill adult patients during the first 48 hours after cardiac surgery.

Advanced Practice Consensus Model-Based Certifications

ACNPC-AG® is for the adult-gerontology acute care nurse practitioner educated at the graduate level.

The ACCNS credentials are for clinical nurse specialists educated at the graduate level to provide care across the continuum from wellness through acute care:

ACCNS-AG® is for the adult-gerontology clinical nurse specialist.

ACCNS-P® is for the pediatric clinical nurse specialist.

ACCNS-N® is for the neonatal clinical nurse specialist.

Advanced Practice Certifications

With implementation of the Consensus Model in 2015, ACNPC and CCNS are available as *renewal options only*.

ACNPC® is for acute care nurse practitioners educated to provide care to adult patients.

CCNS® is for acute/critical care clinical care specialists educated to provide care to adult, pediatric or neonatal patients.

We continually seek to provide quality certification programs that meet the changing needs of nurses and patients. Please visit www.certcorp.org > Documents and Handbooks, or call (800) 899-2226 for more information about the above certifications.

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CCRN® is a specialty certification for nurses who provide direct bedside care to acutely/critically ill adult, pediatric or neonatal patients and their families. These patients may be found in such units as: intensive care, cardiac care, combined ICU/CCU, medical/surgical ICU, trauma unit or critical care transport/flight.

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The following information can be found in the *Certification Exam Policy Handbook* online at www.certcorp.org >
Documents and Handbooks:

- | | |
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| <ul style="list-style-type: none"> • AACN Certification Programs • Name and Address Changes • Confidentiality of Exam Application Status • Testing Site Information • Exam Scheduling and Cancellation • On the Day of Your Exam | <ul style="list-style-type: none"> • Duplicate Score Reports • Recognition of Certification • Use of Credentials • Denial of Certification • Revocation of Certification • Review and Appeal of Certification Eligibility |
|--|---|

CCRN CERTIFICATION PROGRAM

CCRN Registered Service Mark

CCRN is a registered service mark and denotes certification in acute/critical care nursing as granted by AACN Certification Corporation. Registered nurses who have not achieved CCRN certification, whose CCRN certification has lapsed or who have chosen Inactive status are not authorized to use the CCRN credential.

Although a common misconception, CCRN is not an acronym for "critical care registered nurse." This would imply that nurses are registered as critical care nurses, which is not accurate.

Validated Knowledge and Specialized Skills

Each CCRN certification exam is based on a study of practice, also known as a job analysis, which defines the dimensions of acute/critical care practice, identifying what is required of registered nurses providing care to acutely/critically ill patients.

In the study, acute/critical care nurses across the United States were surveyed to ascertain the significance of the various elements of their practice. Through an extensive review and evaluation process, the knowledge, skills and abilities crucial to acute/critical care nursing were defined using the AACN Synergy Model for Patient Care as an organizing framework. The CCRN certification exams are based on these skills and abilities and the knowledge required to perform them.

CCRN certification is achieved by those acute/critical care nurses who pass the CCRN exam in neonatal, pediatric and/or adult critical care nursing. CCRN certification denotes to the public those practitioners who possess a distinct and clearly defined body of knowledge called acute/critical care nursing.

CCRN Exam Content

The CCRN exams are 3-hour tests consisting of 150 multiple-choice items. Of the 150 items, 125 are scored and 25 are used to gather statistical data on item performance for future exams.

The CCRN exams focus on adult, pediatric and neonatal patient populations. Eighty percent (80%) of each exam focuses on clinical judgment and is age-specific for the adult, pediatric and neonatal populations. The remaining 20% covers professional caring and ethical practice. Professional caring and ethical practice questions may be asked about any age across the life span while clinical judgment questions are restricted to adult, neonatal or pediatric populations.

CCRN Test Plans

The content of the CCRN exams is described in the test plans included in this handbook. Candidates are tested on a variety of patient care problems that are organized under major categories. Please note the percentage of the CCRN exam devoted to each category.

CCRN EXAM ELIGIBILITY

Licensure

Current unencumbered licensure as an RN or APRN in the United States is required.

- An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit the nurse's practice in any way.
- If randomly selected for audit, you will be asked to provide a copy of your RN or APRN license.
- Candidates and CCRN-certified nurses must notify AACN Certification Corporation **within 30 days** if any restriction is placed on their RN or APRN license.

Practice

Candidates must meet *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely/critically ill patients during the previous 2 years, with 875 of those hours accrued in the most recent year preceding application.

OR

- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely/critically ill patients, with 144 of those hours accrued in the most recent year preceding application.

Eligible hours are those spent caring for the patient population (adult, pediatric or neonatal) in alignment with the exam for which you are applying. A significant portion of the clinical hours for CCRN exam and renewal eligibility must be spent caring for critically ill patients.

Orientation hours spent shadowing/working with another nurse who is the one with the patient assignment *cannot* be counted toward clinical hours for CCRN eligibility; however, orientation hours during which you are the assigned nurse providing direct bedside care to acutely/critically ill patients may be counted.

Clinical hours must be completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet Status or Joint Commission International accreditation.

Nurses serving as manager, educator (in-service or academic), APRN or preceptor may apply hours spent supervising nursing students or nurses at the bedside.

- Nurses in these roles must be actively involved in caring for patients **at the bedside**; for example, demonstrating how to measure pulmonary artery pressures or supervising a new employee or student nurse performing a procedure.

Practice Verification

The name and contact information of a professional associate must be given for verification of eligibility related to clinical practice hours. If you are randomly selected for audit, this associate will need to verify in writing that you have met the clinical hour requirements.

- A professional associate is defined as your clinical supervisor or a colleague (RN or physician) with whom you work.

AACN Certification Corporation may adopt additional eligibility requirements at its sole discretion. Any such requirements will be designed to establish, for purposes of CCRN certification, the adequacy of a candidate's knowledge in care of the acutely/critically ill.

APPLICATION FEES

CCRN Computer-Based Exam	
AACN Members	\$225
Nonmembers	\$330

CCRN Retest	
AACN Members	\$170
Nonmembers	\$275

CCRN Renewal by Exam	
AACN Members	\$170
Nonmembers	\$275

Payable in U.S. funds. Fees are subject to change without notice. A \$15 fee will be charged for a returned check.

Computer-based testing discounts are available for groups of **10 or more** candidates submitting their AACN certification exam applications in the same envelope. Employers may pre-purchase exam vouchers at a further discounted rate.

For details about the group and bulk discount programs, visit www.certcorp.org > General Information or call (800) 899-2226.

AACN Certification Corporation recommends that you be ready to test before applying for the CCRN exam.

ONLINE APPLICATION PROCESS

- ▶ **Register online** for computer-based testing at www.certcorp.org > Apply Online
- ▶ **Before you get started**, have available the following:
 - RN or APRN license number and expiration date
 - Name, address, phone and email address of your clinical supervisor or a professional colleague (RN or physician) who can verify your practice eligibility
 - Credit card (Visa, MasterCard, Discover or American Express)
- ▶ **Same day processing**

PAPER APPLICATION PROCESS

- ▶ **Paper applications are required** for those applying with a group, for paper and pencil exams and for testing outside the U.S.
- ▶ **Complete the application** on pages 41-42 and **honor statement** on page 43
 - Fill in all requested information, including that for your RN or APRN license
- ▶ **Include application fee**
 - Credit card, check or money order
- ▶ **Allow 2-3 weeks for processing**

Use your legal name on the application.
This name must match photo identification used for exam entry and will be the name printed on your certificate.

1. Receive notice of processed application

- AACN will send you an email confirming that you have successfully applied to take the CCRN exam.

2. Receive approval-to-test email

- AACN's testing service (AMP) will send an email and mail a postcard to eligible candidates within **5 to 10 days** after the confirmation email that will include:
 - A toll-free number and online instructions to schedule your testing appointment
 - The **90-day** period during which you must schedule and take the exam
 - Your **exam identification number**, which is your unique AACN customer number preceded by the letter "C" (e.g., C00123456).
- If you do not receive an email or postcard from AMP **within 2 weeks of receiving confirmation email**, please contact AACN Customer Care at (800) 899-2226.

3. Schedule the exam

- Upon receipt of AMP's email or postcard:
 - Confirm that you are scheduled for the correct certification exam
 - Promptly schedule your exam appointment for a date and time that falls within your **90-day** testing window
- Testing is offered twice daily, Monday through Friday, at **9 a.m. and 1:30 p.m.**. Saturday appointments are available at some locations.
- To locate one of the more than 175 AMP testing centers within the U.S., visit www.goAMP.com.

4. Sit for the exam

- Upon completion of computer-based exams, results with a score breakdown will be presented on-site.
- Results of paper and pencil exams will be mailed to candidates 3 to 4 weeks following paper testing.
- Successful candidates will receive their wall certificate within 3 to 4 weeks of passing the exam.

Please ensure that AACN has your current contact information on record.
Updates may be made online at www.aacn.org/myaccount or emailed to info@aacn.org.
For name changes, please call AACN Customer Care at (800) 899-2226.

CCRN CERTIFICATION RENEWAL

Renewal Period

CCRN certification is granted for a period of 3 years. Your certification period begins the first day of the month in which the CCRN certification exam is passed and ends 3 years later; for example, October 1, 2015 through September 30, 2018. The purpose of certification renewal is to enhance continued competence.

Renewal notifications will be mailed and emailed to you starting 4 months before your scheduled CCRN renewal date. **You are responsible for renewing your certification even if you do not receive renewal notification.** Refer to www.certcorp.org for current information.

Eligibility

Candidates for CCRN renewal must meet the following requirements:

- Current unencumbered U.S. RN or APRN license that was not subjected to formal discipline by any state board of nursing during the 3-year certification renewal period
- Completion of 432 hours of direct bedside care of acutely/critically ill patients as an RN or APRN within the 3-year certification period, with 144 of those hours in the 12-month period preceding the scheduled renewal date
 - Eligible hours are those spent caring for the patient population (adult, pediatric or neonatal) in which certification is held.
- Completion of the required CERPs or take/pass the CCRN exam

Renewal Options

You may seek CCRN certification renewal via Renewal by Synergy CERPs or Renewal by Exam, or you may choose Inactive status.

► Option 1 - Renewal by Synergy CERPs

- Meet eligibility requirements for CCRN renewal and complete the Continuing Education Recognition Point (CERP) Program, which requires 100 CERPs in various categories (A, B & C).
- Online Renewal by Synergy CERPs is available to all active CCRNs as early as 4 months prior to their scheduled renewal date. For more information, visit www.certcorp.org > Renew Your Certification.
- For more details, refer to the Renewal by Synergy CERPs Brochure and other Synergy CERP resources available online at www.certcorp.org.

► Option 2 - Renewal by Exam

- Meet the eligibility requirements for CCRN renewal and successfully apply for and schedule your exam.
 - The CCRN exam must be completed **before** your scheduled renewal date.
 - You may not take the exam early, then attempt to renew by CERPs if you do not pass.

► Option 3 - Inactive Status

- Inactive status is available to CCRN-certified nurses who do not meet the renewal eligibility requirements but do not wish to lose their CCRN certification status. Inactive status provides CCRN-certified nurses additional time, **up to 3 years** from the scheduled renewal date, to meet the eligibility requirements.
- **During the time of inactive status, the CCRN credential may not be used.**
- Inactive status may be held more than once, but not for two consecutive renewal periods.

For more details, refer to the *CCRN Renewal Handbook* online at www.certcorp.org > Documents and Handbooks.

continued

CCRN CERTIFICATION RENEWAL (CONTINUED)

CCRN-E Certification

If you work primarily or exclusively in a tele-ICU caring for acutely/critically ill adult patients from a remote location and do not meet the requirements for CCRN renewal, CCRN-E renewal may be an option.

For more details, refer to the **CCRN-E Renewal Handbook** online at www.certcorp.org.

CCRN-K Certification

CCRN-K is a new program that validates the clinical specialty knowledge of acute/critical care nurses who do not exclusively or primarily practice at the bedside. Eligible practice hours include those in which the nurse applies knowledge in a way that influences patients, nurses and/or organizations to have a positive impact on the care delivered to acutely/critically ill adult, pediatric or neonatal patients.

- Nurses with practice hours in roles such as Clinical or Patient Educator, Academic Faculty, Manager/Supervisor, Clinical Director, Nursing Administrator, Case Manager, Transitional Care Coordinator **may** qualify. This is not an all-inclusive list, nor does it mean all nurses working in these roles are eligible for CCRN-K renewal.

For more details, refer to the **CCRN-K Renewal Handbook** online at www.certcorp.org.

Alternative Designations

Alumnus Status

Alumnus status is for nurses who have been CCRN-certified but no longer provide direct bedside care to acutely/critically ill patients for enough hours to meet the clinical hour requirement for active CCRN certification, but are still in the nursing profession in some other capacity and wish to remain connected with the credential.

- Renewable every 3 years, the "Alumnus CCRN" designation, written out, may be used on your resume or below your name and credentials on a business card, but may not be used with your signature or on a name badge.
- To be eligible for Alumnus CCRN status, you must have held CCRN certification and have no plans to renew CCRN certification in the future.
- There are no CE or CERP requirements to maintain Alumnus CCRN status.

Retired Status

Retired status provides the CCRN-certified nurse or Alumnus CCRN who is retiring from the nursing profession with a continued sense of career identity and professional connectedness. The Retired CCRN designation recognizes CCRN-certified nurses for their years of service in the care of acutely/critically ill patients. It also acknowledges their pride and dedication in maintaining their certification.

- To be eligible for Retired CCRN status, you must have been a CCRN without plans of returning to nursing practice or renewing certification.
- The retired nurse must not be working in any type of position that requires the possession of an RN license. You are not eligible if you are changing from bedside practice to another nursing role.
- The "Retired CCRN" designation, written out, may be used on your resume or below your name and credentials on a business card, but may not be used with your signature or on a name badge.
- There are no CE or CERP requirements to maintain Retired CCRN status.

For more details, please refer to the Alumnus and Retired applications available online at www.certcorp.org > Documents and Handbooks.

AACN SYNERGY MODEL FOR PATIENT CARE

Synergy is an evolving phenomenon that occurs when individuals work together in mutually enhancing ways toward a common goal. AACN Certification Corporation is committed to ensuring that certified nursing practice is based on the needs of patients. Integration of the AACN Synergy Model for Patient Care into AACN Certification Corporation's certification programs puts emphasis on the patient and says to the world that patients come first.

The Synergy Model creates a comprehensive look at the patient. It puts the patient in the center of nursing practice. The model identifies nursing's unique contributions to patient care and uses language to describe the professional nurse's role. It provides nursing with a venue that clearly states what we do for patients and allows us to start linking ourselves to, and defining ourselves within, the context of the patient and patient outcomes.

NOTE: AACN certification exams do not test for knowledge of the Synergy Model or its terminology; this is the theoretical model within which the tests have been designed.

Patient Characteristics

The Synergy Model encourages nurses to view patients in a holistic manner rather than the "body systems" medical model. Each patient and family is unique, with a varying capacity for health and vulnerability to illness. Each patient, regardless of the clinical setting, brings a set of unique characteristics to the care situation. Depending on where they are on the healthcare continuum, patients may display varying levels of the following characteristics:

Resiliency	Capacity to return to a restorative level of functioning using compensatory/coping mechanisms; the ability to bounce back quickly after an insult.
Vulnerability	Susceptibility to actual or potential stressors that may adversely affect patient outcomes.
Stability	Ability to maintain a steady-state equilibrium.
Complexity	Intricate entanglement of two or more systems (e.g., body, family, therapies).
Resource Availability	Extent of resources (e.g., technical, fiscal, personal, psychological and social) the patient/family/community bring to the situation.
Participation in Care	Extent to which patient/family engages in aspects of care.
Participation in Decision Making	Extent to which patient/family engages in decision making.
Predictability	A characteristic that allows one to expect a certain course of events or course of illness.

FOR EXAMPLE:

A healthy, uninsured, 40-year-old woman undergoing a pre-employment physical could be described as an individual who is (a) stable (b) not complex (c) very predictable (d) resilient (e) not vulnerable (f) able to participate in decision making and care, but (g) has inadequate resource availability.

On the other hand: a critically ill, insured infant with multisystem organ failure can be described as an individual who is (a) unstable (b) highly complex (c) unpredictable (d) highly resilient (e) vulnerable (f) unable to become involved in decision making and care, but (g) has adequate resource availability.

continued

AACN SYNERGY MODEL FOR PATIENT CARE (CONTINUED)

Nurse Characteristics

Nursing care reflects an integration of knowledge, skills, abilities and experience necessary to meet the needs of patients and families. Thus, nurse characteristics are derived from patient needs and include:

Clinical Judgment	Clinical reasoning, which includes clinical decision making, critical thinking and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating education, experiential knowledge and evidence-based guidelines.
Advocacy/ Moral Agency	Working on another's behalf and representing the concerns of the patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.
Caring Practices	Nursing activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. These caring behaviors include but are not limited to vigilance, engagement and responsiveness of caregivers. Caregivers include family and healthcare personnel.
Collaboration	Working with others (e.g., patients, families, healthcare providers) in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Collaboration involves intra- and inter-disciplinary work with colleagues and community.
Systems Thinking	Body of knowledge and tools that allow the nurse to manage whatever environmental and system resources that exist for the patient/family and staff, within or across healthcare systems and non-healthcare systems.
Response to Diversity	The sensitivity to recognize, appreciate and incorporate differences into the provision of care. Differences may include, but are not limited to, individuality, cultural, spiritual, gender, race, ethnicity, lifestyle, socioeconomic, age and values.
Facilitation of Learning	The ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team and community. Includes both formal and informal facilitation of learning.
Clinical Inquiry	The ongoing process of questioning and evaluating practice and providing informed practice. Creating changes through evidence-based practice, research utilization and experiential knowledge.

Nurses become competent within each continuum at a level that best meets the fluctuating needs of their population of patients. More compromised patients have more severe or complex needs, requiring nurses to have advanced knowledge and skills in an associated continuum.

FOR EXAMPLE:

If the gestalt of a patient were stable but unpredictable, minimally resilient and vulnerable, primary competencies of the nurse would be centered on clinical judgment and caring practices (which includes vigilance). If the gestalt of a patient were vulnerable, unable to participate in decision making and care, and inadequate resource availability, the primary competencies of the nurse would focus on advocacy and moral agency, collaboration and systems thinking.

Although all eight competencies are essential for contemporary nursing practice, each assumes more or less importance depending on a patient's characteristics. **Synergy results when a patient's needs and characteristics are matched with the nurse's competencies.**

Based on the most recent AACN Certification Corporation study of nursing practice, the test plans for AACN certification exams reflect the Synergy Model as well as findings related to nursing care of the patient population studied, e.g., adult, pediatric and neonatal.

For more information about the AACN Synergy Model for Patient Care visit www.certcorp.org.

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ADULT CCRN TEST PLAN

Applies to exams taken on or before October 14, 2015.

If testing after the above date, refer to www.certcorp.org > Certification News

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (20%)

1. Acute coronary syndromes (including unstable angina)
2. Acute myocardial infarction/ischemia (including papillary muscle rupture)
3. Acute peripheral vascular insufficiency (e.g., acute arterial occlusion, carotid artery stenosis, endarterectomy, peripheral stents, Fem-Pop bypass)
4. Acute pulmonary edema
5. Cardiac surgery (e.g., valve replacement, CABG)
6. Cardiac trauma
7. Cardiogenic shock
8. Cardiomyopathies (e.g., hypertrophic, dilated, restrictive, idiopathic)
9. Dysrhythmias
10. Heart failure
11. Hypertensive crisis
12. Hypovolemic shock
13. Interventional cardiology (e.g., catheterization)
14. Myocardial conduction system defects
15. Ruptured or dissecting aneurysm (e.g., thoracic, abdominal, thoraco-abdominal)
16. Structural heart defects (acquired and congenital, including valvular disease)

B. Pulmonary (18%)

1. Acute lung injury (e.g., ARDS, RDS)
2. Acute pulmonary embolus
3. Acute respiratory failure
4. Acute respiratory infections (e.g., acute pneumonia, bronchiolitis)
5. Air leak syndromes (e.g., pneumothorax, pneumopericardium)
6. Aspirations (e.g., aspiration pneumonia, foreign body)
7. COPD, asthma, chronic bronchitis, emphysema
8. Pulmonary hypertension

9. Status asthmaticus

10. Thoracic surgery

11. Thoracic trauma (e.g., fractured ribs, lung contusions, tracheal perforation)

C. Endocrine (5%)

1. Acute hypoglycemia
2. Diabetes insipidus
3. Diabetic ketoacidosis
4. Hyperglycemic hyperosmolar nonketotic syndrome (HHNK)
5. Syndrome of inappropriate secretion of antidiuretic hormone (SIADH)

D. Hematology/Immunology (2%)

1. Coagulopathies (e.g., ITP, DIC, HIT)

E. Neurology (12%)

1. Aneurysm
2. Brain death (irreversible cessation of whole brain function)
3. Congenital neurological abnormalities (e.g., AV malformation)
4. Encephalopathy (e.g., anoxic, hypoxic-ischemic, metabolic, infectious)
5. Head trauma (e.g., blunt, penetrating skull fractures)
6. Hydrocephalus
7. Intracranial hemorrhage/intraventricular hemorrhage (e.g., subarachnoid, epidural, subdural)
8. Neurologic infectious disease (e.g., viral, bacterial)
9. Neuromuscular disorders (e.g., muscular dystrophy, Guillain-Barré, myasthenia gravis)
10. Neurosurgery
11. Seizure disorders
12. Space-occupying lesions (e.g., brain tumors)
13. Stroke (e.g., ischemic, hemorrhagic)

continued

ADULT CCRN TEST PLAN (CONTINUED)**F. Gastrointestinal (6%)**

1. Acute abdominal trauma
2. Acute GI hemorrhage
3. Bowel infarction/obstruction/perforation (e.g., mesenteric ischemia, adhesions)
4. GI surgeries
5. Hepatic failure/coma (e.g., portal hypertension, cirrhosis, esophageal varices)
6. Malnutrition and malabsorption
7. Pancreatitis

G. Renal (6%)

1. Acute renal failure
2. Chronic renal failure
3. Life-threatening electrolyte imbalances

H. Multisystem (8%)

1. Asphyxia
2. Distributive shock (e.g., anaphylaxis)
3. Multiorgan dysfunction syndrome (MODS)
4. Multisystem trauma
5. Sepsis/septic shock
6. Systemic inflammatory response syndrome (SIRS)
7. Toxic ingestions/inhalations (e.g., drug/alcohol overdose)
8. Toxin/drug exposure

I. Behavioral/Psychosocial (4%)

1. Abuse/neglect
2. Antisocial behaviors, aggression, violence
3. Delirium and dementia
4. Developmental delays
5. Failure to thrive
6. Mood disorders and depression
7. Substance dependence (e.g., withdrawal, drug-seeking behavior, chronic alcohol or drug dependence)
8. Suicidal behavior

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)**A. Advocacy/Moral Agency (3%)****B. Caring Practices (4%)****C. Collaboration (4%)****D. Systems Thinking (2%)****E. Response to Diversity (2%)****F. Clinical Inquiry (2%)****G. Facilitation of Learning (3%)**

The sum of these percentages is not 100 due to rounding.

Order of content does not necessarily reflect importance.

ADULT CCRN TEST PLAN TESTABLE NURSING ACTIONS

Cardiovascular

- Identify/monitor normal and abnormal physical assessment findings
- Apply leads for cardiac monitoring
- Identify, interpret and monitor cardiac rhythms
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Recognize indications for and manage patients requiring:
 - 12-lead ECG
 - arterial line
 - cardiac catheterization
 - cardiocentesis
 - cardioversion
 - central venous access
 - central venous pressure monitoring
 - defibrillation
 - PA catheter
 - SvO₂ monitoring
 - transthoracic pacing
 - transvenous pacing
- Manage patients receiving cardiovascular medications (e.g., thrombolytics, vasoactive agents, platelet inhibitors, anti-arrhythmic medications)
- Monitor patients and follow protocols for cardiac surgery
- Recognize signs and symptoms of cardiovascular emergencies, initiate interventions and seek assistance as needed
- Recognize indications for and manage patients requiring:
 - IABP
 - percutaneous coronary interventions

Pulmonary

- Identify and monitor normal and abnormal physical assessment findings
- Interpret ABGs
- Monitor patient for response to pulmonary medications (e.g., bronchodilators, mucolytics)
- Recognize indications for and manage patients requiring:
 - artificial airway
 - bronchoscopy
 - chest tubes
 - conventional modes of mechanical ventilation
 - high-frequency mechanical ventilation
 - non-invasive positive pressure ventilation (e.g., BiPAP, CPAP, high-flow nasal cannula)
 - oxygen therapy delivery devices

- prevention of complications related to mechanical ventilation (e.g., barotraumas, VAP)
- pulmonary therapeutic interventions (e.g., airway clearance, intubation, weaning, extubation)
- respiratory monitoring devices (e.g., SPO₂, SvO₂, ETCO₂) and report values
- therapeutic gases (e.g., nitric, heliox, CO₂)
- thoracentesis
- Recognize signs and symptoms of respiratory emergencies, initiate interventions and seek assistance as needed
- Monitor patient and follow protocols for thoracic and ENT surgery

Endocrine

- Recognize normal and abnormal physical assessment findings
- Recognize signs and symptoms of endocrine emergencies, initiate interventions and seek assistance as needed
- Identify and monitor normal and abnormal diagnostic test results
- Implement treatment modalities for acute hypo/hyperglycemia (e.g., insulin therapy)
- Monitor patient and follow protocols for surgery related to the endocrine system
- Manage patients receiving medications and monitor response

Hematology/Immunology

- Recognize normal and abnormal physical assessment findings of patients with:
 - hematologic problems
 - immunologic problems
- Identify and monitor normal and abnormal diagnostic test results (e.g., PT/INR, PTT, fibrinogen, CBC)
- Manage patients receiving medications (e.g., IVIG, steroids, chemotherapy) and monitor response
- Recognize and manage complications associated with transfusion of blood products
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., plasmapheresis, exchange Transfusion, autotransfusion)
- Recognize signs and symptoms of hematologic/immunologic emergencies, initiate interventions and seek assistance as needed

continued

ADULT CCRN TEST PLAN TESTABLE NURSING ACTIONS (CONTINUED)

Neurology

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal neurological diagnostic test results (e.g., ICP, head CT scan, lumbar puncture)
- Recognize indications for and monitor/manage patients requiring neurological monitoring devices and drains
- Manage patients receiving medications (e.g., mannitol, hypertonic saline, sedation, neuromuscular blockade, anticonvulsants) and monitor response
- Recognize signs and symptoms of neurological emergencies (e.g., increased intracranial pressure, herniation, decreased LOC, seizure), initiate interventions and seek appropriate consultation
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., ICP insertion, lumbar puncture)
- Monitor patients and follow protocols for neuro-surgery

Gastrointestinal

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal gastrointestinal diagnostic test results
- Recognize indications for and manage patients requiring gastrointestinal:
 - monitoring devices (e.g., intra-abdominal compartment pressure)
 - drains
- Manage patients receiving gastrointestinal medications and monitor response
- Monitor patient and follow protocols, pre-, intra- and post-procedure (e.g., EGD, PEG placement)
- Recognize indications for and complications of enteral and parenteral nutrition
- Monitor patients and follow protocols for gastrointestinal surgery
- Recognize signs and symptoms of emergencies (e.g., GI bleed, ischemic bowel), initiate interventions and seek assistance as needed

Renal

- Recognize normal and abnormal physical assessment findings
- Identify and monitor normal and abnormal diagnostic test results

- Manage patients receiving renal medications and monitor response
- Recognize indications for and manage patients requiring renal therapeutic intervention (e.g., CRRT, Peritoneal dialysis)
- Monitor patients and follow protocols for:
 - renal surgery
 - pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)
- Recognize signs and symptoms of renal emergencies, initiate interventions and seek assistance as needed

Multisystem

- Recognize and monitor normal and abnormal diagnostic test results (e.g., lab, radiology)
- Recognize indications for and manage patients undergoing:
 - continuous sedation
 - procedural sedation
 - therapeutic hypothermia
- Assess patient's pain
- Manage patients receiving:
 - medications (e.g., pain medications, reversal agents) and monitor response
 - non-pharmacologic methods for pain relief and monitor response
- Recognize signs and symptoms of multisystem emergencies (e.g., shock states, trauma), initiate interventions and seek assistance as needed

Behavioral/Psychosocial

- Recognize normal and abnormal:
 - physical and psychosocial assessment findings
 - developmental assessment findings and provide developmentally appropriate care
- Recognize the need for and manage patients requiring restraints
- Recognize indications for and manage patients requiring behavioral therapeutic interventions
- Identify and monitor normal and abnormal diagnostic test results
- Manage patients receiving medications (e.g., anti-psychotics, antidepressants) and monitor response
- Recognize signs and symptoms of behavioral/psychosocial emergencies, initiate interventions and seek assistance as needed

ADULT CCRN SAMPLE EXAM QUESTIONS

1. A patient with a recent myocardial infarction suddenly develops a loud systolic murmur. The most likely cause is which of the following?

- A. pulmonary embolism
- B. congestive heart failure
- C. ruptured papillary muscle
- D. increased systemic vascular resistance

2. A patient with unstable angina has an IABP inserted. Hemodynamics are:

HR	148 (sinus tachycardia)
MAP	40 mm Hg
PAOP	25 mm Hg
CI	1.4 L/min/m ²

Which of the following should be included in the patient's plan of care?

- A. checking timing of the IABP, decreasing balloon to 1:2 frequency
- B. stat echocardiogram, furosemide (Lasix), checking timing of the IABP
- C. dobutamine (Dobutrex), isoproterenol (Isuprel), 12-lead ECG
- D. adenosine, stat Hgb and Hct, dobutamine (Dobutrex)

3. The family of a critically ill patient wishes to spend the night, which is contrary to visiting policy. The nurse's best action would be to

- A. adhere to the visiting policy.
- B. allow the family to stay in the room.
- C. obtain a motel room near the hospital where the family can spend the night.
- D. allow one or two family members to stay, then evaluate the patient's response.

4. A patient who is one day post-gastroplasty has a sudden onset of restlessness, dyspnea and chest pain. His heart rate is 122, and auscultation of heart sound reveals an increased intensity of a pulmonary S2. The most likely cause is

- A. aspiration pneumonia.
- B. a spontaneous pneumothorax.
- C. a pleural effusion.
- D. a pulmonary embolus.

5. The nursing staff is resisting being assigned to a disruptive patient. An appropriate resolution would be to

- A. ask the physician to transfer the patient.
- B. rotate the patient assignment among staff.
- C. confront the family and demand an end to the disruptive behavior.
- D. hold a nursing team conference to discuss possible alternatives.

6. A patient who is 72 hours postoperative repair of a ruptured abdominal aortic aneurysm suddenly becomes dyspneic with an increased respiratory rate from 24 to 40. An arterial blood gas sample obtained while the patient is receiving oxygen at 6 L/min via nasal cannula reveals the following results:

pH	7.50
pCO ₂	31
pO ₂	48

A chest x-ray is obtained and a "ground-glass-like appearance" is reported. Auscultation of the lungs reveals basilar crackles that were not previously present. On the basis of this information, the nurse should suspect that the patient has developed

- A. a pulmonary embolus.
- B. bacterial pneumonia.
- C. chronic obstructive pulmonary disease.
- D. acute respiratory distress syndrome.

continued

ADULT CCRN SAMPLE EXAM QUESTIONS (CONTINUED)

7. Members of the nursing staff are developing written patient education materials for a group of patients with diverse reading abilities. It would be most effective for the staff to
- A. design individual handouts for each patient.
 - B. develop a computer-based education series.
 - C. write the materials at a fourth-grade reading level.
 - D. limit text and provide color pictures.
8. A postoperative patient has been in the unit for 4 days. He was unusually disengaged the previous day, and today he is agitated, thinks staff is trying to poison him and forgot his wife was at the bedside an hour ago. Other physiological factors are ruled out. Pharmaceutical interventions would include which of the following?
- A. midazolam (Versed)
 - B. haloperidol (Haldol)
 - C. propofol (Diprivan)
 - D. sertraline (Zoloft)

Answers

- 1. C
- 2. A
- 3. D
- 4. D
- 5. D
- 6. D
- 7. C
- 8. B

PEDIATRIC CCRN TEST PLAN

Applies to exams taken on or before October 14, 2015.
If testing after the above date, refer to www.certcorp.org > Certification News

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (14%)

1. Acute pulmonary edema
2. Cardiac surgery (e.g., Norwood, BT shunt, TOF repair, arterial switch)
3. Cardiogenic shock
4. Cardiomyopathies (e.g., hypertrophic, dilated, restrictive, idiopathic)
5. Dysrhythmias
6. Heart failure
7. Hypovolemic shock
8. Interventional cardiology (e.g., catheterization)
9. Myocardial conduction system defects
10. Structural heart defects (acquired and congenital, including valvular disease)

B. Pulmonary (18%)

1. Acute lung injury (e.g., ARDS, RDS)
2. Acute pulmonary embolus
3. Acute respiratory failure
4. Acute respiratory infections (e.g., acute pneumonia, croup, bronchiolitis)
5. Air-leak syndromes (e.g., pneumothorax, pneumopericardium)
6. Aspiration (e.g., aspiration pneumonia, foreign-body, meconium)
7. Asthma, chronic bronchitis
8. Bronchopulmonary dysplasia
9. Congenital anomalies (e.g., diaphragmatic hernia, tracheoesophageal fistula, choanal atresia, pulmonary hypoplasia, tracheal malacia, tracheal stenosis)
10. Pulmonary hypertension
11. Status asthmaticus
12. Thoracic surgery
13. Thoracic trauma (e.g., fractured ribs, lung contusions, tracheal perforation)

C. Endocrine (5%)

1. Acute hypoglycemia
2. Diabetes insipidus
3. Diabetic ketoacidosis
4. Inborn errors of metabolism
5. Syndrome of inappropriate secretion of antidiuretic hormone (SIADH)

D. Hematology/Immunology (3%)

1. Coagulopathies (e.g., ITP, DIC, HIT)
2. Oncologic complications

E. Neurology (14%)

1. Acute spinal cord injury
2. Brain death (irreversible cessation of whole brain function)
3. Congenital neurological abnormalities (e.g., myelomeningocele, encephalocele, AV malformation)
4. Encephalopathy (e.g., anoxic, hypoxic-ischemic, metabolic, infectious)
5. Head trauma (e.g., blunt, penetrating, skull fractures)
6. Hydrocephalus
7. Intracranial hemorrhage/intraventricular hemorrhage (e.g., subarachnoid, epidural, subdural)
8. Neurologic infectious disease (e.g., congenital, viral, bacterial)
9. Neuromuscular disorders (e.g., muscular dystrophy, Guillain-Barré, myasthenia gravis)
10. Neurosurgery
11. Seizure disorders
12. Space-occupying lesions (e.g., brain tumors)
13. Spinal fusion
14. Stroke (e.g., ischemic, hemorrhagic)

continued

PEDIATRIC CCRN TEST PLAN (CONTINUED)

F. Gastrointestinal (6%)

1. Acute abdominal trauma
2. Acute GI hemorrhage
3. Bowel infarction/obstruction/perforation (e.g., necrotizing enterocolitis, mesenteric ischemia, adhesions)
4. Gastroesophageal reflux
5. GI abnormalities (e.g., omphalocele, gastrochisis, volvulus, Hirschsprung's disease, malrotation, intussusception)
6. GI surgeries
7. Hepatic failure/coma (e.g., portal hypertension, cirrhosis, esophageal varices, biliary atresia)
8. Malnutrition and malabsorption

G. Renal (6%)

1. Acute renal failure
2. Chronic renal failure
3. Life-threatening electrolyte imbalances

H. Multisystem (11%)

1. Asphyxia
2. Distributive shock (e.g., anaphylaxis)
3. Hemolytic uremic syndrome
4. Multiorgan dysfunction syndrome (MODS)
5. Multisystem trauma
6. Near-drowning
7. Sepsis/septic shock
8. Systemic inflammatory response syndrome (SIRS)
9. Toxic ingestions/inhalations (e.g., drug/alcohol overdose)
10. Toxin/drug exposure

I. Behavioral/Psychosocial (3%)

1. Abuse/neglect
2. Developmental delays
3. Failure to thrive

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)

- A. Advocacy/Moral Agency (2%)
- B. Caring Practices (4%)
- C. Collaboration (4%)
- D. Systems Thinking (2%)
- E. Response to Diversity (2%)
- F. Clinical Inquiry (2%)
- G. Facilitation of Learning (4%)

Order of content does not necessarily reflect importance.

PEDIATRIC CCRN TEST PLAN TESTABLE NURSING ACTIONS

Cardiovascular

- Identify/monitor normal and abnormal physical assessment findings
- Apply leads for cardiac monitoring
- Identify, interpret and monitor cardiac rhythms
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Recognize indications for and manage patients requiring:
 - 12-lead ECG
 - arterial line
 - cardiac catheterization
 - cardioversion
 - central venous access
 - central venous pressure monitoring
 - defibrillation
 - PA catheter
 - cardiocentesis
 - SvO₂ monitoring
 - transthoracic pacing
 - transvenous pacing
- Manage and monitor patients receiving cardiovascular medications (e.g., thrombolytics, vasoactive agents, platelet inhibitors, anti-arrhythmic medications) and follow protocols for cardiac surgery
- Recognize signs and symptoms of cardiovascular emergencies, initiate interventions and seek assistance as needed

Pulmonary

- Identify and monitor normal and abnormal physical assessment findings
- Interpret ABGs
- Monitor patient for response to pulmonary medications (e.g., bronchodilators, mucolytics)
- Recognize indications for and manage patients requiring:
 - artificial airway
 - bronchoscopy
 - chest tubes
 - conventional modes of mechanical ventilation
 - high-frequency mechanical ventilation
 - non-invasive positive pressure ventilation (e.g., BIPAP, CPAP, high-flow nasal cannula)
 - oxygen therapy delivery devices
 - prevention of complications related to mechanical ventilation (e.g., barotraumas, VAP)

- pulmonary therapeutic interventions (e.g., airway clearance, intubation, weaning, extubation)
- respiratory monitoring devices (e.g., SPO₂, SvO₂, ETCO₂) and report values
- therapeutic gases (e.g., nitric, heliox, CO₂)
- thoracentesis
- Recognize signs and symptoms of respiratory emergencies, initiate interventions and seek assistance as needed
- Monitor patient and follow protocols for thoracic and ENT surgery

Endocrine

- Recognize normal and abnormal physical assessment findings
- Recognize signs and symptoms of endocrine emergencies, initiate interventions and seek assistance as needed
- Identify and monitor normal and abnormal diagnostic test results
- Implement treatment modalities for acute hypo/hyperglycemia (e.g., insulin therapy)
- Monitor patient and follow protocols for surgery related to the endocrine system
- Manage patients receiving medications and monitor response

Hematology/Immunology

- Recognize normal and abnormal physical assessment findings of patients with:
 - hematologic problems
 - immunologic problems
- Identify and monitor normal and abnormal diagnostic test results (e.g., PT/INR, PTT, fibrinogen, CBC)
- Manage patients receiving medications (e.g., IVIG, steroids, chemotherapy) and monitor response
- Recognize and manage complications associated with transfusion of blood products
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., plasmapheresis, exchange transfusion, autotransfusion)
- Recognize signs and symptoms of hematologic/immunologic emergencies, initiate interventions and seek assistance as needed

continued

PEDIATRIC CCRN TEST PLAN TESTABLE NURSING ACTIONS

(CONTINUED)

Neurology

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal neurological diagnostic test results (e.g., ICP, head CT scan, lumbar puncture)
- Recognize indications for and monitor/manage patients requiring neurological monitoring devices and drains
- Manage patients receiving medications (e.g., mannitol, hypertonic saline, sedation, neuro-muscular blockade, anticonvulsants) and monitor response
- Recognize signs and symptoms of neurological emergencies (e.g., increased intracranial pressure, herniation, decreased LOC, seizure), initiate interventions and seek appropriate consultation
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., ICP insertion, lumbar puncture)
- Monitor patient and follow protocols for neurosurgery

Gastrointestinal

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal gastrointestinal diagnostic test results
- Recognize indications for and manage patients with gastrointestinal:
 - monitoring devices (e.g., intra-abdominal compartment pressure)
 - drains
 - complications of enteral and parenteral nutrition
- Manage patients receiving gastrointestinal medications and monitor response
- Monitor patient and follow protocols, pre-, intra- and post-procedure (e.g., EGD, PEG placement)
- Monitor patients and follow protocols for gastrointestinal surgery
- Recognize signs and symptoms of emergencies (e.g., GI bleed, ischemic bowel), initiate interventions and seek assistance as needed

Renal

- Recognize normal and abnormal physical assessment findings
- Identify and monitor normal and abnormal diagnostic test results

- Manage patients receiving renal medications and monitor response
- Recognize indications for and manage patients requiring renal therapeutic intervention (e.g., CRRT, peritoneal dialysis)
- Monitor patients and follow protocols for:
 - renal surgery
 - pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)
- Recognize signs and symptoms of renal emergencies, initiate interventions and seek assistance as needed

Multisystem

- Recognize and monitor normal and abnormal diagnostic test results (e.g., lab, radiology)
- Recognize indications for and manage patients undergoing:
 - continuous sedation
 - procedural sedation
 - therapeutic hypothermia
- Assess patient's pain
- Manage patients receiving:
 - medications (e.g., pain medications, reversal agents) and monitor response
 - non-pharmacologic methods for pain relief and monitor response
- Recognize signs and symptoms of multisystem emergencies (e.g., shock states, trauma), initiate interventions and seek assistance as needed

Behavioral/Psychosocial

- Recognize normal and abnormal:
 - physical and psychosocial assessment findings
 - developmental assessment findings and provide developmentally appropriate care
- Recognize the need for and manage patients requiring restraints
- Recognize indications for and manage patients requiring behavioral therapeutic interventions
- Identify and monitor normal and abnormal diagnostic test results
- Manage patients receiving medications (e.g., anti-psychotics, antidepressants) and monitor response
- Recognize signs and symptoms of behavioral/psychosocial emergencies, initiate interventions and seek assistance as needed

PEDIATRIC CCRN SAMPLE EXAM QUESTIONS

1. While caring for a patient with salicylate intoxication, the critical care nurse would anticipate which of the following as a primary treatment measure?

- A. administration of protamine sulfate
- B. administration of glucose
- C. transfusion of packed RBCs
- D. replacement of fluid and electrolytes

2. An adolescent with the developmental age of a 4-year-old requires placement of a chest tube. The best way to prepare the patient for this procedure is to

- A. use short simple sentences and limit descriptions to concrete explanations.
- B. show the patient a chest tube and explain how it will feel.
- C. explain in detail why a chest tube is needed and how it works.
- D. tell the parents what will be done so they can explain it to their child.

3. A child is admitted with a gunshot wound to the head, accidentally inflicted by an older sibling. The parents are overcome with grief and appear to be ignoring the following statements made by the older sibling: "It was an accident. I didn't mean to do it. I'm sorry!" Which of the following actions by the nurse would be most appropriate?

- A. Discuss the importance of gun safety with the older sibling while the parents are at the bedside.
- B. Seek additional support for the parents for ways they can assist the older sibling.
- C. Tell the parents that they need to provide support for the older sibling.
- D. Tell the older sibling, "Accidents happen. I know you didn't mean to do it."

4. Which of the following laboratory findings is indicative of the syndrome of inappropriate ADH secretion (SIADH)?

- A. serum sodium 148 mEq/L
- B. decreased serum osmolality
- C. blood urea nitrogen (BUN) 28 mg/dl
- D. serum potassium 5.1 mEq/L

5. A 3-year-old is admitted to the ICU with a 10-hour history of an acute-onset asthma attack. Initial assessment reveals the following:

BP	112/76	pH	7.25
HR	160	pCO ₂	35
RR	48	pO ₂	40
T	99.6° F/32° C (oral)	HCO ₃	22

In this situation, which would the nurse expect initial treatment to include?

- A. administration of NaHCO₃
- B. fluid resuscitation
- C. racemic epinephrine
- D. intubation

6. A 2-year-old is experiencing manifestations of digoxin (Lanoxin) toxicity. BP is 94/60, capillary refill time is 2 seconds and the electrocardiogram reveals AV block with a heart rate of 60. The critical care nurse would anticipate which of the following interventions?

- A. performance of cardioversion
- B. administration of Atropine
- C. performance of vasovagal maneuvers
- D. monitoring of HR and rhythm and perfusion status

continued

PEDIATRIC CCRN SAMPLE EXAM QUESTIONS (CONTINUED)

7. An adolescent with asthma is readmitted just a week after discharge from the hospital. On questioning, the nurse learns that the patient refuses to use the inhalers at school. The nurse should
- A. talk to the teen about long-term consequences of the disease if the treatment plan is not followed.
 - B. talk to the school nurse to find out why they are not monitoring the medications at school.
 - C. help the parents set up a disciplinary contract with the teen.
 - D. arrange for the teen to attend an asthma support group.
8. An unconscious 5-month-old is admitted. The parent reports the baby fell off the table during a diaper change by an older sibling. What findings would indicate further inquiry of the history?
- A. a reddened or bruised area on the skull
 - B. poorly reactive pupils
 - C. retinal hemorrhage
 - D. a linear skull fracture

Answers

- 1. D
- 2. A
- 3. B
- 4. B
- 5. D
- 6. D
- 7. D
- 8. C

NEONATAL CCRN TEST PLAN

Applies to exams taken on or before October 14, 2015.
If testing after the above date, refer to www.certcorp.org > Certification News

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (10%)

1. Cardiogenic shock
2. Dysrhythmias
3. Heart failure
4. Hypovolemic shock
5. Structural heart defects (e.g., acquired and congenital, patent ductus arteriosus)

B. Pulmonary (24%)

1. Acute lung injury (e.g., ARDS, RDS)
2. Acute respiratory failure
3. Acute respiratory infections (e.g., acute pneumonia, croup, bronchiolitis)
4. Air-leak syndromes (e.g., pneumothorax, PIE, pneumopericardium)
5. Apnea of prematurity
6. Aspiration (e.g., aspiration pneumonia, foreign-body, meconium)
7. Bronchopulmonary dysplasia
8. Congenital anomalies (e.g., diaphragmatic hernia, tracheoesophageal fistula, choanal atresia, pulmonary hypoplasia, tracheal malacia, tracheal stenosis)
9. Pulmonary hypertension
10. Thoracic surgery
11. Transient tachypnea of the newborn

C. Endocrine (3%)

1. Inborn errors of metabolism
2. Neonatal hypoglycemia (e.g., IDM, LGA, SGA)

D. Hematology/Immunology (6%)

1. Anemia of prematurity
2. Coagulopathies (e.g., ITP, DIC, HIT)
3. Pathological hyperbilirubinemia
4. Physiological hyperbilirubinemia
5. Rh incompatibilities, ABO incompatibilities, hydrops fetalis

E. Neurology (10%)

1. Birth injuries (e.g., caput succedaneum, Erb's palsy, shoulder dystocia)
2. Brain death (irreversible cessation of whole brain function)
3. Congenital neurological abnormalities (e.g., myelomeningocele, encephalocele, AV malformation)
4. Encephalopathy (e.g., anoxic, hypoxic-ischemic, metabolic, infectious)
5. Hydrocephalus
6. Intracranial hemorrhage/intraventricular hemorrhage (e.g., subarachnoid, epidural, subdural)
7. Neurologic infectious disease (e.g., congenital, viral, bacterial)
8. Neuromuscular disorders (e.g., muscular dystrophy, Guillain-Barré)
9. Neurosurgery
10. Seizure disorders

F. Gastrointestinal (6%)

1. Bowel infarction/obstruction/perforation (e.g., necrotizing enterocolitis, mesenteric ischemia, adhesions)
2. Gastroesophageal reflux
3. GI abnormalities (e.g., omphalocele, gastrochisis, volvulus, imperforate anus, Hirschsprung's disease, malrotation, intussusception)
4. GI surgeries
5. Hepatic failure/coma (e.g., biliary atresia)
6. Malnutrition and malabsorption

G. Renal (5%)

1. Acute renal failure
2. Life-threatening electrolyte imbalances

continued

NEONATAL CCRN TEST PLAN (CONTINUED)

H. Multisystem (10%)

1. Asphyxia
2. Life-threatening maternal-fetal complications (e.g., eclampsia, HELLP syndrome, maternal-fetal transfusion, abruption placenta, placenta previa)
3. Low birth weight/prematurity
4. Multiorgan dysfunction syndrome (MODS)
5. Sepsis/septic shock
6. Toxin/drug exposure

I. Behavioral/Psychosocial (7%)

1. Abuse/neglect
2. Developmental delays
3. Failure to thrive
4. Substance dependence (e.g., withdrawal, maternal alcohol or drug dependence)
5. Stress in extremely low birth-weight infants

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)

A. Advocacy/Moral Agency (3%)

B. Caring Practices (4%)

C. Collaboration (4%)

D. Systems Thinking (2%)

E. Response to Diversity (2%)

F. Clinical Inquiry (2%)

G. Facilitation of Learning (3%)

The sum of these percentages is not 100 due to rounding.

Order of content does not necessarily reflect importance.

NEONATAL CCRN TEST PLAN TESTABLE NURSING ACTIONS

Cardiovascular

- Identify/monitor normal and abnormal physical assessment findings
- Apply leads for cardiac monitoring
- Identify, interpret and monitor cardiac rhythms
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Recognize indications for and manage patients requiring:
 - 12-lead ECG
 - arterial line
 - cardiac catheterization
 - cardiocentesis
 - cardioversion
 - central venous access
 - central venous pressure monitoring
 - defibrillation
 - PA catheter
 - SvO₂ monitoring
 - transthoracic pacing
 - transvenous pacing
- Manage patients receiving cardiovascular medications (e.g., thrombolytics, vasoactive agents, platelet inhibitors, anti-arrhythmic medications)
- Monitor patients and follow protocols for cardiac surgery
- Recognize signs and symptoms of cardiovascular emergencies, initiate interventions and seek assistance as needed
- Recognize normal fetal circulation and transition to extra-uterine life
- Recognize indications for and manage patients requiring umbilical line

Pulmonary

- Identify and monitor normal and abnormal physical assessment findings
- Interpret ABGs
- Monitor patient for response to pulmonary medications (e.g., bronchodilators, mucolytics)
- Recognize indications for and manage patients requiring:
 - artificial airway
 - bronchoscopy
 - chest tubes
 - conventional modes of mechanical ventilation
 - high-frequency mechanical ventilation
 - non-invasive positive pressure ventilation (e.g., BIPAP, CPAP, high-flow nasal cannula)

- oxygen therapy delivery devices
- prevention of complications related to mechanical ventilation (e.g., barotraumas, VAP)
- pulmonary therapeutic interventions (e.g., airway clearance, intubation, weaning, extubation)
- respiratory monitoring devices (e.g., SPO₂, SvO₂, ETCO₂) and report values
- therapeutic gases (e.g., nitric, heliox, CO₂)
- thoracentesis
- Recognize signs and symptoms of respiratory emergencies, initiate interventions and seek assistance as needed
- Monitor patient and follow protocols for thoracic and ENT surgery

Endocrine

- Recognize normal and abnormal physical assessment findings
- Recognize signs and symptoms of endocrine emergencies, initiate interventions and seek assistance as needed
- Identify and monitor normal and abnormal diagnostic test results
- Implement treatment modalities for acute hypo/hyperglycemia (e.g., insulin therapy)
- Monitor patient and follow protocols for surgery related to the endocrine system
- Manage patients receiving medications and monitor response

Hematology/Immunology

- Recognize normal and abnormal physical assessment findings of patients with hematologic problems
- Recognize normal and abnormal physical assessment findings of patients with immunologic problems
- Identify and monitor normal and abnormal diagnostic test results (e.g., PT/INR, PTT, fibrinogen, CBC)
- Manage patients receiving medications (e.g., IVIG, steroids, chemotherapy) and monitor response
- Recognize and manage complications associated with transfusion of blood products
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., plasmapheresis, exchange transfusion, autotransfusion)
- Recognize signs and symptoms of hematologic/immunologic emergencies, initiate interventions, and seek assistance as needed

continued

NEONATAL CCRN TEST PLAN TESTABLE NURSING ACTIONS (CONTINUED)

Neurology

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal neurological diagnostic test results (e.g., ICP, head CT scan, lumbar puncture)
- Recognize indications for and monitor/manage patients requiring neurological monitoring devices and drains
- Manage patients receiving medications (e.g., mannitol, hypertonic saline, sedation, neuromuscular blockade, anticonvulsants) and monitor response
- Recognize signs and symptoms of neurological emergencies (e.g., increased intracranial pressure, herniation, decreased LOC, seizure), initiate interventions and seek appropriate consultation
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., ICP insertion, lumbar puncture)
- Monitor patients and follow protocols for neurosurgery

Gastrointestinal

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal gastrointestinal diagnostic test results
- Recognize indications for and manage patients requiring gastrointestinal monitoring devices (e.g., intra-abdominal compartment pressure)
- Recognize indications for and manage patients requiring gastrointestinal drains
- Manage patients receiving gastrointestinal medications and monitor response
- Monitor patient and follow protocols for:
 - pre-, intra- and post-procedure (e.g., EGD, PEG placement)
 - gastrointestinal surgery
- Recognize indications for and complications of enteral and parenteral nutrition
- Recognize signs and symptoms of emergencies (e.g., GI bleed, ischemic bowel), initiate interventions and seek assistance as needed

Renal

- Recognize normal and abnormal physical assessment findings

- Identify and monitor normal and abnormal diagnostic test results
- Manage patients receiving renal medications and monitor response
- Recognize indications for and manage patients requiring renal therapeutic intervention (e.g., CRRT, peritoneal dialysis)
- Monitor patients and follow protocols for:
 - renal surgery
 - pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)
- Recognize signs and symptoms of renal emergencies, initiate interventions and seek assistance as needed
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)

Multisystem

- Recognize and monitor normal and abnormal diagnostic test results (e.g., lab, radiology)
- Recognize indications for and manage patients undergoing:
 - continuous sedation
 - procedural sedation
 - therapeutic hypothermia
- Assess patient's pain:
 - manage patients receiving medications (e.g., pain medications, reversal agents) and monitor response
 - manage patients receiving non-pharmacologic methods for pain relief and monitor response
- Recognize signs and symptoms of multisystem emergencies (e.g., shock states, trauma), initiate interventions and seek assistance as needed
- Recognize indications for and manage patients undergoing neonatal skin care for low birth weight infants

Behavioral/Psychosocial

- Recognize normal and abnormal:
 - physical and psychosocial assessment findings
 - developmental assessment findings and provide developmentally appropriate care
- Recognize the need for and manage patients requiring restraints
- Recognize indications for and manage patients requiring behavioral therapeutic interventions

NEONATAL CCRN SAMPLE EXAM QUESTIONS

1. After application of a warm saline-soaked gauze dressing to an infant's abdominal wall defect, the most effective method for preventing evaporative heat loss is to

 - A. place the infant in a warmed isolette.
 - B. place the infant under a radiant heat source.
 - C. moisten the gauze dressing every 30 minutes.
 - D. cover the gauze dressing with plastic.
2. An infant has just been intubated for respiratory failure due to respiratory distress syndrome (RDS). The infant's breath sounds are heard on the right side but not on the left. Which of the following interventions would be most appropriate?

 - A. leave the tube in position and increase bag pressure
 - B. advance the tube until breath sounds are heard bilaterally
 - C. withdraw the tube until breath sounds are heard bilaterally
 - D. remove the tube and re-intubate
3. A preterm infant with necrotizing enterocolitis and resultant bowel perforation has returned from the operating room with an ileostomy. The first step in management of the ostomy should include

 - A. contacting the dietitian for recommendations regarding easily digested formula.
 - B. contacting the enterostomal nurse to provide a pattern for the ostomy appliance.
 - C. applying a dry sterile dressing over the ostomy.
 - D. clini-testing stool to determine degree of malabsorption.
4. An infant at 38-weeks-gestation is born via cesarean section. At 4 hours of age, heart rate is 155 and respiratory rate is at 60. Physical assessment reveals grunting, mild retractions and nasal flaring. A chest x-ray reveals perihilar streaking bilaterally. The following arterial blood gas (ABG) results are obtained:

pH	7.40
pCO ₂	36
pO ₂	40
HCO ₃	22

Appropriate management of this patient would consist of

 - A. intubation and mechanical ventilation.
 - B. surfactant replacement therapy.
 - C. chest tube insertion.
 - D. oxygen administration via hood.
5. A meeting is planned to discuss the parents' ethical concerns regarding life support interventions for their neonate with Trisomy 18. The nurse's role would be to

 - A. assist the parents in articulating their questions and concerns.
 - B. provide legal information regarding end-of-life decisions.
 - C. describe reasons for the infant's poor prognosis.
 - D. inform the parents that the goal of the meeting is to obtain a DNR order.
6. An infant with documented hypoglycemia is being started on a continuous dextrose infusion following a bolus injection of glucose. An appropriate rate of dextrose infusion would be

 - A. 1 - 3 mg/kg/min.
 - B. 4 - 8 mg/kg/min.
 - C. 9 - 12 mg/kg/min.
 - D. 13 - 16 mg/kg/min.

continued

NEONATAL CCRN SAMPLE EXAM QUESTIONS (CONTINUED)

7. An infant with isometric hydrops is delivered at 28-weeks-gestation by cesarean section. Which of the following interventions should be anticipated in the initial management of this infant?
- A. administration of sodium polystyrene sulfonate (Kayexalate)
 - B. placement of an umbilical venous catheter and slow push of O-positive whole blood
 - C. thoracentesis and/or paracentesis
 - D. a difficult intubation
8. The following results were obtained from a cerebrospinal fluid (CSF) sample obtained by lumbar puncture:
- 40 WBC/mm
 - 65% polymorphonuclear cells
 - Glucose 50 mg/dl
 - Protein 165 mg/dl
 - Bacteria shown by Gram-staining
- On the basis of these results, the most appropriate additional study would include
- A. drawing blood for sedimentation rate.
 - B. obtaining surface cultures.
 - C. continuing monitoring without intervention.
 - D. obtaining blood and urine cultures.
9. The mother of an infant with severe PPHN would like to hold her infant. The infant's oxygen saturation is 88% to 92% at rest and mean blood pressure is 28. The nurse's best response would be to
- A. explain signs and symptoms that demonstrate instability of the infant.
 - B. assist the mother in holding the infant skin-to-skin.
 - C. encourage the mother to talk to the infant.
 - D. show the mother how to provide gentle infant massage.
10. Lab tests from the mother of a neonate reveal the presence of cocaine. The baby demonstrates irritability, hypertonicity and sleep disturbances. Nursing care for the neonate should include
- A. swaddling and periods of undisturbed rest.
 - B. removal of parental rights and designation of a guardian.
 - C. encouragement of breast feeding and increased frequency of feedings.
 - D. mechanical ventilation and sedation.

Answers

- 1. D
- 2. C
- 3. B
- 4. D
- 5. A
- 6. B
- 7. C
- 8. D
- 9. A
- 10. A

CCRN EXAM BIBLIOGRAPHY

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Applies to exams taken on or before October 14, 2015.
If testing after the above date, refer to www.certcorp.org > Certification News

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Many references are available through AACN; visit www.aacn.org/bookstore.

More current versions may be available.

PUBLISHER CONTACTS:

AACN - (800) 899-2226

Acorn Publishing - (919) 786-1155

American Heart Association - (800) 242-8721

Blackwell Publishing - (877) 762-2974

Elsevier (including Mosby, W. B. Saunders, and Hanley & Belfus) - (800) 545-2522

F. A. Davis - (800) 323-3555

Jones & Bartlett - (800) 832-0034

Lippincott Williams & Wilkins - (800) 638-3030

Neonatal Network - (888) 642-8465

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CCRN - General	Item #
AACN Certification and Core Review for High Acuity and Critical Care. 6th ed. (2007). Alspach, G. Book and CD-ROM. 192 pages.	128800
AACN Core Curriculum for Critical Care Nursing. 6th ed. (2006). Alspach, G. 962 pages.	128700
AACN Procedure Manual for Critical Care. 6th ed. (2011). Wiegand, D. J. 1,312 pages.	128150
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* Online Adult CCRN/CCRN-E/CCRN-K Self-Assessment Exam (SAE) – mirrors content of CCRN, CCRN-E and CCRN-K exams; includes 60 questions with correct answers and rationales; score report upon completion to assess strengths and areas for further study; access for 90 days from purchase date.	Purchase online only at www.certcorp.org .
Online Adult CCRN/CCRN-E/CCRN-K Certification Review Course: Individual Purchase. AACN. For additional information, go to www.aacn.org/ondemand .	ACCRNOD
Adult CCRN/CCRN-E/CCRN-K Certification Review Course (2011). Available in 3 formats: CD-ROM for PC CD-ROM for Mac MP3	301950 301951 301973
** Review packages also available; see below.	200305
* Adult Practice CCRN/CCRN-E/CCRN-K Exam Questions. 6th ed. (2009). 190 questions..	

CCRN - Pediatric	Item #
Online Pediatric CCRN/CCRN-K Certification Review Course: Individual Purchase. For additional information, go to www.aacn.org/ondemand .	PEDCCRNOD
AACN Core Curriculum for Pediatric Critical Care Nursing. 2nd ed. (2006). Slota, M. 889 pages.	128870
Pediatric CCRN/CCRN-K Certification Review Course (2011). Available in 3 formats: CD-ROM for PC CD-ROM for Mac MP3	301982 301981 301980
*** Review Packages also available; see next page.	200205
* Pediatric Practice CCRN/CCRN-K Exam Questions. 6th ed. (2009). 130 questions.	

continued

AACN PRODUCTS FOR CCRN EXAM PREPARATION (CONTINUED)

CCRN - Neonatal	Item #
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- * Denotes product developed by AACN Certification Corporation.
- ** Adult CCRN/CCRN-E/CCRN-K Review Packages include Adult CCRN/CCRN-E/CCRN-K Review Course, Adult Practice CCRN/CCRN-E/CCRN-K Exam Questions and AACN Core Curriculum for Critical Care Nursing. Item numbers are 302010 (CD-ROM for PC), 302012 (CD-ROM for Mac) and 302005 (MP3).
- *** Pediatric CCRN/CCRN-K Review Packages include Pediatric/Neonatal CCRN/CCRN-K Review Course, Pediatric Practice CCRN/CCRN-K Exam Questions and AACN Core Curriculum for Pediatric Critical Care Nursing. Item numbers are 302011 (CD-ROM for PC), 302008 (CD-ROM for Mac) and 302006 (MP3).

For more details and to place an order, visit www.aacn.org/marketplace, or call AACN Customer Care at (800) 899-2226, Monday through Friday between 7:30 a.m. and 4:30 p.m. Pacific Time.

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Online exam registration is available at www.certcorp.org > Apply Online.

STAPLE CHECK HERE



CCRN EXAM APPLICATION

1. REGISTRATION INFORMATION

PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE. LEGAL NAME AS IT APPEARS ON YOUR GOVERNMENT-ISSUED ID CARD IS REQUIRED FOR EXAM.

AACN CUSTOMER: _____ **RN/APRN LICENSE:** _____

Number Exp. Date Number State Exp. Date

LEGAL NAME: _____

Last First MI Maiden

HOME ADDRESS: _____

City State ZIP

EMAIL: _____ **HOME PHONE:** _____

EMPLOYER NAME: _____ **BUSINESS PHONE:** _____

EMPLOYER ADDRESS: _____

City State ZIP

2. AACN MEMBERSHIP

I would also like to join/renew/extend my AACN membership at this time and select member pricing for my exam fees:

- (check one box only)
- 1-year AACN membership.....\$78
 - 2-year AACN membership.....\$148
 - 3-year AACN membership.....\$200

AACN membership includes nonrefundable \$12 and \$15 one-year subscriptions to *Critical Care Nurse*® and the *American Journal of Critical Care*®, respectively. AACN dues are not deductible as charitable contributions for tax purposes, but may be deducted as a business expense in keeping with Internal Revenue Service regulations.

Member exam fee (\$225) + 1-year Membership (\$78) = Savings of \$27 over Nonmember fee

3. EXAM FOR WHICH YOU ARE APPLYING

- CCRN Adult CCRN Pediatric CCRN Neonatal (check one box only)

CCRN	Initial Exam Fee		Retest Fee	
	AACN Member	Nonmember	AACN Member	Nonmember
Check one box only	<input type="checkbox"/> \$225	<input type="checkbox"/> \$330	<input type="checkbox"/> \$170	<input type="checkbox"/> \$275

Check this box if you've attached a request and supporting documentation for special testing accommodations.

Membership Fee:

\$ _____

+

Exam Fee:

\$ _____

=

Total Payment:

\$ _____

4. PAYMENT INFORMATION - application must be accompanied by payment

- Check or money order attached - payable to AACN Certification Corporation. U.S. funds only.
- Bill my credit card Visa MasterCard American Express Discover Card

Credit Card # _____ Exp. Date (mm/yy) _____

Name on Card _____ Signature _____

Amount Billed \$ _____ Address of Payor (if different than applicant) _____

Please do not include my name on lists sold to other organizations.

Please complete pages 2 & 3 of application.



CCRN EXAM APPLICATION

PRINTED LEGAL NAME _____

AACN # _____

5. DEMOGRAPHIC INFORMATION

Check **one** box in each category. Information used for statistical purposes and may be used in eligibility determination.

Primary Area Employed

- Acute Hemodialysis Unit (21)
- Burn Unit (13)
- Cardiac Rehabilitation (26)
- Cardiac Surgery/OR (36)
- Cardiovascular/Surgical ICU (09)
- Catheterization Lab (22)
- Combined Adult/Ped. ICU (23)
- Combined ICU/CCU (01)
- Coronary Care Unit (03)
- Corporate Industry (24)
- Crit. Care Transport/Flight (17)
- Direct Observation Unit (39)
- Emergency Dept. (12)
- General Med./Surg. Floor (18)
- Home Care (25)
- Intensive Care Unit (02)
- Interventional Cardiology (31)
- Long-Term Acute Care (27)
- Medical Cardiology (34)
- Medical ICU (04)
- Medical Surgical ICU (35)
- Neonatal ICU (06)
- Neuro./Neurosurgical ICU (10)
- Oncology Unit (18)
- Operating Room (15)
- Outpatient Clinic (29)
- Pediatric ICU (05)
- Private Practice (32)
- Progressive Care Unit (16)
- Recovery Room/PACU (14)
- Respiratory ICU (08)
- Stepdown Unit (30)

- Subacute Care (28)
- Surgical ICU (07)
- Tele-ICU (37)
- Telemetry (20)
- Trauma Unit (11)
- Other - specify below _____ (99)

Primary Position Held

- Academic Faculty (07)
- Acute Care Nurse Practitioner (09)
- Bedside/Staff Nurse (01)
- Case Manager (39)
- Charge Nurse (45)
- Clinic Nurse (40)
- Clinical Coordinator (44)
- Clinical Director (04)
- Clinical Nurse Specialist (08)
- Corporate/Industry (11)
- Hospital Administrator (38)
- Internist (37)
- Legal Nurse Consultant (47)
- Manager (03)
- Nurse Anesthetist (02)
- Nurse Educator (46)
- Nurse Midwife (13)
- Nurse Practitioner (05)
- Outcomes Manager (42)
- Physician (16)
- Physician Assistant (17)
- Researcher (18)
- Respiratory Therapist (19)

- Technician (21)
- Unit Coordinator (22)
- Other - specify below _____ (99)

Highest Nursing Degree

- Associate's Degree
- Bachelor's Degree
- Diploma
- Doctorate
- Master's Degree

Ethnicity

- African American (02)
- Asian (05)
- Hispanic (03)
- Native American (04)
- Pacific Islander (06)
- White/Non-Hispanic (01)
- Other - specify below _____ (99)

Primary Type of Facility in Which Employed

- College/University (08)
- Community Hospital (Nonprofit) (01)
- Community Hospital (Profit) (02)
- Corporate/Industry (11)
- County Hospital (07)
- Federal Hospital (05)
- HMO/Managed Care (12)

- Home Health (13)
- Long-Term Acute Care Hosp. (16)
- Military/Government Hospital (04)
- Non-Academic Teaching Hosp. (14)
- Registry (10)
- Self-Employed (09)
- State Hospital (06)
- Travel Nurse (15)
- University Med. Ctr. (03)
- Other - specify below _____ (99)

Number of Beds in Institution: _____

Years of Experience in Nursing: _____

Years of Experience in Acute/Critical Care Nursing: _____

Date of Birth: (mm/dd/yy) _____

Gender: Female Male

6. HONOR STATEMENT - 3rd page of application to be submitted with this form
Complete the Honor Statement on page 39.

7. SUBMIT APPLICATION

Attach Honor Statement to this application and submit with payment to:

AACN Certification Corporation
101 Columbia
Aliso Viejo, CA 92656-4109

or fax to: (949) 362-2020

DO NOT mail AND fax your application - please choose only ONE method.

NOTE: Allow **2 to 3 weeks** from the date received by AACN Certification Corporation for application processing.

Questions? Please visit www.certcorp.org, email certcorp@aacn.org or call us at (800) 899-2226.

Please complete page 3 of application (honor statement).

Online exam registration is available at www.certcorp.org > Apply Online.



CCRN EXAM HONOR STATEMENT

PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.

PLEASE PRINT CLEARLY.

NAME: _____ AACN CUSTOMER #: _____
Last First MI

I hereby apply for the CCRN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *CCRN Exam Handbook* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit my practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any disciplinary action is taken against my RN or APRN license in the future.

PRACTICE: I have fulfilled one of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely/critically ill patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application.
- OR**
- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely/critically ill patients, with 144 of those hours accrued in the most recent year preceding application.

These clinical hours were in direct care of the following acutely/critically ill patient population:

Adult Pediatric Neonatal (check one box only)

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet Status or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

VERIFIER'S NAME: _____ FACILITY NAME: _____
Last First

VERIFIER'S PHONE NUMBER: _____ VERIFIER'S EMAIL ADDRESS: _____

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification application is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NON-DISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____

Date: _____



Exam

PCCN Exam Handbook (Adult)

PCCN

Progressive Care
Nursing Certification



AACN
CERTIFICATION
CORPORATION

Certification Organization for the American Association of Critical Care Nurses

MISSION

AACN Certification Corporation contributes to consumer health and safety through comprehensive credentialing of nurses to ensure their practice is consistent with established standards of excellence in caring for acutely and critically ill patients and their families.

VISION

As the undisputed leader in credentialing nurses, AACN Certification Corporation has demonstrated that certification contributes to achieving optimal outcomes that are consistent with the goals and values of acutely and critically ill patients and their families.

VALUES

As the Corporation works to advance its mission and vision and fulfill its purpose and inherent obligation to ensure the health and well-being of patients experiencing acute and critical illness, the Corporation is guided by a set of deeply rooted values.

- Providing **leadership** to bring all stakeholders together to create and foster cultures of excellence and innovation.
- Acting with **integrity** and upholding ethical values and principles in all relationships and in the provision of sound, fair and defensible credentialing programs.
- Committing to **excellence** in credentialing programs by striving to exceed industry standards and expectations.
- Promoting **leading edge, research-based** credentialing programs that reach diverse certificants.
- Demonstrating **stewardship** through fair and responsible management of resources and cost-effective business processes.

ETHICS

AACN and AACN Certification Corporation consider the American Nurses Association (ANA) Code of Ethics for Nurses foundational for nursing practice, providing a framework for making ethical decisions and fulfilling responsibilities to the public, colleagues and the profession. AACN Certification Corporation's mission of public protection supports a standard of excellence that certified nurses have a responsibility to read, understand and act in a manner congruent with the ANA Code of Ethics for Nurses.

The following AACN Certification Corporation programs have been accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence (ICE):



CCRN[®] (Adult)
 CCRN[®] (Pediatric)
 CCRN[®] (Neonatal)
 CCRN-E[™] (Adult)

PCCN[®]
 CMC[®]
 CSC[®]

ACNPC-AG[®]
 ACCNS-AG[®]
 ACCNS-P[®]
 ACCNS-N[®]

Our advanced practice certification programs, ACCNS-AG, ACCNS-P, ACCNS-N and ACNPC-AG, meet the National Council of State Boards of Nursing (NCSBN) criteria for APRN certification programs.

AACN
CERTIFICATION
CORPORATION

Certification Organization for the American Association of Critical-Care Nurses

PCCN EXAM HANDBOOK

Progressive Care Nursing Certification - Adult

As healthcare becomes increasingly complex and challenging, certification has emerged as a mark of excellence showing patients, employers and the public that a nurse is qualified and competent, and has met the rigorous requirements to achieve specialty and/or subspecialty certification.

AACN Certification Corporation programs were created to protect healthcare consumers by validating the knowledge of nurses who care for the acutely and critically ill. We are pleased to provide you with this handbook with information about our programs and how to apply for and take the PCCN certification exams.

Today, more than 90,000 practicing nurses hold one or more of these certifications from AACN Certification Corporation:

Specialty Certifications

- CCRN®** is for nurses providing direct bedside care to acutely and/or critically ill adult, pediatric or neonatal patients.
- CCRN-E™** is for nurses working in a tele-ICU monitoring acutely and/or critically ill adult patients from a remote location.
- CCRN-K™** is for nurses whose non-bedside practice influences patients, nurses and/or organizations to have a positive impact on acutely and/or critically ill adult, pediatric or neonatal patients.
- PCCN®** is for progressive care nurses providing direct bedside care to acutely ill adult patients.
- CNML** is for nurse managers and leaders; offered in partnership with AONE (American Organization of Nurse Executives) Credentialing Center.

Subspecialty Certifications

- CMC®** is for certified nurses providing direct bedside care to acutely and/or critically ill adult cardiac patients.
- CSC®** is for certified nurses providing direct bedside care to acutely and/or critically ill adult patients during the first 48 hours after cardiac surgery.

Advanced Practice Consensus Model-Based Certifications

- ACNPC-AG®** is for the adult-gerontology acute care nurse practitioner educated at the graduate level.
- The **ACCNS** credentials are for clinical nurse specialists educated at the graduate level to provide care across the continuum from **wellness through acute care**:
- ACCNS-AG®** is for the adult-gerontology clinical nurse specialist.
- ACCNS-P®** is for the pediatric clinical nurse specialist.
- ACCNS-N®** is for the neonatal clinical nurse specialist.

Advanced Practice Certifications

With implementation of the Consensus Model in 2015, ACNPC and CCNS are available as *renewal options only*:

- ACNPC®** is for acute care nurse practitioners educated to provide care to adult patients.
- CCNS®** is for acute/critical care clinical care specialists educated to provide care to adult, pediatric or neonatal patients.

We continually seek to provide quality certification programs that meet the changing needs of nurses and patients. Please visit www.certcorp.org > Documents and Handbooks, or call (800) 899-2226 for more information about the above certifications.

Thank you for your commitment to patients and their families and to becoming certified.



Please direct inquiries to:

AACN Certification Corporation, 101 Columbia, Aliso Viejo, CA 92656-4109
(800) 898-2228 • Fax: (949) 362-2020 • certcorp@aacn.org

Please include your AACN customer number with all correspondence to AACN Certification Corporation.

PCCN® is a specialty certification for nurses who provide care for acutely ill adult patients, regardless of the geographic location of their nursing care. Specialty nurses interested in this certification may work in such areas as intermediate care units; direct observation units; stepdown units; telemetry units; transitional care units; or emergency departments.

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- Review and Appeal of Certification Eligibility

PCCN CERTIFICATION PROGRAM

Definition

Progressive Care Certified Nurse (PCCN) certification validates your knowledge of nursing of acutely ill adult patients in your specialty area to hospitals, peers, patients and, most importantly, to yourself. PCCN certification promotes continuing excellence in progressive care nursing. AACN recognizes progressive care as part of the continuum of critical care.

PCCN® Registered Service Mark

PCCN is a registered service mark and denotes certification in progressive care nursing as granted by AACN Certification Corporation. Registered nurses who have not achieved PCCN certification status, whose PCCN status has lapsed, or who have chosen inactive status are not authorized to use the PCCN credential.

Validated Knowledge and Specialized Skills

Each PCCN certification exam is based on a study of practice, also known as a job analysis. The most recent study, completed in 2012, defines the dimensions of acute care practice, identifying what is required of registered nurses providing care to acutely ill patients.

In the study, acute and critical care nurses across the United States were surveyed to ascertain the significance of the various elements of their practice. Through an extensive review and evaluation process, the knowledge, skills and abilities crucial to progressive care nursing were defined using the AACN Synergy Model for Patient Care as an organizing framework. The PCCN certification exam is based on these skills and abilities and the knowledge required to perform them.

PCCN certification is achieved by those progressive care nurses who pass the PCCN exam in adult progressive care nursing. PCCN certification denotes to the public those practitioners who possess a distinct and clearly defined body of knowledge called progressive care nursing.

PCCN Exam Contents

The PCCN exam is a 2-and-1/2-hour test consisting of 125 multiple-choice items. Of the 125 items, 100 are scored and 25 are used to gather statistical data on item performance for future exams. Please refer to the PCCN Test Plan for detailed content information. The PCCN exam focuses on adult patient populations only.

PCCN Test Plan

The content of the PCCN exam is described in the test plan included in this handbook. Candidates are tested on a variety of patient care problems that are organized under major categories. Please note the percentage of the PCCN exam devoted to each category.

PCCN EXAM ELIGIBILITY

Licensure

Current unencumbered licensure as an RN or APRN in the United States is required.

- An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit the nurse's practice in any way.
- If randomly selected for audit, you will be asked to provide a copy of your RN or APRN license.
- Candidates and PCCN-certified nurses must notify AACN Certification Corporation **within 30 days** if any restriction is placed on their RN or APRN license.

Practice

Candidates must meet one of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely ill adult patients during the previous 2 years, with 875 of those hours accrued in the most recent year preceding application.

OR

- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely ill adult patients, with 144 of those hours accrued in the most recent year preceding application.

Orientation hours spent shadowing/working with another nurse who is the one with the patient assignment *cannot* be counted toward clinical hours for PCCN eligibility; however, orientation hours during which you are the assigned nurse providing direct bedside care to acutely ill adult patients may be counted.

Clinical practice hours for the PCCN exam and renewal eligibility must be completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet Status or Joint Commission International accreditation.

Nurses serving as manager, educator (in-service or academic), APRN or preceptor may apply their hours spent supervising nursing students or nurses at the bedside.

- Nurses in these roles must be actively involved in caring for patients **at the bedside**; for example, performing a procedure or supervising a new employee or student nurse performing a procedure.

Practice Verification

The name and contact information of a professional associate must be given for verification of eligibility related to clinical practice hours. If you are randomly selected for audit, this associate will need to verify in writing that you have met the clinical hour requirements.

- A professional associate is defined as either your clinical supervisor or a colleague (RN or physician) with whom you work.

AACN Certification Corporation may adopt additional eligibility requirements at its sole discretion. Any such requirements will be designed to establish, for the purposes of PCCN certification, the adequacy of a candidate's knowledge in caring for the acutely ill.

APPLICATION FEES

PCCN Computer-Based Exam

AACN Members	\$175
Nonmembers	\$275

PCCN Retest

AACN Members	\$135
Nonmembers	\$215

PCCN Renewal by Exam

AACN Members	\$135
Nonmembers	\$215

Payable in U.S. funds. Fees are subject to change without notice. A \$15 fee will be charged for a returned check.

Computer-based testing discounts are available for groups of **10 or more** candidates submitting their AACN certification exam applications in the same envelope. Employers may pre-purchase exam vouchers at a further discounted rate.

For details about the group and bulk discount programs, visit www.certcorp.org > General Information or call (800) 899-2226.

AACN Certification Corporation recommends that you be ready to test *before* applying for the PCCN exam.

ONLINE APPLICATION PROCESS

- ▶ **Register online** for computer-based testing at www.certcorp.org > Apply Online
- ▶ **Before you get started**, have available the following:
 - RN or APRN license number and expiration date
 - Name, address, phone and email address of your clinical supervisor or a professional colleague (RN or physician) who can verify your practice eligibility
 - Credit card (Visa, MasterCard, Discover or American Express)
- ▶ **Same day processing**

PAPER APPLICATION PROCESS

- ▶ **Paper applications are required** for those applying with a group, for paper and pencil exams and for testing outside the U.S.
- ▶ **Complete the application** on pages 21-22 and **honor statement** on page 23
 - Fill in all requested information, including that for your RN or APRN license
- ▶ **Include application fee**
 - Credit card, check or money order
- ▶ **Allow 2-3 weeks for processing**

Use your legal name on the application.
This name must match photo identification used for exam entry and will be the name printed on your certificate.

1. Receive notice of processed application

- AACN will send you an email confirming that you have successfully applied to take the PCCN exam.

2. Receive approval-to-test email

- AACN's testing service (AMP) will send an email and mail a postcard to eligible candidates within **5 to 10 days** after confirmation email that will include:
 - A toll-free number and online instructions to schedule your testing appointment
 - The **90-day** period during which you must schedule and take the exam
 - Your **exam identification number**, which is your unique AACN customer number preceded by the letter "C" (e.g., C00123456).
- If you do not receive an email or postcard from AMP **within 2 weeks of receiving confirmation email**, please contact AACN Customer Care at (800) 899-2226.

3. Schedule the exam

- Upon receipt of AMP's email or postcard:
 - Confirm that you are scheduled for the correct certification exam
 - Promptly schedule your exam appointment for a date and time that falls within your **90-day** testing window
- Testing is offered twice daily, Monday through Friday, at **9 a.m. and 1:30 p.m.** Saturday appointments are available at some locations.
- To locate one of the more than 175 AMP testing centers within the U.S., visit www.goAMP.com.

4. Sit for the exam

- Upon completion of computer-based exams, results with a score breakdown will be presented on-site.
- Results of paper and pencil exams will be mailed to candidates 3 to 4 weeks following paper testing.
- Successful candidates will receive their wall certificate within 3 to 4 weeks of passing the exam.

Please ensure that AACN has your current contact information.
Updates may be made online at www.aacn.org/myaccount or emailed to Info@aacn.org.
For name changes, please call AACN Customer Care at (800) 899-2226.

PCCN CERTIFICATION RENEWAL

Renewal Period

PCCN certification is granted for a period of 3 years. Your certification period begins the first day of the month in which the PCCN certification exam is passed and ends 3 years later; for example, October 1, 2014 through September 30, 2017. The purpose of certification renewal is to enhance continued competence.

Renewal notifications will be mailed and emailed to you starting 4 months before your scheduled PCCN renewal date. **You are responsible for renewing your certification even if you do not receive renewal notification.** Refer to www.certcorp.org for current information.

Eligibility

Candidates for PCCN renewal must meet the following requirements:

- Current unencumbered U.S. RN or APRN license that was not subjected to formal discipline by any state board of nursing during the 3-year certification renewal period
- Completion of 432 hours of direct bedside care of acutely ill adult patients as an RN or APRN within the 3-year certification period, with 144 of those hours in the 12-month period preceding the scheduled renewal date
- Completion of the required CERPs or take/pass the PCCN exam

Renewal Options

You may seek certification renewal via Renewal by Synergy CERPs or Renewal by Exam, or you may choose Inactive, Retired or Alumnus status. Do not apply for more than one option.

► Option 1 - Renewal by Synergy CERPs

- Meet eligibility requirements for PCCN renewal and complete the Continuing Education Recognition Point (CERP) Program, which requires 100 CERPs in various categories (A, B & C).
- Online Renewal by Synergy CERPs is available to all active PCCNs as early as 4 months prior to their scheduled renewal date. For more information visit www.certcorp.org > Renew Your Certification.
- For more details refer to the Renewal by Synergy CERPs Brochure and other Synergy CERP resources available online at www.certcorp.org.

► Option 2 - Renewal by Exam

- Meet the eligibility requirements for PCCN renewal and successfully apply for and schedule your exam.
 - The PCCN exam must be completed **before** your scheduled renewal date.
 - You may not take the exam early, then attempt to renew by CERPs if you do not pass.

► Option 3 - Inactive Status

- Inactive status is available to PCCN-certified nurses who do not meet the renewal eligibility requirements but do not wish to lose their PCCN certification status. Inactive status provides PCCN-certified nurses additional time, **up to 3 years** from the scheduled renewal date, to meet the eligibility requirements.
- **During the time of inactive status, the PCCN credential may not be used.**
- Inactive status may be held more than once, but not for two consecutive renewal periods.

For more details, refer to the *PCCN Renewal Handbook* available at www.certcorp.org > Documents and Handbooks.

continued

PCCN CERTIFICATION RENEWAL (CONTINUED)

Alternative Designations

Alumnus Status

Alumnus status is for nurses who have been PCCN-certified but no longer provide direct bedside care to acutely ill patients for enough hours to meet the clinical hour requirement for active PCCN certification, but are still in the nursing profession in some other capacity and wish to remain connected with the credential.

- Renewable every 3 years, the "Alumnus PCCN" designation, written out, may be used on your resume or below your name and credentials on a business card, but may not be used with your signature or on a name badge.
- To be eligible for Alumnus PCCN status, you must have held PCCN certification and have no plans to renew PCCN certification in the future.
- There are no CE or CERP requirements to maintain Alumnus PCCN status.

Retired Status

Retired status provides the PCCN-certified nurse or Alumnus PCCN who is retiring from the nursing profession with a continued sense of career identity and professional connectedness. The Retired PCCN designation recognizes PCCN-certified nurses for their years of service at the bedside. It also acknowledges their pride and dedication in maintaining their certification.

- To be eligible for Retired PCCN status, you must have been a PCCN without plans of returning to nursing practice or renewing certification.
- The retired nurse must not be working in any type of position that requires the possession of an RN license. You are not eligible if you are changing from bedside practice to another nursing role.
- The "Retired PCCN" designation, written out, may be used on your resume or below your name and credentials on a business card, but may not be used with your signature or on a name badge.
- There are no CE or CERP requirements to maintain Retired PCCN status.

For more details, refer to the Alumnus and Retired applications available online at www.certcorp.org > Documents and Handbooks.

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AACN SYNERGY MODEL FOR PATIENT CARE

Synergy is an evolving phenomenon that occurs when individuals work together in mutually enhancing ways toward a common goal. AACN Certification Corporation is committed to ensuring that certified nursing practice is based on the needs of patients. Integration of the AACN Synergy Model for Patient Care into AACN Certification Corporation's certification programs puts emphasis on the patient and says to the world that patients come first.

The Synergy Model creates a comprehensive look at the patient. It puts the patient in the center of nursing practice. The model identifies nursing's unique contributions to patient care and uses language to describe the professional nurse's role. It provides nursing with a venue that clearly states what we do for patients and allows us to start linking ourselves to, and defining ourselves within, the context of the patient and patient outcomes.

NOTE: AACN certification exams do not test for knowledge of the Synergy Model or its terminology; this is the theoretical model within which the tests have been designed.

Patient Characteristics

The Synergy Model encourages nurses to view patients in a holistic manner rather than the "body systems" medical model. Each patient and family is unique, with a varying capacity for health and vulnerability to illness. Each patient, regardless of the clinical setting, brings a set of unique characteristics to the care situation. Depending on where they are on the healthcare continuum, patients may display varying levels of the following characteristics:

Resiliency	Capacity to return to a restorative level of functioning using compensatory/coping mechanisms; the ability to bounce back quickly after an insult.
Vulnerability	Susceptibility to actual or potential stressors that may adversely affect patient outcomes.
Stability	Ability to maintain a steady-state equilibrium.
Complexity	Intricate entanglement of two or more systems (e.g., body, family, therapies).
Resource Availability	Extent of resources (e.g., technical, fiscal, personal, psychological and social) the patient/family/community bring to the situation.
Participation in Care	Extent to which patient/family engages in aspects of care.
Participation in Decision Making	Extent to which patient/family engages in decision making.
Predictability	A characteristic that allows one to expect a certain course of events or course of illness.

FOR EXAMPLE:

A healthy, uninsured, 40-year-old woman undergoing a pre-employment physical could be described as an individual who is (a) stable (b) not complex (c) very predictable (d) resilient (e) not vulnerable (f) able to participate in decision making and care, but (g) has inadequate resource availability.

On the other hand: a critically ill, insured infant with multisystem organ failure can be described as an individual who is (a) unstable (b) highly complex (c) unpredictable (d) highly resilient (e) vulnerable (f) unable to become involved in decision making and care, but (g) has adequate resource availability.

continued

AACN SYNERGY MODEL FOR PATIENT CARE (CONTINUED)

Nurse Characteristics

Nursing care reflects an integration of knowledge, skills, abilities and experience necessary to meet the needs of patients and families. Thus, nurse characteristics are derived from patient needs and include:

Clinical Judgment	Clinical reasoning, which includes clinical decision making, critical thinking and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating education, experiential knowledge and evidence-based guidelines.
Advocacy/ Moral Agency	Working on another's behalf and representing the concerns of the patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.
Caring Practices	Nursing activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. These caring behaviors include but are not limited to vigilance, engagement and responsiveness of caregivers. Caregivers include family and healthcare personnel.
Collaboration	Working with others (e.g., patients, families, healthcare providers) in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Collaboration involves intra- and inter-disciplinary work with colleagues and community.
Systems Thinking	Body of knowledge and tools that allow the nurse to manage whatever environmental and system resources that exist for the patient/family and staff, within or across healthcare systems and non-healthcare systems.
Response to Diversity	The sensitivity to recognize, appreciate and incorporate differences into the provision of care. Differences may include, but are not limited to, individuality, cultural, spiritual, gender, race, ethnicity, lifestyle, socioeconomic, age and values.
Facilitation of Learning	The ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team and community. Includes both formal and informal facilitation of learning.
Clinical Inquiry	The ongoing process of questioning and evaluating practice and providing informed practice. Creating changes through evidence-based practice, research utilization and experiential knowledge.

Nurses become competent within each continuum at a level that best meets the fluctuating needs of their population of patients. More compromised patients have more severe or complex needs, requiring nurses to have advanced knowledge and skills in an associated continuum.

FOR EXAMPLE:

If the gestalt of a patient were stable but unpredictable, minimally resilient and vulnerable, primary competencies of the nurse would be centered on clinical judgment and caring practices (which includes vigilance). If the gestalt of a patient were vulnerable, unable to participate in decision making and care, and inadequate resource availability, the primary competencies of the nurse would focus on advocacy and moral agency, collaboration and systems thinking.

Although all eight competencies are essential for contemporary nursing practice, each assumes more or less importance depending on a patient's characteristics. **Synergy results when a patient's needs and characteristics are matched with the nurse's competencies.**

Based on the most recent AACN Certification Corporation study of nursing practice, the test plans for AACN certification exams reflect the Synergy Model as well as findings related to nursing care of the adult patient population studied.

For more information about the AACN Synergy Model for Patient Care visit www.certcorp.org.

PCCN TEST PLAN

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (33%)

1. Acute coronary syndromes
 - a. non-ST segment elevation myocardial infarction
 - b. ST segment elevation myocardial infarction
 - c. unstable angina
2. Acute inflammatory disease (e.g., myocarditis, endocarditis, pericarditis)
3. Aneurysm
 - a. dissecting
 - b. repair
4. Cardiac surgery (e.g., open chest surgery) more than 48 hours postoperative
5. Cardiac tamponade
6. Cardiogenic shock
7. Cardiomyopathies
 - a. dilated (e.g., ischemic/non-ischemic)
 - b. hypertrophic
 - c. stress-induced (e.g., Takotsubo)
8. Dysrhythmias
 - a. bradydysrhythmias
 - b. conduction defects and blocks
 - c. device-related (e.g., ICD and pacemaker)
 - d. lethal ventricular dysrhythmias
 - e. tachydysrhythmias
9. Genetic cardiac disease (e.g., long QT syndrome, Brugada syndrome)
10. Heart failure
 - a. acute exacerbations (e.g., pulmonary edema)
 - b. chronic
11. Hypertensive crisis
12. Minimally invasive cardiac surgery (i.e., non-sternal approach)
13. Septal defects (congenital and acquired)
14. Valvular heart disease
 - a. aortic
 - b. mitral
15. Vascular disease
 - a. carotid artery stenosis
 - b. minimally invasive interventions (e.g., stents, endografts)
 - c. peripheral arterial occlusions
 - d. peripheral surgical interventions
 - e. peripheral venous thrombosis

B. Pulmonary (14%)

1. Acute respiratory distress syndrome (ARDS, to include acute lung injury or ALI)
2. Exacerbation of COPD
3. Obstructive sleep apnea
4. Pleural space abnormalities and complications (e.g., pneumothorax, hemothorax, pleural effusion, empyema)
5. Pulmonary embolism
6. Pulmonary hypertension
7. Respiratory depression (e.g., medication-induced, decreased-LOC-induced)
8. Respiratory failure
 - a. acute
 - b. chronic
9. Respiratory infections (e.g., pneumonia)
10. Severe asthma
11. Thoracic surgery
 - a. lobectomy
 - b. pneumonectomy

C. Endocrine/Hematology/Gastrointestinal/Renal (18%)

1. Endocrine
 - a. diabetes mellitus
 - b. diabetic ketoacidosis
 - c. hyperglycemic hyperosmolar syndrome (HHS)
 - d. hypoglycemia
 - e. metabolic syndrome
2. Hematology/Immunology/Oncology
 - a. anemia
 - b. cancer
 - c. hemostasis disorders (i.e., coagulopathies)
 - i. heparin-induced thrombocytopenia (HIT)
 - ii. other drug-induced overdose (e.g., Coumadin, Pradaxa)
 - d. immunosuppressive disorders
3. Gastrointestinal
 - a. functional GI disorders (e.g., obstruction, ileus, diabetic gastroparesis, gastroesophageal reflux, irritable bowel syndrome)
 - b. GI bleed
 - i. lower
 - ii. upper
 - c. GI infections

continued

PCCN TEST PLAN (CONTINUED)

- d. hepatic failure
 - e. ischemic bowel
 - f. malnutrition (e.g., failure to thrive, malabsorption disorders)
 - g. pancreatitis
4. Renal
- a. acute renal failure
 - b. chronic renal failure
 - c. contrast-induced nephropathy
 - d. end-stage renal disease (ESRD)
 - e. electrolyte imbalances
 - f. medication-induced renal failure
 - g. nephritic syndrome

D. Neurology/Multisystem/Behavioral (15%)

1. Neurology
- a. cerebrovascular malformation (including aneurysm, AV malformation)
 - b. encephalopathy (e.g., hypoxic-ischemic, metabolic, edema, infectious, hepatic)
 - c. intracranial hemorrhage (e.g., subarachnoid, epidural, encephalitis)
 - d. seizure disorders
 - e. stroke (cerebrovascular accident)
 - i. ischemic (embolic)
 - ii. hemorrhagic
 - iii. transient ischemic attack (TIA)
2. Multisystem
- a. complex wounds and pressure ulcers
 - b. healthcare-acquired infections
 - i. catheter-associated urinary tract infections (CAUTI)
 - ii. central-line-associated bloodstream infections (CLABSI)
 - c. palliative care
 - d. end-of-life (e.g., comfort care measures, hospice)
 - e. infectious diseases
 - i. influenza
 - ii. multidrug-resistant organisms (e.g., MRSA, VRE)
 - f. pain
 - g. sepsis continuum
 - i. systemic inflammatory response syndrome (SIRS)
 - ii. sepsis
 - iii. severe sepsis
 - iv. septic shock
 - h. shock states (hypovolemic and anaphylactic)

3. Behavioral/Psychosocial
- a. altered mental status
 - b. delirium
 - c. dementia
 - d. psychological disorders
 - i. anxiety disorders
 - ii. depression
 - e. substance abuse
 - i. alcohol withdrawal
 - ii. chronic alcohol abuse
 - iii. chronic drug abuse
 - iv. drug-seeking behavior

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)

- A. Advocacy
- B. Caring Practices
- C. Collaboration
- D. Systems Thinking
- E. Response to Diversity
- F. Clinical Inquiry
- G. Facilitation of Learning

Order of content does not necessarily reflect importance.

PCCN TEST PLAN TESTABLE NURSING ACTIONS

CLINICAL JUDGMENT

Cardiovascular

- Perform a comprehensive cardiovascular assessment
- Identify, interpret and monitor:
 - dysrhythmias
 - ST segments
 - QTc intervals
- Select leads for cardiac monitoring for the indicated disease process
- Recognize indications for and manage patients requiring hemodynamic monitoring using non-invasive hemodynamic monitoring
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Monitor patients and follow protocols for managing patients with:
 - pacemakers
 - defibrillation
 - arterial/venous sheaths
 - transesophageal echocardiogram (TEE)
- Monitor patients pre- and post-procedure:
 - cardioversion
 - pericardiocentesis
 - cardiac catheterization
 - ablation
 - arterial closure devices
- Monitor normal and abnormal cardiovascular diagnostic test results
- Administer cardiovascular medications and monitor response
- Titrate vasoactive medications
- Recognize signs and symptoms of cardiovascular emergencies, initiate standardized interventions and seek assistance as needed
- Monitor and manage patient following coronary intervention

Pulmonary

- Perform a comprehensive pulmonary assessment
- Monitor normal and abnormal diagnostic test results
- Interpret ABGs and report findings

- Monitor patient for response to pulmonary medications
- Manage patients requiring non-invasive O₂ or ventilation delivery systems
 - nasal cannula
 - face mask
 - venti-mask
 - non-rebreather mask
 - BiPAP
 - CPAP
- Manage patients requiring mechanical ventilation - tracheostomy tube
- Manage patients requiring respiratory monitoring devices:
 - continuous SPO₂
 - intermittent SPO₂
 - end-tidal CO₂ (capnography)
- Recognize signs and symptoms of respiratory complications and seek assistance as needed
- Maintain airway
- Manage patients with chest tubes
- Assist with procedures:
 - thoracentesis
 - chest tube insertion
- Administer medications for procedural (conscious) sedation and monitor patient response

Endocrine/Hematology/Gastrointestinal/Renal

- Endocrine
 - identify signs and symptoms associated with endocrine disorders
 - monitor normal and abnormal endocrine diagnostic test results
 - administer medications and monitor patient response
 - manage and titrate insulin infusions
 - manage patients using insulin pumps
- Hematology/Immunology/Oncology
 - identify signs and symptoms associated with hematologic/immunologic/oncologic disorders
 - monitor normal and abnormal diagnostic hematologic/immunologic/oncologic test results
 - administer medications and monitor patient response

continued

PCCN TEST PLAN TESTABLE NURSING ACTIONS (CONTINUED)

- **Gastrointestinal**
 - perform a comprehensive gastrointestinal assessment
 - monitor normal and abnormal gastrointestinal diagnostic test results
 - recognize indications for and complications of enteral and parenteral nutrition
 - administer medications and monitor patient response
- **Renal**
 - identify normal and abnormal renal assessment findings
 - monitor normal and abnormal renal diagnostic test results
 - monitor peritoneal dialysis
 - identify medications that may cause nephrotoxicity
 - initiate renal protective measures for nephrotoxic procedures
- **Behavioral/Psychosocial**
 - perform a comprehensive psychosocial, behavioral and risk assessment
 - administer medications and monitor patient response
 - recognize signs and symptoms of behavioral emergencies and initiate interventions
 - perform Clinical Institute Withdrawal Assessment (CIWA, CIWA-Ar scale)
 - screen patients using a delirium assessment tool
 - implement suicide prevention measures

Neurology/Multisystem/Behavioral

- **Neurology**
 - perform a comprehensive neurological assessment
 - monitor normal and abnormal neurological diagnostic test results
 - administer medications and monitor patient response
 - recognize signs and symptoms of increased intracranial pressure
 - use the NIH Stroke Scale (NIHSS)
 - perform bedside screening for dysphagia
- **Multisystem**
 - administer medications and monitor patient response
 - identify early signs and symptoms of sepsis (SIRS criteria)
 - initiate early goal-directed therapy (EGDT) for treating sepsis
 - initiate emergency interventions (e.g., ACLS, rapid response team)
 - differentiate types of wounds, pressure ulcers, and deep tissues injuries
 - manage patients with complex wounds (e.g., fistulas, drains, and vacuum-assisted closure devices)
 - manage patients with infections
 - manage patients at the end of life
 - facilitate the organ/tissue donation process

PROFESSIONAL CARING AND ETHICAL PRACTICE

Systems Thinking

- **Informatics**
 - use word processing applications use internet resources to locate patient support groups, online resources
 - use hospital or nursing information systems to access, enter and retrieve data related to patient care
 - use database applications to enter and retrieve data and information
 - conduct online and database literature searches
 - use computer applications to document patient care
 - use computer applications to plan patient care, including discharge planning
 - use information management systems for patient education
 - use technology-based patient monitoring systems
 - operate peripheral/point-of-care devices, bedside and hand-held (e.g., smart pump)

SAMPLE PCCN EXAM QUESTIONS

1. Two days post admission for rapid atrial fibrillation, a patient has been weaned from IV diltiazem (Cardizem) to PO administration. The patient develops new onset of hallucinations, agitation and disorientation. The most appropriate *initial* nursing action is to
 - A. obtain an order for lorazepam (Ativan) every six hours.
 - B. assess the patient's SpO₂ and neurological status.
 - C. obtain an order for haloperidol (Haldol) and monitor QT intervals.
 - D. consult with the pharmacy regarding a possible drug interaction.

2. A patient with an extensive history of substance abuse including alcohol, tobacco, methyl amphetamine and IV heroin use is suspected to have valvular endocarditis. He states he doesn't understand how he is now in this situation. Which of the following statements best reflects his diagnosis?
 - A. ingestion of alcohol causes myocardial depression
 - B. inhalation of stimulants causes instability to the electrical system of the heart
 - C. contaminated needles can introduce bacteria into the bloodstream
 - D. repeated exposure to nicotine is related to stenosis of the leaflets

3. A patient with CAD complains of paresthesia to the foot. The nurse notes the right foot is cooler than the other extremity, and pedal pulses are difficult to palpate. Which additional assessment findings in the right leg would lead the nurse to suspect peripheral arterial disease?
 - A. pallor when elevating the extremity
 - B. redness of the ankle and foot
 - C. dependent edema
 - D. engorged varicose veins

4. After PCI for a STEMI, the patient complains of shortness of breath. Crackles are auscultated throughout all lung fields. VS: BP 72/50, HR 124, RR 32, O₂ Sat 88% on 2L nasal cannula. Which of the following would be the immediate goal for treatment strategies?
 - A. volume to enhance venous return
 - B. diuresis to reduce myocardial workload
 - C. antiarrhythmics to restore electrical stability
 - D. thrombolytics to eliminate the pulmonary embolus

5. A patient who is 1 week post MI suddenly becomes agitated, restless and diaphoretic. Pulse pressure drops to 20 mm Hg. Assessment also reveals faint radial and apical pulses that weaken significantly on inspiration. This patient is most likely experiencing
 - A. mitral valve rupture.
 - B. pulmonary embolus.
 - C. pulmonary edema.
 - D. cardiac tamponade.

6. Which of the following may predispose an individual to ventricular fibrillation?
 - A. hypernatremia and hypomagnesemia
 - B. hypophosphatemia and hyperchloremia
 - C. hypermagnesemia and hyponatremia
 - D. hyperkalemia and hypocalcemia

7. Chest auscultation of a patient in status asthmaticus commonly reveals which of the following?
 - A. expiratory wheezes
 - B. inspiratory crackles
 - C. diminished bilateral breath sounds
 - D. a pleural friction rub

8. The family of a critically ill patient wishes to spend the night, which is contrary to the visiting policy. The nurse's best action would be to
 - A. adhere to the visiting policy.
 - B. allow the family to stay in the room.
 - C. obtain a motel room near the hospital where the family may spend the night.
 - D. allow one or two family members to stay, then evaluate the patient's response.

9. Members of the nursing staff are developing written patient education materials for a group of patients with diverse reading abilities. It would be most effective for the staff to
 - A. design individual handouts for each patient.
 - B. develop a computer-based education series.
 - C. write the materials at a fourth-grade reading level.
 - D. limit text and provide color pictures.

Answers

- | | | |
|------|------|------|
| 1. B | 4. B | 7. A |
| 2. C | 5. D | 8. D |
| 3. A | 6. D | 9. C |

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Primary Area Employed

- Acute Hemodialysis Unit (24)
- Burn Unit (13)
- Cardiac Rehabilitation (26)
- Cardiac Surgery/OR (38)
- Cardiovascular/Surgical ICU (09)
- Catheterization Lab (22)
- Combined Adult/Ped. ICU (23)
- Combined ICU/CCU (01)
- Coronary Care Unit (03)
- Crit. Care Transport/Flight (17)
- Direct Observation Unit (39)
- Emergency Dept. (12)
- General Med./Surg. Floor (18)
- Home Care (25)
- Intensive Care Unit (02)
- Interventional Cardiology (31)
- Long-Term Care (27)
- Medical Cardiology (34)
- Medical ICU (04)
- Medical Surgical ICU (35)
- Neonatal ICU (06)
- Neuro./Neurosurgical ICU (10)
- Oncology Unit (19)
- Operating Room (15)
- Outpatient Clinic (29)
- Pediatric ICU (05)
- Private Practice (32)
- Progressive Care Unit (18)
- Recovery Room/PACU (14)
- Respiratory ICU (08)
- Stepdown Unit (30)
- Subacute Care (28)
- Surgical ICU (07)
- Tele-ICU (37)

- Telemetry (20)
- Trauma Unit (11)
- Other - specify below _____ (99)

Primary Position Held

- Academic Faculty (07)
- Acute Care Nurse Practitioner (09)
- Administrator/V.P. (43)
- Bedside/Staff Nurse (01)
- Charge Nurse (45)
- Clinic Nurse (40)
- Clinical Coordinator (44)
- Clinical Director (04)
- Clinical Nurse Specialist (08)
- Electad Official (12)
- Home Healthcare Nurse (41)
- In-service/Staff Devel. Instructor (06)
- Legal Nurse Consultant (47)
- Manager (03)
- Nurse Anesthetist (02)
- Nurse Educator (46)
- Nurse Midwife (13)
- Nurse Practitioner (05)
- Physician (16)
- Physician Assistant (17)
- Researcher (18)
- Respiratory Therapist (19)
- Social Worker (20)
- Unit Coordinator (22)
- Other - specify below _____ (99)

Highest Nursing Degree

- Associate's Degree
- Bachelor's Degree
- Diploma
- Doctorate
- Master's Degree

- University Med. Ctr. (03)
- Other - specify below _____ (99)

Number of Beds in Institution

Years of Experience in Nursing

Years of Experience in Acute/Critical Care Nursing

Date of Birth (month/Day/Year)

Gender

- Female Male

Ethnicity

- African American (02)
- Asian (05)
- Hispanic/Latino (03)
- Native American (04)
- Pacific Islander (08)
- White/Non-Hispanic (01)
- Other - specify below _____ (99)

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- College/University (08)
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- HMO/Managed Care (12)
- Home Health (13)
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PRACTICE: I have fulfilled one of the following clinical practice requirement options:

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OR

- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely ill adult patients, with 144 of those hours accrued in the most recent year preceding application.
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PRACTICE VERIFICATION: Following is the contact information of my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

VERIFIER'S NAME: _____ FACILITY NAME: _____
Last First

VERIFIER'S PHONE NUMBER: _____ VERIFIER'S EMAIL ADDRESS: _____

You may not list yourself or a relative as your verifier.

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ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

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To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____ Date: _____



PCCN

Generations Family Health Center
October 2, 2015

**EXHIBIT 4: Society of Critical Care Medicine Guidelines for Inter- and
Intra-Hospital Transport of Critically Ill Patients**

Special Articles

Guidelines for the inter- and intrahospital transport of critically ill patients*

Jonathan Warren, MD, FCCM, FCCP; Robert E. Fromm Jr, MD, MPH, MS; Richard A. Orr, MD; Leo C. Rotello, MD, FCCM, FCCP, FACP; H. Mathilda Horst, MD, FCCM; American College of Critical Care Medicine

Objective: The development of practice guidelines for the conduct of intra- and interhospital transport of the critically ill patient.

Data Source: Expert opinion and a search of Index Medicus from January 1986 through October 2001 provided the basis for these guidelines. A task force of experts in the field of patient transport provided personal experience and expert opinion.

Study Selection and Data Extraction: Several prospective and clinical outcome studies were found. However, much of the published data comes from retrospective reviews and anecdotal reports. Experience and consensus opinion form the basis of much of these guidelines.

Results of Data Synthesis: Each hospital should have a formalized plan for intra- and interhospital transport that addresses

a) pretransport coordination and communication; b) transport personnel; c) transport equipment; d) monitoring during transport; and e) documentation. The transport plan should be developed by a multidisciplinary team and should be evaluated and refined regularly using a standard quality improvement process.

Conclusion: The transport of critically ill patients carries inherent risks. These guidelines promote measures to ensure safe patient transport. Although both intra- and interhospital transport must comply with regulations, we believe that patient safety is enhanced during transport by establishing an organized, efficient process supported by appropriate equipment and personnel. (Crit Care Med 2004; 32:256-262)

Key Words: Intrahospital transport; Interhospital transport; critical care; health planning; policy making; monitoring; standards

The decision to transport a critically ill patient, either within a hospital or to another facility, is based on an assessment of the potential benefits of transport weighed against the potential risks. Critically ill patients are transported to alternate locations to obtain additional care, whether technical, cognitive, or procedural, that is not available at the existing location. Provision of this additional care may require patient transport to a diagnostic department, operating room, or specialized care unit within a hospital, or

it may require transfer to another hospital. If a diagnostic test or procedural intervention under consideration is unlikely to alter the management or outcome of that patient, then the need for transport must be questioned. When feasible and safe, diagnostic testing or simple procedures in unstable or potentially unstable patients often can be performed at the bedside in the intensive care unit (1, 2). Financial considerations are not a factor when contemplating moving a critically ill patient.

Critically ill patients are at increased risk of morbidity and mortality during transport (3-17). Risk can be minimized and outcomes improved with careful planning, the use of appropriately qualified personnel, and selection and availability of appropriate equipment (16-37). During transport, there is no hiatus in the monitoring or maintenance of a patient's vital functions. Furthermore, the accompanying personnel and equipment are selected by training to provide for any ongoing or anticipated acute care needs of the patient.

Ideally, all critical care transports, both inter- and intrahospital, are performed by

specially trained individuals. Since there will almost certainly be situations when a specialized team is not available for interhospital transport, each referring and tertiary institution must develop contingency plans using locally available resources for those instances when the referring facility cannot perform the transport. A comprehensive and effective interhospital transfer plan can be developed using a systematic approach comprised of four critical elements: a) A multidisciplinary team of physicians, nurses, respiratory therapists, hospital administration, and the local emergency medical service is formed to plan and coordinate the process; b) the team conducts a needs assessment of the facility that focuses on patient demographics, transfer volume, transfer patterns, and available resources (personnel, equipment, emergency medical service, communication); c) with this data, a written standardized transfer plan is developed and implemented; and d) the transfer plan is evaluated and refined regularly using a standard quality improvement process.

This document outlines the minimum recommendations for transport of the critically ill patient. Detailed guidelines

*See also p. 305.

From Northwest Community Hospital, Arlington Heights, IL (JW); Baylor College of Medicine, Houston, TX (REF); Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine, Pittsburgh, PA (RAO); Suburban Hospital, Bethesda, MD (LCR); Henry Ford Hospital, Detroit, MI (HMH).

These guidelines have been developed by the American College of Critical Care Medicine and the Society of Critical Care Medicine. These guidelines reflect the official opinion of the Society of Critical Care Medicine and do not necessarily reflect, and should not be construed to reflect, the views of certification bodies, regulatory agencies, or other medical review organizations.

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DOI: 10.1097/01.CCM.0000104917.39204.0A

targeted to the transport of infants and children have been published by the American Academy of Pediatrics (23). Institutions performing commercial or organized interhospital transports are required to function at and meet a higher standard, as the requirements for organized transport services are considerably more rigorous than the recommendations in this guideline (24, 38-41).

The references for this guideline were obtained from a review of Index Medicus (see key words) from January 1986 through October 2001 and are categorized according to the degree of evidence-based data employed. The specific category assigned to each reference is noted in the References at the end of this article. The letter *a* denotes a randomized, prospective controlled investigation; *b* denotes a nonrandomized, concurrent, or historical cohort investigation; *c* denotes a peer-reviewed "state-of-the-art" article, review article, editorial, or substantial case series; and *d* denotes a non-peer-reviewed opinion such as a textbook statement or official organizational publication. The asterisk symbol will follow a statement of practice standards. This indicates a recommendation by the American College of Critical Care Medicine that is based on expert opinion and is used in circumstances where published supporting data are unavailable.

INTRAHOSPITAL TRANSPORT

Because the transport of critically ill patients to procedures or tests outside the intensive care unit is potentially hazardous, the transport process must be organized and efficient. To provide for this, at least four concerns need to be addressed through written intensive care unit policies and procedures: communication, personnel, equipment, and monitoring.

Pretransport Coordination and Communication. When an alternate team at a receiving location will assume management responsibility for the patient after arrival, continuity of patient care will be ensured by physician-to-physician and/or nurse-to-nurse communication to review patient condition and the treatment plan in operation. This communication occurs each time patient care responsibility is transferred. Before transport, the receiving location confirms that it is ready to receive the patient for immediate procedure or testing. Other members of the healthcare team (e.g., respiratory ther-

apy, hospital security) then are notified as to the timing of the transport and the equipment support that will be needed. The responsible physician is made aware of the transport. Documentation in the medical record includes the indications for transport and patient status throughout the time away from the unit of origin.

Accompanying Personnel. It is strongly recommended that a minimum of two people accompany a critically ill patient.* One of the accompanying personnel is usually a nurse who has completed a competency-based orientation and has met previously described standards for critical care nurses (42, 43). Additional personnel may include a respiratory therapist, registered nurse, or critical care technician as needed. It is strongly recommended that a physician with training in airway management and advanced cardiac life support, and critical care training or equivalent, accompany unstable patients.* When the procedure is anticipated to be lengthy and the receiving location is staffed by appropriately trained personnel, patient care may be transferred to those individuals if acceptable to both parties. This allows for maximum utilization of staff and resources. If care is not transferred, the transport personnel will remain with the patient until returned to the intensive care unit.

Accompanying Equipment. A blood pressure monitor (or standard blood pressure cuff), pulse oximeter, and cardiac monitor/defibrillator accompany every patient without exception.* When available, a memory-capable monitor with the capacity for storing and reproducing patient bedside data will allow review of data collected during the procedure and transport. Equipment for airway management, sized appropriately for each patient, is also transported with each patient, as is an oxygen source of ample supply to provide for projected needs plus a 30-min reserve.

Basic resuscitation drugs, including epinephrine and antiarrhythmic agents, are transported with each patient in the event of sudden cardiac arrest or arrhythmia. A more complete array of pharmacologic agents either accompanies the basic agents or is available from supplies ("crash carts") located along the transport route and at the receiving location. Supplemental medications, such as sedatives and narcotic analgesics, are considered in each specific case. An ample supply of appropriate intravenous fluids and continuous drip medications (regulated by battery-operated infusion pumps) is

ensured. All battery-operated equipment is fully charged and capable of functioning for the duration of the transport. If a physician will not be accompanying the patient during transport, protocols must be in place to permit the administration of these medications and fluids by appropriately trained personnel under emergency circumstances.

In many hospitals, pediatric patients share diagnostic and procedural facilities with adult patients. Under these circumstances, a complete set of pediatric resuscitation equipment and medications will accompany infants and children during transport and also will be available in the diagnostic or procedure area.

For practical reasons, bag-valve ventilation is most commonly employed during intrahospital transports. Portable mechanical ventilators are gaining increasing popularity in this arena, as they more reliably administer prescribed minute ventilation and desired oxygen concentrations. In adults and children, a default oxygen concentration of 100% generally is used. However, oxygen concentration must be precisely regulated for neonates and for those patients with congenital heart disease who have single ventricle physiology or are dependent on a right-to-left shunt to maintain systemic blood flow. For patients requiring mechanical ventilation, equipment is optimally available at the receiving location capable of delivering ventilatory support equivalent to that being delivered at the patient's origin. In mechanically ventilated patients, endotracheal tube position is noted and secured before transport, and the adequacy of oxygenation and ventilation is reconfirmed. Occasionally patients may require modes of ventilation or ventilator settings not reproducible at the receiving location or during transportation. Under these circumstances, the origin location must trial alternate modes of mechanical ventilation before transport to ensure acceptability and patient stability with this therapy. If the patient is incapable of being maintained safely with alternate therapy, the risks and benefits of transport are cautiously reexamined. If a transport ventilator is to be employed, it must have alarms to indicate disconnection and excessively high airway pressures and must have a backup battery power supply.*

Monitoring During Transport. All critically ill patients undergoing transport receive the same level of basic physiologic monitoring during transport as they had

in the intensive care unit. This includes, at a minimum, continuous electrocardiographic monitoring, continuous pulse oximetry (44), and periodic measurement of blood pressure, pulse rate, and respiratory rate. In addition, selected patients may benefit from capnography, continuous intra-arterial blood pressure, pulmonary artery pressure, or intracranial pressure monitoring. There may be special circumstances that warrant intermittent cardiac output or pulmonary artery occlusion pressure measurements.

INTERHOSPITAL TRANSPORT

Patient outcomes depend to a large degree on the technology and expertise of personnel available within each health-care facility. When services are needed that exceed available resources, a patient ideally will be transferred to a facility that has the required resources (45). Interhospital patient transfers occur when the benefits to the patient exceed the risks of the transfer. A decision to transfer a patient is the responsibility of the attending physician at the referring institution. Once this decision has been made, the transfer is effected as soon as possible. When needed, resuscitation and stabilization will begin before the transfer (46, 47), realizing that complete stabilization may be possible only at the receiving facility.

In the United States, it is essential for practitioners to be aware of federal and state laws regarding interhospital patient transfers. The Emergency Medical Treatment and Active Labor Act (EMTALA) laws and regulations (updated at intervals from the 1986 COBRA laws and the 1990 OBRA amendment) define in detail the legal responsibilities of the transferring and receiving facilities and practitioners. The American College of Emergency Physicians has published a book (48) that reviews the legal responsibilities of referring institutions as well as the ramifications of noncompliance with the COBRA/EMTALA regulations, and it is an excellent resource for any facility involved in patient transfers. In general, under COBRA/EMTALA, financially motivated transfers are illegal and put both the referring institution and the individual practitioner at risk for serious penalty (49, 50).

Current regulations and good medical practice require that a competent patient, guardian, or the legally authorized representative of an incompetent patient give

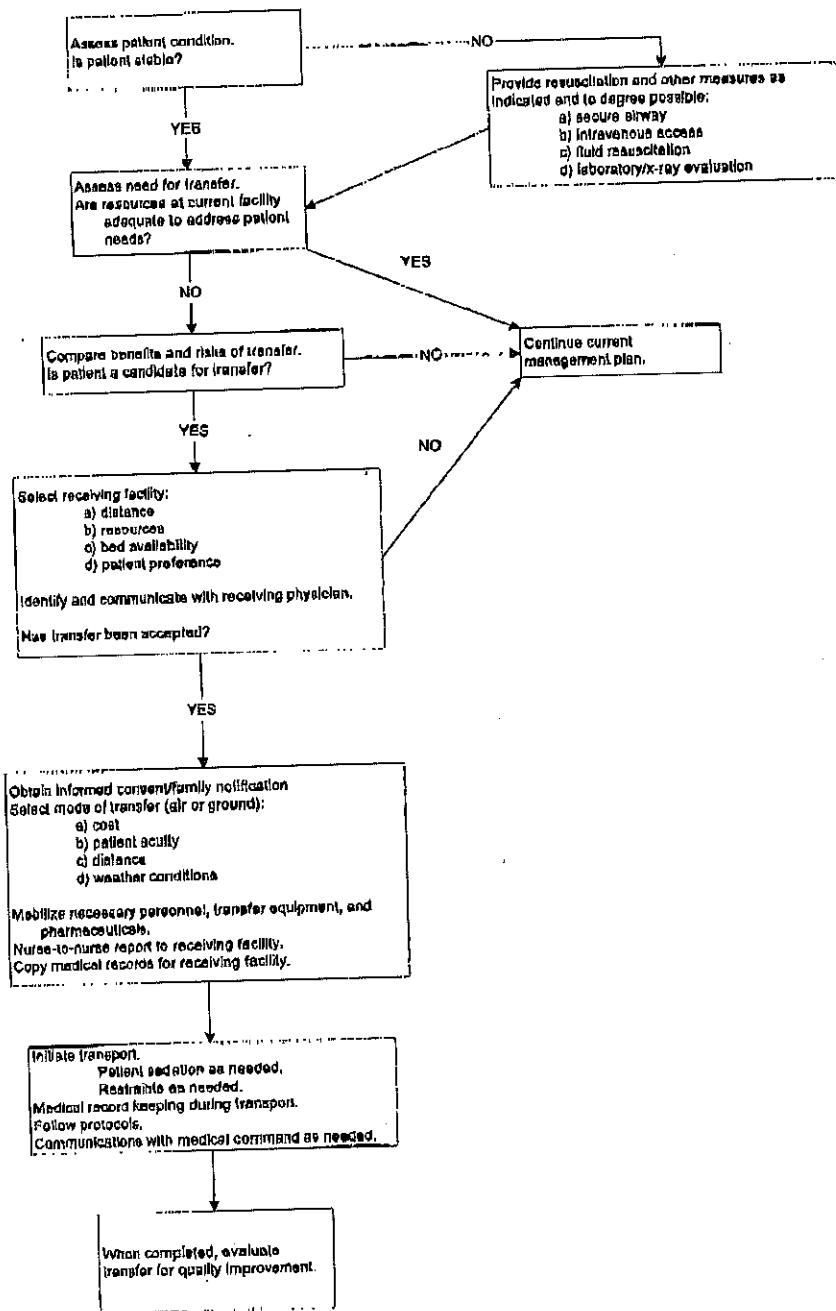


Figure 1. Interfacility transfer algorithm.

informed consent before interhospital transfer. The informed consent process includes a discussion of the risks and benefits of transfer. These discussions are documented in the medical record before transfer. A signed consent should be obtained, if possible. If circumstance do not allow for the informed consent process (e.g., life-threatening emergency), then both the indications for transfer and the reason for not obtaining consent are documented in the medical record. The re-

ferring physician always writes an order for transfer in the medical record.

Several elements are included in the process of interhospital transfer, and all fall within minimum guidelines, as described subsequently. It is important to recognize that these process elements may frequently, and out of necessity, be implemented simultaneously, especially when stabilization and treatment are needed before transfer. An algorithm has been developed to guide prac-

Table I. Recommended minimum transport equipment

Airway management/oxygenation—adult and pediatric

- Adult and pediatric bag-valve systems with oxygen reservoir
- Adult and pediatric masks for bag-valve system (multiple sizes as appropriate)
- Flexible adaptors to connect bag-valve system to endotracheal/tracheostomy tube
- End-tidal carbon dioxide monitors (pediatric and adult)
- Infant medium- and high-concentration masks with tubing
- Macintosh laryngoscope blades (#1, #2, #3, #4)
- Miller laryngoscope blades (#0, #1, #2)
- Endotracheal tube stylets (adult and pediatric)
- Magill forceps (adult and pediatric)
- Booted hemostat
- Cuffed endotracheal tubes (5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0)
- Uncuffed endotracheal tubes (2.5, 3.0, 3.5, 4.0, 4.5, 5.0)
- Laryngoscope handles (adult and pediatric)
- Extra laryngoscope batteries and light bulbs
- Nasopharyngeal airways (#26, #30)
- Oral airways (#0, #1, #2, #3, #4)
- Scalpel with blade for cricothyroidotomy
- Needle cricothyroidotomy kit
- Water-soluble lubricant
- Nasal cannulas (adult and pediatric)
- Oxygen tubing
- PEEP valve (adjustable)

Adhesive tape

Aerosol medication delivery system (nebulizer)

Alcohol swabs

Arm boards (adult and pediatric)

Arterial line tubing

Bone marrow needle (for pediatric infusion)

Blood pressure cuffs (neonatal, infant, child, adult large and small)

Butterfly needles (23-gauge, 25-gauge)

Communications backup (e.g., cellular telephone)

Defibrillator electrolyte pads or jelly

Dextrostix

ECC monitor/defibrillator (preferably with pressure transducer capabilities)

ECC electrodes (infant, pediatric, adult)

Flashlights with extra batteries

Heimlich valve

Infusion pumps

Intravenous fluid administration tubing (adult and pediatric)

Y-blood administration tubing

Extension tubing

Three-way stopcocks

Intravenous catheters, sizes 14- to 24-gauge

Intravenous solutions (plastic bags)

- 1000 mL, 500 mL of normal saline
- 1000 mL of Ringers lactate
- 250 mL of 5% dextrose

Irrigating syringe (60 mL), catheter tip

Kelley clamp

Hypodermic needles, assorted sizes

Hypodermic syringes, assorted sizes

Normal saline for irrigation

Pressure bags for fluid administration

Pulse oximeter with multiple site adhesive or reusable sensors

Salem sump nasogastric tubes, assorted sizes

Soft restraints for upper and lower extremities

Stethoscope

Suction apparatus

Suction catheters (#5, #8, #10, #14, tonsil)

Surgical dressings (sponges, Kling, Kerlix)

Tourniquets for venipuncture/IV access

Trauma scissors

The following are considered as needed

- Transcutaneous pacemaker
- Neonatal/pediatric isolette
- Spinal immobilization device
- Transport ventilator

PEEP, positive end-expiratory pressure; ECC, electrocardiogram; IV, intravenous.

tioners through the transfer process (Fig. 1).

Pretransport Coordination and Communication. The referring physician will identify and contact an admitting physician at the receiving hospital to accept the patient in transfer and confirm before the transfer occurs that appropriate higher level resources are available. The receiving physician is given a full description of the patient's condition. At that time, advice can be requested concerning treatment and stabilization before transport. The appropriateness of transferring a patient from an inpatient setting (critical care unit) to an outpatient setting (e.g., emergency department) at a receiving institution must be cautiously examined. If a physician will not be accompanying the patient during transport (34), the referring and accepting physicians will ensure there is a command physician for the transport team who will assume responsibility for medical treatment during the transport. It may be appropriate for this individual to receive a medical report before the team departs.

In some instances (e.g., when a receiving institution provides the transport team), the receiving physician may determine the mode of transport. However, the mode of transportation (ground or air) usually is determined by the transferring physician, in consultation with the receiving physician, based on the urgency of the medical condition (stability of the patient), time savings anticipated with air transport, weather conditions, medical interventions necessary for ongoing life support during transfer, and the availability of personnel and resources (51, 52). The transport service then will be contacted to confirm its availability, to prepare for anticipated patient needs during transport, and to coordinate the timing of the transport.

A nurse-to-nurse report is given by the referring facility to the appropriate nursing unit at the receiving hospital. Alternatively, the report can be given by a transport team member at the time of arrival. A copy of the medical record, including a patient care summary and all relevant laboratory and radiographic studies, will accompany the patient. The preparation of records should not delay patient transport, however, as these records can be forwarded separately (by facsimile or courier) if and when the urgency of transfer precludes their assemblage beforehand. Under these circumstances, the most critical information is

Table 2. Recommended minimum transport medications

Adenosine, 6 mg/2 mL
Albuterol, 2.5 mg/2 mL
Amiodarone, 150 mg/3 mL
Atropine, 1 mg/10 mL
Calcium chloride, 1 g/10 mL
Cetacaine/Hurricane spray
Dextrose 25%, 10 mL
Dextrose 50%, 50 mL
Digoxin, 0.5 mg/2 mL
Diltiazem, 25 mg/5 mL
Diphenhydramine, 50 mg/1 mL
Dopamine, 200 mg/5 mL
Epinephrine, 1 mg/10 mL (1:10,000)
Epinephrine, 1 mg/1 mL (1:1000) multiple-dose vial
Fosphenytoin, 750 mg/10 mL (500 PE mg/10 mL)
Furosemide, 100 mg/10 mL
Glucagon, 1 mg vial (powder)
Heparin, 1000 units/1 mL
Isoproterenol, 1 mg/5 mL
Labetalol, 40 mg/8 mL
Lidocaine, 100 mg/10 mL
Lidocaine, 2 g/10 mL
Mannitol, 50 g/50 mL
Magnesium sulfate, 1 g/2 mL
Methylprednisolone, 125 mg/2 mL
Metoprolol, 5 mg/5 mL
Naloxone, 2 mg/2 mL
Nitroglycerin injection, 50 mg/10 mL
Nitroglycerin tablets, 0.4 mg (bottle)
Nitroprusside, 50 mg/2 mL
Normal saline, 30 mL for injection
Phenobarbital, 65 mg/mL or 130 mg/mL
Potassium chloride, 20 mEq/10 mL
Procainamide, 1000 mg/10 mL
Sodium bicarbonate, 5 mEq/10 mL
Sodium bicarbonate, 50 mEq/50 mL
Sterile water, 30 mL for injection
Terbutaline, 1 mg/1 mL
Verapamil, 5 mg/2 mL

The following specialized/controlled medications are added immediately before transport as indicated

Narcotic analgesics (e.g., morphine, fentanyl) (59)
Sedatives/hypnotics (e.g., lorazepam, midazolam, propofol, etomidate, ketamine) (59)
Neuromuscular blocking agents (e.g. succinylcholine, pancuronium, atracurium, rocuronium) (60)
Prostaglandin E1
Pulmonary surfactant

communicated verbally. It is strongly suggested that policies be established within each institution regarding the content of documentation and communication between personnel involved in the transfer.

Accompanying Personnel. It is recommended that a minimum of two people, in addition to the vehicle operators, accompany a critically ill patient during interhospital transport.* When transporting unstable patients, the transport team leader should be a physician or nurse (41, 53, 54), preferably with additional training in transport medicine. For critical but stable patients, the team leader may be a paramedic (41). These individuals provide the essential capabilities

of advanced airway management, intravenous therapy, dysrhythmia interpretation and treatment, and basic and advanced cardiac life support. In the absence of a physician team member, there will be a mechanism by which the transport team can communicate with a command physician. If communication of this type becomes impossible, the team will have preauthorization by standing orders to perform acute lifesaving interventions. In the absence of a readily available external transport team, a transport team and vehicle may need to be assembled locally. The development of policies and procedures for such emergencies is strongly recommended.

Minimum Equipment Required. Ta-

Although both intra- and interhospital transport must comply with regulations, we believe patient safety is enhanced during transport by establishing an organized efficient process supported by appropriate equipment and personnel.

bles 1 and 2 provide a detailed list of the minimum recommended equipment and pharmaceuticals needed for safe interhospital transport. Emphasis is placed on airway and oxygenation, vital signs monitoring, and the pharmaceutical agents necessary for emergency resuscitation and stabilization as well as maintenance of vital functions. Very short or very long transports may necessitate deviations from the listed items, depending on the severity and nature of illness or injury. Furthermore, advances in knowledge over time will result in periodic review and modification of these lists. All items are checked regularly for expiration of sterility and/or potency, especially when transports are infrequent. Equipment function is verified on a scheduled basis, not at the time of transport when there may be insufficient time to find replacements.

Monitoring During Transport. All critically ill patients undergoing interhospital transport must have, at a minimum, continuous pulse oximetry, electrocardiographic monitoring, and regular measurement of blood pressure and respiratory rate.* Selected patients, based on clinical status, may benefit from the monitoring of intra-arterial blood pressure (55), central venous pressure, pulmonary artery pressure, intracranial pressure, and/or capnography (56). With mechanically ventilated patients, endotracheal tube position is noted and secured before transport, and the adequacy of oxygenation and ventilation is reconfirmed.

Occasionally, patients may require specialized modes of ventilation not re-

producable in the transport setting. Under these circumstances, alternate modes of mechanical ventilation are evaluated before transport to ensure acceptability and patient stability with this therapy. If the patient is incapable of being maintained safely with alternate ventilator therapy, the risks and benefits of transport are cautiously reexamined.

Patient status and management during transport are recorded and filed in the patient medical record at the referring facility. Copies are provided to the receiving institution.

Preparing a Patient for Interhospital Transport There is no evidence to support a "scoop and run" approach to the interhospital transport of critically ill patients. Therefore, referring facilities will, before transport, begin appropriate evaluation and stabilization to the degree possible to ensure patient safety during transport. Unnecessary delays may be experienced if the transport team must perform lengthy or complex procedures to stabilize the patient before the transfer (57). Nonessential testing and procedures will delay transfer and should be avoided. Information and recommendations about this aspect of patient care generally can be requested from the accepting physician at the time of initial contact with the receiving facility.

All critically ill patients need secure intravenous access before transport. If peripheral venous access is unavailable, central venous access is established. If needed, fluid resuscitation and inotropic support are initiated, with all intravenous fluids and medications maintained in plastic (not glass) containers. A patient should not be transported before airway stabilization if it is judged likely that airway intervention will be needed en route (a process made more difficult in a moving vehicle). The airway must be evaluated before transport and secured as indicated by endotracheal tube (or tracheostomy).^{*} Laryngeal mask airways are not an acceptable method of airway management for critically ill patients undergoing transport. For trauma victims, spinal immobilization is maintained during transport unless the absence of significant spinal injury has been reliably verified. A nasogastric tube is inserted in patients with an ileus or intestinal obstruction and in those requiring mechanical ventilation. A Foley catheter is inserted in patients requiring strict fluid management, for transports of extended duration, and for patients receiving di-

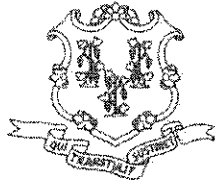
uretics. If indicated, chest decompression with a chest tube is accomplished before transport. A Heimlich valve or vacuum chest drainage system is employed to maintain decompression. Soft wrist and/or leg restraints are applied when agitation could compromise the safety of the patient or transport crew, especially with air transport. If the patient is combative or uncooperative, the use of sedative and/or neuromuscular blocking agents may be indicated. A neuromuscular blocking agent should not be used without sedation and analgesia.

Finally, the patient medical record and relevant laboratory and radiographic studies are copied for the receiving facility. In the United States, a COBRA/EMTALA checklist is strongly suggested to ensure compliance with all federal regulations regarding interhospital patient transfers. Items on this checklist will include documentation of initial medical evaluation and stabilization (to the degree possible), informed consent disclosing benefits and risks of transfer, medical indications for the transfer, and physician-to-physician communication with the names of the accepting physician and the receiving hospital.

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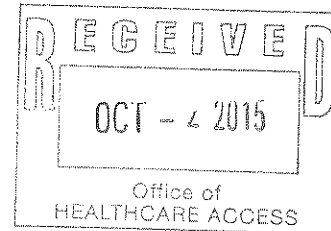
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State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

September 30, 2015

Ms. Kimberly R. Martone
Connecticut Department of Public Health
Director of Operations
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, Connecticut 06134-0308



RE: Request to Reopen Certificate of Need (CON) Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone:

This is a request for the Office of Health Care Access (OHCA) to reopen its September 9, 2015 determination that a "CON is not required for the Petitioner's proposal" in the above-entitled matter. See, the final sentence of the September 9, 2015 OHCA determination.

In mid-June of this year, Windham Community Memorial Hospital (WCMH) Administrator David Whitehead held a "community conversation" at Eastern Connecticut State University (ECSU) outlining our community's medical needs and WCMH's plan to address them. Up to 75 providers and interested area residents attended this session which is required as part of the IRS 990 nonprofit status form and the Affordable Care Act.

During that "community conversation" there was no mention of downsizing or eliminating the critical care unit (CCU) at WCMH. A few days later Hartford Health Care (HHC) through its press aide announced the closure of the CCU at Windham and layoffs of approximately 113 WCMH employees. This announcement came as a surprise to the Windham area community served by WCMH. The announcement caused providers of healthcare to register their concerns with their respective legislators in no uncertain terms.

After hearing from numerous constituents, providers, doctors, nurses, and retired hospital nurses, doctors and social workers, area legislators became very concerned regarding this proposed change. We

held a press conference at which we expressed our expectations that a CON hearing would be required if HHC were to close the CCU.

Later, very well attended follow up events were part of our regional process culminating in this letter to request that OCHA reopen its determination based only on the form 2020 submission of HHC. The events included three community forums which providers and constituents in the area attended to present their concerns. At these events, some practicing doctors stated on the record that at their July "Division of Medicine" meeting there was a unanimous vote to keep the CCU open and in its current fully operational state.

Several practicing and retired doctors and nurses stated that if the CCU were to change to a Progressive Care Unit (PCU) they would be hesitant to send their patients to WCMH because the patient might be subjected to insufficient care that would put the patient at risk. If patients were to be sent to other hospitals because of the change to a PCU, then ultimately WCMH and its patients would be incurring a termination of services because doctors would lose interest in working in the Windham area.

Historically, Windham has had a difficult time attracting and retaining physicians. Just a few years ago WCMH received \$8,000,000.00 in state bonding funds for professional offices on site so that WCMH would be better able to attract and keep doctors in this area. The change from a CCU to a PCU will have just the opposite affect according to most doctors who addressed this issue at our public forums.

During our legislative forums, we were told about the impact this change might have on our emergency transportation services. For example, because this region has limited emergency transportation services and Windham is isolated from the rest of the state due to the lack of any major highway out of this area, moving critically ill patients to Hartford or elsewhere will cause a hardship on all concerned. One accident often shuts Route 6 down for hours. Moving critically ill patients by helicopter to Hartford Hospital because WCMH no longer has a CCU makes no sense financially or otherwise.

This termination of services proposed by HHC will also limit access to the full range of services now available to our large low income community. Windham has more public housing per capita than any other town in Connecticut except maybe Hartford. Our population includes many who do not speak English or have English as their second language. Moving many of these patients to a different area outside the public transportation system will put an unfair and impractical burden on families already strained because of low or no income and language barriers.

The emergency ambulance services are either area Emergency Medical Technicians (EMTs) volunteers or paid Willimantic Fire Department (WFD) EMTs which may be equipped and willing and able to make a trip to Hartford or Norwich occasionally, but for them to do so on a regular basis would strain the entire emergency transportation service in this region. While Hartford Health at WCMH has paramedic intercept services it does not have ambulances with which to transport patients.

Another consideration regarding the size and staffing of the CCU is the area population changes that occur during the spring and fall semesters. This area hosts University of Connecticut and Eastern Connecticut State University students. The population increases during the fall and spring semesters by approximately 25,000 students including those who reside on and off campus.

We appreciate the efforts of HHC and OCHA to work to solve the problems of finance and health care access. A CON hearing will allow healthcare professionals and diverse groups of citizens to present their

views to OHCA regarding the serious limitations these proposed reductions will have on health care access in the Windham area.

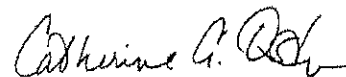
Respectfully submitted,



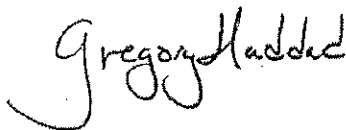
Representative Susan Johnson



Senator Mae Flexer



Senator Catherine Osten



Representative Gregg Haddad



Representative Linda Orange

Greer, Leslie

Subject: FW: CON Request from the Windham Delegation
Attachments: CONRequest.pdf
Importance: High

From: Palladino, Danielle [<mailto:Danielle.Palladino@cga.ct.gov>]
Sent: Friday, October 02, 2015 2:34 PM
To: Martone, Kim
Subject: CON Request from the Windham Delegation
Importance: High

Hello Kimberly,
On behalf of Rep. Johnson and the Windham Delegation, please find attached in this email a CON Request.
Thank you for your consideration,
Danielle

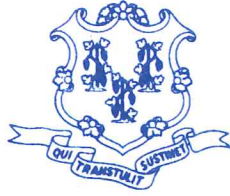
Danielle Palladino
Legislative Aide, House Democrats

Deputy Majority Leader **Representative Michelle Cook**, 65th House District
Proudly Serving Torrington
Deputy Majority Leader **Representative Susan Johnson**, 49th House District
Proudly Serving Windham
Deputy Majority Leader **Representative Russell Morin**, 28th House District
Proudly Serving Wethersfield

Staff, *Task Force on Domestic Workers*

860-240-1479
danielle.palladino@cga.ct.gov

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State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

September 30, 2015

Ms. Kimberly R. Martone
Connecticut Department of Public Health
Director of Operations
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
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Historically, Windham has had a difficult time attracting and retaining physicians. Just a few years ago WCMH received \$8,000,000.00 in state bonding funds for professional offices on site so that WCMH would be better able to attract and keep doctors in this area. The change from a CCU to a PCU will have just the opposite affect according to most doctors who addressed this issue at our public forums.

During our legislative forums, we were told about the impact this change might have on our emergency transportation services. For example, because this region has limited emergency transportation services and Windham is isolated from the rest of the state due to the lack of any major highway out of this area, moving critically ill patients to Hartford or elsewhere will cause a hardship on all concerned. One accident often shuts Route 6 down for hours. Moving critically ill patients by helicopter to Hartford Hospital because WCMH no longer has a CCU makes no sense financially or otherwise.

This termination of services proposed by HHC will also limit access to the full range of services now available to our large low income community. Windham has more public housing per capita than any other town in Connecticut except maybe Hartford. Our population includes many who do not speak English or have English as their second language. Moving many of these patients to a different area outside the public transportation system will put an unfair and impractical burden on families already strained because of low or no income and language barriers.

The emergency ambulance services are either area Emergency Medical Technicians (EMTs) volunteers or paid Willimantic Fire Department (WFD) EMTs which may be equipped and willing and able to make a trip to Hartford or Norwich occasionally, but for them to do so on a regular basis would strain the entire emergency transportation service in this region. While Hartford Health at WCMH has paramedic intercept services it does not have ambulances with which to transport patients.

Another consideration regarding the size and staffing of the CCU is the area population changes that occur during the spring and fall semesters. This area hosts University of Connecticut and Eastern Connecticut State University students. The population increases during the fall and spring semesters by approximately 25,000 students including those who reside on and off campus.

We appreciate the efforts of HHC and OCHA to work to solve the problems of finance and health care access. A CON hearing will allow healthcare professionals and diverse groups of citizens to present their

views to OHCA regarding the serious limitations these proposed reductions will have on health care access in the Windham area.

Respectfully submitted,



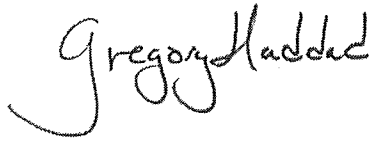
Representative Susan Johnson



Senator Mae Flexer



Senator Catherine Osten



Representative Gregg Haddad



Representative Linda Orange



FAX COVER SHEET

To: Kimberly Matone

From: Eastern AHEC_1996

Company: CT of Dept. of Public Health **Date:** 10/06/15 09:59:31 AM

Fax Number: 860-418-7053

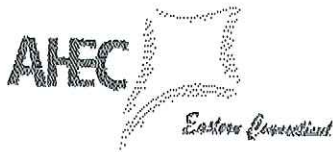
Pages (Including cover): 3

Re: Alignment of Clinical Services at Windham Hospital



Notes:

Please contact Lorraine Gruber at 465-8281 x 403 to confirm fax was received.



Eastern AHEC, Inc.
 672 Main St.
 Willimantic, CT 06226
 Mailing Address:
 165 Main St. Suite 313
 New London, CT
 Phone: (860)465-8281
 www.easternctahec.org

October 2, 2015

VIA FIRST CLASS MAIL AND FACSIMILE



Kimberly R. Martone
 Director of Operations
 Connecticut Department of Public Health
 Office of Health Care Access
 410 Capitol Ave., MS#13HCA
 P.O. Box 340308
 Hartford, CT 06134-0308

RE: Certificate of Need Determination Report 12-32026-DTR
 Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone:

As a local nonprofit organization who implements programs that aim to enhance access to culturally and linguistically appropriate healthcare education and increase the diversity, quality, and distribution of future healthcare professionals within Eastern Connecticut, I urge your agency to reconsider its decision to not require a CON for the service changes taken place at Windham Hospital. This region is primarily rural with pockets of urban areas that are comprised of low socioeconomic status¹ including veterans and urban Hispanic residents who are primarily Spanish speaking. Regionalizing healthcare is not an adequate means to quality and equitable care.

Hospitals are considered to be the locus of rural health care systems. Not only are important health services based at hospitals, but many of a community's health care personnel are either directly employed by or supported by the local hospital. Furthermore, hospitals are often considered vital to local economies as they bring outside dollars into the communities via third-party payers, provide jobs, stimulate local purchasing, and help attract industry and retirees. Pursuant to provisions of the Patient & Affordable Care Act of 2010, nonprofit hospitals were charged to conduct Community Health Needs Assessments (CHNA) to determine the health status, behaviors and needs of residents within their service area to ensure that hospitals make the great impact on community health status. While the most recent CHNA published in June 2015 identified 12 priority health areas, the report lacked inclusivity of constituents in the 16 town service area, including provisions to ensure services were kept or maintained where the communities live. Instead, the Hartford Health Care and the Professional Research Consultants recommended care for health services primarily outside of the service areas; developed a survey instrument that failed to offer surveys to non-English speakers (more than 5% in service area are Spanish speakers); and identified key informants they felt should be interviewed.¹

¹ Windham Hospital Community Health Needs Assessment, <http://www.windhamhospital.org/health-community/community-health-care-needs-assessment>, accessed on October 1, 2015

Reducing, eliminating, our outsourcing health services will be detrimental to communities' ability to access adequate and timely care, impact our health care workforce, and worsen health disparities among underserved communities. The community in Windham County deserve quality health care that is delivered in a culturally and linguistic appropriate manner. Transporting patients to facilities over 30 minutes away can be catastrophic. In particular, the ability for ambulatory care to effectively communicate with patients that experience language barriers is nonexistent. There has been no published plan on how Hartford Health Care system will deliver these services and further information is needed to ensure that there are effective measures being taken into consideration.

In closing, I urge that OHCA allow additional evidence to be entered into consideration and that a public hearing be held to allow the opportunity for an equitable process of review and testimonies to be submitted and/or heard. If you wish to contact me, I can be reached at (860) 465-8281 or bond@easternahec.org

Sincerely,



Maritza Bond, MPH
Executive Director
Eastern AHEC, Inc.
165 State St. Suite. 313
New London, CT 06320

cc: Commissioner Mullen



Eastern AHEC, Inc.
872 Main St.
Willimantic, CT 06226
Mailing Address:
165 Main St. Suite 313
New London, CT
Phone: (860)465-8281
www.easternctahhec.org

October 2, 2015

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Sincerely,

A handwritten signature in blue ink, appearing to read "M. Bond".

Maritza Bond, MPH
Executive Director
Eastern AHEC, Inc.
165 State St. Suite. 313
New London, CT 06320

cc: Commissioner Mullen


GENERATIONS
FAMILY HEALTH CENTER

October 2, 2015

VIA FIRST CLASS MAIL AND FACSIMILE

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308



RE: Certificate of Need Determination Report 12-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone:

I am writing on behalf of the staff, physicians and patients of Generations Family Health Center (“Generations”), the Federally Qualified Health Center (“FQHC”) serving Eastern Connecticut, regarding the determination that a Certificate of Need (“CON”) is not required for Windham Community Memorial Hospital (“Petitioner” or “Hospital”) to close its critical care unit (“CCU”) and develop a 4-bed progressive care unit (“PCU”). In the above referenced determination, OHCA writes:

“The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a *CON is not required* for the Petitioner’s proposal.”

It appears that the above finding is inconsistent with facts in this matter as well as information provided to OHCA in the Petitioner’s submission to OHCA on September 3, 2015. First, Petitioner acknowledges in its Proposal Description that it does indeed provide critical care services in the CCU and that at least 2 critically ill patients are in that unit on a daily basis. However, Petitioner goes on to state that these patients can be cared for in a PCU which is factually incorrect. Both the Society of Critical Care Medicine and the American Association of Critical-Care Nurses (“AACM”) regard CCU and PCU as distinct levels of care with specifically delineated admission criteria and staff competencies.

Progressive Care is a term used by AACM to collectively refer to patient care settings also known as Intermediate Care, Step-Down Care, Telemetry, Direct Observation or Transitional Care (**Exhibit 1**). Further, the Society of Critical Care Medicine Guidelines for ICU Admission, Discharge, and Triage as well as the Guidelines on Admission and Discharge for Adult Intermediate Care Units clearly distinguish the two levels of care (**Exhibit 2**). Petitioner’s statement that CCU patients can be treated in a PCU does not comport with published guidelines.

40 Mansfield Ave. • Willimantic, Connecticut 06226
860.450.7471 • genhealth.org

On the second page of the Proposal Description, Petitioner states:

“In the last five years, patients who have been treated in the Windham CCU have met the definition for PCU level of care.”

This statement is false. The Hospital’s CCU treats hemodynamically unstable patients as well as patients with acute respiratory distress and/or failure requiring intubation and mechanical ventilation. These patients do not meet published admitting criteria for PCU level of care (Exhibit 2). It is also false to state that CCU and PCU staff competencies are the same. For years, AACM has recognized the two nursing practices as distinct and offers unique credentialing and certification for PCU and CCU (**Exhibit 3**).

And while Petitioner claims to have paramedic transport available to transfer patients to Hartford Hospital, Petitioner fails to disclose the increasing demand for these services, that it does not own an ambulance and the municipality service is BLS only, and without increasing services is therefore not equipped to deal with the timely transfer critically of ill patients. The Society of Critical Care Medicine has published specific guidelines regarding inter-hospital transfers of critically ill patients (**Exhibit 4**). Because adequate and appropriate ambulance inter-hospital transportation does not exist in Willimantic, Life Star is routinely deployed to transfer patients that can be cared for at the Hospital.

Lastly, Petitioner Exhibit 1 lists services that Petitioner proposes to provide in the PCU. Several of these services are appropriate only to a CCU and are inconsistent with published guidelines (Exhibit 2).

Generations is concerned that OHCA relied on inaccurate representations in making its decision that a service is not being terminated. CCU care and PCU care are not interchangeable. Either Petitioner is terminating critical care services or it is proposing to provide critical care in an inappropriate setting. We believe the former to be true and respectfully request that OHCA reconsider its determination.

Very truly yours,



Arvind Shaw
Chief Executive Officer

bcc.

Generations Family Health Center
October 2, 2015

EXHIBIT 1: AACN Progressive Care Fact Sheet

Progressive Care Fact Sheet

Background

In the early 1970s, major medical center recruiters placed advertisements for both critical care and progressive care nurses in *Heart and Lung*. Initially, progressive care units housed post myocardial infarction patients requiring cardiac monitoring, but not requiring intensive care and observation. With the changing healthcare environment, the acuity of patients admitted to hospitals steadily increased and caused an increase in the demand for critical care beds. With the increased demand and decreased availability of critical care beds, patients were often transferred from critical care units while still requiring an increased level of nursing care and vigilance. Patients admitted to critical care units five to ten years ago are now routinely admitted to progressive care.

Progressive care is the term the American Association of Critical-Care Nurses (AACN) uses to collectively describe areas that are also referred to as Intermediate Care Units, Direct Observation Units, Step-down Units, Telemetry Units, or Transitional Care Units as well as to define a specific level of patient care. AACN recognizes the need to define and identify the special needs of progressive care nurses. In 2008, the Certification Corporation convened a progressive care nursing study of practice. The study of practice determined the scope of practice, populations served, the core competencies and basic knowledge and skill requirements of progressive care nurses and provided a foundation for development of certification exams. Progressive care nurses across the country participated in the study of practice.

Definition

The American Association of Critical-Care Nurses recognizes progressive care as part of the continuum of critical care. AACN is dedicated to creating a healthcare system driven by the needs of patients and families where critical care nurses make their optimal contribution. The AACN Synergy Model for Patient Care is the conceptual framework that actualizes the vision. It defines nursing practice based on the needs of the patient and the characteristics of the nurse to attain optimal patient outcomes.

Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care. Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

Progressive Care Patient Location

AACN's Synergy Model assists in defining the progressive care patient. The Synergy Model identifies patients based on the characteristics and needs that they present and not on the location of the bed they occupy. As in critical care, the geographic domain of progressive care is expanding. Care provided to progressive care patients is not limited by geography but is based on the needs and required interventions of the patient. While specific progressive care units can be identified, patients requiring progressive care nursing can be located throughout the hospital.

According to the Synergy Model, stability, complexity, vulnerability, resiliency, predictability, resource availability, participation in care and participation in decision making are the patient characteristics that describe patient function. The nurse characteristics that typically represent comprehensive nursing practice include clinical judgment, advocacy, caring practices, collaboration, systems thinking, response to diversity, clinical inquiry and learning facilitation. The framework, therefore, takes into account the unpredictability of the progressive care patient and, based on the patient's and family's needs, the competencies of the progressive care nurse. Progressive care can be very specialized, with care focused on a specific system such as cardiac, or more generalized, as in the care of patients with multi-system problems.

Educational Requirements

Progressive care nursing has expanded beyond the basic cardiac telemetry that marked its beginning and now encompasses many of the same technologies and therapies that were once limited to critical care units. To meet the changing needs of the patient, nurses caring for progressive care patients must demonstrate competencies that are influenced by ever changing technology. Progressive care nurses must demonstrate the following core competencies:

- Cardiac monitoring techniques and lead placement.
- Basic & advanced life support.
- Basic dysrhythmia interpretation and treatment, including ST segment and QTc interpretation.
- Drug dosage calculation, continuous medication infusion administration, and patient monitoring for medication effects.
- Titration of selected vasoactive medications such as nitroglycerin.
- Monitoring patients using standardized procedures for pre, intra, and post procedures (i.e., cardioversion, TEE, cardiac catheterization with PCI, bronchoscopy, EGD, PEG placement, chest tube insertion)
- Invasive arterial pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Non-invasive hemodynamic pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Recognition of the signs and symptoms of cardiopulmonary emergencies and initiate standardized interventions to stabilize the patient awaiting transfer to critical care including cardioversion, defibrillation and transcutaneous pacing. Seek assistance as needed.
- Monitoring normal and abnormal diagnostic test results.
- Interpretation of ABGs and communicating findings.
- Recognition of indications for and management of patients requiring non-invasive O2 delivery systems including oral airways, bipap, and nasal CPAP
- Assessment of the ventilated patient to assure delivery of the prescribed treatment and patient response including tracheostomy care, and continuous and intermittent SpO₂ monitoring.

- Managing patients with chest tubes.
- Assisting with thoracentesis and chest tube insertion.
- Administering medications for procedural sedation and monitor patient's response.
- Assessing, monitoring and managing patients with stroke, seizure disorders and intracranial hemorrhage.
- Managing and titrating insulin infusions.
- Recognition of indications for and complications of enteral and parental nutrition
- Assessing, monitoring and managing patients requiring renal therapeutic interventions; e.g. hemodialysis, peritoneal dialysis, stents, continuous bladder irrigation, and urostomies
- Management of patients with complex wounds with fistulas, drains, and vacuum-assisted closure devices.
- Recognition of signs and symptoms of behavioral emergencies (e.g. delirium and dementia, mood disorders and substance abuse).
- Evaluating the family's need for enhanced involvement in care to facilitate the transition from hospital to home.

Reference List

AACN Scope and Standards for Acute and Critical Care Nursing Practice. AACN. Aliso Viejo, CA. 2008.

American College of Critical Care Medicine of the Society of Critical Care Medicine: Guidelines on admission and discharge for adult intermediate care units, 1997.

Generations Family Health Center
October 2, 2015

EXHIBIT 2: Society of Critical Care Medicine Guidelines for CCU and PCU

Guidelines for ICU Admission, Discharge, and Triage



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These guidelines can also be found in the March 1999 issue of *Critical Care Medicine* --
Crit Care Med 1999 Mar; 27(3):633-638

Society of Critical Care Medicine
701 Lee Street
Suite 200
Des Plaines, IL 60016
Phone: 847/827-6869

Guidelines for ICU Admission, Discharge, and Triage

American College of Critical Care Medicine
of the Society of Critical Care Medicine

ABSTRACT

Appropriate utilization of Intensive Care Unit (ICU) resources is an important issue as the nation struggles to contain health care expenditures. The guidelines proposed here provide models which ICUs may use in formulating admission, discharge and triage criteria. A process for implementation, monitoring and performance review of policies and procedures is also included.

INTRODUCTION

The ICU concept prevalent today proliferated in the 60's (1-3). The first Consensus Conference on Critical Care Medicine led by the National Institutes of Health (NIH) in 1983 pointed out that clinical practice has led to expanded indications for admissions to critical care units (4). Most physicians are of the opinion that the benefits of ICU care are unmeasured rather than uncertain (5). Because of the utilization of expensive resources, ICUs should, in general, be reserved for those patients with reversible medical conditions who have a "reasonable prospect of substantial recovery" (4-6). With recent changes in the health care environment, efficient use of ICUs has become a priority. Unfortunately, few studies have examined the indications for and the outcome of ICU care (7-10). Those that have, suggest that we may not be categorizing patients accurately. For example, Kraiss, et al. evaluated 196 patients undergoing carotid endarterectomy over a two-year period. There was no difference in outcome or complications between the group admitted to intensive care and those admitted to a general ward (8).

The Ethics Committee of the Society of Critical Care Medicine has previously published a consensus statement on triage (11). Guidelines for developing admission and discharge criteria were also proposed (12). The current document is a compilation and revision of the previously published guidelines.

Individual ICUs, using the guidelines presented below, should create policies specific to their unit. Criteria for ICU admission and discharge should be explicitly described. In addition, each ICU should define the scope of services it provides, and the patient population it serves, as approved by the professional staff. Specific circumstances under which the patients are admitted should also be defined (12-14). Guidelines and implementation policy should be written by a multiprofessional team. While the composition of the ICU Committee may vary, it should assure an adequate voice for those who regularly provide service to ICU patients, including respiratory care practitioners, nurses, physicians, and social workers.

The ICU Committee should review the policies of the intensive and intermediate care units. The Committee should also help educate the staff on admission/discharge/triage criteria, and efficient resource consumption.

Policies written for admission, discharge, and triage should be reviewed on a regular basis and revised as needed. Revisions should be based on objective data. Compliance with the policy should be monitored in an appropriate forum, which in most institutions would be the ICU Committee. A policy should be in place for accommodating admissions when unit capacity is reached. Options may include limiting elective surgery or re-routing critical care admissions from the emergency department. Increasing the functional capacity of the ICU by boarding patients in other advanced care areas (assuming appropriate personnel and technological resources are available) may be an alternative to limiting services.

The admission, discharge, and triage criteria should also recognize patient autonomy, including advance directives, living wills, or durable powers of attorney for health care decisions. It also should indicate who can admit patients to the ICU. Specific credentialing procedures should be in place.

Levels of Recommendations for the Intensive Care Unit

The Intensive Care Unit serves as a place for monitoring and care of patients with potentially severe physiological instability requiring technical and/or artificial life support. The level of care in an ICU is greater than that available on the floor or Intermediate Care Unit.

Rating System

Level 1: Convincingly justifiable on scientific evidence alone

Level 2: Reasonably justifiable by available scientific evidence and strongly supported by expert critical care opinion

Level 3: Adequate scientific evidence is lacking but widely supported by available data and critical care expert opinion

1. (Level 3) The Intensive Care Unit should have designated medical and nursing directors who are responsible for assuring appropriate patient triage through enforcement of patient admission and discharge criteria. This triage must consider the needs of the patient and institution.
2. (Level 3) The physician and nurse directors should determine the limits of care, telemetry, mechanical ventilation and types of intravenous medications.
3. (Level 3) Intensive Care Unit Committee - A multiprofessional committee should be involved in developing and implementing the admission and discharge criteria.
4. (Level 2) The provision of intensive care improves the outcome of critically ill patients.
5. (Level 2) An intensivist-led multiprofessional team improves the outcomes of critically ill patients as measured by mortality, length of stay, and resource consumption. (15, 16)

ADMISSION CRITERIA

ICU admission criteria should select patients who are likely to benefit from ICU care (2). Griner identified two conditions in which ICU care was of no greater benefit than conventional care (10). Situations involved patients who were at the two extremes of the risk of death spectrum; relatively low risk of death and exceedingly high risk of death. These groups can be referred to as "too well to benefit" and "too sick to benefit" from critical care services. ICU care has been demonstrated to improve outcome in severely ill, unstable patient populations (17, 18). Defining the "too well to benefit" and "too sick to benefit" population may be difficult solely based on diagnosis (7, 19-24). For example, drug overdose patients are commonly admitted to an ICU. However, Brett et al. (19), demonstrated that patients without clinically determined high risk criteria never required ICU interventions. Nonetheless, 70% of these low risk patients were admitted to an ICU for observation.

In addition to difficulties in determining the patient population who are too well or too sick to benefit, the specific criteria defining "substantial benefit" are subject to interpretation. For example, Paz, et al, examined admissions to the medical ICU following bone marrow transplantation. Bone marrow transplantation patients undergoing

mechanical ventilation had an ICU discharge rate of only 3.8% compared to a discharge rate of 81.3% for those patients not requiring this therapy (21). Previous published reports documented similar poor survival rates for ventilator-requiring bone marrow transplantation patients (2.5% to 7.0%) (22-24). Whether a 2.5% to 7% discharge rate of bone marrow transplantation patients requiring mechanical ventilation is substantial or not may depend on the institution. These interpretations will lead to differences in admission criteria between institutions and physicians.

Thus, it is recommended that ICU practitioners understand tools for assessing severity of illness and prognosis of critically ill patients. These instruments in conjunction with clinical judgement represent the best tools currently available to determine prognosis (11, 25-27). **It should be noted, however, that in general, these predictive instruments have only been applied to patients already admitted to an ICU and have not been tested as preadmission screening tools.**

The ICU admission decision may be based on several models utilizing prioritization, diagnosis, and objective parameters models. **We wish to emphasize that these models are presented as guidelines and individual institutions must create specific criteria to meet their special requirements.**

Prioritization Model

This system defines those that will benefit most from the ICU (Priority 1) to those that will not benefit at all (Priority 4) from ICU admission.

Priority 1: These are critically ill, unstable patients in need of intensive treatment and monitoring that cannot be provided outside of the ICU. Usually, these treatments include ventilator support, continuous vasoactive drug infusions, etc. Priority 1 patients generally have no limits placed on the extent of therapy they are to receive. Examples of these patients may include post-operative or acute respiratory failure patients requiring mechanical ventilatory support and shock or hemodynamically unstable patients receiving invasive monitoring and/or vasoactive drugs.

Priority 2: These patients require intensive monitoring and may potentially need immediate intervention. No therapeutic limits are generally stipulated for these patients. Examples include patients with chronic comorbid conditions who develop acute severe medical or surgical illness.

Priority 3: These unstable patients are critically ill but have a reduced likelihood of recovery because of underlying disease or nature of their acute illness. Priority 3 patients may receive intensive treatment to relieve acute illness but limits on therapeutic efforts may be set such as no intubation or cardiopulmonary resuscitation. Examples include patients with metastatic malignancy complicated by infection, cardiac tamponade, or airway obstruction.

Priority 4: These are patients who are generally not appropriate for ICU admission. Admission of these patients should be on an individual basis, under unusual circumstances and at the discretion of the ICU Director. These patients can be placed in the following categories:

- A. Little or no anticipated benefit from ICU care based on low risk of active intervention that could not safely be administered in a non-ICU setting (too well to benefit from ICU care). Examples include patients with peripheral vascular surgery, hemodynamically stable diabetic ketoacidosis, mild congestive heart failure, conscious drug overdose, etc.
- B. Patients with terminal and irreversible illness facing imminent death (too sick to benefit from ICU care). For example: severe irreversible brain damage, irreversible multi-organ system failure, metastatic cancer unresponsive to chemotherapy and/or radiation therapy (unless the patient is on a specific treatment protocol), patients with decision-making capacity who decline intensive care and/or invasive monitoring and who receive comfort care only, brain dead non-organ donors, patients in a persistent vegetative state, patients who are permanently unconscious, etc.

Diagnosis Model

This model uses specific conditions or diseases to determine appropriateness of ICU admission.

- A. **Cardiac System**
 - 1. Acute myocardial infarction with complications
 - 2. Cardiogenic shock
 - 3. Complex arrhythmias requiring close monitoring and intervention
 - 4. Acute congestive heart failure with respiratory failure and/or requiring hemodynamic support
 - 5. Hypertensive emergencies
 - 6. Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain
 - 7. S/P cardiac arrest
 - 8. Cardiac tamponade or constriction with hemodynamic instability
 - 9. Dissecting aortic aneurysms
 - 10. Complete heart block

- B. **Pulmonary System**
 - 1. Acute respiratory failure requiring ventilatory support
 - 2. Pulmonary emboli with hemodynamic instability
 - 3. Patients in an intermediate care unit who are demonstrating respiratory deterioration
 - 4. Need for nursing/respiratory care not available in lesser care areas such as floor or intermediate care unit
 - 5. Massive hemoptysis
 - 6. Respiratory failure with imminent intubation

- C. **Neurologic Disorders**
 - 1. Acute stroke with altered mental status
 - 2. Coma: metabolic, toxic, or anoxic
 - 3. Intracranial hemorrhage with potential for herniation
 - 4. Acute subarachnoid hemorrhage
 - 5. Meningitis with altered mental status or respiratory compromise
 - 6. Central nervous system or neuromuscular disorders with deteriorating neurologic or pulmonary function
 - 7. Status epilepticus
 - 8. Brain dead or potentially brain dead patients who are being aggressively managed while determining organ donation status
 - 9. Vasospasm
 - 10. Severe head injured patients

- D. **Drug Ingestion and Drug Overdose**
 - 1. Hemodynamically unstable drug ingestion
 - 2. Drug ingestion with significantly altered mental status with inadequate airway protection
 - 3. Seizures following drug ingestion

- E. **Gastrointestinal Disorders**
 - 1. Life threatening gastrointestinal bleeding including hypotension, angina, continued bleeding, or with comorbid conditions
 - 2. Fulminant hepatic failure
 - 3. Severe pancreatitis
 - 4. Esophageal perforation with or without mediastinitis

F. Endocrine

1. Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis
2. Thyroid storm or myxedema coma with hemodynamic instability
3. Hyperosmolar state with coma and/or hemodynamic instability
4. Other endocrine problems such as adrenal crises with hemodynamic instability
5. Severe hypercalcemia with altered mental status, requiring hemodynamic monitoring
6. Hypo or hypernatremia with seizures, altered mental status
7. Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias
8. Hypo or hyperkalemia with dysrhythmias or muscular weakness
9. Hypophosphatemia with muscular weakness

G. Surgical

1. Post-operative patients requiring hemodynamic monitoring/ventilatory support or extensive nursing care

H. Miscellaneous

1. Septic shock with hemodynamic instability
2. Hemodynamic monitoring
3. Clinical conditions requiring ICU level nursing care
4. Environmental injuries (lightning, near drowning, hypo/hyperthermia)
5. New/experimental therapies with potential for complications

Objective Parameters Model

Objective criteria have been requested, expected and reviewed from individual hospitals as part of the Joint Commission on Accreditation of Healthcare Organizations' review process of special care units in the past. While the review process has recently been changed (13), it is understandable that hospitals would continue to incorporate objective parameters as part of the admitting criteria. **The criteria listed, while arrived at by consensus, are by necessity arbitrary.** They may be modified based on local circumstances. Data demonstrating improved outcome using specific criteria levels are not available.

Vital Signs

- * Pulse < 40 or > 150 beats/minute
- * Systolic arterial pressure < 80 mm Hg or 20 mm Hg below the patient's usual pressure
- * Mean arterial pressure < 60 mm Hg
- * Diastolic arterial pressure > 120 mm Hg
- * Respiratory rate > 35 breaths/minute

Laboratory Values (newly discovered)

- * Serum sodium < 110 mEq/L or > 170 mEq/L
- * Serum potassium < 2.0 mEq/L or > 7.0 mEq/L
- * PaO₂ < 50 mm Hg
- * pH < 7.1 or > 7.7
- * Serum glucose > 800 mg/dl
- * Serum calcium > 15 mg/dl
- * Toxic level of drug or other chemical substance in a hemodynamically or neurologically compromised patient

Radiography/Ultrasonography/Tomography (newly discovered)

- * Cerebral vascular hemorrhage, contusion or subarachnoid hemorrhage with altered mental status or focal neurological signs
- * Ruptured viscera, bladder, liver, esophageal varices or uterus with hemodynamic instability
- * Dissecting aortic aneurysm

Electrocardiogram

- * Myocardial infarction with complex arrhythmias, hemodynamic instability or congestive heart failure
- * Sustained ventricular tachycardia or ventricular fibrillation
- * Complete heart block with hemodynamic instability

Physical Findings (acute onset)

- * Unequal pupils in an unconscious patient
- * Burns covering > 10% BSA
- * Anuria
- * Airway obstruction
- * Coma
- * Continuous seizures
- * Cyanosis
- * Cardiac tamponade

DISCHARGE CRITERIA

The status of patients admitted to an ICU should be revised continuously to identify patients who may no longer need ICU care.

- A. When a patient's physiologic status has stabilized and the need for ICU monitoring and care is no longer necessary
- B. When a patient's physiological status has deteriorated and active interventions are no longer planned, discharge to a lower level of care is appropriate

Discharge criteria from Critical Care Units should be similar to the admitting criteria for the next level of care such as intermediate care where available. However, not all patients require intermediate care after ICU discharge.

TRIAGE

Under ideal conditions patients would be admitted or discharged strictly on their potential to benefit from ICU care. Unfortunately, in many instances the number of potential ICU patients exceeds the available beds. A method of prioritizing or triaging patients is necessary (11, 29). Initial triage of patients may follow the guidelines given in the prioritization model for admissions. In an environment where ICU admissions are rigorously screened for benefit, and discharge is ongoing and continuous, the need for triage is minimized.

When all ICUs and step-down units are filled, the ICU/Critical Care Director should have access to all of these units and have the responsibility and authority to admit/discharge patients from these units. Triage policies for an institution should be written in advance. Triage decisions should be made explicitly, and without bias. Ethnic origin, race, sex, social status, sexual preference or financial status should never be considered in triage decisions. Triage decisions may be made without patient or surrogate consent, and can be made despite an anticipated untoward outcome. Religious or moral convictions may be the basis for providing treatment "if the costs are not borne by the general society and the provision of such services does not foreclose the treatment of other patients who

would benefit from critical care" (30). The topic of triage of critically ill patients has been recently reviewed by the Society of Critical Care Medicine Ethics Committee (11). The reader is referred to this document for a more in-depth discussion of this topic.

PERFORMANCE REVIEW

The performance evaluation and review of an ICU should include its admission/discharge/triage policy. A multiprofessional team should review performance at least annually. In order to adequately review performance as it relates to admission, outcome, and the decision-making process, a database able to track these and other variables would be extremely useful. Severity adjusted outcomes should be utilized whenever possible in order to minimize the effect of severity of illness on raw mortality data, independent of policy or care standards. As guidelines to limit these types of admissions are instituted, care must be taken to track the patients sent to other areas to assure equivalency of outcome, length of stay, etc. A mechanism to review requested admissions that were denied should be in place to assure appropriateness of both the policy and the decision-making process. Conflicts over discharges should be reviewed so that possible improvements in the discharge policy can be identified and incorporated. Readmissions to the ICU for a similar problem should be monitored closely as they may directly relate to the quality of the discharge process (31-33). The quality and efficiency of an ICU should be continually examined and improved through this process. Studies examining objective criteria for admission and benefit of admission to ICUs should be encouraged in order to better define appropriate utilization of this important and expensive resource.

Administrative Recommendations to Facilitate Appropriate Admissions, Discharges and Delivery of Intensive Care Units

A. Personnel

1. A Physician Director must be appointed who, on the basis of training, interest, type of practice, and availability can give clinical, administrative and educational direction to the Intensive Care Unit. The Physician Director should meet "Guidelines for the definition of an intensivist and the practice of critical care medicine" published by the Society of Critical Care Medicine (34). Collaboration with nursing and ancillary staff should be emphasized. The Director should assume responsibility for assuring the quality, safety, and appropriateness of care in the Intensive Care Unit. The Director must work collaboratively with the Directors of other areas in the institution so that patient care, triage, and patient flow are effective and efficient.

The ultimate authority for ICU admission, discharge, and triage rests with the ICU Director.

2. An ICU Director has the responsibility to ensure that the patients meet ICU admission and discharge criteria. Formal recognition of the role of the ICU Director should occur through established hospital pathways. A knowledge of the various prognostic models is required of the ICU Director (11). A clearly written procedure for conflict resolution as it relates to admission and discharge of patients must be in place.
3. The multiprofessional team of professionals should meet on a regular basis to identify and solve problems through quality assurance and continuous quality improvement activities.

SUMMARY

The Intensive Care Unit can provide efficient and effective care to the critically ill patients by implementing well thought out admission, discharge, and triage policies and procedures.

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 - (b) Nonrandomized, concurrent or historical cohort investigations
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The Task Force members who participated in the review and revision of this document include: Andrew B. Egol, DO, FCCM; Robert E. Fromm, MD, FCCM; Kalpalatha K. Guntupalli, MD, FCCM; Melissa A. Fitzpatrick, RN, MSN, CCRN; David A. Kaufman, MD; Stanley A. Nasraway, MD, FCCM; David L. Ryon, MD; and Jack E. Zimmerman, MD, FCCM

Approved by the Council of the Society of Critical Care Medicine in May 1998. To be revised in 2002.

Guidelines on Admission and Discharge for Adult Intermediate Care Units



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These guidelines can also be found in the March 1998 issue of *Critical Care Medicine* --
Crit Care Med 1998 Mar; 26(3):607-610

Society of Critical Care Medicine
701 Lee Street
Suite 200
Des Plaines, IL 60016
Phone: 847/827-6869

Guidelines on Admission and Discharge for Adult Intermediate Care Units

American College of Critical Care Medicine
of the Society of Critical Care Medicine

INTRODUCTION

In acute care hospitals, one can identify a patient population that does not require intensive care but needs more care than that provided on a general ward. These patients may require frequent monitoring of vital signs and/or nursing interventions, but usually do not require invasive monitoring. In a study of 706 surgical and medical ICU patients, this patient population accounted for approximately 22% of all ICU bed days (1). In a more recent study of 17,440 ICU admissions, 6,180 patients were admitted strictly for intensive monitoring, though they had a less than 10% risk for requiring active treatment based on this monitoring (2). As a consequence, intermediate care has been proposed as a more appropriate means of resource utilization for these patients (2-6). Intermediate care areas can be represented as multipurpose "progressive care units" or as single-organ subspecialty floors such as cardiac telemetry, surgical (thoracic, vascular, etc.), neurosurgical/neurological monitoring areas, or chronic ventilator respiratory care units (7-11). In light of the recent emphasis on cost containment, the intermediate care unit concept is suggested as a strategy that promotes greater flexibility in patient triage, increases accessibility to limited intensive care and provides a cost-effective alternative to critical care unit admission, particularly for patients with a low risk of, but potential for, major complications and who have been admitted for routine monitoring (7, 11-16). Moreover, patient satisfaction may be increased since an intermediate care environment is less noisy and may have more liberal family visitation policies (17).

There are few reports demonstrating the efficacy of intermediate care as a graded option between conventional ward care and intensive care. Most studies are retrospective or uncontrolled observational series (13). There is only one randomized, controlled study demonstrating reduced costs without a negative impact on outcome (16). Franklin and colleagues observed a decrease in the case fatality rate of a large urban medical service after the introduction of an intermediate care unit, noting an important reduction in the number of "low risk monitoring" admissions to their intensive care unit; this unit effectively increased the ready availability of critical care services to those patients most urgently in need, streamlining the ICU admission process, and attenuating unnecessary ICU stays or delays in transfer (7). In addition, these changes were associated with fewer ward cardiac arrests, presumably because of more timely and appropriate levels of observation.

Byrick et al. compared the initial impact on ICU utilization of opening an intermediate care unit, followed by closure of that unit (6,12). The intermediate care unit led to earlier extubation and discharge from the ICU, and shortened overall length of stay with no change in outcome. The availability of intermediate care increased ICU bed availability and freed the operating room schedule from being ICU-dependent. Nine years after opening, the intermediate care unit was dismantled due to hospital budgetary constraints. This closure led to a four-fold increase in ICU admissions with a lower severity of illness. The lack of stepdown resources caused a reduction in triage flexibility, which negatively impacted on ICU discharge planning and required longer ICU stays for "sicker" patients. Based on this comparison, intermediate care was reinstated (12).

Intermediate care reduces hospital costs by decreasing staffing to coincide with the need of the patients (2,3). Since personnel costs may comprise up to 80% of total ICU expenses, the savings afforded by a reduction in staffing necessary for patients with intermediate severities of illness can be substantial (14-18). These savings may be overstated if the reduction in nursing staff is partially offset by the need for additional healthcare team members (i.e., respiratory therapy). Similarly, there may not be a large difference in supplies and capital expenditures if the reduced use of invasive monitoring is counterbalanced by implementation of any of an increasing array of noninvasive monitoring equipment (3). However, there may be real and substantial savings from the change in protocol practice that occurs with transfer out of an ICU. Douglas et al. (16) established a stepdown facility for the

"chronically critically ill" (ICU length of stay >7 days, hemodynamically stable). This study is the only prospective, randomized trial to triage patients to an intermediate care unit who qualified based on pre-established criteria (16). The role of house officers was eliminated and the number of routine diagnostic laboratory tests and radiographs was sharply reduced. This change in protocol practice translated into "hidden" but substantial savings (16).

The investigation by Franklin et al. found a decrease in mortality with intermediate care, but further research is needed in this area (7). Sophisticated designs for the study of intermediate care should include concurrent, randomized controls rather than using sequential prospective study periods. Little attempt has been made to quantify the impact of intermediate care on reducing ICU readmissions ("bouncebacks"), i.e., patients who are discharged from the ICU and require urgent return within 48 to 72 hours (19, 20). The costs of different levels of care must also be studied, with methods that control for diagnosis, comorbidities and severity of illness (13). These kinds of studies are needed before the benefits and limitations of intermediate care can be fully appreciated. Research that evaluates these guidelines will promote their standardization and improvement, and this may improve patient outcome.

RECOMMENDATIONS

The American College of Critical Care Medicine developed by consensus the following recommendations to promote safe triage of patients to intermediate care units.

Rating System

Level 1: Convincingly justifiable on scientific evidence alone.

Level 2: Reasonably justifiable by available scientific evidence and strongly supported by expert critical care opinion.

Level 3: Adequate scientific evidence is lacking but widely supported by available data and expert critical care opinion.

1. (Level 2) The intermediate care unit serves as a place for the monitoring and care of patients with moderate or potentially severe physiologic instability, requiring technical support but not necessarily artificial life support. The Intermediate Care Unit is reserved for those patients requiring less care than standard intensive care but more than that which is available from ward care.
2. (Level 1) The intermediate care unit reduces costs, reduces ICU length of stay without increasing hospital length of stay, does not impact negatively on patient outcome and improves patient/family satisfaction* by providing a physical environment that is quieter and calmer than the ICU.
3. (Level 3) The intermediate care unit should have designated Physician and Nurse Directors who can be responsible for assuring appropriate patient triage through enforcement of the admission and discharge criteria. This triage must involve personnel from the general wards, the ICU, the post-anesthesia care unit (i.e., recovery room), and others so that a system is developed which meets the needs of the patient and the institution efficiently and economically.

*Shown for pediatric but not adult ICUs

4. (Level 3) The Physician and Nurse Directors should determine the limits of care that can be rendered in the intermediate care unit, based on institutional needs, staff qualifications and unit resources. This assessment includes the extent of invasive monitoring, telemetry, mechanical ventilation and types of intravenous medications.
5. (Level 3) Each intermediate care unit should develop specific admission and discharge policies and procedures, patient care standards, and outcome criteria for quality assessment (continuous quality improvement). Tools should be developed to monitor outcomes and other performance measures. Compliance with admission and discharge policies should be monitored and deviations reported to the hospital quality improvement section for action.

Listed below are admission and discharge guidelines with some examples of specific conditions or diseases that could qualify for intermediate care.

I. Admission Criteria

A. Cardiac System

1. Low-probability myocardial infarction; rule out myocardial infarction.
2. Hemodynamically stable myocardial infarction.
3. Any hemodynamically stable dysrhythmia.
4. Any hemodynamically stable patient without evidence of myocardial infarction but requiring temporary or permanent pacemaker.
5. Mild-to-moderate congestive heart failure without shock (Killip Class I, II).
6. Hypertensive urgency without evidence of end-organ damage.

B. Pulmonary System

1. Medically stable ventilator patients for weaning and chronic care.
2. Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or nasal continuous positive airway pressure.
3. Patients who require frequent vital signs or aggressive pulmonary physiotherapy.

C. Neurologic Disorders

1. Patients with established, stable stroke who require frequent neurologic assessments or frequent suctioning or turning.
2. Acute traumatic brain injury patients who have a Glasgow Coma Scale above 9 but require frequent monitoring for signs of neurologic deterioration.
3. Stable severe traumatic brain injury patients who require frequent positioning and pulmonary toilet.
4. Subarachnoid hemorrhage patients post-aneurysm clipping who require observation for signs of vasospasm or hydrocephalus.
5. Stable neurosurgical patients who require a lumbar drain for treatment of cerebrospinal fluid leak.
6. Stable cervical spinal cord injured patients.
7. Patients with chronic but stable neurologic disorders, such as neuromuscular disorders, who required frequent nursing interventions.
8. Grade I-II subarachnoid hemorrhage patients awaiting surgery.
9. Patients with ventriculostomies who are awake and alert awaiting ventriculo-peritoneal (V-P) shunt.

D. Drug Ingestion and Drug Overdose

1. Any patient requiring frequent neurologic, pulmonary, or cardiac monitoring for a drug ingestion or overdose who is hemodynamically stable.

E. Gastrointestinal (GI) Disorders

1. GI bleeding with minimal orthostatic hypotension responsive to fluid therapy.
2. Variceal bleeding without evidence of bright red blood by gastric aspirate and stable vital signs.
3. Acute liver failure with stable vital signs.

- F. Endocrine
 - 1. Diabetic ketoacidosis patients requiring constant intravenous infusion of insulin, or frequent injections of regular insulin during the early regulation phase after recovery from diabetes ketoacidosis.
 - 2. Hyperosmolar state with resolution of coma.
 - 3. Thyrotoxicosis, hypothyroid state requiring frequent monitoring.
 - G. Surgical
 - 1. The postoperative patient who, following major surgery, is hemodynamically stable but may require fluid resuscitation and transfusion due to major fluid shifts.
 - 2. The postoperative patient who requires close nurse monitoring during the first 24 hrs. Examples include but are not limited to carotid endarterectomy; peripheral vascular reconstruction; the neurosurgical patient requiring frequent neurological exams; V-P shunt revision, renal transplant, etc.
 - H. Miscellaneous
 - 1. Appropriately treated and resolving early sepsis without evidence of shock or secondary organ failure.
 - 2. Patients requiring closely titrated fluid management.
 - 3. Obstetrical patients admitted at any point in their pregnancy and postpartum period for treatment of pre-eclampsia/eclampsia or other medical problems.
 - 4. Any patient requiring frequent nursing observation or extensive time requirement for wound management who does not fall under the above categories may be considered for admission (example: Addison's disease, renal failure, delirium tremens, hypercalcemia).
- II. Patients who are usually *NOT* appropriate for admission to Intermediate Care include:
- A. Complicated acute myocardial infarction with temporary pacemaker, angina, hemodynamic instability, significant pulmonary edema or significant ventricular dysrhythmias.
 - B. Patients requiring heavy nursing loads and titrated patient care of 12 to 24 hrs/day.
 - C. Patients with acute respiratory failure who are recently intubated or at imminent risk of requiring intubation.
 - D. Patients requiring invasive hemodynamic monitoring with a pulmonary artery or left atrial catheter, or an intracranial pressure monitor.
 - E. Patients in status epilepticus.
 - F. Patients with catastrophic brain illness or injury who are not to be resuscitated and are not candidates for organ donation.
 - G. Patients from whom aggressive modalities of care are being withheld or have been withdrawn, such that they are receiving only comfort measures.
- III. Discharge Criteria:
- Discharge of patients from an intermediate care unit shall take place:
- A. When a patient's physiologic status has stabilized and the need for intensive patient monitoring is no longer necessary and the patient can be cared for on a general unit.
 - B. When a patient's physiological status has deteriorated and active life support is required or highly likely, the patient will be transferred to a critical care unit per unit-specific protocol.
- IV. Administrative Recommendations to Facilitate Appropriate Admissions, Discharges and Delivery of Intermediate Care.
- A. Personnel
 - 1. A physician director must be appointed who, on the basis of training, interests, type of practice, and availability can give clinical, administrative and educational direction to the Intermediate Care Unit. The Physician Director should meet "Guidelines for the definition of an intensivist and the practice of critical care medicine," published by the Society of Critical Care Medicine (21). Collaboration with nursing and ancillary staff should be emphasized. The Director should assume responsibility for assuring the quality, safety, and appropriateness of care in the intermediate care unit. The Director

must work collaboratively with the Directors of other areas in the institution so that patient care, triage, and patient flow are effective and efficient.

2. A nursing director should be appointed in order to establish precise lines of authority, responsibility, and accountability for delivery of high-quality, safe and appropriate nursing care. The Nurse Director should be an RN with a BSN degree and should have had at least 3 yrs experience working in an ICU. In major teaching institutions the Nurse Director should have a graduate degree (i.e., MS, MSN) with at least 5 yrs of experience in critical care nursing. The Nursing Director shares responsibility with the Physician Director for quality of care and patient safety, and ensures ongoing continuing education and professional development of the nursing staff.
3. The exact nurse-to-patient ratio should be based on patient acuity of illness.
4. Available ancillary staffing should include professionals from respiratory therapy, clinical pharmacy, nutritional support, social work, and rehabilitation services. These staff members should be integrated into a multidisciplinary intermediate care unit team. They must interact with the ICU, post-anesthesia care unit, and other unit staffs.
5. The multidisciplinary team of professionals should meet on a regular basis to identify and solve problems through quality assurance and continuous quality improvement activities.

SUMMARY

The intermediate care unit promotes efficient and effective care by increasing the flexibility of patient triage, utilizing personnel efficiently, and providing cost-effective care.

REFERENCES

Citation Categories

- (a). Randomized, prospective, controlled investigations.
 - (b). Nonrandomized, concurrent or historical cohort investigations.
 - (c). Peer reviewed state of the art articles, review articles, surveys, editorials, or substantial case series.
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The Task Force members who participated in the preparation of this document include: Stanley A. Nasraway, MD, FCCM; Ian L. Cohen, MD, FCCM; Richard C. Dennis, MD, FCCM; Michelle A. Howenstein, MS, RN, CCRN; Diana K. Nikas, RN, MN, FCCM; Jonathan Warren, MD, FCCM; and Suzanne K. Wedel, MD, FCCM

Approved by the Council of the Society of Critical Care Medicine in May 1997. To be revised in 2002.

Generations Family Health Center
October 2, 2015

EXHIBIT 3: AACN CCRN and PCCN Certification

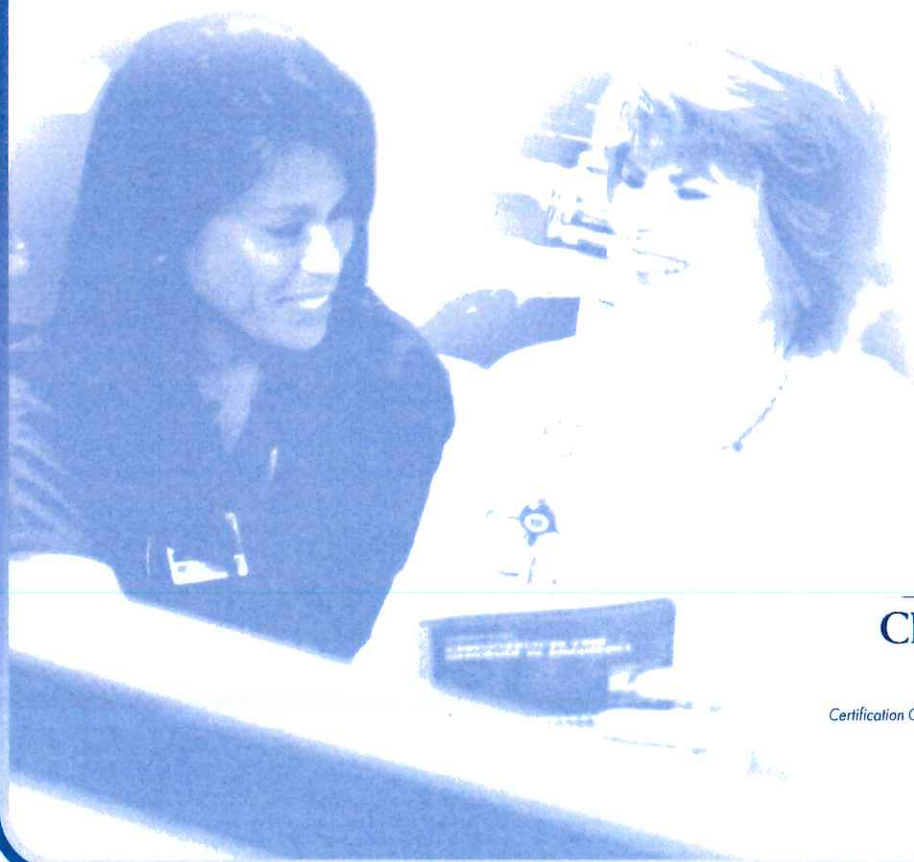
Exam

CCRN Exam Handbook

(Adult • Pediatric • Neonatal)



Acute/Critical Care
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AACN

CERTIFICATION
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Certification Organization for the American Association of Critical-Care Nurses

MISSION

AACN Certification Corporation contributes to consumer health and safety through comprehensive credentialing of nurses to ensure their practice is consistent with established standards of excellence in caring for acutely and critically ill patients and their families.

VISION

As the undisputed leader in credentialing nurses, AACN Certification Corporation has demonstrated that certification contributes to achieving optimal outcomes that are consistent with the goals and values of acutely and critically ill patients and their families.

VALUES

As the Corporation works to advance its mission and vision and fulfill its purpose and inherent obligation to ensure the health and well-being of patients experiencing acute and critical illness, the Corporation is guided by a set of deeply rooted values.

- Providing **leadership** to bring all stakeholders together to create and foster cultures of excellence and innovation.
- Acting with **integrity** and upholding ethical values and principles in all relationships and in the provision of sound, fair and defensible credentialing programs.
- Committing to **excellence** in credentialing programs by striving to exceed industry standards and expectations.
- Promoting **leading edge, research-based** credentialing programs that reach diverse certificants.
- Demonstrating **stewardship** through fair and responsible management of resources and cost-effective business processes.

ETHICS

AACN and AACN Certification Corporation consider the American Nurses Association (ANA) Code of Ethics for Nurses foundational for nursing practice, providing a framework for making ethical decisions and fulfilling responsibilities to the public, colleagues and the profession. AACN Certification Corporation's mission of public protection supports a standard of excellence that certified nurses have a responsibility to read, understand and act in a manner congruent with the ANA Code of Ethics for Nurses.

The following AACN Certification Corporation programs have been accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence (ICE):



CCRN[®] (Adult)
CCRN[®] (Pediatric)
CCRN[®] (Neonatal)
CCRN-E[™] (Adult)

PCCN[®]
CMC[®]
CSC[®]

ACNPC-AG[®]
ACCNS-AG[®]
ACCNS-P[®]
ACCNS-N[®]

Our advanced practice certification programs, ACCNS-AG, ACCNS-P, ACCNS-N and ACNPC-AG, meet the National Council of State Boards of Nursing (NCSBN) criteria for APRN certification programs.

CCRN EXAM HANDBOOK

Acute/Critical Care Nursing Certification - Adult, Pediatric, Neonatal

As healthcare becomes increasingly complex and challenging, certification has emerged as a mark of excellence showing patients, employers and the public that a nurse is qualified and competent, and has met the rigorous requirements to achieve specialty and/or subspecialty certification.

AACN Certification Corporation programs were created to protect healthcare consumers by validating the knowledge of nurses who care for the acutely and critically ill. We are pleased to provide you with this handbook with information about our programs and how to apply for and take the CCRN certification exams.

Today, more than 93,000 practicing nurses hold one or more of these certifications from AACN Certification Corporation:

Specialty Certifications

CCRN® is for nurses providing direct bedside care to acutely/critically ill adult, pediatric or neonatal patients.

CCRN-E™ is for nurses working in a tele-ICU monitoring acutely/critically ill adult patients from a remote location.

CCRN-K™ is for nurses whose non-bedside practice influences patients, nurses and/or organizations to have a positive impact on the care delivered to acutely/critically ill adult, pediatric or neonatal patients.

PCCN® is for progressive care nurses providing direct bedside care to acutely ill adult patients.

CNML is for nurse managers and leaders; offered in partnership with AONE (American Organization of Nurse Executives) Credentialing Center.

Subspecialty Certifications

CMC® is for certified nurses providing direct bedside care to acutely and/or critically ill adult cardiac patients.

CSC® is for certified nurses providing direct bedside care to acutely and/or critically ill adult patients during the first 48 hours after cardiac surgery.

Advanced Practice Consensus Model-Based Certifications

ACNPC-AG® is for the adult-gerontology acute care nurse practitioner educated at the graduate level.

The **ACCNS** credentials are for clinical nurse specialists educated at the graduate level to provide care across the continuum from **wellness through acute care**:

ACCNS-AG® is for the adult-gerontology clinical nurse specialist.

ACCNS-P® is for the pediatric clinical nurse specialist.

ACCNS-N® is for the neonatal clinical nurse specialist.

Advanced Practice Certifications

With implementation of the Consensus Model in 2015, ACNPC and CCNS are available as *renewal options only*.

ACNPC® is for acute care nurse practitioners educated to provide care to adult patients.

CCNS® is for acute/critical care clinical care specialists educated to provide care to adult, pediatric or neonatal patients.

We continually seek to provide quality certification programs that meet the changing needs of nurses and patients. Please visit www.certcorp.org > Documents and Handbooks, or call (800) 899-2226 for more information about the above certifications.

Thank you for your commitment to patients and their families and to becoming certified.



Please direct inquiries to:

AACN Certification Corporation, 101 Columbia, Aliso Viejo, CA 92656-4109
(800) 899-2226 • Fax: (949) 362-2020 • certcorp@aacn.org

Please include your AACN customer number with all correspondence to AACN Certification Corporation.

CCRN® is a specialty certification for nurses who provide direct bedside care to acutely/critically ill adult, pediatric or neonatal patients and their families. These patients may be found in such units as: intensive care, cardiac care, combined ICU/CCU, medical/surgical ICU, trauma unit or critical care transport/flight.

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The following information can be found in the *Certification Exam Policy Handbook* online at www.certcorp.org >
Documents and Handbooks:

- | | |
|--|--|
| • AACN Certification Programs | • Duplicate Score Reports |
| • Name and Address Changes | • Recognition of Certification |
| • Confidentiality of Exam Application Status | • Use of Credentials |
| • Testing Site Information | • Denial of Certification |
| • Exam Scheduling and Cancellation | • Revocation of Certification |
| • On the Day of Your Exam | • Review and Appeal of Certification Eligibility |

CCRN CERTIFICATION PROGRAM

CCRN Registered Service Mark

CCRN is a registered service mark and denotes certification in acute/critical care nursing as granted by AACN Certification Corporation. Registered nurses who have not achieved CCRN certification, whose CCRN certification has lapsed or who have chosen Inactive status are not authorized to use the CCRN credential.

Although a common misconception, CCRN is not an acronym for "critical care registered nurse." This would imply that nurses are registered as critical care nurses, which is not accurate.

Validated Knowledge and Specialized Skills

Each CCRN certification exam is based on a study of practice, also known as a job analysis, which defines the dimensions of acute/critical care practice, identifying what is required of registered nurses providing care to acutely/critically ill patients.

In the study, acute/critical care nurses across the United States were surveyed to ascertain the significance of the various elements of their practice. Through an extensive review and evaluation process, the knowledge, skills and abilities crucial to acute/critical care nursing were defined using the AACN Synergy Model for Patient Care as an organizing framework. The CCRN certification exams are based on these skills and abilities and the knowledge required to perform them.

CCRN certification is achieved by those acute/critical care nurses who pass the CCRN exam in neonatal, pediatric and/or adult critical care nursing. CCRN certification denotes to the public those practitioners who possess a distinct and clearly defined body of knowledge called acute/critical care nursing.

CCRN Exam Content

The CCRN exams are 3-hour tests consisting of 150 multiple-choice items. Of the 150 items, 125 are scored and 25 are used to gather statistical data on item performance for future exams.

The CCRN exams focus on adult, pediatric and neonatal patient populations. Eighty percent (80%) of each exam focuses on clinical judgment and is age-specific for the adult, pediatric and neonatal populations. The remaining 20% covers professional caring and ethical practice. Professional caring and ethical practice questions may be asked about any age across the life span while clinical judgment questions are restricted to adult, neonatal or pediatric populations.

CCRN Test Plans

The content of the CCRN exams is described in the test plans included in this handbook. Candidates are tested on a variety of patient care problems that are organized under major categories. Please note the percentage of the CCRN exam devoted to each category.

CCRN EXAM ELIGIBILITY

Licensure

Current unencumbered licensure as an RN or APRN in the United States is required.

- An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit the nurse's practice in any way.
- If randomly selected for audit, you will be asked to provide a copy of your RN or APRN license.
- Candidates and CCRN-certified nurses must notify AACN Certification Corporation **within 30 days** if any restriction is placed on their RN or APRN license.

Practice

Candidates must meet *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely/critically ill patients during the previous 2 years, with 875 of those hours accrued in the most recent year preceding application.

OR

- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely/critically ill patients, with 144 of those hours accrued in the most recent year preceding application.

Eligible hours are those spent caring for the patient population (adult, pediatric or neonatal) in alignment with the exam for which you are applying. A significant portion of the clinical hours for CCRN exam and renewal eligibility must be spent caring for critically ill patients.

Orientation hours spent shadowing/working with another nurse who is the one with the patient assignment *cannot* be counted toward clinical hours for CCRN eligibility; however, orientation hours during which you are the assigned nurse providing direct bedside care to acutely/critically ill patients may be counted.

Clinical hours must be completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet Status or Joint Commission International accreditation.

Nurses serving as manager, educator (in-service or academic), APRN or preceptor may apply hours spent supervising nursing students or nurses at the bedside.

- Nurses in these roles must be actively involved in caring for patients **at the bedside**; for example, demonstrating how to measure pulmonary artery pressures or supervising a new employee or student nurse performing a procedure.

Practice Verification

The name and contact information of a professional associate must be given for verification of eligibility related to clinical practice hours. If you are randomly selected for audit, this associate will need to verify in writing that you have met the clinical hour requirements.

- A professional associate is defined as your clinical supervisor or a colleague (RN or physician) with whom you work.

AACN Certification Corporation may adopt additional eligibility requirements at its sole discretion. Any such requirements will be designed to establish, for purposes of CCRN certification, the adequacy of a candidate's knowledge in care of the acutely/critically ill.

APPLICATION FEES

CCRN Computer-Based Exam

AACN Members	\$225
Nonmembers	\$330

CCRN Retest

AACN Members	\$170
Nonmembers	\$275

CCRN Renewal by Exam

AACN Members	\$170
Nonmembers	\$275

Payable in U.S. funds. Fees are subject to change without notice. A \$15 fee will be charged for a returned check.

Computer-based testing discounts are available for groups of **10 or more** candidates submitting their AACN certification exam applications in the same envelope. Employers may pre-purchase exam vouchers at a further discounted rate.

For details about the group and bulk discount programs, visit www.certcorp.org > General Information or call (800) 899-2226.

AACN Certification Corporation recommends that you be ready to test *before* applying for the CCRN exam.

ONLINE APPLICATION PROCESS

- ▶ **Register online** for computer-based testing at www.certcorp.org > Apply Online
- ▶ **Before you get started**, have available the following:
 - RN or APRN license number and expiration date
 - Name, address, phone and email address of your clinical supervisor or a professional colleague (RN or physician) who can verify your practice eligibility
 - Credit card (Visa, MasterCard, Discover or American Express)
- ▶ **Same day processing**

PAPER APPLICATION PROCESS

- ▶ **Paper applications are required** for those applying with a group, for paper and pencil exams and for testing outside the U.S.
- ▶ **Complete the application** on pages 41-42 **and honor statement** on page 43
 - Fill in all requested information, including that for your RN or APRN license
- ▶ **Include application fee**
 - Credit card, check or money order
- ▶ **Allow 2-3 weeks for processing**

Use your legal name on the application.
This name must match photo identification used for exam entry and will be the name printed on your certificate.

1. Receive notice of processed application

- AACN will send you an email confirming that you have successfully applied to take the CCRN exam.

2. Receive approval-to-test email

- AACN's testing service (AMP) will send an email and mail a postcard to eligible candidates within **5 to 10 days** after the confirmation email that will include:
 - A toll-free number and online instructions to schedule your testing appointment
 - The **90-day** period during which you must schedule and take the exam
 - Your **exam identification number**, which is your unique AACN customer number preceeded by the letter "C" (e.g., C00123456).
- If you do not receive an email or postcard from AMP **within 2 weeks of receiving confirmation email**, please contact AACN Customer Care at (800) 899-2226.

3. Schedule the exam

- Upon receipt of AMP's email or postcard:
 - Confirm that you are scheduled for the correct certification exam
 - Promptly schedule your exam appointment for a date and time that falls within your **90-day** testing window
- Testing is offered twice daily, Monday through Friday, at **9 a.m. and 1:30 p.m.**. Saturday appointments are available at some locations.
- To locate one of the more than 175 AMP testing centers within the U.S., visit **www.goAMP.com**.

4. Sit for the exam

- Upon completion of computer-based exams, results with a score breakdown will be presented on-site.
- Results of paper and pencil exams will be mailed to candidates 3 to 4 weeks following paper testing.
- Successful candidates will receive their wall certificate within 3 to 4 weeks of passing the exam.

Please ensure that AACN has your current contact information on record.
Updates may be made online at www.aacn.org/myaccount or emailed to info@aacn.org.
For name changes, please call AACN Customer Care at **(800) 899-2226**.

CCRN CERTIFICATION RENEWAL

Renewal Period

CCRN certification is granted for a period of 3 years. Your certification period begins the first day of the month in which the CCRN certification exam is passed and ends 3 years later; for example, October 1, 2015 through September 30, 2018. The purpose of certification renewal is to enhance continued competence.

Renewal notifications will be mailed and emailed to you starting 4 months before your scheduled CCRN renewal date. **You are responsible for renewing your certification even if you do not receive renewal notification.** Refer to www.certcorp.org for current information.

Eligibility

Candidates for CCRN renewal must meet the following requirements:

- Current unencumbered U.S. RN or APRN license that was not subjected to formal discipline by any state board of nursing during the 3-year certification renewal period
- Completion of 432 hours of direct bedside care of acutely/critically ill patients as an RN or APRN within the 3-year certification period, with 144 of those hours in the 12-month period preceding the scheduled renewal date
 - Eligible hours are those spent caring for the patient population (adult, pediatric or neonatal) in which certification is held.
- Completion of the required CERPs or take/pass the CCRN exam

Renewal Options

You may seek CCRN certification renewal via Renewal by Synergy CERPs or Renewal by Exam, or you may choose Inactive status.

► Option 1 - Renewal by Synergy CERPs

- Meet eligibility requirements for CCRN renewal and complete the Continuing Education Recognition Point (CERP) Program, which requires 100 CERPs in various categories (A, B & C).
- Online Renewal by Synergy CERPs is available to all active CCRNs as early as 4 months prior to their scheduled renewal date. For more information, visit www.certcorp.org > Renew Your Certification.
- For more details, refer to the Renewal by Synergy CERPs Brochure and other Synergy CERP resources available online at www.certcorp.org.

► Option 2 - Renewal by Exam

- Meet the eligibility requirements for CCRN renewal and successfully apply for and schedule your exam.
 - The CCRN exam must be completed **before** your scheduled renewal date.
 - You may not take the exam early, then attempt to renew by CERPs if you do not pass.

► Option 3 - Inactive Status

- Inactive status is available to CCRN-certified nurses who do not meet the renewal eligibility requirements but do not wish to lose their CCRN certification status. Inactive status provides CCRN-certified nurses additional time, **up to 3 years** from the scheduled renewal date, to meet the eligibility requirements.
- **During the time of inactive status, the CCRN credential may not be used.**
- Inactive status may be held more than once, but not for two consecutive renewal periods.

For more details, refer to the *CCRN Renewal Handbook* online at www.certcorp.org > Documents and Handbooks.

continued

CCRN CERTIFICATION RENEWAL (CONTINUED)

CCRN-E Certification

If you work primarily or exclusively in a tele-ICU caring for acutely/critically ill adult patients from a remote location and do not meet the requirements for CCRN renewal, CCRN-E renewal may be an option.

For more details, refer to the **CCRN-E Renewal Handbook** online at www.certcorp.org.

CCRN-K Certification

CCRN-K is a new program that validates the clinical specialty knowledge of acute/critical care nurses who do not exclusively or primarily practice at the bedside. Eligible practice hours include those in which the nurse applies knowledge in a way that influences patients, nurses and/or organizations to have a positive impact on the care delivered to acutely/critically ill adult, pediatric or neonatal patients.

- Nurses with practice hours in roles such as Clinical or Patient Educator, Academic Faculty, Manager/Supervisor, Clinical Director, Nursing Administrator, Case Manager, Transitional Care Coordinator **may** qualify. This is not an all-inclusive list, nor does it mean all nurses working in these roles are eligible for CCRN-K renewal.

For more details, refer to the **CCRN-K Renewal Handbook** online at www.certcorp.org.

Alternative Designations

Alumnus Status

Alumnus status is for nurses who have been CCRN-certified but no longer provide direct bedside care to acutely/critically ill patients for enough hours to meet the clinical hour requirement for active CCRN certification, but are still in the nursing profession in some other capacity and wish to remain connected with the credential.

- Renewable every 3 years, the “Alumnus CCRN” designation, written out, may be used on your resume or *below* your name and credentials on a business card, but may not be used with your signature or on a name badge.
- To be eligible for Alumnus CCRN status, you must have held CCRN certification and have no plans to renew CCRN certification in the future.
- There are no CE or CERP requirements to maintain Alumnus CCRN status.

Retired Status

Retired status provides the CCRN-certified nurse or Alumnus CCRN who is retiring from the nursing profession with a continued sense of career identity and professional connectedness. The Retired CCRN designation recognizes CCRN-certified nurses for their years of service in the care of acutely/critically ill patients. It also acknowledges their pride and dedication in maintaining their certification.

- To be eligible for Retired CCRN status, you must have been a CCRN without plans of returning to nursing practice or renewing certification.
- The retired nurse must not be working in any type of position that requires the possession of an RN license. You are not eligible if you are changing from bedside practice to another nursing role.
- The “Retired CCRN” designation, written out, may be used on your resume or *below* your name and credentials on a business card, but may not be used with your signature or on a name badge.
- There are no CE or CERP requirements to maintain Retired CCRN status.

For more details, please refer to the Alumnus and Retired applications available online at www.certcorp.org > Documents and Handbooks.

AACN SYNERGY MODEL FOR PATIENT CARE

Synergy is an evolving phenomenon that occurs when individuals work together in mutually enhancing ways toward a common goal. AACN Certification Corporation is committed to ensuring that certified nursing practice is based on the needs of patients. Integration of the AACN Synergy Model for Patient Care into AACN Certification Corporation's certification programs puts emphasis on the patient and says to the world that patients come first.

The Synergy Model creates a comprehensive look at the patient. It puts the patient in the center of nursing practice. The model identifies nursing's unique contributions to patient care and uses language to describe the professional nurse's role. It provides nursing with a venue that clearly states what we do for patients and allows us to start linking ourselves to, and defining ourselves within, the context of the patient and patient outcomes.

NOTE: AACN certification exams do not test for knowledge of the Synergy Model or its terminology; this is the theoretical model within which the tests have been designed.

Patient Characteristics

The Synergy Model encourages nurses to view patients in a holistic manner rather than the "body systems" medical model. Each patient and family is unique, with a varying capacity for health and vulnerability to illness. Each patient, regardless of the clinical setting, brings a set of unique characteristics to the care situation. Depending on where they are on the healthcare continuum, patients may display varying levels of the following characteristics:

Resiliency	Capacity to return to a restorative level of functioning using compensatory/coping mechanisms; the ability to bounce back quickly after an insult.
Vulnerability	Susceptibility to actual or potential stressors that may adversely affect patient outcomes.
Stability	Ability to maintain a steady-state equilibrium.
Complexity	Intricate entanglement of two or more systems (e.g., body, family, therapies).
Resource Availability	Extent of resources (e.g., technical, fiscal, personal, psychological and social) the patient/family/community bring to the situation.
Participation in Care	Extent to which patient/family engages in aspects of care.
Participation in Decision Making	Extent to which patient/family engages in decision making.
Predictability	A characteristic that allows one to expect a certain course of events or course of illness.

FOR EXAMPLE:

A healthy, uninsured, 40-year-old woman undergoing a pre-employment physical could be described as an individual who is (a) stable (b) not complex (c) very predictable (d) resilient (e) not vulnerable (f) able to participate in decision making and care, but (g) has inadequate resource availability.

On the other hand: a critically ill, insured infant with multisystem organ failure can be described as an individual who is (a) unstable (b) highly complex (c) unpredictable (d) highly resilient (e) vulnerable (f) unable to become involved in decision making and care, but (g) has adequate resource availability.

continued

AACN SYNERGY MODEL FOR PATIENT CARE (CONTINUED)

Nurse Characteristics

Nursing care reflects an integration of knowledge, skills, abilities and experience necessary to meet the needs of patients and families. Thus, nurse characteristics are derived from patient needs and include:

Clinical Judgment	Clinical reasoning, which includes clinical decision making, critical thinking and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating education, experiential knowledge and evidence-based guidelines.
Advocacy/ Moral Agency	Working on another's behalf and representing the concerns of the patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.
Caring Practices	Nursing activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. These caring behaviors include but are not limited to vigilance, engagement and responsiveness of caregivers. Caregivers include family and healthcare personnel.
Collaboration	Working with others (e.g., patients, families, healthcare providers) in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Collaboration involves intra- and inter-disciplinary work with colleagues and community.
Systems Thinking	Body of knowledge and tools that allow the nurse to manage whatever environmental and system resources that exist for the patient/family and staff, within or across healthcare systems and non-healthcare systems.
Response to Diversity	The sensitivity to recognize, appreciate and incorporate differences into the provision of care. Differences may include, but are not limited to, individuality, cultural, spiritual, gender, race, ethnicity, lifestyle, socioeconomic, age and values.
Facilitation of Learning	The ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team and community. Includes both formal and informal facilitation of learning.
Clinical Inquiry	The ongoing process of questioning and evaluating practice and providing informed practice. Creating changes through evidence-based practice, research utilization and experiential knowledge.

Nurses become competent within each continuum at a level that best meets the fluctuating needs of their population of patients. More compromised patients have more severe or complex needs, requiring nurses to have advanced knowledge and skills in an associated continuum.

FOR EXAMPLE:

If the gestalt of a patient were stable but unpredictable, minimally resilient and vulnerable, primary competencies of the nurse would be centered on clinical judgment and caring practices (which includes vigilance). If the gestalt of a patient were vulnerable, unable to participate in decision making and care, and inadequate resource availability, the primary competencies of the nurse would focus on advocacy and moral agency, collaboration and systems thinking.

Although all eight competencies are essential for contemporary nursing practice, each assumes more or less importance depending on a patient's characteristics. **Synergy results when a patient's needs and characteristics are matched with the nurse's competencies.**

Based on the most recent AACN Certification Corporation study of nursing practice, the test plans for AACN certification exams reflect the Synergy Model as well as findings related to nursing care of the patient population studied, e.g., adult, pediatric and neonatal.

For more information about the AACN Synergy Model for Patient Care visit www.certcorp.org.

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ADULT CCRN TEST PLAN

Applies to exams taken on or before October 14, 2015.

If testing after the above date, refer to www.certcorp.org > Certification News

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (20%)

1. Acute coronary syndromes (including unstable angina)
2. Acute myocardial infarction/ischemia (including papillary muscle rupture)
3. Acute peripheral vascular insufficiency (e.g., acute arterial occlusion, carotid artery stenosis, endarterectomy, peripheral stents, Fem-Pop bypass)
4. Acute pulmonary edema
5. Cardiac surgery (e.g., valve replacement, CABG)
6. Cardiac trauma
7. Cardiogenic shock
8. Cardiomyopathies (e.g., hypertrophic, dilated, restrictive, idiopathic)
9. Dysrhythmias
10. Heart failure
11. Hypertensive crisis
12. Hypovolemic shock
13. Interventional cardiology (e.g., catheterization)
14. Myocardial conduction system defects
15. Ruptured or dissecting aneurysm (e.g., thoracic, abdominal, thoraco-abdominal)
16. Structural heart defects (acquired and congenital, including valvular disease)

B. Pulmonary (18%)

1. Acute lung injury (e.g., ARDS, RDS)
2. Acute pulmonary embolus
3. Acute respiratory failure
4. Acute respiratory infections (e.g., acute pneumonia, bronchiolitis)
5. Air leak syndromes (e.g., pneumothorax, pneumopericardium)
6. Aspirations (e.g., aspiration pneumonia, foreign body)
7. COPD, asthma, chronic bronchitis, emphysema
8. Pulmonary hypertension

9. Status asthmaticus

10. Thoracic surgery

11. Thoracic trauma (e.g., fractured ribs, lung contusions, tracheal perforation)

C. Endocrine (5%)

1. Acute hypoglycemia
2. Diabetes insipidus
3. Diabetic ketoacidosis
4. Hyperglycemic hyperosmolar nonketotic syndrome (HHNK)
5. Syndrome of inappropriate secretion of antidiuretic hormone (SIADH)

D. Hematology/Immunology (2%)

1. Coagulopathies (e.g., ITP, DIC, HIT)

E. Neurology (12%)

1. Aneurysm
2. Brain death (irreversible cessation of whole brain function)
3. Congenital neurological abnormalities (e.g., AV malformation)
4. Encephalopathy (e.g., anoxic, hypoxic-ischemic, metabolic, infectious)
5. Head trauma (e.g., blunt, penetrating skull fractures)
6. Hydrocephalus
7. Intracranial hemorrhage/intraventricular hemorrhage (e.g., subarachnoid, epidural, subdural)
8. Neurologic infectious disease (e.g., viral, bacterial)
9. Neuromuscular disorders (e.g., muscular dystrophy, Guillain-Barré, myasthenia gravis)
10. Neurosurgery
11. Seizure disorders
12. Space-occupying lesions (e.g., brain tumors)
13. Stroke (e.g., ischemic, hemorrhagic)

continued

ADULT CCRN TEST PLAN (CONTINUED)

F. Gastrointestinal (6%)

1. Acute abdominal trauma
2. Acute GI hemorrhage
3. Bowel infarction/obstruction/perforation (e.g., mesenteric ischemia, adhesions)
4. GI surgeries
5. Hepatic failure/coma (e.g., portal hypertension, cirrhosis, esophageal varices)
6. Malnutrition and malabsorption
7. Pancreatitis

G. Renal (6%)

1. Acute renal failure
2. Chronic renal failure
3. Life-threatening electrolyte imbalances

H. Multisystem (8%)

1. Asphyxia
2. Distributive shock (e.g., anaphylaxis)
3. Multiorgan dysfunction syndrome (MODS)
4. Multisystem trauma
5. Sepsis/septic shock
6. Systemic inflammatory response syndrome (SIRS)
7. Toxic ingestions/inhalations (e.g., drug/alcohol overdose)
8. Toxin/drug exposure

I. Behavioral/Psychosocial (4%)

1. Abuse/neglect
2. Antisocial behaviors, aggression, violence
3. Delirium and dementia
4. Developmental delays
5. Failure to thrive
6. Mood disorders and depression
7. Substance dependence (e.g., withdrawal, drug-seeking behavior, chronic alcohol or drug dependence)
8. Suicidal behavior

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)

A. Advocacy/Moral Agency (3%)

B. Caring Practices (4%)

C. Collaboration (4%)

D. Systems Thinking (2%)

E. Response to Diversity (2%)

F. Clinical Inquiry (2%)

G. Facilitation of Learning (3%)

The sum of these percentages is not 100 due to rounding.

Order of content does not necessarily reflect importance.

ADULT CCRN TEST PLAN

TESTABLE NURSING ACTIONS

Cardiovascular

- Identify/monitor normal and abnormal physical assessment findings
- Apply leads for cardiac monitoring
- Identify, interpret and monitor cardiac rhythms
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Recognize indications for and manage patients requiring:
 - 12-lead ECG
 - arterial line
 - cardiac catheterization
 - cardiocentesis
 - cardioversion
 - central venous access
 - central venous pressure monitoring
 - defibrillation
 - PA catheter
 - SvO₂ monitoring
 - transthoracic pacing
 - transvenous pacing
- Manage patients receiving cardiovascular medications (e.g., thrombolytics, vasoactive agents, platelet inhibitors, anti-arrhythmic medications)
- Monitor patients and follow protocols for cardiac surgery
- Recognize signs and symptoms of cardiovascular emergencies, initiate interventions and seek assistance as needed
- Recognize indications for and manage patients requiring:
 - IABP
 - percutaneous coronary interventions

Pulmonary

- Identify and monitor normal and abnormal physical assessment findings
- Interpret ABGs
- Monitor patient for response to pulmonary medications (e.g., bronchodilators, mucolytics)
- Recognize indications for and manage patients requiring:
 - artificial airway
 - bronchoscopy
 - chest tubes
 - conventional modes of mechanical ventilation
 - high-frequency mechanical ventilation
 - non-invasive positive pressure ventilation (e.g., BIPAP, CPAP, high-flow nasal cannula)
 - oxygen therapy delivery devices

- prevention of complications related to mechanical ventilation (e.g., barotraumas, VAP)
- pulmonary therapeutic interventions (e.g., airway clearance, intubation, weaning, extubation)
- respiratory monitoring devices (e.g., SPO₂, SvO₂, ETCO₂) and report values
- therapeutic gases (e.g., nitric, heliox, CO₂)
- thoracentesis
- Recognize signs and symptoms of respiratory emergencies, initiate interventions and seek assistance as needed
- Monitor patient and follow protocols for thoracic and ENT surgery

Endocrine

- Recognize normal and abnormal physical assessment findings
- Recognize signs and symptoms of endocrine emergencies, initiate interventions and seek assistance as needed
- Identify and monitor normal and abnormal diagnostic test results
- Implement treatment modalities for acute hypo/hyperglycemia (e.g., insulin therapy)
- Monitor patient and follow protocols for surgery related to the endocrine system
- Manage patients receiving medications and monitor response

Hematology/Immunology

- Recognize normal and abnormal physical assessment findings of patients with:
 - hematologic problems
 - immunologic problems
- Identify and monitor normal and abnormal diagnostic test results (e.g., PT/INR, PTT, fibrinogen, CBC)
- Manage patients receiving medications (e.g., IVIG, steroids, chemotherapy) and monitor response
- Recognize and manage complications associated with transfusion of blood products
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., plasmapheresis, exchange Transfusion, autotransfusion)
- Recognize signs and symptoms of hematologic/immunologic emergencies, initiate interventions and seek assistance as needed

continued

ADULT CCRN TEST PLAN TESTABLE NURSING ACTIONS

(CONTINUED)

Neurology

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal neurological diagnostic test results (e.g., ICP, head CT scan, lumbar puncture)
- Recognize indications for and monitor/manage patients requiring neurological monitoring devices and drains
- Manage patients receiving medications (e.g., mannitol, hypertonic saline, sedation, neuromuscular blockade, anticonvulsants) and monitor response
- Recognize signs and symptoms of neurological emergencies (e.g., increased intracranial pressure, herniation, decreased LOC, seizure), initiate interventions and seek appropriate consultation
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., ICP insertion, lumbar puncture)
- Monitor patients and follow protocols for neuro-surgery

Gastrointestinal

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal gastrointestinal diagnostic test results
- Recognize indications for and manage patients requiring gastrointestinal:
 - monitoring devices (e.g., intra-abdominal compartment pressure)
 - drains
- Manage patients receiving gastrointestinal medications and monitor response
- Monitor patient and follow protocols, pre-, intra- and post-procedure (e.g., EGD, PEG placement)
- Recognize indications for and complications of enteral and parenteral nutrition
- Monitor patients and follow protocols for gastrointestinal surgery
- Recognize signs and symptoms of emergencies (e.g., GI bleed, ischemic bowel), initiate interventions and seek assistance as needed

Renal

- Recognize normal and abnormal physical assessment findings
- Identify and monitor normal and abnormal diagnostic test results

- Manage patients receiving renal medications and monitor response
- Recognize indications for and manage patients requiring renal therapeutic intervention (e.g., CRRT, Peritoneal dialysis)
- Monitor patients and follow protocols for:
 - renal surgery
 - pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)
- Recognize signs and symptoms of renal emergencies, initiate interventions and seek assistance as needed

Multisystem

- Recognize and monitor normal and abnormal diagnostic test results (e.g., lab, radiology)
- Recognize indications for and manage patients undergoing:
 - continuous sedation
 - procedural sedation
 - therapeutic hypothermia
- Assess patient's pain
- Manage patients receiving:
 - medications (e.g., pain medications, reversal agents) and monitor response
 - non-pharmacologic methods for pain relief and monitor response
- Recognize signs and symptoms of multisystem emergencies (e.g., shock states, trauma), initiate interventions and seek assistance as needed

Behavioral/Psychosocial

- Recognize normal and abnormal:
 - physical and psychosocial assessment findings
 - developmental assessment findings and provide developmentally appropriate care
- Recognize the need for and manage patients requiring restraints
- Recognize indications for and manage patients requiring behavioral therapeutic interventions
- Identify and monitor normal and abnormal diagnostic test results
- Manage patients receiving medications (e.g., anti-psychotics, antidepressants) and monitor response
- Recognize signs and symptoms of behavioral/psychosocial emergencies, initiate interventions and seek assistance as needed

ADULT CCRN SAMPLE EXAM QUESTIONS

- 1. A patient with a recent myocardial infarction suddenly develops a loud systolic murmur. The most likely cause is which of the following?**
 - A. pulmonary embolism
 - B. congestive heart failure
 - C. ruptured papillary muscle
 - D. increased systemic vascular resistance
- 2. A patient with unstable angina has an IABP inserted. Hemodynamics are:**

HR	148 (sinus tachycardia)
MAP	40 mm Hg
PAOP	25 mm Hg
CI	1.4 L/min/m ²

Which of the following should be included in this patient's plan of care?

 - A. checking timing of the IABP, decreasing balloon to 1:2 frequency
 - B. stat echocardiogram, furosemide (Lasix), checking timing of the IABP
 - C. dobutamine (Dobutrex), isoproterenol (Isuprel), 12-lead ECG
 - D. adenosine, stat Hgb and Hct, dobutamine (Dobutrex)
- 3. The family of a critically ill patient wishes to spend the night, which is contrary to visiting policy. The nurse's best action would be to**
 - A. adhere to the visiting policy.
 - B. allow the family to stay in the room.
 - C. obtain a motel room near the hospital where the family can spend the night.
 - D. allow one or two family members to stay, then evaluate the patient's response.
- 4. A patient who is one day post-gastroplasty has a sudden onset of restlessness, dyspnea and chest pain. His heart rate is 122, and auscultation of heart sound reveals an increased intensity of a pulmonary S2. The most likely cause is**
 - A. aspiration pneumonia.
 - B. a spontaneous pneumothorax.
 - C. a pleural effusion.
 - D. a pulmonary embolus.
- 5. The nursing staff is resisting being assigned to a disruptive patient. An appropriate resolution would be to**
 - A. ask the physician to transfer the patient.
 - B. rotate the patient assignment among staff.
 - C. confront the family and demand an end to the disruptive behavior.
 - D. hold a nursing team conference to discuss possible alternatives.
- 6. A patient who is 72 hours postoperative repair of a ruptured abdominal aortic aneurysm suddenly becomes dyspneic with an increased respiratory rate from 24 to 40. An arterial blood gas sample obtained while the patient is receiving oxygen at 6 L/min via nasal cannula reveals the following results:**

pH	7.50
pCO ₂	31
pO ₂	48

A chest x-ray is obtained and a "ground-glass-like appearance" is reported. Auscultation of the lungs reveals basilar crackles that were not previously present. On the basis of this information, the nurse should suspect that the patient has developed

 - A. a pulmonary embolus.
 - B. bacterial pneumonia.
 - C. chronic obstructive pulmonary disease.
 - D. acute respiratory distress syndrome.

continued

ADULT CCRN SAMPLE EXAM QUESTIONS (CONTINUED)

7. **Members of the nursing staff are developing written patient education materials for a group of patients with diverse reading abilities. It would be most effective for the staff to**
- A. design individual handouts for each patient.
 - B. develop a computer-based education series.
 - C. write the materials at a fourth-grade reading level.
 - D. limit text and provide color pictures.
8. **A postoperative patient has been in the unit for 4 days. He was unusually disengaged the previous day, and today he is agitated, thinks staff is trying to poison him and forgot his wife was at the bedside an hour ago. Other physiological factors are ruled out. Pharmaceutical interventions would include which of the following?**
- A. midazolam (Versed)
 - B. haloperidol (Haldol)
 - C. propofol (Diprivan)
 - D. sertraline (Zoloft)

Answers

- 1. C
- 2. A
- 3. D
- 4. D
- 5. D
- 6. D
- 7. C
- 8. B

PEDIATRIC CCRN TEST PLAN

Applies to exams taken on or before October 14, 2015.

If testing after the above date, refer to www.certcorp.org > Certification News

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (14%)

1. Acute pulmonary edema
2. Cardiac surgery (e.g., Norwood, BT shunt, TOF repair, arterial switch)
3. Cardiogenic shock
4. Cardiomyopathies (e.g., hypertrophic, dilated, restrictive, idiopathic)
5. Dysrhythmias
6. Heart failure
7. Hypovolemic shock
8. Interventional cardiology (e.g., catheterization)
9. Myocardial conduction system defects
10. Structural heart defects (acquired and congenital, including valvular disease)

B. Pulmonary (18%)

1. Acute lung injury (e.g., ARDS, RDS)
2. Acute pulmonary embolus
3. Acute respiratory failure
4. Acute respiratory infections (e.g., acute pneumonia, croup, bronchiolitis)
5. Air-leak syndromes (e.g., pneumothorax, pneumopericardium)
6. Aspiration (e.g., aspiration pneumonia, foreign-body, meconium)
7. Asthma, chronic bronchitis
8. Bronchopulmonary dysplasia
9. Congenital anomalies (e.g., diaphragmatic hernia, tracheoesophageal fistula, choanal atresia, pulmonary hypoplasia, tracheal malacia, tracheal stenosis)
10. Pulmonary hypertension
11. Status asthmaticus
12. Thoracic surgery
13. Thoracic trauma (e.g., fractured ribs, lung contusions, tracheal perforation)

C. Endocrine (5%)

1. Acute hypoglycemia
2. Diabetes insipidus
3. Diabetic ketoacidosis
4. Inborn errors of metabolism
5. Syndrome of inappropriate secretion of antidiuretic hormone (SIADH)

D. Hematology/Immunology (3%)

1. Coagulopathies (e.g., ITP, DIC, HIT)
2. Oncologic complications

E. Neurology (14%)

1. Acute spinal cord injury
2. Brain death (irreversible cessation of whole brain function)
3. Congenital neurological abnormalities (e.g., myelomeningocele, encephalocele, AV malformation)
4. Encephalopathy (e.g., anoxic, hypoxic-ischemic, metabolic, infectious)
5. Head trauma (e.g., blunt, penetrating, skull fractures)
6. Hydrocephalus
7. Intracranial hemorrhage/intraventricular hemorrhage (e.g., subarachnoid, epidural, subdural)
8. Neurologic infectious disease (e.g., congenital, viral, bacterial)
9. Neuromuscular disorders (e.g., muscular dystrophy, Guillain-Barré, myasthenia gravis)
10. Neurosurgery
11. Seizure disorders
12. Space-occupying lesions (e.g., brain tumors)
13. Spinal fusion
14. Stroke (e.g., ischemic, hemorrhagic)

continued

PEDIATRIC CCRN TEST PLAN (CONTINUED)

F. Gastrointestinal (6%)

1. Acute abdominal trauma
2. Acute GI hemorrhage
3. Bowel infarction/obstruction/perforation (e.g., necrotizing enterocolitis, mesenteric ischemia, adhesions)
4. Gastroesophageal reflux
5. GI abnormalities (e.g., omphalocele, gastrochisis, volvulus, Hirschsprung's disease, malrotation, intussusception)
6. GI surgeries
7. Hepatic failure/coma (e.g., portal hypertension, cirrhosis, esophageal varices, biliary atresia)
8. Malnutrition and malabsorption

G. Renal (6%)

1. Acute renal failure
2. Chronic renal failure
3. Life-threatening electrolyte imbalances

H. Multisystem (11%)

1. Asphyxia
2. Distributive shock (e.g., anaphylaxis)
3. Hemolytic uremic syndrome
4. Multiorgan dysfunction syndrome (MODS)
5. Multisystem trauma
6. Near-drowning
7. Sepsis/septic shock
8. Systemic inflammatory response syndrome (SIRS)
9. Toxic ingestions/inhalations (e.g., drug/alcohol overdose)
10. Toxin/drug exposure

I. Behavioral/Psychosocial (3%)

1. Abuse/neglect
2. Developmental delays
3. Failure to thrive

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)

A. Advocacy/Moral Agency (2%)

B. Caring Practices (4%)

C. Collaboration (4%)

D. Systems Thinking (2%)

E. Response to Diversity (2%)

F. Clinical Inquiry (2%)

G. Facilitation of Learning (4%)

Order of content does not necessarily reflect importance.

PEDIATRIC CCRN TEST PLAN TESTABLE NURSING ACTIONS

Cardiovascular

- Identify/monitor normal and abnormal physical assessment findings
- Apply leads for cardiac monitoring
- Identify, interpret and monitor cardiac rhythms
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Recognize indications for and manage patients requiring:
 - 12-lead ECG
 - arterial line
 - cardiac catheterization
 - cardioversion
 - central venous access
 - central venous pressure monitoring
 - defibrillation
 - PA catheter
 - cardiocentesis
 - SvO₂ monitoring
 - transthoracic pacing
 - transvenous pacing
- Manage and monitor patients receiving cardiovascular medications (e.g., thrombolytics, vasoactive agents, platelet inhibitors, anti-arrhythmic medications) and follow protocols for cardiac surgery
- Recognize signs and symptoms of cardiovascular emergencies, initiate interventions and seek assistance as needed

Pulmonary

- Identify and monitor normal and abnormal physical assessment findings
- Interpret ABGs
- Monitor patient for response to pulmonary medications (e.g., bronchodilators, mucolytics)
- Recognize indications for and manage patients requiring:
 - artificial airway
 - bronchoscopy
 - chest tubes
 - conventional modes of mechanical ventilation
 - high-frequency mechanical ventilation
 - non-invasive positive pressure ventilation (e.g., BIPAP, CPAP, high-flow nasal cannula)
 - oxygen therapy delivery devices
 - prevention of complications related to mechanical ventilation (e.g., barotraumas, VAP)

- pulmonary therapeutic interventions (e.g., airway clearance, intubation, weaning, extubation)
- respiratory monitoring devices (e.g., SPO₂, SvO₂, ETCO₂) and report values
- therapeutic gases (e.g., nitric, heliox, CO₂)
- thoracentesis
- Recognize signs and symptoms of respiratory emergencies, initiate interventions and seek assistance as needed
- Monitor patient and follow protocols for thoracic and ENT surgery

Endocrine

- Recognize normal and abnormal physical assessment findings
- Recognize signs and symptoms of endocrine emergencies, initiate interventions and seek assistance as needed
- Identify and monitor normal and abnormal diagnostic test results
- Implement treatment modalities for acute hypo/hyperglycemia (e.g., insulin therapy)
- Monitor patient and follow protocols for surgery related to the endocrine system
- Manage patients receiving medications and monitor response

Hematology/Immunology

- Recognize normal and abnormal physical assessment findings of patients with:
 - hematologic problems
 - immunologic problems
- Identify and monitor normal and abnormal diagnostic test results (e.g., PT/INR, PTT, fibrinogen, CBC)
- Manage patients receiving medications (e.g., IVIG, steroids, chemotherapy) and monitor response
- Recognize and manage complications associated with transfusion of blood products
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., plasmapheresis, exchange transfusion, autotransfusion)
- Recognize signs and symptoms of hematologic/immunologic emergencies, initiate interventions and seek assistance as needed

continued

PEDIATRIC CCRN TEST PLAN TESTABLE NURSING ACTIONS

(CONTINUED)

Neurology

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal neurological diagnostic test results (e.g., ICP, head CT scan, lumbar puncture)
- Recognize indications for and monitor/manage patients requiring neurological monitoring devices and drains
- Manage patients receiving medications (e.g., mannitol, hypertonic saline, sedation, neuro-muscular blockade, anticonvulsants) and monitor response
- Recognize signs and symptoms of neurological emergencies (e.g., increased intracranial pressure, herniation, decreased LOC, seizure), initiate interventions and seek appropriate consultation
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., ICP insertion, lumbar puncture)
- Monitor patient and follow protocols for neurosurgery

Gastrointestinal

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal gastrointestinal diagnostic test results
- Recognize indications for and manage patients with gastrointestinal:
 - monitoring devices (e.g., intra-abdominal compartment pressure)
 - drains
 - complications of enteral and parenteral nutrition
- Manage patients receiving gastrointestinal medications and monitor response
- Monitor patient and follow protocols, pre-, intra- and post-procedure (e.g., EGD, PEG placement)
- Monitor patients and follow protocols for gastrointestinal surgery
- Recognize signs and symptoms of emergencies (e.g., GI bleed, ischemic bowel), initiate interventions and seek assistance as needed

Renal

- Recognize normal and abnormal physical assessment findings
- Identify and monitor normal and abnormal diagnostic test results

- Manage patients receiving renal medications and monitor response
- Recognize indications for and manage patients requiring renal therapeutic intervention (e.g., CRRT, peritoneal dialysis)
- Monitor patients and follow protocols for:
 - renal surgery
 - pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)
- Recognize signs and symptoms of renal emergencies, initiate interventions and seek assistance as needed

Multisystem

- Recognize and monitor normal and abnormal diagnostic test results (e.g., lab, radiology)
- Recognize indications for and manage patients undergoing:
 - continuous sedation
 - procedural sedation
 - therapeutic hypothermia
- Assess patient's pain
- Manage patients receiving:
 - medications (e.g., pain medications, reversal agents) and monitor response
 - non-pharmacologic methods for pain relief and monitor response
- Recognize signs and symptoms of multisystem emergencies (e.g., shock states, trauma), initiate interventions and seek assistance as needed

Behavioral/Psychosocial

- Recognize normal and abnormal:
 - physical and psychosocial assessment findings
 - developmental assessment findings and provide developmentally appropriate care
- Recognize the need for and manage patients requiring restraints
- Recognize indications for and manage patients requiring behavioral therapeutic interventions
- Identify and monitor normal and abnormal diagnostic test results
- Manage patients receiving medications (e.g., anti-psychotics, antidepressants) and monitor response
- Recognize signs and symptoms of behavioral/psychosocial emergencies, initiate interventions and seek assistance as needed

PEDIATRIC CCRN SAMPLE EXAM QUESTIONS

1. **While caring for a patient with salicylate intoxication, the critical care nurse would anticipate which of the following as a primary treatment measure?**
- A. administration of protamine sulfate
 - B. administration of glucose
 - C. transfusion of packed RBCs
 - D. replacement of fluid and electrolytes
2. **An adolescent with the developmental age of a 4-year-old requires placement of a chest tube. The best way to prepare the patient for this procedure is to**
- A. use short simple sentences and limit descriptions to concrete explanations.
 - B. show the patient a chest tube and explain how it will feel.
 - C. explain in detail why a chest tube is needed and how it works.
 - D. tell the parents what will be done so they can explain it to their child.
3. **A child is admitted with a gunshot wound to the head, accidentally inflicted by an older sibling. The parents are overcome with grief and appear to be ignoring the following statements made by the older sibling: "It was an accident. I didn't mean to do it. I'm sorry!" Which of the following actions by the nurse would be most appropriate?**
- A. Discuss the importance of gun safety with the older sibling while the parents are at the bedside.
 - B. Seek additional support for the parents for ways they can assist the older sibling.
 - C. Tell the parents that they need to provide support for the older sibling.
 - D. Tell the older sibling, "Accidents happen. I know you didn't mean to do it."
4. **Which of the following laboratory findings is indicative of the syndrome of inappropriate ADH secretion (SIADH)?**
- A. serum sodium 148 mEq/L
 - B. decreased serum osmolality
 - C. blood urea nitrogen (BUN) 28 mg/dl
 - D. serum potassium 5.1 mEq/L
5. **A 3-year-old is admitted to the ICU with a 10-hour history of an acute-onset asthma attack. Initial assessment reveals the following:**
- | | | | |
|----|----------------------|------------------|------|
| BP | 112/76 | pH | 7.25 |
| HR | 160 | pCO ₂ | 35 |
| RR | 48 | pO ₂ | 40 |
| T | 89.6 °F/32 °C (oral) | HCO ₃ | 22 |
- In this situation, which would the nurse expect initial treatment to include?**
- A. administration of NaHCO₃
 - B. fluid resuscitation
 - C. racemic epinephrine
 - D. intubation
6. **A 2-year-old is experiencing manifestations of digoxin (Lanoxin) toxicity. BP is 94/60, capillary refill time is 2 seconds and the electrocardiogram reveals AV block with a heart rate of 60. The critical care nurse would anticipate which of the following interventions?**
- A. performance of cardioversion
 - B. administration of Atropine
 - C. performance of vasovagal maneuvers
 - D. monitoring of HR and rhythm and perfusion status

continued

PEDIATRIC CCRN SAMPLE EXAM QUESTIONS (CONTINUED)

- 7. An adolescent with asthma is readmitted just a week after discharge from the hospital. On questioning, the nurse learns that the patient refuses to use the inhalers at school. The nurse should**
- A. talk to the teen about long-term consequences of the disease if the treatment plan is not followed.
 - B. talk to the school nurse to find out why they are not monitoring the medications at school.
 - C. help the parents set up a disciplinary contract with the teen.
 - D. arrange for the teen to attend an asthma support group.
- 8. An unconscious 5-month-old is admitted. The parent reports the baby fell off the table during a diaper change by an older sibling. What findings would indicate further inquiry of the history?**
- A. a reddened or bruised area on the skull
 - B. poorly reactive pupils
 - C. retinal hemorrhage
 - D. a linear skull fracture

Answers

- 1. D
- 2. A
- 3. B
- 4. B
- 5. D
- 6. D
- 7. D
- 8. C

NEONATAL CCRN TEST PLAN

Applies to exams taken on or before October 14, 2015.

If testing after the above date, refer to www.certcorp.org > Certification News

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (10%)

1. Cardiogenic shock
2. Dysrhythmias
3. Heart failure
4. Hypovolemic shock
5. Structural heart defects (e.g., acquired and congenital, patent ductus arteriosus)

B. Pulmonary (24%)

1. Acute lung injury (e.g., ARDS, RDS)
2. Acute respiratory failure
3. Acute respiratory infections (e.g., acute pneumonia, croup, bronchiolitis)
4. Air-leak syndromes (e.g., pneumothorax, PIE, pneumopericardium)
5. Apnea of prematurity
6. Aspiration (e.g., aspiration pneumonia, foreign-body, meconium)
7. Bronchopulmonary dysplasia
8. Congenital anomalies (e.g., diaphragmatic hernia, tracheoesophageal fistula, choanal atresia, pulmonary hypoplasia, tracheal malacia, tracheal stenosis)
9. Pulmonary hypertension
10. Thoracic surgery
11. Transient tachypnea of the newborn

C. Endocrine (3%)

1. Inborn errors of metabolism
2. Neonatal hypoglycemia (e.g., IDM, LGA, SGA)

D. Hematology/Immunology (6%)

1. Anemia of prematurity
2. Coagulopathies (e.g., ITP, DIC, HIT)
3. Pathological hyperbilirubinemia
4. Physiological hyperbilirubinemia
5. Rh incompatibilities, ABO incompatibilities, hydrops fetalis

E. Neurology (10%)

1. Birth injuries (e.g., caput succedaneum, Erb's palsy, shoulder dystocia)
2. Brain death (irreversible cessation of whole brain function)
3. Congenital neurological abnormalities (e.g., myelomeningocele, encephalocele, AV malformation)
4. Encephalopathy (e.g., anoxic, hypoxic-ischemic, metabolic, infectious)
5. Hydrocephalus
6. Intracranial hemorrhage/intraventricular hemorrhage (e.g., subarachnoid, epidural, subdural)
7. Neurologic infectious disease (e.g., congenital, viral, bacterial)
8. Neuromuscular disorders (e.g., muscular dystrophy, Guillain-Barré)
9. Neurosurgery
10. Seizure disorders

F. Gastrointestinal (6%)

1. Bowel infarction/obstruction/perforation (e.g., necrotizing enterocolitis, mesenteric ischemia, adhesions)
2. Gastroesophageal reflux
3. GI abnormalities (e.g., omphalocele, gastrochisis, volvulus, imperforate anus, Hirschsprung's disease, malrotation, intussusception)
4. GI surgeries
5. Hepatic failure/coma (e.g., biliary atresia)
6. Malnutrition and malabsorption

G. Renal (5%)

1. Acute renal failure
2. Life-threatening electrolyte imbalances

continued

NEONATAL CCRN TEST PLAN (CONTINUED)

H. Multisystem (10%)

1. Asphyxia
2. Life-threatening maternal-fetal complications (e.g., eclampsia, HELLP syndrome, maternal-fetal transfusion, abruption placenta, placenta previa)
3. Low birth weight/prematurity
4. Multiorgan dysfunction syndrome (MODS)
5. Sepsis/septic shock
6. Toxin/drug exposure

I. Behavioral/Psychosocial (7%)

1. Abuse/neglect
2. Developmental delays
3. Failure to thrive
4. Substance dependence (e.g., withdrawal, maternal alcohol or drug dependence)
5. Stress in extremely low birth-weight infants

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)

A. Advocacy/Moral Agency (3%)

B. Caring Practices (4%)

C. Collaboration (4%)

D. Systems Thinking (2%)

E. Response to Diversity (2%)

F. Clinical Inquiry (2%)

G. Facilitation of Learning (3%)

The sum of these percentages is not 100 due to rounding.

Order of content does not necessarily reflect importance.

NEONATAL CCRN TEST PLAN

TESTABLE NURSING ACTIONS

Cardiovascular

- Identify/monitor normal and abnormal physical assessment findings
- Apply leads for cardiac monitoring
- Identify, interpret and monitor cardiac rhythms
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Recognize indications for and manage patients requiring:
 - 12-lead ECG
 - arterial line
 - cardiac catheterization
 - cardiocentesis
 - cardioversion
 - central venous access
 - central venous pressure monitoring
 - defibrillation
 - PA catheter
 - SvO₂ monitoring
 - transthoracic pacing
 - transvenous pacing
- Manage patients receiving cardiovascular medications (e.g., thrombolytics, vasoactive agents, platelet inhibitors, anti-arrhythmic medications)
- Monitor patients and follow protocols for cardiac surgery
- Recognize signs and symptoms of cardiovascular emergencies, initiate interventions and seek assistance as needed
- Recognize normal fetal circulation and transition to extra-uterine life
- Recognize indications for and manage patients requiring umbilical line

Pulmonary

- Identify and monitor normal and abnormal physical assessment findings
- Interpret ABGs
- Monitor patient for response to pulmonary medications (e.g., bronchodilators, mucolytics)
- Recognize indications for and manage patients requiring:
 - artificial airway
 - bronchoscopy
 - chest tubes
 - conventional modes of mechanical ventilation
 - high-frequency mechanical ventilation
 - non-invasive positive pressure ventilation (e.g., BIPAP, CPAP, high-flow nasal cannula)

- oxygen therapy delivery devices
 - prevention of complications related to mechanical ventilation (e.g., barotraumas, VAP)
 - pulmonary therapeutic interventions (e.g., airway clearance, intubation, weaning, extubation)
 - respiratory monitoring devices (e.g., SPO₂, SvO₂, ETCO₂) and report values
 - therapeutic gases (e.g., nitric, heliox, CO₂)
 - thoracentesis
- Recognize signs and symptoms of respiratory emergencies, initiate interventions and seek assistance as needed
 - Monitor patient and follow protocols for thoracic and ENT surgery

Endocrine

- Recognize normal and abnormal physical assessment findings
- Recognize signs and symptoms of endocrine emergencies, initiate interventions and seek assistance as needed
- Identify and monitor normal and abnormal diagnostic test results
- Implement treatment modalities for acute hypo/hyperglycemia (e.g., insulin therapy)
- Monitor patient and follow protocols for surgery related to the endocrine system
- Manage patients receiving medications and monitor response

Hematology/Immunology

- Recognize normal and abnormal physical assessment findings of patients with hematologic problems
- Recognize normal and abnormal physical assessment findings of patients with immunologic problems
- Identify and monitor normal and abnormal diagnostic test results (e.g., PT/INR, PTT, fibrinogen, CBC)
- Manage patients receiving medications (e.g., IVIG, steroids, chemotherapy) and monitor response
- Recognize and manage complications associated with transfusion of blood products
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., plasmapheresis, exchange transfusion, autotransfusion)
- Recognize signs and symptoms of hematologic/immunologic emergencies, initiate interventions, and seek assistance as needed

continued

NEONATAL CCRN TEST PLAN TESTABLE NURSING ACTIONS

(CONTINUED)

Neurology

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal neurological diagnostic test results (e.g., ICP, head CT scan, lumbar puncture)
- Recognize indications for and monitor/manage patients requiring neurological monitoring devices and drains
- Manage patients receiving medications (e.g., mannitol, hypertonic saline, sedation, neuromuscular blockade, anticonvulsants) and monitor response
- Recognize signs and symptoms of neurological emergencies (e.g., increased intracranial pressure, herniation, decreased LOC, seizure), initiate interventions and seek appropriate consultation
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., ICP insertion, lumbar puncture)
- Monitor patients and follow protocols for neurosurgery
- Identify and monitor normal and abnormal diagnostic test results
- Manage patients receiving renal medications and monitor response
- Recognize indications for and manage patients requiring renal therapeutic intervention (e.g., CRRT, peritoneal dialysis)
- Monitor patients and follow protocols for:
 - renal surgery
 - pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)
- Recognize signs and symptoms of renal emergencies, initiate interventions and seek assistance as needed
- Monitor patient and follow protocols pre-, intra- and post-procedure (e.g., renal biopsy, ultrasound)

Gastrointestinal

- Identify and monitor normal and abnormal physical assessment findings
- Recognize and monitor normal and abnormal gastrointestinal diagnostic test results
- Recognize indications for and manage patients requiring gastrointestinal monitoring devices (e.g., intra-abdominal compartment pressure)
- Recognize indications for and manage patients requiring gastrointestinal drains
- Manage patients receiving gastrointestinal medications and monitor response
- Monitor patient and follow protocols for:
 - pre-, intra- and post-procedure (e.g., EGD, PEG placement)
 - gastrointestinal surgery
- Recognize indications for and complications of enteral and parenteral nutrition
- Recognize signs and symptoms of emergencies (e.g., GI bleed, ischemic bowel), initiate interventions and seek assistance as needed
- Recognize and monitor normal and abnormal diagnostic test results (e.g., lab, radiology)
- Recognize indications for and manage patients undergoing:
 - continuous sedation
 - procedural sedation
 - therapeutic hypothermia
- Assess patient's pain:
 - manage patients receiving medications (e.g., pain medications, reversal agents) and monitor response
 - manage patients receiving non-pharmacologic methods for pain relief and monitor response
- Recognize signs and symptoms of multisystem emergencies (e.g., shock states, trauma), initiate interventions and seek assistance as needed
- Recognize indications for and manage patients undergoing neonatal skin care for low birth weight infants

Multisystem

Behavioral/Psychosocial

- Recognize normal and abnormal:
 - physical and psychosocial assessment findings
 - developmental assessment findings and provide developmentally appropriate care
- Recognize the need for and manage patients requiring restraints
- Recognize indications for and manage patients requiring behavioral therapeutic interventions

Renal

- Recognize normal and abnormal physical assessment findings

NEONATAL CCRN SAMPLE EXAM QUESTIONS

- 1. After application of a warm saline-soaked gauze dressing to an infant's abdominal wall defect, the most effective method for preventing evaporative heat loss is to**
 - A. place the infant in a warmed isolette.
 - B. place the infant under a radiant heat source.
 - C. moisten the gauze dressing every 30 minutes.
 - D. cover the gauze dressing with plastic.
- 2. An infant has just been intubated for respiratory failure due to respiratory distress syndrome (RDS). The infant's breath sounds are heard on the right side but not on the left. Which of the following interventions would be most appropriate?**
 - A. leave the tube in position and increase bag pressure
 - B. advance the tube until breath sounds are heard bilaterally
 - C. withdraw the tube until breath sounds are heard bilaterally
 - D. remove the tube and re-intubate
- 3. A preterm infant with necrotizing enterocolitis and resultant bowel perforation has returned from the operating room with an ileostomy. The first step in management of the ostomy should include**
 - A. contacting the dietitian for recommendations regarding easily digested formula.
 - B. contacting the enterostomal nurse to provide a pattern for the ostomy appliance.
 - C. applying a dry sterile dressing over the ostomy.
 - D. clini-testing stool to determine degree of malabsorption.
- 4. An infant at 38-weeks-gestation is born via cesarean section. At 4 hours of age, heart rate is 155 and respiratory rate is at 60. Physical assessment reveals grunting, mild retractions and nasal flaring. A chest x-ray reveals perihilar streaking bilaterally. The following arterial blood gas (ABG) results are obtained:**

pH	7.40
pCO ₂	35
pO ₂	40
HCO ₃	22

Appropriate management of this patient would consist of

 - A. intubation and mechanical ventilation.
 - B. surfactant replacement therapy.
 - C. chest tube insertion.
 - D. oxygen administration via hood.
- 5. A meeting is planned to discuss the parents' ethical concerns regarding life support interventions for their neonate with Trisomy 18. The nurse's role would be to**
 - A. assist the parents in articulating their questions and concerns.
 - B. provide legal information regarding end-of-life decisions.
 - C. describe reasons for the infant's poor prognosis.
 - D. inform the parents that the goal of the meeting is to obtain a DNR order.
- 6. An infant with documented hypoglycemia is being started on a continuous dextrose infusion following a bolus injection of glucose. An appropriate rate of dextrose infusion would be**
 - A. 1 - 3 mg/kg/min.
 - B. 4 - 8 mg/kg/min.
 - C. 9 - 12 mg/kg/min.
 - D. 13 - 16 mg/kg/min.

continued

NEONATAL CCRN SAMPLE EXAM QUESTIONS (CONTINUED)

7. An infant with isometric hydrops is delivered at 28-weeks-gestation by cesarean section. Which of the following interventions should be anticipated in the initial management of this infant?
- A. administration of sodium polystyrene sulfonate (Kayexalate)
 - B. placement of an umbilical venous catheter and slow push of O-positive whole blood
 - C. thoracentesis and/or paracentesis
 - D. a difficult intubation
8. The following results were obtained from a cerebrospinal fluid (CSF) sample obtained by lumbar puncture:
40 WBC/mm
65% polymorphonuclear cells
Glucose 50 mg/dl
Protein 165 mg/dl
Bacteria shown by Gram-staining
- On the basis of these results, the most appropriate additional study would include
- A. drawing blood for sedimentation rate.
 - B. obtaining surface cultures.
 - C. continuing monitoring without intervention.
 - D. obtaining blood and urine cultures.
9. The mother of an infant with severe PPHN would like to hold her infant. The infant's oxygen saturation is 88% to 92% at rest and mean blood pressure is 28. The nurse's best response would be to
- A. explain signs and symptoms that demonstrate instability of the infant.
 - B. assist the mother in holding the infant skin-to-skin.
 - C. encourage the mother to talk to the infant.
 - D. show the mother how to provide gentle infant massage.
10. Lab tests from the mother of a neonate reveal the presence of cocaine. The baby demonstrates irritability, hypertonicity and sleep disturbances. Nursing care for the neonate should include
- A. swaddling and periods of undisturbed rest.
 - B. removal of parental rights and designation of a guardian.
 - C. encouragement of breast feeding and increased frequency of feedings.
 - D. mechanical ventilation and sedation.

Answers

- 1. D
- 2. C
- 3. B
- 4. D
- 5. A
- 6. B
- 7. C
- 8. D
- 9. A
- 10. A

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Applies to exams taken on or before October 14, 2015.

If testing after the above date, refer to www.certcorp.org > Certification News

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More current versions may be available.

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Acorn Publishing – (919) 786-1155

American Heart Association – (800) 242-8721

Blackwell Publishing – (877) 762-2974

Elsevier (including Mosby, W. B. Saunders, and Hanley & Belfus) – (800) 545-2522

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Online Adult CCRN/CCRN-E/CCRN-K Certification Review Course: Individual Purchase. AACN. For additional information, go to www.aacn.org/ondemand .	ACCRNOD
<i>Adult CCRN/CCRN-E/CCRN-K Certification Review Course (2011)</i> . Available in 3 formats: CD-ROM for PC CD-ROM for Mac MP3 ** Review packages also available; see below.	301950 301951 301973
* <i>Adult Practice CCRN/CCRN-E/CCRN-K Exam Questions</i> . 6th ed. (2009). 190 questions..	200305

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*** Pediatric CCRN/CCRN-K Review Packages include *Pediatric/Neonatal CCRN/CCRN-K Review Course*, *Pediatric Practice CCRN/CCRN-K Exam Questions* and *AACN Core Curriculum for Pediatric Critical Care Nursing*. Item numbers are 302011 (CD-ROM for PC), 302008 (CD-ROM for Mac) and 302006 (MP3).

For more details and to place an order, visit www.aacn.org/marketplace, or call AACN Customer Care at (800) 899-2226, Monday through Friday between 7:30 a.m. and 4:30 p.m. Pacific Time.

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CCRN EXAM APPLICATION

PRINTED LEGAL NAME

AACN #

5. DEMOGRAPHIC INFORMATION

Check **one** box in each category. Information used for statistical purposes and may be used in eligibility determination.

Primary Area Employed

- Acute Hemodialysis Unit (21)
- Burn Unit (13)
- Cardiac Rehabilitation (26)
- Cardiac Surgery/OR (36)
- Cardiovascular/Surgical ICU (09)
- Catheterization Lab (22)
- Combined Adult/Ped. ICU (23)
- Combined ICU/CCU (01)
- Coronary Care Unit (03)
- Corporate Industry (24)
- Crit. Care Transport/Flight (17)
- Direct Observation Unit (39)
- Emergency Dept. (12)
- General Med./Surg. Floor (18)
- Home Care (25)
- Intensive Care Unit (02)
- Interventional Cardiology (31)
- Long-Term Acute Care (27)
- Medical Cardiology (34)
- Medical ICU (04)
- Medical Surgical ICU (35)
- Neonatal ICU (06)
- Neuro./Neurosurgical ICU (10)
- Oncology Unit (19)
- Operating Room (15)
- Outpatient Clinic (29)
- Pediatric ICU (05)
- Private Practice (32)
- Progressive Care Unit (16)
- Recovery Room/PACU (14)
- Respiratory ICU (08)
- Stepdown Unit (30)

- Subacute Care (28)
- Surgical ICU (07)
- Tele-ICU (37)
- Telemetry (20)
- Trauma Unit (11)
- Other - specify below

Primary Position Held

- Academic Faculty (07)
- Acute Care Nurse Practitioner (09)
- Bedside/Staff Nurse (01)
- Case Manager (39)
- Charge Nurse (45)
- Clinic Nurse (40)
- Clinical Coordinator (44)
- Clinical Director (04)
- Clinical Nurse Specialist (08)
- Corporate/Industry (1.1)
- Hospital Administrator (38)
- Internist (37)
- Legal Nurse Consultant (47)
- Manager (03)
- Nurse Anesthetist (02)
- Nurse Educator (46)
- Nurse Midwife (13)
- Nurse Practitioner (05)
- Outcomes Manager (42)
- Physician (16)
- Physician Assistant (17)
- Researcher (18)
- Respiratory Therapist (19)

- Technician (21)
- Unit Coordinator (22)
- Other - specify below

Highest Nursing Degree

- Associate's Degree
- Bachelor's Degree
- Diploma
- Doctorate
- Master's Degree

Ethnicity

- African American (02)
- Asian (05)
- Hispanic (03)
- Native American (04)
- Pacific Islander (06)
- White/Non-Hispanic (01)
- Other - specify below

Primary Type of Facility in Which Employed

- College/University (08)
- Community Hospital (Nonprofit) (01)
- Community Hospital (Profit) (02)
- Corporate/Industry (1.1)
- County Hospital (07)
- Federal Hospital (05)
- HMO/Managed Care (1.2)

- Home Health (13)
- Long-Term Acute Care Hosp. (16)
- Military/Government Hospital (04)
- Non-Academic Teaching Hosp. (14)
- Registry (10)
- Self-Employed (09)
- State Hospital (06)
- Travel Nurse (15)
- University Med. Ctr. (03)
- Other - specify below

Number of Beds in Institution:

Years of Experience In Nursing:

Years of Experience In Acute/Critical Care Nursing:

Date of Birth: (mm/dd/yy)

Gender: Female Male

6. HONOR STATEMENT - 3rd page of application to be submitted with this form

Complete the Honor Statement on page 39.

7. SUBMIT APPLICATION

Attach Honor Statement to this application and submit with payment to:

AACN Certification Corporation
 101 Columbia
 Aliso Viejo, CA 92656-4109
 or fax to: (949) 362-2020

DO NOT mail AND fax your application - please choose only ONE method.

NOTE: Allow **2 to 3 weeks** from the date received by AACN Certification Corporation for application processing.

Questions? Please visit www.certcorp.org, email certcorp@aacn.org or call us at (800) 899-2226.

Please complete page 3 of application (honor statement).



CCRN EXAM HONOR STATEMENT

PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.

PLEASE PRINT CLEARLY.

NAME: _____ **AACN CUSTOMER #:** _____
 Last First MI

I hereby apply for the CCRN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *CCRN Exam Handbook* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit my practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any disciplinary action is taken against my RN or APRN license in the future.

PRACTICE: I have fulfilled *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely/critically ill patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application.

OR

- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely/critically ill patients, with 144 of those hours accrued in the most recent year preceding application.

These clinical hours were in direct care of the following acutely/critically ill patient population:

Adult **Pediatric** **Neonatal** (check one box only)

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet Status or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information for my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

VERIFIER'S NAME: _____ **FACILITY NAME:** _____
 Last First

VERIFIER'S PHONE NUMBER: _____ **VERIFIER'S EMAIL ADDRESS:** _____

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification application is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NON-DISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____ **Date:** _____



Exam

PCCN Exam Handbook (Adult)

PCCN

Progressive Care
Nursing Certification

AACN

CERTIFICATION
CORPORATION

Certification Organization for the American Association of Critical-Care Nurses



MISSION

AACN Certification Corporation contributes to consumer health and safety through comprehensive credentialing of nurses to ensure their practice is consistent with established standards of excellence in caring for acutely and critically ill patients and their families.

VISION

As the undisputed leader in credentialing nurses, AACN Certification Corporation has demonstrated that certification contributes to achieving optimal outcomes that are consistent with the goals and values of acutely and critically ill patients and their families.

VALUES

As the Corporation works to advance its mission and vision and fulfill its purpose and inherent obligation to ensure the health and well-being of patients experiencing acute and critical illness, the Corporation is guided by a set of deeply rooted values.

- Providing **leadership** to bring all stakeholders together to create and foster cultures of excellence and innovation.
- Acting with **integrity** and upholding ethical values and principles in all relationships and in the provision of sound, fair and defensible credentialing programs.
- Committing to **excellence** in credentialing programs by striving to exceed industry standards and expectations.
- Promoting **leading edge, research-based** credentialing programs that reach diverse certificants.
- Demonstrating **stewardship** through fair and responsible management of resources and cost-effective business processes.

ETHICS

AACN and AACN Certification Corporation consider the American Nurses Association (ANA) Code of Ethics for Nurses foundational for nursing practice, providing a framework for making ethical decisions and fulfilling responsibilities to the public, colleagues and the profession. AACN Certification Corporation's mission of public protection supports a standard of excellence that certified nurses have a responsibility to read, understand and act in a manner congruent with the ANA Code of Ethics for Nurses.

The following AACN Certification Corporation programs have been accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence (ICE):



CCRN[®] (Adult)
CCRN[®] (Pediatric)
CCRN[®] (Neonatal)
CCRN-E[™] (Adult)

PCCN[®]
CMC[®]
CSC[®]

ACNPC-AG[®]
ACCNS-AG[®]
ACCNS-P[®]
ACCNS-N[®]

Our advanced practice certification programs, ACCNS-AG, ACCNS-P, ACCNS-N and ACNPC-AG, meet the National Council of State Boards of Nursing (NCSBN) criteria for APRN certification programs.

PCCN EXAM HANDBOOK

Progressive Care Nursing Certification - Adult

As healthcare becomes increasingly complex and challenging, certification has emerged as a mark of excellence showing patients, employers and the public that a nurse is qualified and competent, and has met the rigorous requirements to achieve specialty and/or subspecialty certification.

AACN Certification Corporation programs were created to protect healthcare consumers by validating the knowledge of nurses who care for the acutely and critically ill. We are pleased to provide you with this handbook with information about our programs and how to apply for and take the PCCN certification exams.

Today, more than 90,000 practicing nurses hold one or more of these certifications from AACN Certification Corporation:

Specialty Certifications

CCRN® is for nurses providing direct bedside care to acutely and/or critically ill adult, pediatric or neonatal patients.

CCRN-E™ is for nurses working in a tele-ICU monitoring acutely and/or critically ill adult patients from a remote location.

CCRN-K™ is for nurses whose non-bedside practice influences patients, nurses and/or organizations to have a positive impact on acutely and/or critically ill adult, pediatric or neonatal patients.

PCCN® is for progressive care nurses providing direct bedside care to acutely ill adult patients.

CNML is for nurse managers and leaders; offered in partnership with AONE (American Organization of Nurse Executives) Credentialing Center.

Subspecialty Certifications

CMC® is for certified nurses providing direct bedside care to acutely and/or critically ill adult cardiac patients.

CSC® is for certified nurses providing direct bedside care to acutely and/or critically ill adult patients during the first 48 hours after cardiac surgery.

Advanced Practice Consensus Model-Based Certifications

ACNPC-AG® is for the adult-gerontology acute care nurse practitioner educated at the graduate level.

The **ACCNS** credentials are for clinical nurse specialists educated at the graduate level to provide care across the continuum from **wellness through acute care**:

ACCNS-AG® is for the adult-gerontology clinical nurse specialist.

ACCNS-P® is for the pediatric clinical nurse specialist.

ACCNS-N® is for the neonatal clinical nurse specialist.

Advanced Practice Certifications

With implementation of the Consensus Model in 2015, ACNPC and CCNS are available as *renewal options only*:

ACNPC® is for acute care nurse practitioners educated to provide care to adult patients.

CCNS® is for acute/critical care clinical care specialists educated to provide care to adult, pediatric or neonatal patients.

We continually seek to provide quality certification programs that meet the changing needs of nurses and patients. Please visit www.certcorp.org > Documents and Handbooks, or call (800) 899-2226 for more information about the above certifications.

Thank you for your commitment to patients and their families and to becoming certified.



Please direct inquiries to:

AACN Certification Corporation, 101 Columbia, Aliso Viejo, CA 92656-4109
(800) 899-2226 • Fax: (949) 362-2020 • certcorp@aacn.org

Please include your AACN customer number with all correspondence to AACN Certification Corporation.

PCCN® is a specialty certification for nurses who provide care for acutely ill adult patients, regardless of the geographic location of their nursing care. Specialty nurses interested in this certification may work in such areas as intermediate care units; direct observation units; stepdown units; telemetry units; transitional care units; or emergency departments.

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The following information can be found in the *Certification Exam Policy Handbook* online at www.certcorp.org >
Documents and Handbooks:

- | | |
|--|--|
| • AACN Certification Programs | • Duplicate Score Reports |
| • Name and Address Changes | • Recognition of Certification |
| • Confidentiality of Exam Application Status | • Use of Credentials |
| • Testing Site Information | • Denial of Certification |
| • Exam Scheduling and Cancellation | • Revocation of Certification |
| • On the Day of Your Exam | • Review and Appeal of Certification Eligibility |

PCCN CERTIFICATION PROGRAM

Definition

Progressive Care Certified Nurse (PCCN) certification validates your knowledge of nursing of acutely ill adult patients in your specialty area to hospitals, peers, patients and, most importantly, to yourself. PCCN certification promotes continuing excellence in progressive care nursing. AACN recognizes progressive care as part of the continuum of critical care.

PCCN® Registered Service Mark

PCCN is a registered service mark and denotes certification in progressive care nursing as granted by AACN Certification Corporation. Registered nurses who have not achieved PCCN certification status, whose PCCN status has lapsed, or who have chosen Inactive status are not authorized to use the PCCN credential.

Validated Knowledge and Specialized Skills

Each PCCN certification exam is based on a study of practice, also known as a job analysis. The most recent study, completed in 2012, defines the dimensions of acute care practice, identifying what is required of registered nurses providing care to acutely ill patients.

In the study, acute and critical care nurses across the United States were surveyed to ascertain the significance of the various elements of their practice. Through an extensive review and evaluation process, the knowledge, skills and abilities crucial to progressive care nursing were defined using the AACN Synergy Model for Patient Care as an organizing framework. The PCCN certification exam is based on these skills and abilities and the knowledge required to perform them.

PCCN certification is achieved by those progressive care nurses who pass the PCCN exam in adult progressive care nursing. PCCN certification denotes to the public those practitioners who possess a distinct and clearly defined body of knowledge called progressive care nursing.

PCCN Exam Contents

The PCCN exam is a 2-and-1/2-hour test consisting of 125 multiple-choice items. Of the 125 items, 100 are scored and 25 are used to gather statistical data on item performance for future exams. Please refer to the PCCN Test Plan for detailed content information. The PCCN exam focuses on adult patient populations only.

PCCN Test Plan

The content of the PCCN exam is described in the test plan included in this handbook. Candidates are tested on a variety of patient care problems that are organized under major categories. Please note the percentage of the PCCN exam devoted to each category.

PCCN EXAM ELIGIBILITY

Licensure

Current unencumbered licensure as an RN or APRN in the United States is required.

- An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit the nurse's practice in any way.
- If randomly selected for audit, you will be asked to provide a copy of your RN or APRN license.
- Candidates and PCCN-certified nurses must notify AACN Certification Corporation **within 30 days** if any restriction is placed on their RN or APRN license.

Practice

Candidates must meet *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely ill adult patients during the previous 2 years, with 875 of those hours accrued in the most recent year preceding application.

OR

- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely ill adult patients, with 144 of those hours accrued in the most recent year preceding application.

Orientation hours spent shadowing/working with another nurse who is the one with the patient assignment *cannot* be counted toward clinical hours for PCCN eligibility; however, orientation hours during which you are the assigned nurse providing direct bedside care to acutely ill adult patients may be counted.

Clinical practice hours for the PCCN exam and renewal eligibility must be completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet Status or Joint Commission International accreditation.

Nurses serving as manager, educator (in-service or academic), APRN or preceptor may apply their hours spent supervising nursing students or nurses at the bedside.

- Nurses in these roles must be actively involved in caring for patients **at the bedside**; for example, performing a procedure or supervising a new employee or student nurse performing a procedure.

Practice Verification

The name and contact information of a professional associate must be given for verification of eligibility related to clinical practice hours. If you are randomly selected for audit, this associate will need to verify in writing that you have met the clinical hour requirements.

- A professional associate is defined as either your clinical supervisor or a colleague (RN or physician) with whom you work.

AACN Certification Corporation may adopt additional eligibility requirements at its sole discretion. Any such requirements will be designed to establish, for the purposes of PCCN certification, the adequacy of a candidate's knowledge in caring for the acutely ill.

APPLICATION FEES

PCCN Computer-Based Exam

AACN Members	\$175
Nonmembers	\$275

PCCN Retest

AACN Members	\$135
Nonmembers	\$215

PCCN Renewal by Exam

AACN Members	\$135
Nonmembers	\$215

Payable in U.S. funds. Fees are subject to change without notice. A \$15 fee will be charged for a returned check.

Computer-based testing discounts are available for groups of **10 or more** candidates submitting their AACN certification exam applications in the same envelope. Employers may pre-purchase exam vouchers at a further discounted rate.

For details about the group and bulk discount programs, visit www.certcorp.org > General Information or call (800) 899-2226.

AACN Certification Corporation recommends that you be ready to test *before* applying for the PCCN exam.

ONLINE APPLICATION PROCESS

- ▶ **Register online** for computer-based testing at www.certcorp.org > Apply Online
- ▶ **Before you get started**, have available the following:
 - RN or APRN license number and expiration date
 - Name, address, phone and email address of your clinical supervisor or a professional colleague (RN or physician) who can verify your practice eligibility
 - Credit card (Visa, MasterCard, Discover or American Express)
- ▶ **Same day processing**

PAPER APPLICATION PROCESS

- ▶ **Paper applications are required** for those applying with a group, for paper and pencil exams and for testing outside the U.S.
- ▶ **Complete the application** on pages 21-22 and **honor statement** on page 23
 - Fill in all requested information, including that for your RN or APRN license
- ▶ **Include application fee**
 - Credit card, check or money order
- ▶ **Allow 2-3 weeks for processing**

Use your legal name on the application.
This name must match photo identification used for exam entry and will be the name printed on your certificate.

1. Receive notice of processed application

- AACN will send you an email confirming that you have successfully applied to take the PCCN exam.

2. Receive approval-to-test email

- AACN's testing service (AMP) will send an email and mail a postcard to eligible candidates within **5 to 10 days** after confirmation email that will include:
 - A toll-free number and online instructions to schedule your testing appointment
 - The **90-day** period during which you must schedule and take the exam
 - Your **exam identification number**, which is your unique AACN customer number preceeded by the letter "C" (e.g., C00123456).
- If you do not receive an email or postcard from AMP **within 2 weeks of receiving confirmation email**, please contact AACN Customer Care at (800) 899-2226.

3. Schedule the exam

- Upon receipt of AMP's email or postcard:
 - Confirm that you are scheduled for the correct certification exam
 - Promptly schedule your exam appointment for a date and time that falls within your **90-day** testing window
- Testing is offered twice daily, Monday through Friday, at **9 a.m. and 1:30 p.m.**. Saturday appointments are available at some locations.
- To locate one of the more than 175 AMP testing centers within the U.S., visit **www.goAMP.com**.

4. Sit for the exam

- Upon completion of computer-based exams, results with a score breakdown will be presented on-site.
- Results of paper and pencil exams will be mailed to candidates 3 to 4 weeks following paper testing.
- Successful candidates will receive their wall certificate within 3 to 4 weeks of passing the exam.

Please ensure that AACN has your current contact information.
Updates may be made online at **www.aacn.org/myaccount** or emailed to **info@aacn.org**.
For name changes, please call AACN Customer Care at **(800) 899-2226**.

PCCN CERTIFICATION RENEWAL

Renewal Period

PCCN certification is granted for a period of 3 years. Your certification period begins the first day of the month in which the PCCN certification exam is passed and ends 3 years later; for example, October 1, 2014 through September 30, 2017. The purpose of certification renewal is to enhance continued competence.

Renewal notifications will be mailed and emailed to you starting 4 months before your scheduled PCCN renewal date. **You are responsible for renewing your certification even if you do not receive renewal notification.** Refer to www.certcorp.org for current information.

Eligibility

Candidates for PCCN renewal must meet the following requirements:

- Current unencumbered U.S. RN or APRN license that was not subjected to formal discipline by any state board of nursing during the 3-year certification renewal period
- Completion of 432 hours of direct bedside care of acutely ill adult patients as an RN or APRN within the 3-year certification period, with 144 of those hours in the 12-month period preceding the scheduled renewal date
- Completion of the required CERPs or take/pass the PCCN exam

Renewal Options

You may seek certification renewal via Renewal by Synergy CERPs or Renewal by Exam, or you may choose Inactive, Retired or Alumnus status. Do not apply for more than one option.

► Option 1 - Renewal by Synergy CERPs

- Meet eligibility requirements for PCCN renewal and complete the Continuing Education Recognition Point (CERP) Program, which requires 100 CERPs in various categories (A, B & C).
- Online Renewal by Synergy CERPs is available to all active PCCNs as early as 4 months prior to their scheduled renewal date. For more information visit www.certcorp.org > Renew Your Certification.
- For more details refer to the Renewal by Synergy CERPs Brochure and other Synergy CERP resources available online at www.certcorp.org.

► Option 2 - Renewal by Exam

- Meet the eligibility requirements for PCCN renewal and successfully apply for and schedule your exam.
 - The PCCN exam must be completed **before** your scheduled renewal date.
 - You may not take the exam early, then attempt to renew by CERPs if you do not pass.

► Option 3 - Inactive Status

- Inactive status is available to PCCN-certified nurses who do not meet the renewal eligibility requirements but do not wish to lose their PCCN certification status. Inactive status provides PCCN-certified nurses additional time, **up to 3 years** from the scheduled renewal date, to meet the eligibility requirements.
- **During the time of inactive status, the PCCN credential may not be used.**
- Inactive status may be held more than once, but not for two consecutive renewal periods.

For more details, refer to the *PCCN Renewal Handbook* available at www.certcorp.org > Documents and Handbooks.

continued

PCCN CERTIFICATION RENEWAL (CONTINUED)

Alternative Designations

Alumnus Status

Alumnus status is for nurses who have been PCCN-certified but no longer provide direct bedside care to acutely ill patients for enough hours to meet the clinical hour requirement for active PCCN certification, but are still in the nursing profession in some other capacity and wish to remain connected with the credential.

- Renewable every 3 years, the "Alumnus PCCN" designation, written out, may be used on your resume or *below* your name and credentials on a business card, but may not be used with your signature or on a name badge.
- To be eligible for Alumnus PCCN status, you must have held PCCN certification and have no plans to renew PCCN certification in the future.
- There are no CE or CERP requirements to maintain Alumnus PCCN status.

Retired Status

Retired status provides the PCCN-certified nurse or Alumnus PCCN who is retiring from the nursing profession with a continued sense of career identity and professional connectedness. The Retired PCCN designation recognizes PCCN-certified nurses for their years of service at the bedside. It also acknowledges their pride and dedication in maintaining their certification.

- To be eligible for Retired PCCN status, you must have been a PCCN without plans of returning to nursing practice or renewing certification.
- The retired nurse must not be working in any type of position that requires the possession of an RN license. You are not eligible if you are changing from bedside practice to another nursing role.
- The "Retired PCCN" designation, written out, may be used on your resume or *below* your name and credentials on a business card, but may not be used with your signature or on a name badge.
- There are no CE or CERP requirements to maintain Retired PCCN status.

For more details, refer to the Alumnus and Retired applications available online at www.certcorp.org > Documents and Handbooks.

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AACN SYNERGY MODEL FOR PATIENT CARE

Synergy is an evolving phenomenon that occurs when individuals work together in mutually enhancing ways toward a common goal. AACN Certification Corporation is committed to ensuring that certified nursing practice is based on the needs of patients. Integration of the AACN Synergy Model for Patient Care into AACN Certification Corporation's certification programs puts emphasis on the patient and says to the world that patients come first.

The Synergy Model creates a comprehensive look at the patient. It puts the patient in the center of nursing practice. The model identifies nursing's unique contributions to patient care and uses language to describe the professional nurse's role. It provides nursing with a venue that clearly states what we do for patients and allows us to start linking ourselves to, and defining ourselves within, the context of the patient and patient outcomes.

NOTE: AACN certification exams do not test for knowledge of the Synergy Model or its terminology; this is the theoretical model within which the tests have been designed.

Patient Characteristics

The Synergy Model encourages nurses to view patients in a holistic manner rather than the "body systems" medical model. Each patient and family is unique, with a varying capacity for health and vulnerability to illness. Each patient, regardless of the clinical setting, brings a set of unique characteristics to the care situation. Depending on where they are on the healthcare continuum, patients may display varying levels of the following characteristics:

Resiliency	Capacity to return to a restorative level of functioning using compensatory/coping mechanisms; the ability to bounce back quickly after an insult.
Vulnerability	Susceptibility to actual or potential stressors that may adversely affect patient outcomes.
Stability	Ability to maintain a steady-state equilibrium.
Complexity	Intricate entanglement of two or more systems (e.g., body, family, therapies).
Resource Availability	Extent of resources (e.g., technical, fiscal, personal, psychological and social) the patient/family/community bring to the situation.
Participation in Care	Extent to which patient/family engages in aspects of care.
Participation in Decision Making	Extent to which patient/family engages in decision making.
Predictability	A characteristic that allows one to expect a certain course of events or course of illness.

FOR EXAMPLE:

A healthy, uninsured, 40-year-old woman undergoing a pre-employment physical could be described as an individual who is (a) stable (b) not complex (c) very predictable (d) resilient (e) not vulnerable (f) able to participate in decision making and care, but (g) has inadequate resource availability.

On the other hand: a critically ill, insured infant with multisystem organ failure can be described as an individual who is (a) unstable (b) highly complex (c) unpredictable (d) highly resilient (e) vulnerable (f) unable to become involved in decision making and care, but (g) has adequate resource availability.

continued

AACN SYNERGY MODEL FOR PATIENT CARE (CONTINUED)

Nurse Characteristics

Nursing care reflects an integration of knowledge, skills, abilities and experience necessary to meet the needs of patients and families. Thus, nurse characteristics are derived from patient needs and include:

Clinical Judgment	Clinical reasoning, which includes clinical decision making, critical thinking and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating education, experiential knowledge and evidence-based guidelines.
Advocacy/ Moral Agency	Working on another's behalf and representing the concerns of the patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.
Caring Practices	Nursing activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. These caring behaviors include but are not limited to vigilance, engagement and responsiveness of caregivers. Caregivers include family and healthcare personnel.
Collaboration	Working with others (e.g., patients, families, healthcare providers) in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Collaboration involves intra- and inter-disciplinary work with colleagues and community.
Systems Thinking	Body of knowledge and tools that allow the nurse to manage whatever environmental and system resources that exist for the patient/family and staff, within or across healthcare systems and non-healthcare systems.
Response to Diversity	The sensitivity to recognize, appreciate and incorporate differences into the provision of care. Differences may include, but are not limited to, individuality, cultural, spiritual, gender, race, ethnicity, lifestyle, socioeconomic, age and values.
Facilitation of Learning	The ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team and community. Includes both formal and informal facilitation of learning.
Clinical Inquiry	The ongoing process of questioning and evaluating practice and providing informed practice. Creating changes through evidence-based practice, research utilization and experiential knowledge.

Nurses become competent within each continuum at a level that best meets the fluctuating needs of their population of patients. More compromised patients have more severe or complex needs, requiring nurses to have advanced knowledge and skills in an associated continuum.

FOR EXAMPLE:

If the gestalt of a patient were stable but unpredictable, minimally resilient and vulnerable, primary competencies of the nurse would be centered on clinical judgment and caring practices (which includes vigilance). If the gestalt of a patient were vulnerable, unable to participate in decision making and care, and inadequate resource availability, the primary competencies of the nurse would focus on advocacy and moral agency, collaboration and systems thinking.

Although all eight competencies are essential for contemporary nursing practice, each assumes more or less importance depending on a patient's characteristics. **Synergy results when a patient's needs and characteristics are matched with the nurse's competencies.**

Based on the most recent AACN Certification Corporation study of nursing practice, the test plans for AACN certification exams reflect the Synergy Model as well as findings related to nursing care of the adult patient population studied.

For more information about the AACN Synergy Model for Patient Care visit www.certcorp.org.

PCCN TEST PLAN

I. CLINICAL JUDGMENT (80%)

A. Cardiovascular (33%)

1. Acute coronary syndromes
 - a. non-ST segment elevation myocardial infarction
 - b. ST segment elevation myocardial infarction
 - c. unstable angina
2. Acute inflammatory disease (e.g., myocarditis, endocarditis, pericarditis)
3. Aneurysm
 - a. dissecting
 - b. repair
4. Cardiac surgery (e.g., open chest surgery) more than 48 hours postoperative
5. Cardiac tamponade
6. Cardiogenic shock
7. Cardiomyopathies
 - a. dilated (e.g., ischemic/non-ischemic)
 - b. hypertrophic
 - c. stress-induced (e.g., Takotsubo)
8. Dysrhythmias
 - a. bradydysrhythmias
 - b. conduction defects and blocks
 - c. device-related (e.g., ICD and pacemaker)
 - d. lethal ventricular dysrhythmias
 - e. tachydysrhythmias
9. Genetic cardiac disease (e.g., long QT syndrome, Brugada syndrome)
10. Heart failure
 - a. acute exacerbations (e.g., pulmonary edema)
 - b. chronic
11. Hypertensive crisis
12. Minimally invasive cardiac surgery (i.e., non-sternal approach)
13. Septal defects (congenital and acquired)
14. Valvular heart disease
 - a. aortic
 - b. mitral
15. Vascular disease
 - a. carotid artery stenosis
 - b. minimally invasive interventions (e.g., stents, endografts)
 - c. peripheral arterial occlusions
 - d. peripheral surgical interventions
 - e. peripheral venous thrombosis

B. Pulmonary (14%)

1. Acute respiratory distress syndrome (ARDS, to include acute lung injury or ALI)
2. Exacerbation of COPD
3. Obstructive sleep apnea
4. Pleural space abnormalities and complications (e.g., pneumothorax, hemothorax, pleural effusion, empyema)
5. Pulmonary embolism
6. Pulmonary hypertension
7. Respiratory depression (e.g., medication-induced, decreased-LOC-induced)
8. Respiratory failure
 - a. acute
 - b. chronic
9. Respiratory infections (e.g., pneumonia)
10. Severe asthma
11. Thoracic surgery
 - a. lobectomy
 - b. pneumonectomy

C. Endocrine/Hematology/Gastrointestinal/Renal (18%)

1. Endocrine
 - a. diabetes mellitus
 - b. diabetic ketoacidosis
 - c. hyperglycemic hyperosmolar syndrome (HHS)
 - d. hypoglycemia
 - e. metabolic syndrome
2. Hematology/Immunology/Oncology
 - a. anemia
 - b. cancer
 - c. hemostasis disorders (i.e., coagulopathies)
 - i. heparin-induced thrombocytopenia (HIT)
 - ii. other drug-induced overdose (e.g., Coumadin, Pradaxa)
 - d. immunosuppressive disorders
3. Gastrointestinal
 - a. functional GI disorders (e.g., obstruction, ileus, diabetic gastroparesis, gastroesophageal reflux, irritable bowel syndrome)
 - b. GI bleed
 - i. lower
 - ii. upper
 - c. GI infections

continued

PCCN TEST PLAN (CONTINUED)

- d. hepatic failure
 - e. ischemic bowel
 - f. malnutrition (e.g., failure to thrive, malabsorption disorders)
 - g. pancreatitis
4. Renal
- a. acute renal failure
 - b. chronic renal failure
 - c. contrast-induced nephropathy
 - d. end-stage renal disease (ESRD)
 - e. electrolyte imbalances
 - f. medication-induced renal failure
 - g. nephritic syndrome

D. Neurology/Multisystem/Behavioral (15%)

1. Neurology
- a. cerebrovascular malformation (including aneurysm, AV malformation)
 - b. encephalopathy (e.g., hypoxic-ischemic, metabolic, edema, infectious, hepatic)
 - c. intracranial hemorrhage (e.g., subarachnoid, epidural, encephalitis)
 - d. seizure disorders
 - e. stroke (cerebrovascular accident)
 - i. ischemic (embolic)
 - ii. hemorrhagic
 - iii. transient ischemic attack (TIA)
2. Multisystem
- a. complex wounds and pressure ulcers
 - b. healthcare-acquired infections
 - i. catheter-associated urinary tract infections (CAUTI)
 - ii. central-line-associated bloodstream infections (CLABSI)
 - c. palliative care
 - d. end-of-life (e.g., comfort care measures, hospice)
 - e. infectious diseases
 - i. influenza
 - ii. multidrug-resistant organisms (e.g., MRSA, VRE)
 - f. pain
 - g. sepsis continuum
 - i. systemic inflammatory response syndrome (SIRS)
 - ii. sepsis
 - iii. severe sepsis
 - iv. septic shock
 - h. shock states (hypovolemic and anaphylactic)

3. Behavioral/Psychosocial
- a. altered mental status
 - b. delirium
 - c. dementia
 - d. psychological disorders
 - i. anxiety disorders
 - ii. depression
 - e. substance abuse
 - i. alcohol withdrawal
 - ii. chronic alcohol abuse
 - iii. chronic drug abuse
 - iv. drug-seeking behavior

II. PROFESSIONAL CARING AND ETHICAL PRACTICE (20%)

- A. Advocacy**
- B. Caring Practices**
- C. Collaboration**
- D. Systems Thinking**
- E. Response to Diversity**
- F. Clinical Inquiry**
- G. Facilitation of Learning**

Order of content does not necessarily reflect importance.

PCCN TEST PLAN

TESTABLE NURSING ACTIONS

CLINICAL JUDGMENT

Cardiovascular

- Perform a comprehensive cardiovascular assessment
- Identify, interpret and monitor:
 - dysrhythmias
 - ST segments
 - QTc intervals
- Select leads for cardiac monitoring for the indicated disease process
- Recognize indications for and manage patients requiring hemodynamic monitoring using non-invasive hemodynamic monitoring
- Monitor hemodynamic status and recognize signs and symptoms of hemodynamic instability
- Monitor patients and follow protocols for managing patients with:
 - pacemakers
 - defibrillation
 - arterial/venous sheaths
 - transesophageal echocardiogram (TEE)
- Monitor patients pre- and post-procedure:
 - cardioversion
 - pericardiocentesis
 - cardiac catheterization
 - ablation
 - arterial closure devices
- Monitor normal and abnormal cardiovascular diagnostic test results
- Administer cardiovascular medications and monitor response
- Titrate vasoactive medications
- Recognize signs and symptoms of cardiovascular emergencies, initiate standardized interventions and seek assistance as needed
- Monitor and manage patient following coronary intervention

Pulmonary

- Perform a comprehensive pulmonary assessment
- Monitor normal and abnormal diagnostic test results
- Interpret ABGs and report findings

- Monitor patient for response to pulmonary medications
- Manage patients requiring non-invasive O₂ or ventilation delivery systems
 - nasal cannula
 - face mask
 - venti-mask
 - non-rebreather mask
 - BiPAP
 - CPAP
- Manage patients requiring mechanical ventilation - tracheostomy tube
- Manage patients requiring respiratory monitoring devices:
 - continuous SPO₂
 - intermittent SPO₂
 - end-tidal CO₂ (capnography)
- Recognize signs and symptoms of respiratory complications and seek assistance as needed
- Maintain airway
- Manage patients with chest tubes
- Assist with procedures:
 - thoracentesis
 - chest tube insertion
- Administer medications for procedural (conscious) sedation and monitor patient response

Endocrine/Hematology/Gastrointestinal/Renal

- Endocrine
 - identify signs and symptoms associated with endocrine disorders
 - monitor normal and abnormal endocrine diagnostic test results
 - administer medications and monitor patient response
 - manage and titrate insulin infusions
 - manage patients using insulin pumps
- Hematology/Immunology/Oncology
 - identify signs and symptoms associated with hematologic/immunologic/oncologic disorders
 - monitor normal and abnormal diagnostic hematologic/immunologic/oncologic test results
 - administer medications and monitor patient response

continued

PCCN TEST PLAN
TESTABLE NURSING ACTIONS
(CONTINUED)

- Gastrointestinal
 - perform a comprehensive gastrointestinal assessment
 - monitor normal and abnormal gastrointestinal diagnostic test results
 - recognize indications for and complications of enteral and parenteral nutrition
 - administer medications and monitor patient response
- Renal
 - identify normal and abnormal renal assessment findings
 - monitor normal and abnormal renal diagnostic test results
 - monitor peritoneal dialysis
 - identify medications that may cause nephrotoxicity
 - initiate renal protective measures for nephrotoxic procedures
- Behavioral/Psychosocial
 - perform a comprehensive psychosocial, behavioral and risk assessment
 - administer medications and monitor patient response
 - recognize signs and symptoms of behavioral emergencies and initiate interventions
 - perform Clinical Institute Withdrawal Assessment (CIWA, CIWA-Ar scale)
 - screen patients using a delirium assessment tool
 - implement suicide prevention measures

Neurology/Multisystem/Behavioral

- Neurology
 - perform a comprehensive neurological assessment
 - monitor normal and abnormal neurological diagnostic test results
 - administer medications and monitor patient response
 - recognize signs and symptoms of increased intracranial pressure
 - use the NIH Stroke Scale (NIHSS)
 - perform bedside screening for dysphagia
- Multisystem
 - administer medications and monitor patient response
 - identify early signs and symptoms of sepsis (SIRS criteria)
 - initiate early goal-directed therapy (EGDT) for treating sepsis
 - initiate emergency interventions (e.g., ACLS, rapid response team)
 - differentiate types of wounds, pressure ulcers, and deep tissues injuries
 - manage patients with complex wounds (e.g., fistulas, drains, and vacuum-assisted closure devices)
 - manage patients with infections
 - manage patients at the end of life
 - facilitate the organ/tissue donation process

PROFESSIONAL CARING AND ETHICAL PRACTICE

Systems Thinking

- Informatics
 - use word processing applications use internet resources to locate patient support groups, online resources
 - use hospital or nursing information systems to access, enter and retrieve data related to patient care
 - use database applications to enter and retrieve data and information
 - conduct online and database literature searches
 - use computer applications to document patient care
 - use computer applications to plan patient care, including discharge planning
 - use information management systems for patient education
 - use technology-based patient monitoring systems
 - operate peripheral/point-of-care devices, bedside and hand-held (e.g., smart pump)

SAMPLE PCCN EXAM QUESTIONS

- Two days post admission for rapid atrial fibrillation, a patient has been weaned from IV diltiazem (Cardizem) to PO administration. The patient develops new onset of hallucinations, agitation and disorientation. The most appropriate *initial* nursing action is to**
 - obtain an order for lorazepam (Ativan) every six hours.
 - assess the patient's SpO₂ and neurological status.
 - obtain an order for haloperidol (Haldol) and monitor QT intervals.
 - consult with the pharmacy regarding a possible drug interaction.
- A patient with an extensive history of substance abuse including alcohol, tobacco, methyl amphetamine and IV heroin use is suspected to have valvular endocarditis. He states he doesn't understand how he is now in this situation. Which of the following statements best reflects his diagnosis?**
 - ingestion of alcohol causes myocardial depression
 - inhalation of stimulants causes instability to the electrical system of the heart
 - contaminated needles can introduce bacteria into the bloodstream
 - repeated exposure to nicotine is related to stenosis of the leaflets
- A patient with CAD complains of parasthesia to the foot. The nurse notes the right foot is cooler than the other extremity, and pedal pulses are difficult to palpate. Which additional assessment findings in the right leg would lead the nurse to suspect peripheral arterial disease?**
 - pallor when elevating the extremity
 - redness of the ankle and foot
 - dependent edema
 - engorged varicose veins
- After PCI for a STEMI, the patient complains of shortness of breath. Crackles are auscultated throughout all lung fields. VS: BP 72/50, HR 124, RR 32, O₂Sat 88% on 2L nasal cannula. Which of the following would be the immediate goal for treatment strategies?**
 - volume to enhance venous return
 - diuresis to reduce myocardial workload
 - antiarrhythmics to restore electrical stability
 - thrombolytics to eliminate the pulmonary embolus
- A patient who is 1 week post MI suddenly becomes agitated, restless and diaphoretic. Pulse pressure drops to 20 mm Hg. Assessment also reveals faint radial and apical pulses that weaken significantly on inspiration. This patient is *most likely* experiencing**
 - mitral valve rupture.
 - pulmonary embolus.
 - pulmonary edema.
 - cardiac tamponade.
- Which of the following may predispose an individual to ventricular fibrillation?**
 - hypernatremia and hypomagnesemia
 - hypophosphatemia and hyperchloremia
 - hypermagnesemia and hyponatremia
 - hyperkalemia and hypocalcemia
- Chest auscultation of a patient in status asthmaticus commonly reveals which of the following?**
 - expiratory wheezes
 - inspiratory crackles
 - diminished bilateral breath sounds
 - a pleural friction rub
- The family of a critically ill patient wishes to spend the night, which is contrary to the visiting policy. The nurse's *best* action would be to**
 - adhere to the visiting policy.
 - allow the family to stay in the room.
 - obtain a motel room near the hospital where the family may spend the night.
 - allow one or two family members to stay, then evaluate the patient's response.
- Members of the nursing staff are developing written patient education materials for a group of patients with diverse reading abilities. It would be *most effective* for the staff to**
 - design individual handouts for each patient.
 - develop a computer-based education series.
 - write the materials at a fourth-grade reading level.
 - limit text and provide color pictures.

Answers

- | | | |
|------|------|------|
| 1. B | 4. B | 7. A |
| 2. C | 5. D | 8. D |
| 3. A | 6. D | 9. C |

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Many references are available through AACN; visit www.aacn.org/bookstore.

More current versions may be available.

PUBLISHER CONTACTS:

AACN – (800) 899-2226

American Heart Association – (800) 242-8721

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<i>Synergy: The Unique Relationship Between Nurses and Patients</i> . (2007). Curley, M. A. Q. 304 pages.	100148

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STAPLE CHECK HERE

PCCN EXAM APPLICATION

1. REGISTRATION INFORMATION PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.
LEGAL NAME AS IT APPEARS ON YOUR GOVERNMENT-ISSUED ID CARD IS REQUIRED FOR EXAM.

AACN CUSTOMER:		RN/APRN LICENSE:			
	Number	Exp. Date	Number	State	Exp. Date
LEGAL NAME:					
	Last	First	MI	Maiden	
HOME ADDRESS:					
			City	State	ZIP
EMAIL:			HOME PHONE:		
EMPLOYER NAME:			BUSINESS PHONE:		
EMPLOYER ADDRESS:					
			City	State	ZIP

2. AACN MEMBERSHIP

I would also like to join/renew/extend my AACN membership at this time and *select member pricing* for my exam fees:
(check **one** box only)

- 1-year AACN membership.....\$78
- 2-year AACN membership.....\$148
- 3-year AACN membership.....\$200

AACN membership includes nonrefundable \$12 and \$15 one-year subscriptions to *Critical Care Nurse*® and the *American Journal of Critical Care*®, respectively. AACN dues are not deductible as charitable contributions for tax purposes, but may be deducted as a business expense in keeping with Internal Revenue Service regulations.

Member exam fee (\$175) + 1-year Membership (\$78) = Savings of \$22 over Nonmember fee

Membership Fee:

\$ _____

+

Exam Fee:

\$ _____

=

Total Payment:

\$ _____

3. EXAM FEE

PCCN Adult	Initial Exam Fee		Retest Fee	
	AACN Member	Nonmember	AACN Member	Nonmember
<i>Check one box only</i>	<input type="checkbox"/> \$175	<input type="checkbox"/> \$275	<input type="checkbox"/> \$135	<input type="checkbox"/> \$215

Check this box if you've attached a request and supporting documentation for special testing accommodations.

4. PAYMENT INFORMATION – *application must be accompanied by payment*

Check or money order attached – payable to AACN Certification Corporation. U.S. funds only.

Bill my credit card Visa MasterCard American Express Discover Card

Credit Card # Exp. Date (mm/yy)

Name on Card _____ Signature _____

Amount Billed \$ _____ Address of Payor (if different than applicant) _____

Please do not include my name on lists sold to other organizations.

Please complete pages 2 & 3 of application.

PCCN EXAM APPLICATION

PRINTED LEGAL NAME:

AACN#:

5. DEMOGRAPHIC INFORMATION

Check **one** box in each category. Information used for statistical purposes.

Primary Area Employed

- Acute Hemodialysis Unit (21)
- Burn Unit (13)
- Cardiac Rehabilitation (26)
- Cardiac Surgery/OR (36)
- Cardiovascular/Surgical ICU (09)
- Catheterization Lab (22)
- Combined Adult/Ped. ICU (23)
- Combined ICU/CCU (01)
- Coronary Care Unit (03)
- Crit. Care Transport/Flight (17)
- Direct Observation Unit (39)
- Emergency Dept. (12)
- General Med./Surg. Floor (18)
- Home Care (25)
- Intensive Care Unit (02)
- Interventional Cardiology (31)
- Long-Term Care (27)
- Medical Cardiology (34)
- Medical ICU (04)
- Medical Surgical ICU (35)
- Neonatal ICU (06)
- Neuro./Neurosurgical ICU (10)
- Oncology Unit (19)
- Operating Room (15)
- Outpatient Clinic (29)
- Pediatric ICU (05)
- Private Practice (32)
- Progressive Care Unit (16)
- Recovery Room/PACU (14)
- Respiratory ICU (08)
- Stepdown Unit (30)
- Subacute Care (28)
- Surgical ICU (07)
- Tele-ICU (37)

- Telemetry (20)
- Trauma Unit (11)
- Other - specify below _____ (99)

Primary Position Held

- Academic Faculty (07)
- Acute Care Nurse Practitioner (09)
- Administrator/V.P. (43)
- Bedside/Staff Nurse (01)
- Charge Nurse (45)
- Clinic Nurse (40)
- Clinical Coordinator (44)
- Clinical Director (04)
- Clinical Nurse Specialist (08)
- Elected Official (12) _____ (99)
- Home Healthcare Nurse (41)
- In-service/Staff Devel. Instructor (06)
- Legal Nurse Consultant (47)
- Manager (03)
- Nurse Anesthetist (02)
- Nurse Educator (46)
- Nurse Midwife (13)
- Nurse Practitioner (05)
- Physician (16)
- Physician Assistant (17)
- Researcher (18)
- Respiratory Therapist (19)
- Social Worker (20)
- Unit Coordinator (22)
- Other - specify below _____ (99)

Highest Nursing Degree

- Associate's Degree
- Bachelor's Degree
- Diploma
- Doctorate
- Master's Degree

- University Med. Ctr. (03)
- Other - specify below _____ (99)

Number of Beds in Institution

_____ (99)

Years of Experience in Nursing

_____ (99)

Years of Experience in Acute/Critical Care Nursing

_____ (99)

Date of Birth (Month/Day/Year)

_____ (99)

Gender

- Female Male

Ethnicity

- African American (02)
- Asian (05)
- Hispanic/Latino (03)
- Native American (04)
- Pacific Islander (06)
- White/Non-Hispanic (01)
- Other - specify below _____ (99)

Primary Type of Facility in Which Employed

- College/University (08)
- Community Hospital (Nonprofit) (01)
- Community Hospital (Profit) (02)
- County Hospital (07)
- Federal Hospital (05)
- HMO/Managed Care (12)
- Home Health (13)
- Military/Government Hospital (04)
- Non-Academic Teaching Hosp. (14)
- Private Industry (11)
- Registry (10)
- Self-Employed (09)
- State Hospital (06)
- Travel Nurse (15)

6. HONOR STATEMENT - 3rd page of application to be submitted with this form

Complete the Honor Statement on page 23.

7. SUBMIT APPLICATION

Attach Honor Statement to this application and submit with payment to:

AACN Certification Corporation
101 Columbia
Aliso Viejo, CA 92656-4109
or fax to: (949) 362-2020

DO NOT mail AND fax your application - please choose only ONE method.

NOTE: Allow **2 to 3 weeks** from the date received by AACN Certification Corporation for application processing.

Questions? Please visit www.certcorp.org, email certcorp@aacn.org or call us at (800) 899-2226.

Please complete page 3 of application (honor statement).



PCCN EXAM HONOR STATEMENT

PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.

PLEASE PRINT CLEARLY.

NAME: _____ **AACN CUSTOMER #:** _____
Last First MI

I hereby apply for the PCCN certification exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *PCCN Exam Handbook* and the *Certification Exam Policy Handbook*.

LICENSURE: I possess a current unencumbered U.S. RN or APRN license. My _____ (state) nursing license _____ (number) is due to expire _____ (date). An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit my practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any disciplinary action is taken against my RN or APRN license in the future.

PRACTICE: I have fulfilled *one* of the following clinical practice requirement options:

- Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely ill **adult** patients during the past 2 years, with 875 of those hours accrued in the most recent year preceding application.

OR

- Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely ill **adult** patients, with 144 of those hours accrued in the most recent year preceding application.

Hours were completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice as evidenced by Magnet Status or Joint Commission International accreditation.

PRACTICE VERIFICATION: Following is the contact information of my clinical supervisor or a professional colleague (RN or physician) who can verify that I have met the clinical hour eligibility requirements:

VERIFIER'S NAME: _____ **FACILITY NAME:** _____
Last First

VERIFIER'S PHONE NUMBER: _____ **VERIFIER'S EMAIL ADDRESS:** _____

You may not list yourself or a relative as your verifier.

AUDIT: I understand that my certification application is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NON-DISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: _____ **Date:** _____

PCCN

Generations Family Health Center
October 2, 2015

EXHIBIT 4: Society of Critical Care Medicine Guidelines for Inter- and Intra-Hospital Transport of Critically Ill Patients

Guidelines for the inter- and intrahospital transport of critically ill patients*

Jonathan Warren, MD, FCCM, FCCP; Robert E. Fromm Jr, MD, MPH, MS; Richard A. Orr, MD; Leo C. Rotello, MD, FCCM, FCCP, FACP; H. Mathilda Horst, MD, FCCM; American College of Critical Care Medicine

Objective: The development of practice guidelines for the conduct of intra- and interhospital transport of the critically ill patient.

Data Source: Expert opinion and a search of Index Medicus from January 1986 through October 2001 provided the basis for these guidelines. A task force of experts in the field of patient transport provided personal experience and expert opinion.

Study Selection and Data Extraction: Several prospective and clinical outcome studies were found. However, much of the published data comes from retrospective reviews and anecdotal reports. Experience and consensus opinion form the basis of much of these guidelines.

Results of Data Synthesis: Each hospital should have a formalized plan for intra- and interhospital transport that addresses

a) pretransport coordination and communication; b) transport personnel; c) transport equipment; d) monitoring during transport; and e) documentation. The transport plan should be developed by a multidisciplinary team and should be evaluated and refined regularly using a standard quality improvement process.

Conclusion: The transport of critically ill patients carries inherent risks. These guidelines promote measures to ensure safe patient transport. Although both intra- and interhospital transport must comply with regulations, we believe that patient safety is enhanced during transport by establishing an organized, efficient process supported by appropriate equipment and personnel. (*Crit Care Med* 2004; 32:256–262)

Key Words: intrahospital transport; interhospital transport; critical care; health planning; policy making; monitoring; standards

The decision to transport a critically ill patient, either within a hospital or to another facility, is based on an assessment of the potential benefits of transport weighed against the potential risks. Critically ill patients are transported to alternate locations to obtain additional care, whether technical, cognitive, or procedural, that is not available at the existing location. Provision of this additional care may require patient transport to a diagnostic department, operating room, or specialized care unit within a hospital, or

it may require transfer to another hospital. If a diagnostic test or procedural intervention under consideration is unlikely to alter the management or outcome of that patient, then the need for transport must be questioned. When feasible and safe, diagnostic testing or simple procedures in unstable or potentially unstable patients often can be performed at the bedside in the intensive care unit (1, 2). Financial considerations are not a factor when contemplating moving a critically ill patient.

Critically ill patients are at increased risk of morbidity and mortality during transport (3–17). Risk can be minimized and outcomes improved with careful planning, the use of appropriately qualified personnel, and selection and availability of appropriate equipment (16–37). During transport, there is no hiatus in the monitoring or maintenance of a patient's vital functions. Furthermore, the accompanying personnel and equipment are selected by training to provide for any ongoing or anticipated acute care needs of the patient.

Ideally, all critical care transports, both inter- and intrahospital, are performed by

specially trained individuals. Since there will almost certainly be situations when a specialized team is not available for interhospital transport, each referring and tertiary institution must develop contingency plans using locally available resources for those instances when the referring facility cannot perform the transport. A comprehensive and effective interhospital transfer plan can be developed using a systematic approach comprised of four critical elements: a) A multidisciplinary team of physicians, nurses, respiratory therapists, hospital administration, and the local emergency medical service is formed to plan and coordinate the process; b) the team conducts a needs assessment of the facility that focuses on patient demographics, transfer volume, transfer patterns, and available resources (personnel, equipment, emergency medical service, communication); c) with this data, a written standardized transfer plan is developed and implemented; and d) the transfer plan is evaluated and refined regularly using a standard quality improvement process.

This document outlines the minimum recommendations for transport of the critically ill patient. Detailed guidelines

***See also p. 305.**

From Northwest Community Hospital, Arlington Heights, IL (JW); Baylor College of Medicine, Houston, TX (REF); Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine, Pittsburgh, PA (RAO); Suburban Hospital, Bethesda, MD (LCR); Henry Ford Hospital, Detroit, MI (HMH).

These guidelines have been developed by the American College of Critical Care Medicine and the Society of Critical Care Medicine. These guidelines reflect the official opinion of the Society of Critical Care Medicine and do not necessarily reflect, and should not be construed to reflect, the views of certification bodies, regulatory agencies, or other medical review organizations.

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DOI: 10.1097/01.CCM.0000104917.39204.0A

targeted to the transport of infants and children have been published by the American Academy of Pediatrics (23). Institutions performing commercial or organized interhospital transports are required to function at and meet a higher standard, as the requirements for organized transport services are considerably more rigorous than the recommendations in this guideline (24, 38–41).

The references for this guideline were obtained from a review of Index Medicus (see key words) from January 1986 through October 2001 and are categorized according to the degree of evidence-based data employed. The specific category assigned to each reference is noted in the References at the end of this article. The letter *a* denotes a randomized, prospective controlled investigation; *b* denotes a nonrandomized, concurrent, or historical cohort investigation; *c* denotes a peer-reviewed “state-of-the-art” article, review article, editorial, or substantial case series; and *d* denotes a non-peer-reviewed opinion such as a textbook statement or official organizational publication. The asterisk symbol will follow a statement of practice standards. This indicates a recommendation by the American College of Critical Care Medicine that is based on expert opinion and is used in circumstances where published supporting data are unavailable.

INTRAHOSPITAL TRANSPORT

Because the transport of critically ill patients to procedures or tests outside the intensive care unit is potentially hazardous, the transport process must be organized and efficient. To provide for this, at least four concerns need to be addressed through written intensive care unit policies and procedures: communication, personnel, equipment, and monitoring.

Pretransport Coordination and Communication. When an alternate team at a receiving location will assume management responsibility for the patient after arrival, continuity of patient care will be ensured by physician-to-physician and/or nurse-to-nurse communication to review patient condition and the treatment plan in operation. This communication occurs each time patient care responsibility is transferred. Before transport, the receiving location confirms that it is ready to receive the patient for immediate procedure or testing. Other members of the healthcare team (e.g., respiratory ther-

apy, hospital security) then are notified as to the timing of the transport and the equipment support that will be needed. The responsible physician is made aware of the transport. Documentation in the medical record includes the indications for transport and patient status throughout the time away from the unit of origin.

Accompanying Personnel. It is strongly recommended that a minimum of two people accompany a critically ill patient.* One of the accompanying personnel is usually a nurse who has completed a competency-based orientation and has met previously described standards for critical care nurses (42, 43). Additional personnel may include a respiratory therapist, registered nurse, or critical care technician as needed. It is strongly recommended that a physician with training in airway management and advanced cardiac life support, and critical care training or equivalent, accompany unstable patients.* When the procedure is anticipated to be lengthy and the receiving location is staffed by appropriately trained personnel, patient care may be transferred to those individuals if acceptable to both parties. This allows for maximum utilization of staff and resources. If care is not transferred, the transport personnel will remain with the patient until returned to the intensive care unit.

Accompanying Equipment. A blood pressure monitor (or standard blood pressure cuff), pulse oximeter, and cardiac monitor/defibrillator accompany every patient without exception.* When available, a memory-capable monitor with the capacity for storing and reproducing patient bedside data will allow review of data collected during the procedure and transport. Equipment for airway management, sized appropriately for each patient, is also transported with each patient, as is an oxygen source of ample supply to provide for projected needs plus a 30-min reserve.

Basic resuscitation drugs, including epinephrine and antiarrhythmic agents, are transported with each patient in the event of sudden cardiac arrest or arrhythmia. A more complete array of pharmacologic agents either accompanies the basic agents or is available from supplies (“crash carts”) located along the transport route and at the receiving location. Supplemental medications, such as sedatives and narcotic analgesics, are considered in each specific case. An ample supply of appropriate intravenous fluids and continuous drip medications (regulated by battery-operated infusion pumps) is

ensured. All battery-operated equipment is fully charged and capable of functioning for the duration of the transport. If a physician will not be accompanying the patient during transport, protocols must be in place to permit the administration of these medications and fluids by appropriately trained personnel under emergency circumstances.

In many hospitals, pediatric patients share diagnostic and procedural facilities with adult patients. Under these circumstances, a complete set of pediatric resuscitation equipment and medications will accompany infants and children during transport and also will be available in the diagnostic or procedure area.

For practical reasons, bag-valve ventilation is most commonly employed during intrahospital transports. Portable mechanical ventilators are gaining increasing popularity in this arena, as they more reliably administer prescribed minute ventilation and desired oxygen concentrations. In adults and children, a default oxygen concentration of 100% generally is used. However, oxygen concentration must be precisely regulated for neonates and for those patients with congenital heart disease who have single ventricle physiology or are dependent on a right-to-left shunt to maintain systemic blood flow. For patients requiring mechanical ventilation, equipment is optimally available at the receiving location capable of delivering ventilatory support equivalent to that being delivered at the patient's origin. In mechanically ventilated patients, endotracheal tube position is noted and secured before transport, and the adequacy of oxygenation and ventilation is reconfirmed. Occasionally patients may require modes of ventilation or ventilator settings not reproducible at the receiving location or during transportation. Under these circumstances, the origin location must trial alternate modes of mechanical ventilation before transport to ensure acceptability and patient stability with this therapy. If the patient is incapable of being maintained safely with alternate therapy, the risks and benefits of transport are cautiously reexamined. If a transport ventilator is to be employed, it must have alarms to indicate disconnection and excessively high airway pressures and must have a backup battery power supply.*

Monitoring During Transport. All critically ill patients undergoing transport receive the same level of basic physiologic monitoring during transport as they had

in the intensive care unit. This includes, at a minimum, continuous electrocardiographic monitoring, continuous pulse oximetry (44), and periodic measurement of blood pressure, pulse rate, and respiratory rate. In addition, selected patients may benefit from capnography, continuous intra-arterial blood pressure, pulmonary artery pressure, or intracranial pressure monitoring. There may be special circumstances that warrant intermittent cardiac output or pulmonary artery occlusion pressure measurements.

INTERHOSPITAL TRANSPORT

Patient outcomes depend to a large degree on the technology and expertise of personnel available within each health-care facility. When services are needed that exceed available resources, a patient ideally will be transferred to a facility that has the required resources (45). Interhospital patient transfers occur when the benefits to the patient exceed the risks of the transfer. A decision to transfer a patient is the responsibility of the attending physician at the referring institution. Once this decision has been made, the transfer is effected as soon as possible. When needed, resuscitation and stabilization will begin before the transfer (46, 47), realizing that complete stabilization may be possible only at the receiving facility.

In the United States, it is essential for practitioners to be aware of federal and state laws regarding interhospital patient transfers. The Emergency Medical Treatment and Active Labor Act (EMTALA) laws and regulations (updated at intervals from the 1986 COBRA laws and the 1990 OBRA amendment) define in detail the legal responsibilities of the transferring and receiving facilities and practitioners. The American College of Emergency Physicians has published a book (48) that reviews the legal responsibilities of referring institutions as well as the ramifications of noncompliance with the COBRA/EMTALA regulations, and it is an excellent resource for any facility involved in patient transfers. In general, under COBRA/EMTALA, financially motivated transfers are illegal and put both the referring institution and the individual practitioner at risk for serious penalty (49, 50).

Current regulations and good medical practice require that a competent patient, guardian, or the legally authorized representative of an incompetent patient give

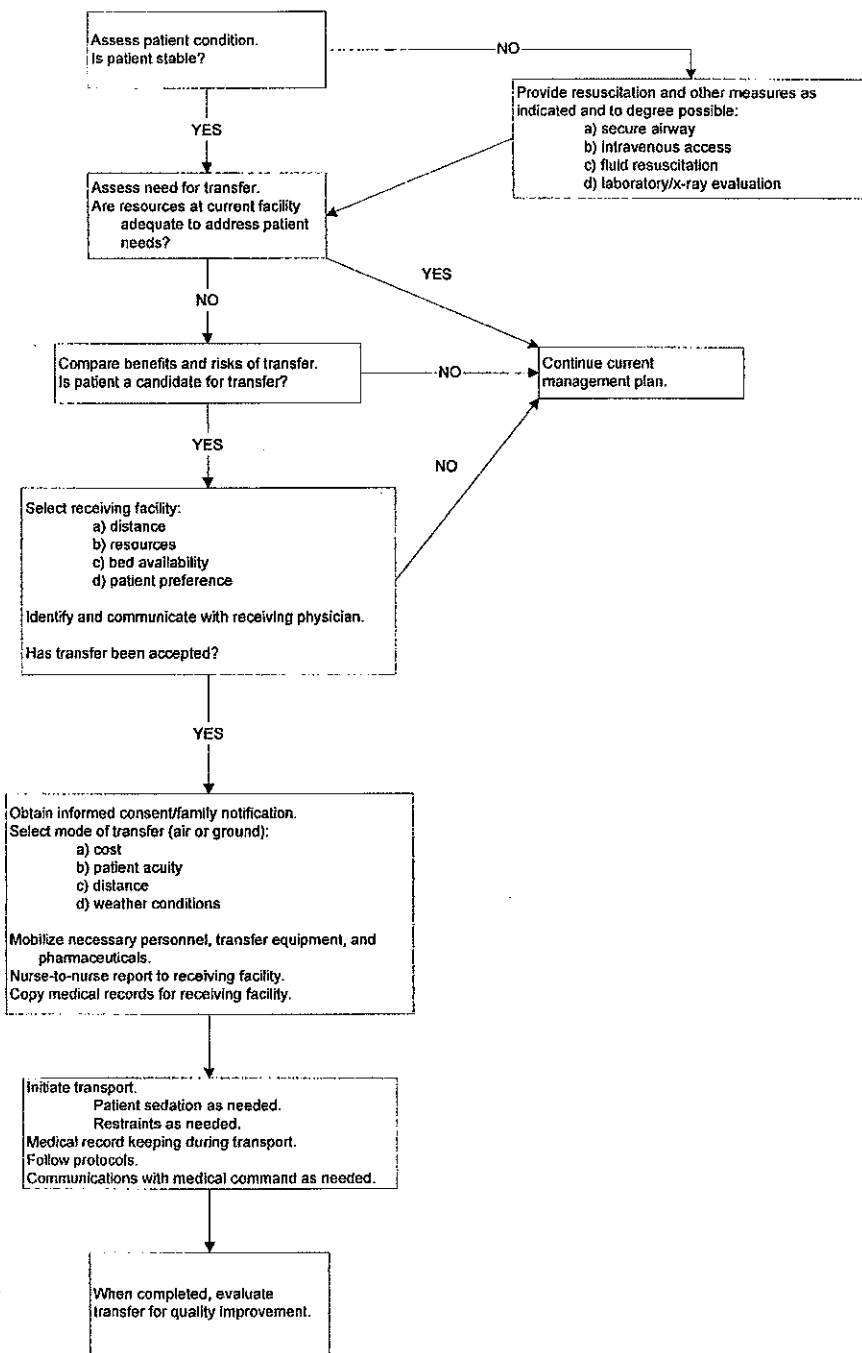


Figure 1. Interfacility transfer algorithm.

informed consent before interhospital transfer. The informed consent process includes a discussion of the risks and benefits of transfer. These discussions are documented in the medical record before transfer. A signed consent should be obtained, if possible. If circumstance do not allow for the informed consent process (e.g., life-threatening emergency), then both the indications for transfer and the reason for not obtaining consent are documented in the medical record. The re-

ferred physician always writes an order for transfer in the medical record.

Several elements are included in the process of interhospital transfer, and all fall within minimum guidelines, as described subsequently. It is important to recognize that these process elements may frequently, and out of necessity, be implemented simultaneously, especially when stabilization and treatment are needed before transfer. An algorithm has been developed to guide prac-

Table 1. Recommended minimum transport equipment

- Airway management/oxygenation—adult and pediatric
 - Adult and pediatric bag-valve systems with oxygen reservoir
 - Adult and pediatric masks for bag-valve system (multiple sizes as appropriate)
 - Flexible adaptors to connect bag-valve system to endotracheal/tracheostomy tube
 - End-tidal carbon dioxide monitors (pediatric and adult)
 - Infant medium- and high-concentration masks with tubing
 - MacIntosh laryngoscope blades (#1, #2, #3, #4)
 - Miller laryngoscope blades (#0, #1, #2)
 - Endotracheal tube stylets (adult and pediatric)
 - Magil forceps (adult and pediatric)
 - Booted hemostat
 - Cuffed endotracheal tubes (5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0)
 - Uncuffed endotracheal tubes (2.5, 3.0, 3.5, 4.0, 4.5, 5.0)
 - Laryngoscope handles (adult and pediatric)
 - Extra laryngoscope batteries and light bulbs
 - Nasopharyngeal airways (#26, #30)
 - Oral airways (#0, #1, #2, #3, #4)
 - Scalpel with blade for cricothyroidotomy
 - Needle cricothyroidotomy kit
 - Water-soluble lubricant
 - Nasal cannulas (adult and pediatric)
 - Oxygen tubing
 - PEEP valve (adjustable)
- Adhesive tape
- Aerosol medication delivery system (nebulizer)
- Alcohol swabs
- Arm boards (adult and pediatric)
- Arterial line tubing
- Bone marrow needle (for pediatric infusion)
- Blood pressure cuffs (neonatal, infant, child, adult large and small)
- Butterfly needles (23-gauge, 25-gauge)
- Communications backup (e.g., cellular telephone)
- Defibrillator electrolyte pads or jelly
- Dextrostix
- ECG monitor/defibrillator (preferably with pressure transducer capabilities)
- ECG electrodes (infant, pediatric, adult)
- Flashlights with extra batteries
- Heimlich valve
- Infusion pumps
- Intravenous fluid administration tubing (adult and pediatric)
- Y-blood administration tubing
- Extension tubing
- Three-way stopcocks
- Intravenous catheters, sizes 14- to 24-gauge
- Intravenous solutions (plastic bags)
 - 1000 mL, 500 mL of normal saline
 - 1000 mL of Ringers lactate
 - 250 mL of 5% dextrose
- Irrigating syringe (60 mL), catheter tip
- Kelley clamp
- Hypodermic needles, assorted sizes
- Hypodermic syringes, assorted sizes
- Normal saline for irrigation
- Pressure bags for fluid administration
- Pulse oximeter with multiple site adhesive or reusable sensors
- Salem sump nasogastric tubes, assorted sizes
- Soft restraints for upper and lower extremities
- Stethoscope
- Suction apparatus
- Suction catheters (#5, #8, #10, #14, tonsil)
- Surgical dressings (sponges, Kling, Kerlix)
- Tourniquets for venipuncture/IV access
- Trauma scissors
- The following are considered as needed
 - Transcutaneous pacemaker
 - Neonatal/pediatric isolette
 - Spinal immobilization device
 - Transport ventilator

PEEP, positive end-expiratory pressure; ECG, electrocardiogram; IV, intravenous.

tioners through the transfer process (Fig. 1).

Pretransport Coordination and Communication. The referring physician will identify and contact an admitting physician at the receiving hospital to accept the patient in transfer and confirm before the transfer occurs that appropriate higher level resources are available. The receiving physician is given a full description of the patient's condition. At that time, advice can be requested concerning treatment and stabilization before transport. The appropriateness of transferring a patient from an inpatient setting (critical care unit) to an outpatient setting (e.g., emergency department) at a receiving institution must be cautiously examined. If a physician will not be accompanying the patient during transport (34), the referring and accepting physicians will ensure there is a command physician for the transport team who will assume responsibility for medical treatment during the transport. It may be appropriate for this individual to receive a medical report before the team departs.

In some instances (e.g., when a receiving institution provides the transport team), the receiving physician may determine the mode of transport. However, the mode of transportation (ground or air) usually is determined by the transferring physician, in consultation with the receiving physician, based on the urgency of the medical condition (stability of the patient), time savings anticipated with air transport, weather conditions, medical interventions necessary for ongoing life support during transfer, and the availability of personnel and resources (51, 52). The transport service then will be contacted to confirm its availability, to prepare for anticipated patient needs during transport, and to coordinate the timing of the transport.

A nurse-to-nurse report is given by the referring facility to the appropriate nursing unit at the receiving hospital. Alternatively, the report can be given by a transport team member at the time of arrival. A copy of the medical record, including a patient care summary and all relevant laboratory and radiographic studies, will accompany the patient. The preparation of records should not delay patient transport, however, as these records can be forwarded separately (by facsimile or courier) if and when the urgency of transfer precludes their assemblage beforehand. Under these circumstances, the most critical information is

Table 2. Recommended minimum transport medications

Adenosine, 6 mg/2 mL
Albuterol, 2.5 mg/2 mL
Amiodarone, 150 mg/3 mL
Atropine, 1 mg/10 mL
Calcium chloride, 1 g/10 mL
Cetacaine/Hurricane spray
Dextrose 25%, 10 mL
Dextrose 50%, 50 mL
Digoxin, 0.5 mg/2 mL
Diltiazem, 25 mg/5 mL
Diphenhydramine, 50 mg/1 mL
Dopamine, 200 mg/5 mL
Epinephrine, 1 mg/10 mL (1:10,000)
Epinephrine, 1 mg/1 mL (1:1000) multiple-dose vial
Fosphenytoin, 750 mg/10 mL (500 PE mg/10 mL)
Furosemide, 100 mg/10 mL
Glucagon, 1 mg vial (powder)
Heparin, 1000 units/1 mL
Isoproterenol, 1 mg/5 mL
Labetalol, 40 mg/8 mL
Lidocaine, 100 mg/10 mL
Lidocaine, 2 g/10 mL
Mannitol, 50 g/50 mL
Magnesium sulfate, 1 g/2 mL
Methylprednisolone, 125 mg/2 mL
Metoprolol, 5 mg/5 mL
Naloxone, 2 mg/2 mL
Nitroglycerin injection, 50 mg/10 mL
Nitroglycerin tablets, 0.4 mg (bottle)
Nitroprusside, 50 mg/2 mL
Normal saline, 30 mL for injection
Phenobarbital, 65 mg/mL or 130 mg/mL
Potassium chloride, 20 mEq/10 mL
Procainamide, 1000 mg/10 mL
Sodium bicarbonate, 5 mEq/10 mL
Sodium bicarbonate, 50 mEq/50 mL
Sterile water, 30 mL for injection
Terbutaline, 1 mg/1 mL
Verapamil, 5 mg/2 mL

The following specialized/controlled medications are added immediately before transport as indicated

- Narcotic analgesics (e.g., morphine, fentanyl) (59)
- Sedatives/hypnotics (e.g., lorazepam, midazolam, propofol, etomidate, ketamine) (59)
- Neuromuscular blocking agents (e.g. succinylcholine, pancuronium, atracurium, rocuronium) (60)
- Prostaglandin E1
- Pulmonary surfactant

communicated verbally. It is strongly suggested that policies be established within each institution regarding the content of documentation and communication between personnel involved in the transfer.

Accompanying Personnel. It is recommended that a minimum of two people, in addition to the vehicle operators, accompany a critically ill patient during interhospital transport.* When transporting unstable patients, the transport team leader should be a physician or nurse (41, 53, 54), preferably with additional training in transport medicine. For critical but stable patients, the team leader may be a paramedic (41). These individuals provide the essential capabilities

of advanced airway management, intravenous therapy, dysrhythmia interpretation and treatment, and basic and advanced cardiac life support. In the absence of a physician team member, there will be a mechanism by which the transport team can communicate with a command physician. If communication of this type becomes impossible, the team will have preauthorization by standing orders to perform acute lifesaving interventions. In the absence of a readily available external transport team, a transport team and vehicle may need to be assembled locally. The development of policies and procedures for such emergencies is strongly recommended.

Minimum Equipment Required. Ta-

Although both intra- and interhospital transport must comply with regulations, we believe patient safety is enhanced during transport by establishing an organized efficient process supported by appropriate equipment and personnel.

bles 1 and 2 provide a detailed list of the minimum recommended equipment and pharmaceuticals needed for safe interhospital transport. Emphasis is placed on airway and oxygenation, vital signs monitoring, and the pharmaceutical agents necessary for emergency resuscitation and stabilization as well as maintenance of vital functions. Very short or very long transports may necessitate deviations from the listed items, depending on the severity and nature of illness or injury. Furthermore, advances in knowledge over time will result in periodic review and modification of these lists. All items are checked regularly for expiration of sterility and/or potency, especially when transports are infrequent. Equipment function is verified on a scheduled basis, not at the time of transport when there may be insufficient time to find replacements.

Monitoring During Transport. All critically ill patients undergoing interhospital transport must have, at a minimum, continuous pulse oximetry, electrocardiographic monitoring, and regular measurement of blood pressure and respiratory rate.* Selected patients, based on clinical status, may benefit from the monitoring of intra-arterial blood pressure (55), central venous pressure, pulmonary artery pressure, intracranial pressure, and/or capnography (56). With mechanically ventilated patients, endotracheal tube position is noted and secured before transport, and the adequacy of oxygenation and ventilation is reconfirmed.

Occasionally, patients may require specialized modes of ventilation not re-

producible in the transport setting. Under these circumstances, alternate modes of mechanical ventilation are evaluated before transport to ensure acceptability and patient stability with this therapy. If the patient is incapable of being maintained safely with alternate ventilator therapy, the risks and benefits of transport are cautiously reexamined.

Patient status and management during transport are recorded and filed in the patient medical record at the referring facility. Copies are provided to the receiving institution.

Preparing a Patient for Interhospital Transport There is no evidence to support a "scoop and run" approach to the interhospital transport of critically ill patients. Therefore, referring facilities will, before transport, begin appropriate evaluation and stabilization to the degree possible to ensure patient safety during transport. Unnecessary delays may be experienced if the transport team must perform lengthy or complex procedures to stabilize the patient before the transfer (57). Nonessential testing and procedures will delay transfer and should be avoided. Information and recommendations about this aspect of patient care generally can be requested from the accepting physician at the time of initial contact with the receiving facility.

All critically ill patients need secure intravenous access before transport. If peripheral venous access is unavailable, central venous access is established. If needed, fluid resuscitation and inotropic support are initiated, with all intravenous fluids and medications maintained in plastic (not glass) containers. A patient should not be transported before airway stabilization if it is judged likely that airway intervention will be needed en route (a process made more difficult in a moving vehicle). The airway must be evaluated before transport and secured as indicated by endotracheal tube (or tracheostomy).^{*} Laryngeal mask airways are not an acceptable method of airway management for critically ill patients undergoing transport. For trauma victims, spinal immobilization is maintained during transport unless the absence of significant spinal injury has been reliably verified. A nasogastric tube is inserted in patients with an ileus or intestinal obstruction and in those requiring mechanical ventilation. A Foley catheter is inserted in patients requiring strict fluid management, for transports of extended duration, and for patients receiving di-

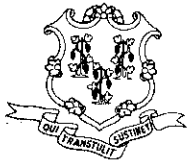
uretics. If indicated, chest decompression with a chest tube is accomplished before transport. A Heimlich valve or vacuum chest drainage system is employed to maintain decompression. Soft wrist and/or leg restraints are applied when agitation could compromise the safety of the patient or transport crew, especially with air transport. If the patient is combative or uncooperative, the use of sedative and/or neuromuscular blocking agents may be indicated. A neuromuscular blocking agent should not be used without sedation and analgesia.

Finally, the patient medical record and relevant laboratory and radiographic studies are copied for the receiving facility. In the United States, a COBRA/EMTALA checklist is strongly suggested to ensure compliance with all federal regulations regarding interhospital patient transfers. Items on this checklist will include documentation of initial medical evaluation and stabilization (to the degree possible), informed consent disclosing benefits and risks of transfer, medical indications for the transfer, and physician-to-physician communication with the names of the accepting physician and the receiving hospital.

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

October 8, 2015

Janette Edwards
Director Planning & Business Development
Windham Community Memorial Hospital
112 Mansfield Avenue
Windham, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Edwards:

As you are aware, on September 9, 2015, the Office of Health Care Access ("OHCA") issued a Certificate of Need ("CON") Determination under Docket Number 15-32026-DTR regarding the transition of the critical care unit at Windham Community Memorial Hospital ("Windham") to a progressive care unit. OHCA issued the Determination based upon the information contained in Windham's Determination Form 2020.

Recently, OHCA has received several letters which question the accuracy of certain representations contained in Windham's Determination Form 2020. Copies of the letters are enclosed for your review. OHCA hereby requests that Windham provide a response to the letters and include any appropriate supporting documentation. The response must be in writing and sworn under oath. Please submit the response to OHCA by the close of business on October 22, 2015.

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosures

C: Representative Michelle Cook
Representative Susan Johnson
Representative Russell Morin
Representative Gregg Haddad
Representative Linda Orange
Senator Mae Flexer
Senator Catherine Osten

Arvind Shaw, Generations Family Health Center
Maritza Bond, Eastern AHEC, Inc.
Greg Kotecki, AFT Connecticut
Dennis O'Brien, Esq.
Rose McLellan, License and Applications Supervisor, DPH, DHSR

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Please see attached regarding Windham Community Memorial Hospital
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PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Thursday, October 08, 2015 3:09 PM
To: 'daniellepalladino@cga.ct.gov'; 'bond@easternctahoc.org'; 'gkotecki@aftct.org';
'ashaw@henhealth.org' - *Called reception 10/8/15*
Cc: McLellan, Rose; Martone, Kim; Hansted, Kevin
Subject: Windham Community Memorial Hospital
Attachments: 32026-4.pdf; Pages from Pages from 32026-1.pdf; Pages from Pages from 32026-2.pdf

10/8/15

The attached letter has gone out to Windham Community Memorial Hospital (DN15-32026) regarding Alignment of Clinical Services at Windham.

Barbara K. Olejarz
Administrative Assistant for Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (86) 418-7005
Email: Barbara.Olejarz@ct.gov



Olejarz, Barbara

From: Maritza Bond <bond@easternctahoc.org>
Sent: Thursday, October 08, 2015 4:13 PM
To: Olejarz, Barbara
Subject: Re: Windham Community Memorial Hospital

Thank you for making the request to Windham Hospital.

Sent using OWA for iPhone

From: Olejarz, Barbara <Barbara.Olejarz@ct.gov>
Sent: Thursday, October 8, 2015 3:16:46 PM
To: Maritza Bond
Subject: FW: Windham Community Memorial Hospital

From: Olejarz, Barbara
Sent: Thursday, October 08, 2015 3:09 PM
To: 'daniellepalladino@cga.ct.gov' <daniellepalladino@cga.ct.gov>; 'bond@easternctahoc.org' <bond@easternctahoc.org>; 'gkotecki@aftct.org' <gkotecki@aftct.org>; 'ashaw@henhealth.org' <ashaw@henhealth.org>
Cc: McLellan, Rose <Rose.C.McLellan@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Hansted, Kevin <Kevin.Hansted@ct.gov>
Subject: Windham Community Memorial Hospital

10/8/15

The attached letter has gone out to Windham Community Memorial Hospital (DN15-32026) regarding Alignment of Clinical Services at Windham.

Barbara K. Olejarz
Administrative Assistant for Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (86) 418-7005
Email: Barbara.Olejarz@ct.gov



Olejarz, Barbara

From: Palladino, Danielle <Danielle.Palladino@cga.ct.gov>
Sent: Thursday, October 08, 2015 3:37 PM
To: Olejarz, Barbara
Subject: RE: Windham Community Memorial Hospital

Thank you for sending this over. I appreciate it.

Danielle Palladino
Legislative Aide, House Democrats

Deputy Majority Leader **Representative Michelle Cook**, 65th House District
Proudly Serving Torrington
Deputy Majority Leader **Representative Susan Johnson**, 49th House District
Proudly Serving Windham
Deputy Majority Leader **Representative Russell Morin**, 28th House District
Proudly Serving Wethersfield

Staff, Task Force on Domestic Workers

860-240-1479
danielle.palladino@cga.ct.gov

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From: Olejarz, Barbara [mailto:Barbara.Olejarz@ct.gov]
Sent: Thursday, October 08, 2015 3:20 PM
To: Palladino, Danielle
Subject: Windham Community Memorial Hospital

10/8/15

The attached letter has gone out to Windham Community Memorial Hospital (DN15-32026) regarding Alignment of Clinical Services at Windham.

Barbara K. Olejarz
Administrative Assistant for Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (86) 418-7005
Email: Barbara.Olejarz@ct.gov



Olejarz, Barbara

From: Edwards, Janette <Janette.Edwards@hhchealth.org>
Sent: Tuesday, October 13, 2015 10:24 AM
To: Olejarz, Barbara
Cc: Martone, Kim; Hansted, Kevin
Subject: RE: Windham Community Memorial Hospital

Barbara,

I am in receipt of your email and the attachments.

Thank you,
Janette Edwards

From: Olejarz, Barbara [Barbara.Olejarz@ct.gov]
Sent: Thursday, October 08, 2015 2:12 PM
To: Edwards, Janette
Cc: Martone, Kim; Hansted, Kevin
Subject: Windham Community Memorial Hospital

10/8/15

Attached is a letter regarding the alignment of clinical services at Windham Community Memorial Hospital. Please let me know that you have received this email and that you were able to open it.

Thank you

Barbara K. Olejarz
Administrative Assistant for Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (86) 418-7005
Email: Barbara.Olejarz@ct.gov



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Dr. Jewell Mullen, *Dept. of Public Health Commissioner &*
Kimberly Martone, *Office of Health Care Access Director:*

We wrote to the leadership of Hartford HealthCare to say:

*Save
Our
Services!*

PATIENTS BEFORE PROFITS!

**We are concerned that you are putting profits ahead of
patients in Eastern Connecticut.**

**We believe it is wrong for Hartford HealthCare to
prioritize cutting vital services and direct patient
caregivers at our community hospitals while allowing
millions in bonuses and incentives to be handed out to
your executives.**

**Our community is standing together and we demand
that Hartford HealthCare leadership put
patients before profits.**

Stephen Wilmoth

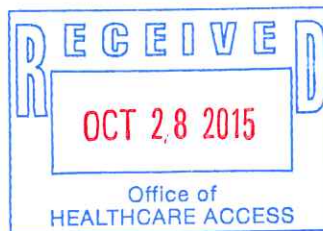
NAME

Norwich

TOWN



40 Mansfield Avenue
Willimantic, CT 06226
Phone: (860) 456-6270
Fax: (860) 450-7475



Fax

To: Kimberly R. Martone, Director of Operations **From:** Arvind Shaw, CEO

Fax: 860-418-7053 **Pages:** (16) including cover sheet

Phone: _____ **Date:** October 28, 2015

Re: Certificate of Need Determination Report 15-32026-DTR,
Alignment of Clinical Services at Windham Hospital

- Urgent For Review Please Comment Please Reply Please Recycle

• **Comments:**

*Arvind Shaw
Chief Executive Officer
Generations Family Health Center
40 Mansfield Avenue
Willimantic, CT 06226
Main Phone: 860-450-7456 X-6200
Direct Number: 860-456-6200
Fax: 860-450-7475
E-Mail: ashaw@genhealth.org*

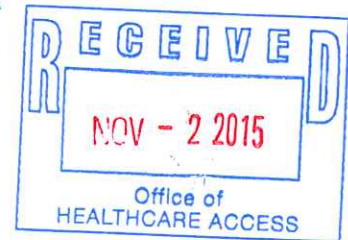
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GENERATIONS
FAMILY HEALTH CENTER

October 28, 2015

VIA FIRST CLASS MAIL AND FACSIMILE

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308



RE: Certificate of Need Determination Report 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone:

I am writing on behalf of the staff, physicians and patients of Generations Family Health Center (“Generations”), the Federally Qualified Health Center (“FQHC”) serving Eastern Connecticut, regarding the letter dated October 22, 2015 filed by Windham Community Memorial Hospital (“Petitioner” or “Hospital”) in response to OHCA’s letter dated October 8, 2015 concerning Petitioner’s plan to close its critical care unit (“CCU”) and develop a 4-bed progressive care unit (“PCU”). Petitioner’s response fails to adequately address the issues raised in our letter to OHCA dated October 2, 2015.

Specifically, Petitioner’s response fails to address the contradictory representation that all patients treated in its CCU can be treated in a PCU or ILC. In fact, Petitioner’s own Request for Determination acknowledges treating patients requiring CCU level of care:

“Average daily census for critical care patients was 2.06 or 17% of patients treated on the CCU . . .” (DN 15-32026-DTR, page 5 of OHCA record).

Some of these patients, in accordance with Petitioner’s own CCU Admission Criteria, are adults requiring intubation and mechanical ventilation for acute respiratory distress and/or failure to CCU.

Further, Petitioner differentiates CCU and PCU/ILC levels of care when it states in its October 22nd letter:

“Windham’s definition of intermediate care is consistent with the AACN definition of progressive care, and this fact has not changed.” (DN 15-32026-DTR, page 280 of OHCA record)

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860.450.7471 • genhealth.org

The above statement is troubling in three regards. First, Petitioner's Intermediate Care Admission Criteria – as well as the AACN guidelines – *exclude* patients with acute respiratory distress/failure requiring intubation and mechanical ventilation (DN 15-32026-DTR, page 339 of OHCA record). Second, this statement and the implied interchangeable terminology does not comport with statements made in Petitioner's Request for Determination:

“Average daily census for intermediate level of care (“ILC”) patients in the CCU was 1.5 or 12.5% of total patients treated on the CCU (these patients do not need CCU/PCU level of care)”. (DN 15-32026-DTR, page 5 of OHCA record)

Third, Petitioner's decision to close the CCU is in direct contradiction to the stated needs of the Hospital's medical staff to maintain CCU services. During the Division of Medicine meeting held July 15, 2015, those present unanimously voted against Petitioner's proposal to terminate CCU services (**Exhibit 1**). The physician assessment of need for CCU services at the Hospital has not changed in the intervening months as evidenced by the letter to the editor of *The Chronicle* dated October 25, 2015 written by Nelson C. Walker II, MD (**Exhibit 2**).

Petitioner also fails to address the significant patient transport issues raised in our letter of October 2nd, which leads to a discussion of the differences between DN 15-31981-DTR and Petitioner's proposal. Unlike Petitioner, Western Connecticut Health Network has Emergency Medical Services in both New Milford (transferring site) and Danbury (receiving site) that provides emergency medical care *and* state-of-the-art ambulances. Further, New Milford Hospital is a satellite campus of Danbury Hospital and is fully integrated, providing for seamless transfers. It must be noted that New Milford is 15.7 miles (23 minutes) away from Danbury whilst the Hospital is 27.9 miles (40 minutes) away from Hartford Hospital without traffic. Minutes count when transporting critically ill patients.

Another significant difference between DN 15-31981-DTR and Petitioner's proposal is that New Milford Hospital did not terminate critical care services. New Milford Hospital did not and does not admit patients requiring intubation and mechanical ventilation for acute respiratory distress/failure. Conversely, Petitioner *does* have a history of admitting patients to its CCU who require intubation and mechanical ventilation for acute respiratory distress/failure. If Petitioner is to follow its own admission criteria and national guidelines, its proposal requires that Petitioner terminate providing CCU level of care and discontinue the admission of patients with acute respiratory distress and/or failure requiring intubation and mechanical ventilation.

Generations remains concerned that Petitioner continues to offer specious arguments when representing that a service is not being terminated. We are troubled by the tenor of Petitioner's statement:

“Notwithstanding the Final Decision Order for Docket No. 08-31178, the only reason that Windham requested the above-referenced Determination was because there was precedent in the State wherein another hospital requested a Determination in connection with the transition of critical care services to a progressive care unit (“PCU”).” (DN 15-32026-DTR, page 279 of OHCA record.)

The above statement causes our physicians, staff and patients to wonder whether the Petitioner will seek Determinations regarding its plans to terminate its Sleep Lab, Surgery Clinic and Wound Clinic at the Hospital, or mammography and bone density services in Hebron as outlined in Petitioner's East Region Transition Plan (**Exhibit 3**). Willimantic is a medically underserved community that is geographically isolated and without reasonable access to another acute care provider. We respectfully request that OHCA reconsider its Determination and find that a Certificate of Need is needed to terminate CCU services at the Hospital.

Very Truly Yours,



Arvind Shaw
Chief Executive Officer

Bcc

Generations Family Health Center
October 28, 2015

EXHIBIT 1: Division of Medicine Minutes

Windham Hospital

Division of Medicine Meeting

Wednesday, July 15, 2015

12:00 Noon, Bernard & Desrosier Room

In attendance: Mary Barry, M.D.; Michelle Boudreau, D.O.; Eugene Ciccone, M.D.; Kenneth Dardick, M.D.; Kismat Detroja, M.D.; Craig Elliott, M.D.; Mark Fisherkeller, M.D.; John Foley, M.D.; Morton Glasser, M.D.; Steve Goldblatt, M.D.; Michael Kilgannon, M.D.; Anne Lovejoy, M.D.; Ayaz Madraswalla, M.D.; Syera Mathews, M.D.; Nadia Nashid, M.D.; Marlene Schwartz, M.D.; Gregory Shangold, M.D., Chair; Charles Shooks, M.D. (phone); Amer Skopic, D.O.; Victorio Te, M.D.; Nelson Walker, M.D.; Deborah Weidner, M.D.(phone); Chair; Dana Wiseman, M.D.; Sharon Lee, Medical Staff Coordinator.

Not present: Melisha Cumberland, M.D.; Robert Dinwoodie, D.O.; Orland Donald, M.D.; Mark Dzedzic, M.D.; Max Goldstein, M.D.; Thomas Gorin, M.D.; Peter Jones, M.D.; Ronald Kelly, M.D.; Ajit Kokkat, M.D.; Obinna Maduka, M.D.; Julian Munoz, M.D.; Ann Semolic, M.D.; Robert Sidman, M.D.; Stanley Stutz, M.D.; David Whitehead, President & CEO; Cary Trantalis, RN, MSN, VP of Clinical Services and Operations, East Region.

I. Call to Order.

Dr. Shangold called the meeting to order at 12:07 PM.

Dr. Glasser introduced Dr. Dana Wiseman from Generations. Dr. Wiseman is now Regional Medical Director at Generations in Willimantic. Dr. Glasser is still Chief Medical Officer for the entire organization.

II. Approval of Prior Month's Minutes. Dr. Detroja made a motion to approve the June 17, 2015 Division of Medicine meeting minutes. Motion was seconded. Vote was taken with all in favor (19), none opposed, and motion carries.

III. Section Reports.

Cardiology.

Dr. Shangold reported that a lot more Cardiology patients are going to Hartford directly from the ED. Discussion ensued about what type of cardiology patients are being transferred. We are tracking data to see how it goes over next 3 mos. Dr. Ciccone asked if we can track the outcome of those transfers. Dr. Lovejoy made a motion that the hospital create a system whereby patients transferred are subsequently tracked so we can better understand which patients benefit from transferring. Dr. Mathews seconded the

motion. Discussion: Dr. Detroja asked what kind of data we looking for. Dr. Shangold said he can work on which metrics would be useful. Dr. Barry suggested creating a group of people who can look at it, i.e. a subcommittee. Someone from the hospital will organize and collect data. Then we will see who from the Medical Staff will participate. Dr. Lovejoy said the key is whether the patient can be safely treated here. Vote was taken with all in favor (21), none opposed, and motion carries. Dr. Shangold will draft a letter to Drs. Bundy and Sidman with a copy to Cary Trantalis.

Cancer Committee. Dr. Barry reported that there are no nurse navigators anymore. We have a triage system for that. She will send information to the Medical Staff. This is a huge loss. Dr. Bundy said that Thomas Yakoubian from Hartford Hospital is on standby to replace Pat Zikorus in respect to the cancer screening component.

Pulmonary/Sleep Medicine. Dr. Bundy reported that the Sleep Medicine Center has been selected to close as part of the impending cuts. We made our best efforts with Dr. Foley's representation from HHCMG and hospital colleagues to maintain as much as we can. We feel it is a true cornerstone service for all of you and all specialties. Sleep disorders run through all specialties. This is a gem of an operation due to a multitude of people. This is an insult to our efforts. We are trying to salvage it. If we had had discussion prior to it would have gone a long way. We are carrying on business as usual. A CON is needed for closing the Sleep Program. Once submitted it will be reviewed by DPH. We are working on a business plan.

The following Sections had no formal report: Pediatrics, Family Practice, Gastroenterology, Hospitalist Medicine, Internal Medicine, Emergency Medicine, Neurology, and Psychiatry.

IV. Administrative Report. None. No administrative representative present.

V. New Business.

Cornerstone Services. Dr. Shangold said we should take the rest of the time to discuss the cornerstone service plan presented. His understanding was that the hospital was going to maintain an inpatient census of 30-34 which includes potentially 2 boarded in the ED with no ICU level care. LOS would not exceed 4 days; on average. We can talk about what we will keep and not keep. The Sleep Lab and Wound Clinic are big cuts. Dr. Foley said the Wound Clinic is being closed and the Surgical Group will be assuming responsibility for it. Pertaining to Cardiology, he said they will continue to provide services but will define what would be available. Each department head was asked to put together a list of who can stay and who can't; Cardiology submitted its recommendations to Dr. Sidman last night. . It is not much different than what's been going on. Dr. Foley

said he looked at every admission for last year. Dr. Lovejoy is concerned that Hospitalists are not involved. Dr. Detroja is and will talk with all the Hospitalists. Start date is Aug. 8th for cap of 30-34 patients and no ICU. Dr. Fisherkeller said we don't even know if there's a CON needed for ICU closure, we don't know the time process. This is 3 weeks away. Staffing is involved. Dr. Mathews asked when we will stop admitting ICU patients.

Dr. Kilgannon said that he sits on MEC and that he is disappointed that neither Cary nor David was there. We are not getting answers from Administration. Nobody has asked for feedback from the Medical Staff on making decisions.

Referring to cardiology input urgently, Dr. Foley said it depends on your comfort level. Dr. Shangold said we are trying to figure out a triage system, they want us to work on this. Dr. Lovejoy said we need guidelines. Dr. Glasser: If we are accepting 35, think of the next epidemic, patients waiting in the ED, you are sending lots of people out who live in the community and should be here. 35 fills up quickly. Dr. Detroja said short stay is confusing. Some patients are going out anyway. It will be very complicated, 35 will be met quickly. Dr. Foley said the submitted lists will be compared with admission diagnoses over the last year. Judgement is always critical. Dr. Shangold said we admit about 250 patients per month through the ED. Divide this by 30 equals 9 a day; we need to get it down to 5. Dr. Glasser thinks we will give poor care, people will be sent home that should be hospitalized. There are some patients that refuse to go to Hartford. Then we will have a bigger problem.

Dr. Bundy wanted to clarify that he met with Dr. Sidman and a 2-7 day stay is more average. Dr. Bundy reported that MEC endorsed trying to maintain 4 CCU beds. 2-4 days is the average they'd like to hit but it's really 4-7. We don't want intense high level of care, severe sepsis, septic shock, acute MI, etc. will likely be transferred after stabilization. We need to take care of them here, which may include an initial surgery but post-surgery they may need to be transferred. We still have obligations to take care of patients to get CCU level of care until they are safe to transfer.

Dr. Barry said the Division of Medicine needs to take a stand and make it clear to Administration that it is completely unacceptable to not have an ICU. Surgeons are beside themselves. We will be deteriorating multiple services. **Dr. Barry made a motion that we, the Division of Medicine find the concept of no ICU completely unacceptable.** Dr. Madraswalla said he would reconsider sending patients here but they might need to go to Manchester. To subject a patient to go to the ED and possibly get transferred is unacceptable. If surgery is done and we can't put them on a ventilator, this is unbelievable.

Dr. Walker is in favor of the motion. We are clinicians. This was a business decision started when HHC came in. They have not enhanced our services. You have to invest money, time, and talent. It has been two years now. HHC would like to see Windham close. Meanwhile this is unacceptable for the community; patients can't get to Hartford Hospital. It's all about the doctor patient relationship and continuity of care.

Dr. Bundy said they were asked at the meeting at Stott how we can move this forward. There is a large voice to be heard. It is important that the voice of the individual practices be heard with appropriate correspondence to our leaders. There are those in offices and those here in the hospital when people show up here. These are two separate voices.

Dr. Foley's reaction to the motion that we will fight to keep the ICU open is that board certified intensive care people are not available 24 hours a day. There is no cardiology to support this. We will lose money. Dr. Kilgannon said we understand but if someone crashes surgeons need it. We can't get a central line. Dr. Bundy mentioned the desire to maintain the care of a patient for 48 hours before transferring.

Dr. Skopic asked what kind of leverage we have. If we lose \$11,000 a day and patients are floating, the loss will be here or Hartford Hospital, it doesn't matter. You are losing it no matter what, the same person writes the check. Dr. Barry said we are saving money the way we are taking care of patients here. It was agreed that we need a safety net for when patients go sour. You cannot operate on someone without ICU backup. Dr. Fisherkeller said patients are all concerned, this is a contracted influence, no one will come here, and the Hospital will close. Dr. Bundy said Elliot Joseph and Jeff Flaks entertained these questions at the leadership meeting this morning. They said only bad things happen when you shrink. Dr. Fisherkeller said his point is the community is closing the hospital, not HHC.

The motion made by Dr. Barry was re-read, **"We, the Division of Medicine, find the concept of no ICU completely unacceptable."** Motion was seconded. Vote was taken and unanimously approved (20), 1 abstention, and motion carries.

Meeting was adjourned 1:12 PM.

Respectfully submitted,

Reviewed and approved,

Sharon K. Lee
Medical Staff Coordinator

Gregory L. Shangold, M.D.
Chair, Division of Medicine

Generations Family Health Center
October 28, 2015

EXHIBIT 2: Nelson C. Walker II, MD Letter to the Editor

MANSFIELD
F·A·M·I·L·Y
PRACTICE

A LIMITED LIABILITY COMPANY

34 PROFESSIONAL PARK ROAD
STORRS, CONNECTICUT 06268
860/487-0002
FAX 860/429-1663

The Editor of The Chronicle
1 Chronicle Road
Willimantic, CT 06226

October 25, 2015

Editor:

Hartford Health Care (**HHC**) must hear and listen to the community and medical staff of
Windham **COMMUNITY** Memorial **HOSPITAL** (**WCMH**)

In response to the front page article in The Chronicle on 10/24/15, it is important to remember that "The Hospital" ie WCMH is not just HHC. In 2009, WCMH was merged into HHC to hopefully strengthen its position in a rapidly changing Health Industry which has now evolved into Corporate controlled delivery of health care services. According to Moody's Investors Services, "HHC is a large integrated healthcare delivery system including six acute care hospitals and a large employed physician group with a combined \$2.4 billion revenue base and 85,000 admissions operating in multiple markets in central Connecticut." Many of the physicians in our community are now employees of HHC which has changed the dynamics of how WCMH is run. Since HHC took over management of WCMH, our community hospital has gone from being financially solvent to over 8 million dollar in losses per year. We are constantly being reminded about how much money the hospital is losing, which has fueled the vicious cycle of further cuts by HHC, leading to less service and less revenue. This erosion in service has left our community with fewer Pulmonologist/intensivist, cardiologist, and trained experienced nurses to care for the patients in the intensive care unit (ICU). The issue of eliminating the intensive care unit (ICU) and calling it a progressive care unit (PCU) is just the tip of the iceberg for what has happened to our community hospital. WCMH has fewer surgeons, there is no longer a full time neurologist and other physicians that have served our community have had to relocate their offices. HHC's solution has not been to support the providers who supply the services to the community or bring in more providers and added service, but rather cut back and lay off, which has forced our community physicians to refer elsewhere and transfer patients out of their community and home environment. WCMH and the community it serves is not better off by the management of HHC and patients have lost access to care in our community because of it. HHC has not invested in our community, it has syphoned patients and their revenues away to other institutions.

HHC corporate headquarters is in Hartford and WCMH has been lumped into the Eastern Region with a focus on Backus Hospital in Norwich. This is not the orientation for much of the community that WCMH has traditionally served. If an ambulance is called to the University of Connecticut it would take the patient to WCMH and I dare say the patient would not be thinking of going to Norwich. WCMH President and CEO, David Whitehead has his office in Norwich at Backus Hospital. Prior to the merger with HHC, the CEO of WCMH would attend all the key large meetings of the medical staff, including Med Exec and the Division of Medicine. It is at these meetings that clinical services are reviewed and discussed, often with input, give and take by the hospital administration. This has all changed since WCMH was taken over by HHC and merged into the Eastern Region with Backus Hospital. Mr. Whitehead does not attend the division of Medicine meetings. He was marked as absent on May 19 when significant changes in cardiology coverage at WCMH were discussed. On July 15, 2015, when the Division of Medicine voted unanimously that **"We, the Division of Medicine, find the concept of no ICU completely unacceptable"** Mr. Whitehead and HHC administration was again not present to hear the discussion about their announced decision to close the ICU. Mr. Whitehead does not want to hear let alone listen to what our community has to say, even though HHC is supposed to be serving us not just Hartford, Norwich and corporate headquarters.

The way things are going under the management of HHC, WCMH will lose the C for community and H for hospital. I am not naive about the challenges and difficult times hospitals face to cover expenses and supply the quality of care we all deserve, but to read "Hospital says public hearing is not needed" makes me shudder. It is not the community or those that work at WCMH that are saying this, it is HHC managing our community hospital to wither on the vine. When Mr. Whitehead talks in the Chronicle about "Cornerstone of Care" this should be coming from dialogue with the community and the medical staff of WCMH, not just what HHC corporate headquarters thinks we want or should hear. When 3000 members of our community sign a petition to be heard, I hope the Office of Health Care Access (OHCA) listens to the people of the community who need the access to care.

Respectively,



Nelson C. Walker II, MD, Chief section of Family Medicine at WCMH
Nwalker@mfp1.com

Generations Family Health Center
October 28, 2015

EXHIBIT 3: East Region Transition Plan

East Region Transition plan

Why changes are needed

- As you know, the healthcare environment has been extremely challenging.
 - We have taken huge cuts in our state and federal payments
 - We are dealing with declining inpatient volume and increased competition
 - And there is an increased reliance on government payments.
- We cannot live in the world as we might wish it to be. In our desired world, hospitals and doctors would be paid fairly for taking care of the oldest and poorest of our patients.
- In order to remain open and accessible for all who rely on us, we are making some very difficult decisions.

What the changes are

- Job reductions across Hartford HealthCare have been announced, and whenever possible we are taking advantage of attrition, position vacancies and retirements to minimize the impact on people. We are also taking other steps to reduce costs.
- The job reductions and changes are being made at every level and every region at HHC.
 - In all, 335 FTEs (full-time equivalents) and 418 positions will be affected.
- Here in the East Region, we anticipate a reduction of 105 FTEs, impacting 142 positions -- 119 positions at Windham and 23 positions at Backus.
- The impact on Windham is magnified because we must transform the health care delivery system there to focus on cornerstone services. For the past five years, financial losses at Windham have totaled more than \$17 million, with another nearly \$8 million projected for this fiscal year, which averages out to \$11,000 per day. This is despite the incredible efforts of Windham Hospital staff who do their work in the most efficient, cost effective manner.
- However, this is not just a Windham Hospital issue. At both Backus and Windham, we will continue to face a harsh economic environment, so we must be proactive at Backus as well. We must collaborate with one another and our community partners to continue to meet the needs of the communities that we serve, and offer them a seamless, coordinated system of care that provides access at Backus, Windham and throughout our health care delivery network.
- We are committed to keeping Windham Hospital's doors open, offering cornerstone services and serving as a gateway for patients to get the right care at the right place at the right time.
- At Windham Hospital, our community has told us that cornerstone services include, but are not limited to:
 - Emergency Care
 - Cardiology
 - Oncology
 - Women's health
 - Diagnostic Imaging

- Short stay inpatient care
- Other coordinated services on the campus and nearby.
- Changes at Windham Hospital will include (some of these may require regulatory action)
 - Staffing to 32 inpatient beds
 - Not providing CCU-level care
 - No longer offering complex inpatient surgery
 - Transferring Interventional Radiology to the OR
 - No longer offering Sleep Lab/Clinic
 - We are working to transfer General Surgery/Wound Care Clinic to another place in the health system
 - No longer offer radiology school
 - No longer offering mammography and bone density at Hebron's Women's Center
 - Transfer the Meals on Wheels to Home Program to HHC at home
- Changes at Backus and Windham include:
 - Downsize and regionalize various community benefit and support services, including nutrition and diabetes.
 - No longer offer librarian services when the current librarian retires
 - Close Auxiliary coffee shop at Windham and the Medical Office Building coffee shop at Backus
 - Exploring lab efficiencies
 - General management changes.

Changes at Backus include:

- Closing of simulation lab
- Elimination of ID physician relationship around antibiotic stewardship
- Decentralization of EKG
- Reorganization of Care Management
- We are currently finalizing plans and affected colleagues will be notified starting next week. We will, of course, be compassionate and fair in completing this reduction. We will offer our departing colleagues all appropriate support and assistance.
- We understand this announcement may cause anxiety, and want to assure you that our plans fully support our patients and families and keep our values in the forefront as we reduce staff.
- These changes are difficult but necessary so we can be here for the people who rely on us.
- The reductions and program changes are needed to deal with the financial pressures we face. Our total HHC Medicaid reductions from the State of Connecticut amount to \$100 million over five years.
- Our decisions were based on data, not "what we've always done" or emotions. We cannot live in the world as we might wish it to be. We need to face the economic realities that are prevalent throughout healthcare in our system, the state and the nation.

- We can't sacrifice the future to sustain a past that is honorable, but is no longer our reality. The time for transformation is now, so we can create a sustainable future for the region.
- We are not just cutting. We are investing in the jobs, facilities and technologies that will allow Hartford HealthCare to lead in the new era of healthcare.
- We are especially focused on providing more outpatient care, including the addition of ambulatory centers.
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- We can — and we must — remain a cornerstone of care for this community.

Miscellaneous Q&A

Q. Does Cary Trantalis' new position as Vice President, Clinical Services and Operations, mean that we are adding to our executive salaries?

A. No. Cary is continuing her operations duties and taking on added responsibilities following the resignation of Mary Bylone and James O'Dea's transfer to a system-level position.

Q. There is talk of outsourcing food and nutrition, environmental services and patient transport. What does that mean for Windham and Backus?

A. The system is exploring a consultant partnership to manage these services. We are exploring only management consultant services, and would do so only if it means providing more efficient and better services.

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A. We are working with the HHCMG to provide neurology services for the Windham area at the new Vernon Family Health Center and she will take new general patients, movement disorder patients and Medicaid patients. We can continue to make referrals to Dr. Anthony Alessi and Neurology Associates of Norwich.

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A. Executive compensation is market driven, data driven and subject to rigorous board oversight and government regulation. Hospitals and health systems need to attract experienced, talented leaders capable of improving care, expanding access and supporting staff in the face of diminishing resources. Compensation must be competitive and set at levels that will draw and keep top talent. In addition to managing advanced medical services and technology, extensive physical plants, highly educated and skilled staff, hospital executives often are responsible for an array of services beyond the hospital which can include physician groups, primary care offices, clinical laboratory networks, surgery centers, long-term care organizations and home health organizations.



GENERATIONS
FAMILY HEALTH CENTER

October 28, 2015

VIA FIRST CLASS MAIL AND FACSIMILE

Kimberly R. Martone
Director of Operations
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Determination Report 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone:

I am writing on behalf of the staff, physicians and patients of Generations Family Health Center ("Generations"), the Federally Qualified Health Center ("FQHC") serving Eastern Connecticut, regarding the letter dated October 22, 2015 filed by Windham Community Memorial Hospital ("Petitioner" or "Hospital") in response to OHCA's letter dated October 8, 2015 concerning Petitioner's plan to close its critical care unit ("CCU") and develop a 4-bed progressive care unit ("PCU"). Petitioner's response fails to adequately address the issues raised in our letter to OHCA dated October 2, 2015.

Specifically, Petitioner's response fails to address the contradictory representation that all patients treated in its CCU can be treated in a PCU or ILC. In fact, Petitioner's own Request for Determination acknowledges treating patients requiring CCU level of care:

"Average daily census for critical care patients was 2.06 or 17% of patients treated on the CCU . . ." (DN 15-32026-DTR, page 5 of OHCA record).

Some of these patients, in accordance with Petitioner's own CCU Admission Criteria, are adults requiring intubation and mechanical ventilation for acute respiratory distress and/or failure to CCU.

Further, Petitioner differentiates CCU and PCU/ILC levels of care when it states in its October 22nd letter:

"Windham's definition of intermediate care is consistent with the AACN definition of progressive care, and this fact has not changed." (DN 15-32026-DTR, page 280 of OHCA record)

The above statement is troubling in three regards. First, Petitioner's Intermediate Care Admission Criteria – as well as the AACN guidelines – *exclude* patients with acute respiratory distress/failure requiring intubation and mechanical ventilation (DN 15-32026-DTR, page 339 of OHCA record). Second, this statement and the implied interchangeable terminology does not comport with statements made in Petitioner's Request for Determination:

“Average daily census for intermediate level of care (“ILC”) patients in the CCU was 1.5 or 12.5% of total patients treated on the CCU (these patients do not need CCU/PCU level of care)”. (DN 15-32026-DTR, page 5 of OHCA record)

Third, Petitioner's decision to close the CCU is in direct contradiction to the stated needs of the Hospital's medical staff to maintain CCU services. During the Division of Medicine meeting held July 15, 2015, those present unanimously voted against Petitioner's proposal to terminate CCU services (**Exhibit 1**). The physician assessment of need for CCU services at the Hospital has not changed in the intervening months as evidenced by the letter to the editor of *The Chronicle* dated October 25, 2015 written by Nelson C. Walker II, MD (**Exhibit 2**).

Petitioner also fails to address the significant patient transport issues raised in our letter of October 2nd, which leads to a discussion of the differences between DN 15-31981-DTR and Petitioner's proposal. Unlike Petitioner, Western Connecticut Health Network has Emergency Medical Services in both New Milford (transferring site) and Danbury (receiving site) that provides emergency medical care *and* state-of-the-art ambulances. Further, New Milford Hospital is a satellite campus of Danbury Hospital and is fully integrated, providing for seamless transfers. It must be noted that New Milford is 15.7 miles (23 minutes) away from Danbury whilst the Hospital is 27.9 miles (40 minutes) away from Hartford Hospital without traffic. Minutes count when transporting critically ill patients.

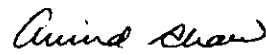
Another significant difference between DN 15-31981-DTR and Petitioner's proposal is that New Milford Hospital did not terminate critical care services. New Milford Hospital did not and does not admit patients requiring intubation and mechanical ventilation for acute respiratory distress/failure. Conversely, Petitioner *does* have a history of admitting patients to its CCU who require intubation and mechanical ventilation for acute respiratory distress/failure. If Petitioner is to follow its own admission criteria and national guidelines, its proposal requires that Petitioner terminate providing CCU level of care and discontinue the admission of patients with acute respiratory distress and/or failure requiring intubation and mechanical ventilation.

Generations remains concerned that Petitioner continues to offer specious arguments when representing that a service is not being terminated. We are troubled by the tenor of Petitioner's statement:

“Notwithstanding the Final Decision Order for Docket No. 08-31178, the only reason that Windham requested the above-referenced Determination was because there was precedent in the State wherein another hospital requested a Determination in connection with the transition of critical care services to a progressive care unit (“PCU”).” (DN 15-32026-DTR, page 279 of OHCA record.)

The above statement causes our physicians, staff and patients to wonder whether the Petitioner will seek Determinations regarding its plans to terminate its Sleep Lab, Surgery Clinic and Wound Clinic at the Hospital, or mammography and bone density services in Hebron as outlined in Petitioner's East Region Transition Plan (**Exhibit 3**). Willimantic is a medically underserved community that is geographically isolated and without reasonable access to another acute care provider. We respectfully request that OHCA reconsider its Determination and find that a Certificate of Need is needed to terminate CCU services at the Hospital.

Very Truly Yours,



Arvind Shaw
Chief Executive Officer

Bcc

Generations Family Health Center
October 28, 2015

EXHIBIT 1: Division of Medicine Minutes

Windham Hospital

Division of Medicine Meeting

Wednesday, July 15, 2015

12:00 Noon, Bernard & Desrosier Room

In attendance: Mary Barry, M.D.; Michelle Boudreau, D.O.; Eugene Ciccone, M.D.; Kenneth Dardick, M.D.; Kismat Detroja, M.D.; Craig Elliott, M.D.; Mark Fisherkeller, M.D.; John Foley, M.D.; Morton Glasser, M.D.; Steve Goldblatt, M.D.; Michael Kilgannon, M.D.; Anne Lovejoy, M.D.; Ayaz Madraswalla, M.D.; Syera Mathews, M.D.; Nadia Nashid, M.D.; Marlene Schwartz, M.D.; Gregory Shangold, M.D., Chair; Charles Shooks, M.D. (phone); Amer Skopic, D.O.; Victorio Te, M.D.; Nelson Walker, M.D.; Deborah Weidner, M.D.(phone); Chair; Dana Wiseman, M.D.; Sharon Lee, Medical Staff Coordinator.

Not present: Melisha Cumberland, M.D.; Robert Dinwoodie, D.O.; Orland Donald, M.D.; Mark Dzedzic, M.D.; Max Goldstein, M.D.; Thomas Gorin, M.D.; Peter Jones, M.D.; Ronald Kelly, M.D.; Ajit Kokkat, M.D.; Obinna Maduka, M.D.; Julian Munoz, M.D.; Ann Semolic, M.D.; Robert Sidman, M.D.; Stanley Stutz, M.D.; David Whitehead, President & CEO; Cary Trantalis, RN, MSN, VP of Clinical Services and Operations, East Region.

I. Call to Order.

Dr. Shangold called the meeting to order at 12:07 PM.

Dr. Glasser introduced Dr. Dana Wiseman from Generations. Dr. Wiseman is now Regional Medical Director at Generations in Willimantic. Dr. Glasser is still Chief Medical Officer for the entire organization.

II. Approval of Prior Month's Minutes. Dr. Detroja made a motion to approve the June 17, 2015 Division of Medicine meeting minutes. Motion was seconded. Vote was taken with all in favor (19), none opposed, and motion carries.

III. Section Reports.**Cardiology.**

Dr. Shangold reported that a lot more Cardiology patients are going to Hartford directly from the ED. Discussion ensued about what type of cardiology patients are being transferred. We are tracking data to see how it goes over next 3 mos. Dr. Ciccone asked if we can track the outcome of those transfers. Dr. Lovejoy made a motion that the hospital create a system whereby patients transferred are subsequently tracked so we can better understand which patients benefit from transferring. Dr. Mathews seconded the

motion. Discussion: Dr. Detroja asked what kind of data we looking for. Dr. Shangold said he can work on which metrics would be useful. Dr. Barry suggested creating a group of people who can look at it, i.e. a subcommittee. Someone from the hospital will organize and collect data. Then we will see who from the Medical Staff will participate. Dr. Lovejoy said the key is whether the patient can be safely treated here. Vote was taken with all in favor (21), none opposed, and motion carries. Dr. Shangold will draft a letter to Drs. Bundy and Sidman with a copy to Cary Trantalis.

Cancer Committee. Dr. Barry reported that there are no nurse navigators anymore. We have a triage system for that. She will send information to the Medical Staff. This is a huge loss. Dr. Bundy said that Thomas Yakoubian from Hartford Hospital is on standby to replace Pat Zikorus in respect to the cancer screening component.

Pulmonary/Sleep Medicine. Dr. Bundy reported that the Sleep Medicine Center has been selected to close as part of the impending cuts. We made our best efforts with Dr. Foley's representation from HHCMG and hospital colleagues to maintain as much as we can. We feel it is a true cornerstone service for all of you and all specialties. Sleep disorders run through all specialties. This is a gem of an operation due to a multitude of people. This is an insult to our efforts. We are trying to salvage it. If we had had discussion prior to it would have gone a long way. We are carrying on business as usual. A CON is needed for closing the Sleep Program. Once submitted it will be reviewed by DPH. We are working on a business plan.

The following Sections had no formal report: Pediatrics, Family Practice, Gastroenterology, Hospitalist Medicine, Internal Medicine, Emergency Medicine, Neurology, and Psychiatry.

IV. Administrative Report. None. No administrative representative present.

V. New Business.

Cornerstone Services. Dr. Shangold said we should take the rest of the time to discuss the cornerstone service plan presented. His understanding was that the hospital was going to maintain an inpatient census of 30-34 which includes potentially 2 boarded in the ED with no ICU level care. LOS would not exceed 4 days; on average. We can talk about what we will keep and not keep. The Sleep Lab and Wound Clinic are big cuts. Dr. Foley said the Wound Clinic is being closed and the Surgical Group will be assuming responsibility for it. Pertaining to Cardiology, he said they will continue to provide services but will define what would be available. Each department head was asked to put together a list of who can stay and who can't; Cardiology submitted its recommendations to Dr. Sidman last night. . It is not much different than what's been going on. Dr. Foley

said he looked at every admission for last year. Dr. Lovejoy is concerned that Hospitalists are not involved. Dr. Detroja is and will talk with all the Hospitalists. Start date is Aug. 8th for cap of 30-34 patients and no ICU. Dr. Fisherkeller said we don't even know if there's a CON needed for ICU closure, we don't know the time process. This is 3 weeks away. Staffing is involved. Dr. Mathews asked when we will stop admitting ICU patients.

Dr. Kilgannon said that he sits on MEC and that he is disappointed that neither Cary nor David was there. We are not getting answers from Administration. Nobody has asked for feedback from the Medical Staff on making decisions.

Referring to cardiology input urgently, Dr. Foley said it depends on your comfort level. Dr. Shangold said we are trying to figure out a triage system, they want us to work on this. Dr. Lovejoy said we need guidelines. Dr. Glasser: If we are accepting 35, think of the next epidemic, patients waiting in the ED, you are sending lots of people out who live in the community and should be here. 35 fills up quickly. Dr. Detroja said short stay is confusing. Some patients are going out anyway. It will be very complicated, 35 will be met quickly. Dr. Foley said the submitted lists will be compared with admission diagnoses over the last year. Judgement is always critical. Dr. Shangold said we admit about 250 patients per month through the ED. Divide this by 30 equals 9 a day; we need to get it down to 5. Dr. Glasser thinks we will give poor care, people will be sent home that should be hospitalized. There are some patients that refuse to go to Hartford. Then we will have a bigger problem.

Dr. Bundy wanted to clarify that he met with Dr. Sidman and a 2-7 day stay is more average. Dr. Bundy reported that MEC endorsed trying to maintain 4 CCU beds. 2-4 days is the average they'd like to hit but it's really 4-7. We don't want intense high level of care, severe sepsis, septic shock, acute MI, etc. will likely be transferred after stabilization. We need to take care of them here, which may include an initial surgery but post-surgery they may need to be transferred. We still have obligations to take care of patients to get CCU level of care until they are safe to transfer.

Dr. Barry said the Division of Medicine needs to take a stand and make it clear to Administration that it is completely unacceptable to not have an ICU. Surgeons are beside themselves. We will be deteriorating multiple services. **Dr. Barry made a motion that we, the Division of Medicine find the concept of no ICU completely unacceptable.** Dr. Madraswalla said he would reconsider sending patients here but they might need to go to Manchester. To subject a patient to go to the ED and possibly get transferred is unacceptable. If surgery is done and we can't put them on a ventilator, this is unbelievable.

Dr. Walker is in favor of the motion. We are clinicians. This was a business decision started when HHC came in. They have not enhanced our services. You have to invest money, time, and talent. It has been two years now. HHC would like to see Windham close. Meanwhile this is unacceptable for the community; patients can't get to Hartford Hospital. It's all about the doctor patient relationship and continuity of care.

Dr. Bundy said they were asked at the meeting at Stott how we can move this forward. There is a large voice to be heard. It is important that the voice of the individual practices be heard with appropriate correspondence to our leaders. There are those in offices and those here in the hospital when people show up here. These are two separate voices.

Dr. Foley's reaction to the motion that we will fight to keep the ICU open is that board certified intensive care people are not available 24 hours a day. There is no cardiology to support this. We will lose money. Dr. Kilgannon said we understand but if someone crashes surgeons need it. We can't get a central line. Dr. Bundy mentioned the desire to maintain the care of a patient for 48 hours before transferring.

Dr. Skopic asked what kind of leverage we have. If we lose \$11,000 a day and patients are floating, the loss will be here or Hartford Hospital, it doesn't matter. You are losing it no matter what, the same person writes the check. Dr. Barry said we are saving money the way we are taking care of patients here. It was agreed that we need a safety net for when patients go sour. You cannot operate on someone without ICU backup. Dr. Fisherkeller said patients are all concerned, this is a contracted influence, no one will come here, and the Hospital will close. Dr. Bundy said Elliot Joseph and Jeff Flaks entertained these questions at the leadership meeting this morning. They said only bad things happen when you shrink. Dr. Fisherkeller said his point is the community is closing the hospital, not HHC.

The motion made by Dr. Barry was re-read, **"We, the Division of Medicine, find the concept of no ICU completely unacceptable."** Motion was seconded. Vote was taken and unanimously approved (20), 1 abstention, and motion carries.

Meeting was adjourned 1:12 PM.

Respectfully submitted,

Reviewed and approved,

Sharon K. Lee
Medical Staff Coordinator

Gregory L. Shangold, M.D.
Chair, Division of Medicine

Generations Family Health Center
October 28, 2015

EXHIBIT 2: Nelson C. Walker II, MD Letter to the Editor

MANSFIELD F·A·M·I·L·Y PRACTICE

A LIMITED LIABILITY COMPANY

34 PROFESSIONAL PARK ROAD
STORRS, CONNECTICUT 06268

860/487-0002
FAX 860/429-1663

The Editor of The Chronicle
1 Chronicle Road
Willimantic, CT 06226

October 25, 2015

Editor:

Hartford Health Care (**HHC**) must hear and listen to the community and medical staff of Windham **COMMUNITY** Memorial **HOSPITAL** (**WCMH**)

In response to the front page article in The Chronicle on 10/24/15, it is important to remember that "The Hospital" ie WCMH is not just HHC. In 2009, WCMH was merged into HHC to hopefully strengthen its position in a rapidly changing Health Industry which has now evolved into Corporate controlled delivery of health care services. According to Moody's Investors Services, "HHC is a large integrated healthcare delivery system including six acute care hospitals and a large employed physician group with a combined \$2.4 billion revenue base and 85,000 admissions operating in multiple markets in central Connecticut." Many of the physicians in our community are now employees of HHC which has changed the dynamics of how WCMH is run. Since HHC took over management of WCMH, our community hospital has gone from being financially solvent to over 8 million dollar in losses per year.. We are constantly being reminded about how much money the hospital is losing, which has fueled the vicious cycle of further cuts by HHC, leading to less service and less revenue. This erosion in service has left our community with fewer Pulmonologist/intensivist, cardiologist, and trained experienced nurses to care for the patients in the intensive care unit (ICU). The issue of eliminating the intensive care unit (ICU) and calling it a progressive care unit (PCU) is just the tip of the iceberg for what has happened to our community hospital. WCMH has fewer surgeons, there is no longer a full time neurologist and other physicians that have served our community have had to relocate their offices. HHC's solution has not been to support the providers who supply the services to the community or bring in more providers and added service, but rather cut back and lay off, which has forced our community physicians to refer elsewhere and transfer patients out of their community and home environment. WCMH and the community it serves is not better off by the management of HHC and patients have lost access to care in our community because of it. HHC has not invested in our community, it has syphoned patients and their revenues away to other institutions.

HHC corporate headquarters is in Hartford and WCMH has been lumped into the Eastern Region with a focus on Backus Hospital in Norwich. This is not the orientation for much of the community that WCMH has traditionally served. If an ambulance is called to the University of Connecticut it would take the patient to WCMH and I dare say the patient would not be thinking of going to Norwich. WCMH President and CEO, David Whitehead has his office in Norwich at Backus Hospital. Prior to the merger with HHC, the CEO of WCMH would attend all the key large meetings of the medical staff, including Med Exec and the Division of Medicine. It is at these meetings that clinical services are reviewed and discussed, often with input, give and take by the hospital administration. This has all changed since WCMH was taken over by HHC and merged into the Eastern Region with Backus Hospital. Mr. Whitehead does not attend the division of Medicine meetings. He was marked as absent on May 19 when significant changes in cardiology coverage at WCMH were discussed. On July 15, 2015, when the Division of Medicine voted unanimously that **"We, the Division of Medicine, find the concept of no ICU completely unacceptable"** Mr. Whitehead and HHC administration was again not present to hear the discussion about their announced decision to close the ICU. Mr. Whitehead does not want to hear let alone listen to what our community has to say, even though HHC is supposed to be serving us not just Hartford, Norwich and corporate headquarters.

The way things are going under the management of HHC, WCMH will lose the C for community and H for hospital. I am not naive about the challenges and difficult times hospitals face to cover expenses and supply the quality of care we all deserve, but to read "Hospital says public hearing is not needed" makes me shudder. It is not the community or those that work at WCMH that are saying this, it is HHC managing our community hospital to wither on the vine. When Mr. Whitehead talks in the Chronicle about "Cornerstone of Care" this should be coming from dialogue with the community and the medical staff of WCMH, not just what HHC corporate headquarters thinks we want or should hear. When 3000 members of our community sign a petition to be heard, I hope the Office of Health Care Access (OHCA) listens to the people of the community who need the access to care.

Respectively,



Nelson C. Walker II, MD, Chief section of Family Medicine at WCMH
Nwalker@mfp1.com

Generations Family Health Center
October 28, 2015

EXHIBIT 3: East Region Transition Plan

June 23, 2015

East Region Transition plan

Why changes are needed

- As you know, the healthcare environment has been extremely challenging.
 - We have taken huge cuts in our state and federal payments
 - We are dealing with declining inpatient volume and increased competition
 - And there is an increased reliance on government payments.
- We cannot live in the world as we might wish it to be. In our desired world, hospitals and doctors would be paid fairly for taking care of the oldest and poorest of our patients.
- In order to remain open and accessible for all who rely on us, we are making some very difficult decisions.

What the changes are

- Job reductions across Hartford HealthCare have been announced, and whenever possible we are taking advantage of attrition, position vacancies and retirements to minimize the impact on people. We are also taking other steps to reduce costs.
- The job reductions and changes are being made at every level and every region at HHC.
 - In all, 335 FTEs (full-time equivalents) and 418 positions will be affected.
- Here in the East Region, we anticipate a reduction of 105 FTEs, impacting 142 positions -- 119 positions at Windham and 23 positions at Backus.
- The impact on Windham is magnified because we must transform the health care delivery system there to focus on cornerstone services. For the past five years, financial losses at Windham have totaled more than \$17 million, with another nearly \$8 million projected for this fiscal year, which averages out to \$11,000 per day. This is despite the incredible efforts of Windham Hospital staff who do their work in the most efficient, cost effective manner.
- However, this is not just a Windham Hospital issue. At both Backus and Windham, we will continue to face a harsh economic environment, so we must be proactive at Backus as well. We must collaborate with one another and our community partners to continue to meet the needs of the communities that we serve, and offer them a seamless, coordinated system of care that provides access at Backus, Windham and throughout our health care delivery network.
- We are committed to keeping Windham Hospital's doors open, offering cornerstone services and serving as a gateway for patients to get the right care at the right place at the right time.
- At Windham Hospital, our community has told us that cornerstone services include, but are not limited to:
 - Emergency Care
 - Cardiology
 - Oncology
 - Women's health
 - Diagnostic Imaging

- Short stay inpatient care
- Other coordinated services on the campus and nearby.
- Changes at Windham Hospital will include (some of these may require regulatory action)
 - Staffing to 32 inpatient beds
 - Not providing CCU-level care
 - No longer offering complex inpatient surgery
 - Transferring Interventional Radiology to the OR
 - No longer offering Sleep Lab/Clinic
 - We are working to transfer General Surgery/Wound Care Clinic to another place in the health system
 - No longer offer radiology school
 - No longer offering mammography and bone density at Hebron's Women's Center
 - Transfer the Meals on Wheels to Home Program to HHC at home
- Changes at Backus and Windham include:
 - Downsize and regionalize various community benefit and support services, including nutrition and diabetes.
 - No longer offer librarian services when the current librarian retires
 - Close Auxiliary coffee shop at Windham and the Medical Office Building coffee shop at Backus
 - Exploring lab efficiencies
 - General management changes.

Changes at Backus include:

- Closing of simulation lab
- Elimination of ID physician relationship around antibiotic stewardship
- Decentralization of EKG
- Reorganization of Care Management
- We are currently finalizing plans and affected colleagues will be notified starting next week. We will, of course, be compassionate and fair in completing this reduction. We will offer our departing colleagues all appropriate support and assistance.
- We understand this announcement may cause anxiety, and want to assure you that our plans fully support our patients and families and keep our values in the forefront as we reduce staff.
- These changes are difficult but necessary so we can be here for the people who rely on us.
- The reductions and program changes are needed to deal with the financial pressures we face. Our total HHC Medicaid reductions from the State of Connecticut amount to \$100 million over five years.
- Our decisions were based on data, not "what we've always done" or emotions. We cannot live in the world as we might wish it to be. We need to face the economic realities that are prevalent throughout healthcare in our system, the state and the nation.

- We can't sacrifice the future to sustain a past that is honorable, but is no longer our reality. The time for transformation is now, so we can create a sustainable future for the region.
- We are not just cutting. We are investing in the jobs, facilities and technologies that will allow Hartford HealthCare to lead in the new era of healthcare.
- We are especially focused on providing more outpatient care, including the addition of ambulatory centers.
- We are committed to keeping Windham Hospital open and accessible to all who rely on us for their care. We pledge to continue to provide the cornerstone services that our community needs locally. We will continue to work collaboratively to enable access to the specialty care services that our affiliation with Hartford HealthCare makes possible.
- We can — and we must — remain a cornerstone of care for this community.

Miscellaneous Q&A

Q. Does Cary Trantalis' new position as Vice President, Clinical Services and Operations, mean that we are adding to our executive salaries?

A. No. Cary is continuing her operations duties and taking on added responsibilities following the resignation of Mary Bylone and James O'Dea's transfer to a system-level position.

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Q. The media is reporting on executive salaries at Hartford HealthCare. Why are executive salaries as much as they are?

A. Executive compensation is market driven, data driven and subject to rigorous board oversight and government regulation. Hospitals and health systems need to attract experienced, talented leaders capable of improving care, expanding access and supporting staff in the face of diminishing resources. Compensation must be competitive and set at levels that will draw and keep top talent. In addition to managing advanced medical services and technology, extensive physical plants, highly educated and skilled staff, hospital executives often are responsible for an array of services beyond the hospital which can include physician groups, primary care offices, clinical laboratory networks, surgery centers, long-term care organizations and home health organizations.

Greer, Leslie

From: Martone, Kim
Sent: Friday, October 23, 2015 9:41 AM
To: Hansted, Kevin
Cc: Greer, Leslie; Olejarz, Barbara
Subject: FW: Windham Community Memorial Hospital
Attachments: Letter to OHCA FINAL.pdf

From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, October 22, 2015 5:01 PM
To: Martone, Kim
Cc: 'Feldman, Joan'
Subject: RE: Windham Community Memorial Hospital

Please find attached the response from Windham Hospital, as requested by OHCA on 10/8/2015.

The original copy will follow via FedEx.

Please let me know if you require any further information.

Sincerely,

Janette Edwards

From: Olejarz, Barbara [<mailto:Barbara.Olejarz@ct.gov>]
Sent: Thursday, October 08, 2015 2:13 PM
To: Edwards, Janette
Cc: Martone, Kim; Hansted, Kevin
Subject: Windham Community Memorial Hospital

10/8/15

Attached is a letter regarding the alignment of clinical services at Windham Community Memorial Hospital. Please let me know that you have received this email and that you were able to open it.

Thank you

Barbara K. Olejarz
Administrative Assistant for Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (86) 418-7005
Email: Barbara.Olejarz@ct.gov

Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access
410 Capital Avenue, MS#13HCA
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone,

In response to your letter dated October 8, 2015, on behalf of Windham Community Memorial Hospital (“Windham,” or “WCMH”), I am writing to confirm the accuracy of all statements and representations made by Windham in connection with the above-referenced submission.

The Request for Determination submitted to the Office of Health Care Access (“OHCA”) on September 3, 2015, is in alignment with the Final Decision Order for Docket No. 08-31178-CON, “Windham Community Memorial Hospital & Hartford HealthCare Corporation” (**Exhibit 1**). Condition 4 of the Order states “if in the future there is any change in WCMH service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.” Notwithstanding the Final Decision Order for Docket No. 08-31178, the only reason that Windham requested the above-referenced Determination was because there was precedent in the State wherein another hospital requested a Determination in connection with the transition of critical care services to a progressive care unit (“PCU”). See Exhibit 4. As stated in the September 30, 2015, letter from OHCA to Attorney Dennis O’Brien, “although Windham is reducing the extent to which critical care services are being offered, it is not terminating any services” (**Exhibit 2**).

This is further supported by OHCA’s September 9 determination that no Certificate of Need (“CON”) was required to transition to a PCU model of care (**Exhibit 3**). This determination states, “Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), a certificate of need is required for the ‘termination of inpatient or outpatient services offered by a hospital...’ The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a *CON is not required* for the Petitioner’s proposal.”

OHCA had made the same determination for previous proposals. Specifically, this same determination applied for Certificate of Need Determination Report Number 15-31981-DTR, “Alignment of Clinical Services at New Milford Hospital” (**Exhibit 4**). In that Request for Determination, New Milford Hospital proposed to transition its critical care unit (“CCU”) to a progressive care unit to better manage its patient population and bridge the gap between a critical care unit and the care delivered within its current medical-surgical units. As in the case of Windham Hospital, New Milford stated it would maintain the same level of care and competencies post progressive care unit transition and, also like Windham would not be terminating any inpatient services currently provided.

In addition, and as requested by OHCA, Windham Hospital leadership has carefully reviewed all of the documentation submitted by various individuals to OHCA in opposition to OHCA's decision confirming that Windham did not need a CON in connection with its alignment of its existing critical care unit as a progressive care unit. While we truly appreciate the feedback and the commitment that these individuals have all demonstrated on behalf of Windham, we do not agree with their position that Windham has terminated a service.

As stated in the September 3rd submission, the same level of service that Windham provides today to patients cared for in its space designated as the critical care unit will continue to be provided to Windham's patients, but within a progressive care model (See **Exhibit 6** for the list of services filed in the original request for Determination by Windham Hospital). Clinical competencies will not be reduced, and services appropriate for the acuity level of patients treated by Windham will continue to be provided.

The need to transition the critical care unit to a progressive care unit at Windham was precipitated by a declining average daily census for critical care patients, as well as the patient acuity treated in the clinical space to date. The American Association of Critical Care Nurses ("AACN") "Progressive Care Fact Sheet" (**Exhibit 5**) cites progressive care as a part of the continuum of critical care, and "patients admitted to critical care units five to ten years ago are now routinely admitted to progressive care." The AACN defines progressive care as care delivered to patients who "fall along the less acute end" of the critical care spectrum. Additionally, the AACN describes progressive care nursing competencies as encompassing many of the "same technologies and therapies that were once limited to critical care units." The critical care patients treated in the Windham critical care unit meet the definition of progressive care patients.

Windham cannot provide the same level of care that is provided by tertiary and quaternary hospitals. Tremendous resources are required to provide such critical care, including the latest medical technology and life-saving equipment; 24/7 staffing by board certified intensivists, specifically trained to address complex medical needs of critically ill patients, and supported by a variety of specialists not available at Windham Hospital, and certified critical care nurses, referred to as "CCRN's."¹ Windham is capable, and well equipped, however, to treat patients requiring lower-acuity critical care and progressive care services, as evidenced by its "Intermediate Care Guidelines for patients in the Critical Care Unit: Admissions, Down-grades, Transfers, and Discharge Criteria Policy" and its "Critical Care Unit

¹ CCRN certification is a credential granted by AACN Certification Corporation (**Exhibit 7**). CCRNs meet specific standards, including holding a current and unencumbered licensure as an RN or APRN and clinical practice requirements; eligibility is granted upon passing an exam which is accredited by the National Commission for Certifying Agencies. The AACN states "the CCRN exam is for nurses who work at the bedside of acutely and/or critically ill patients in areas such as ICUs, CCUs, respiratory ICUs, surgical ICUs, medical/surgical ICUs, cardiac/surgical ICUs, neuro/neurosurgical ICUs, PICUs, NICUs, critical care transport/flight, trauma units, emergency departments and in nurse anesthesia — or in other units as appropriate. Final determination of eligibility is *not based on unit type but on patient acuity*, as patient placement varies by facility and bed availability" [emphasis added]. No registered nurses currently employed by Windham Hospital hold the CCRN certification simply because Windham nurses do not have the type of experience that would qualify them to achieve or maintain certification.

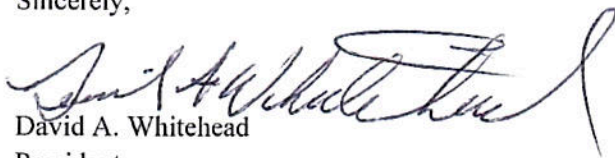
Admission, Transfer, and Discharge Criteria Policy” (**Exhibit 8**). Windham’s definition of intermediate care is consistent with the AACN definition of progressive care, and this fact has not changed. The progressive care unit at Windham will attain efficient management of resources and operational efficiencies which are vital to the sustainability of Windham, while still enabling the provision of the right care, at the right time, in the right place for patients.

Based on historical utilization and patient-complexity (as represented in the original Determination submitted to OHCA) Windham will address the clinical needs of its critical care patients, and create sustainable operational efficiencies, by transitioning the current 12-bed unit historically referred to as the critical care unit at Windham Hospital to a unit that includes four progressive-care beds and eight medical/surgical beds. Windham Hospital is creating a progressive care unit where the critical care unit currently exists.

In summary, the level of care that Windham currently provides falls along the less acute end of the critical care spectrum and that is exactly what will continue to be provided in a progressive care unit. Based on OHCA’s Determination, the transition is currently underway. Windham, not unlike New Milford Hospital, has appropriately allocated its limited resources in the most efficient manner so that it can continue to best serve the community’s health needs.

If you have any further questions, please let me know.

Sincerely,



David A. Whitehead

President

Windham Community Memorial Hospital


cc: Joan Feldman, Esq.

Affidavit

Petitioner: Windham Community Memorial Hospital

Project Title: Alignment of Critical Care Unit as a Progressive Care Unit (15-32026-DTR)

I, David A. Whitehead, President of Windham Community Memorial Hospital, being duly sworn, depose and state that the information provided in the enclosed letter is true and accurate to the best of my knowledge.


Signature

10/22/15
Date

Subscribed and sworn to before me on October 22, 2015



Notary Public/Commissioner of Superior Court

My commission expires: 11/30/2017

Exhibit 1



Office of Health Care Access Certificate of Need Application

Final Decision

Applicants: Windham Community Memorial Hospital,
Inc. and Hartford Health Care
Corporation, Inc.

Docket Number: 08-31178-CON

Project Title: Integration of Windham Community
Memorial Hospital, Inc. into Hartford
Health Care Corporation, Inc.

Statutory Reference: Sections 19a-638, C.G.S.

Filing Date: November 3, 2008

Public Hearing Date: January 6, 2009

Decision Date: January 29, 2009

Default Date: February 1, 2009

Staff: Tillman Foster
Steven W. Lazarus
Sharon Malinowski

Project Description: Windham Community Memorial Hospital, Inc. (“WCMH” or “Hospital”) and Hartford Health Care Corporation, Inc. (“HHCC”) propose the integration of WCMH into HHCC, with no associated capital expenditure.

Nature of Proceedings: On November 3, 2008, the Office of Health Care Access (“OHCA”) received the completed Certificate of Need (“CON”) Application of WCMH and HHCC for the integration of WCMH into HHCC, with no associated capital expenditure. WCMH and HHCC

(collectively known as the “Applicants”) are considered to be health care facilities or institutions for purposes of this CON as defined by Section 19a-630 of the Connecticut General Statutes (“C.G.S.”).

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on January 6, 2008. On December 8, 2008, the Applicants were notified of the date, time, and place of the hearing. On December 6, 2008, notices to the public announcing the hearing were published in *The Hartford Courant* and on December 8, 2008, in *The Chronicle*.

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., the Presiding Officer heard testimony from the Applicants and their witnesses.

OHCA’s authority to review and approve, modify or deny this proposal 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

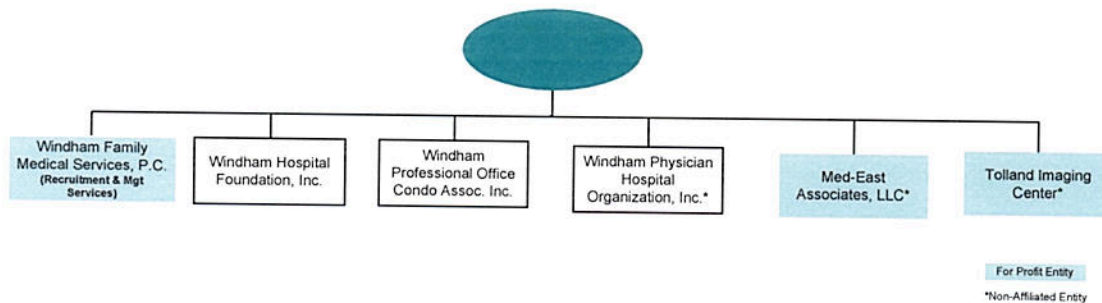
Clear Public Need

Impact on the Applicants’ Current Utilization Statistics Contribution of the Proposal to the Accessibility and Quality of Health Care Delivery in the Region

1. Windham Community Memorial Hospital, Inc. (“WCMH” or “Hospital”) is a Connecticut corporation located at 112 Mansfield Avenue, Willimantic, Connecticut and operates a 144 licensed bed acute care hospital. (*CON Application, 08-31178-CON, HHCC and WCMH Integration Agreement, Appendix B, and Office of Health Care Access, Hospital Reporting System, FY 2007, Report 400*)
2. Hartford Health Care Corporation (“HHCC”) located at 80 Seymour Street, Hartford, Connecticut, is the parent corporation of Hartford Hospital, in Hartford and MidState Medical Center in Meriden. (*November 3, 2008, CON Application, page 1 and Office of Health Care Access, Hospital Reporting System, FY 2007, Report 400*)

3. WCMH and HHCC (“Applicants”) are proposing the integration of WCMH into HHCC, with no associated capital expenditure. *(June 2, 2008, Letter of Intent and November 3, 2008, CON Application, pages 1-8)*
4. Under the proposed integration WCMH will become a wholly-owned subsidiary of HHCC similar to Hartford Hospital and MidState Medical Center. *(June 2, 2008, Letter of Intent)*
5. The organization chart of WCMH and its affiliates before integration with HHCC is as follows:

Chart One: WCMH Organization Chart Prior to Integration into HHCC:



Source: CON Application DN 08-31178-CON, Proposed Integration Agreement, Schedule 2.2

6. The following table lists affiliated and non-affiliated entities currently under WCMH (prior to the proposed the integration):

Table 1: Affiliated and Non-Affiliated WCMH Entities

Affiliated Entities		
	Entity	WCMH Ownership Percentage
	Windham Family Medical Services, P.C.	One Hundred Percent
	Windham Hospital Foundation, Inc.	One Hundred Percent
	Windham Professional Office Condominium Association, Inc.	One Hundred Percent
Non-Affiliated Entities		
	Windham Physician – Hospital Organization, Inc.	Fifty Percent
	Med-East Associates, LLC	Fifty Percent
	Tolland Imaging Center, LLC	Fifteen Percent
	Health Connecticut, LLC (Connecticut Hospital Association Entity)	WCMH one of 18 Hospital owners

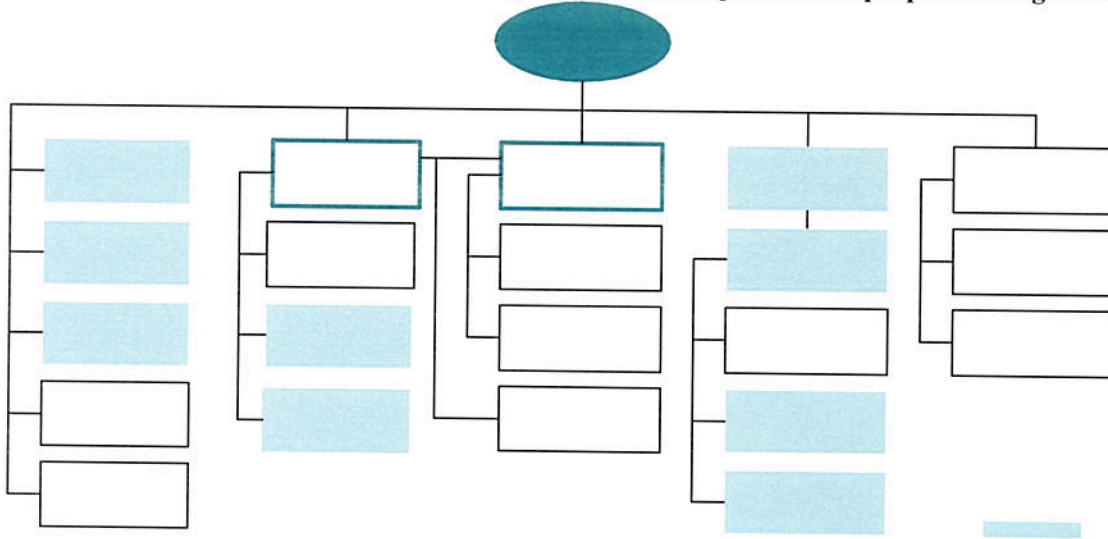
Note: “Affiliated” entities are describe as having greater than 50% WCMH ownership;

“Non-Affiliated” are described as having 50% or less WCMH ownership

(CON Application, 08-31178-CON, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008 Prefile Testimony, Response to OHCA Interrogatories, page 127 and January 6, 2009, Applicants Public Hearing Testimony)

7. The organization chart of HHCC before integration with WCMH is as follows:

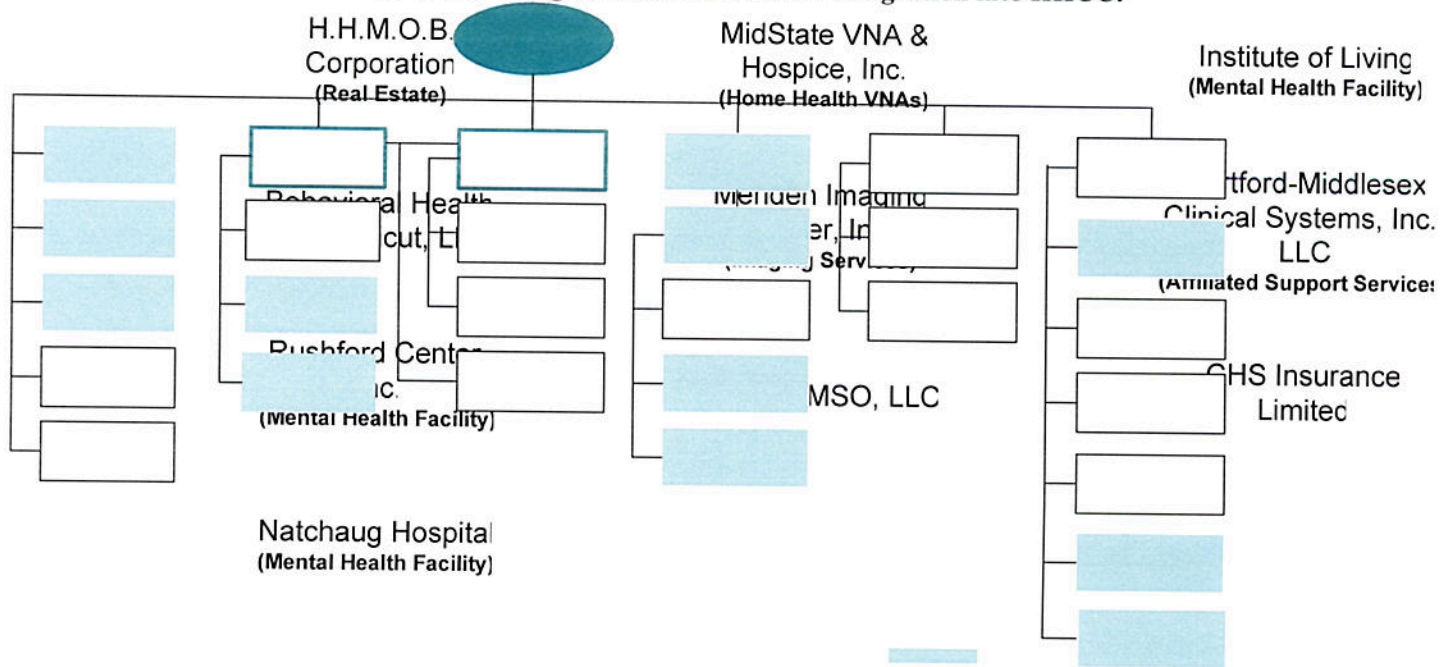
Chart Two: HHCC Organization Chart prior to the proposed Integration:



Source: Hartford Hospital, Docket Number 07-005AR, FY 2007 Annual Reporting

8. The proposed organization chart of WCMH and its affiliates after integration into HHCC as Hartford Hospital follows:

Chart Three: WCMH Organization Chart After Integration into HHCC:



Sources: CON Application DN 08-31178-CON, Proposed Integration Agreement, Schedule 2.2 and Hartford Hospital, Docket Number 07-005AR, FY 2007 Annual Reporting

9. As of Integration Agreement's closing date, the Board of Directors of WCMH will consist of eighteen (18) individuals, three (3) of which are ex-officio, serving on the WCMH Board of Directors as set forth in Schedule 1.3 of the Integration Agreement. *(CON Application, 08-31178-CON, December 30, 2008, Prefile Testimony and Response to OHCA Interrogatories, HHCC and WCMH Integration Agreement, page 126)*
10. Section 3.1 of the Pre-Closing Amended and Restated Bylaws (or Schedule 1.2 of Integration Agreement) sets forth that the WCMH Board shall not consist of any more than 18 directors, and only HHCC shall have the exclusive right to elect directors or fill any vacancy on WCMH's Board. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of HHCC and WCMH Integration Agreement, page 4)*
11. Under Article V of the Pre-Closing Amended and Restated Certificate of Incorporation WCMH shall operate under the management of its Board of Directors having all the necessary corporate power and authority to own, lease and use its properties and to operate its businesses as now being conducted as set forth in Clause 2.2 of the Integration Agreement. *(September 18, 2008, Initial Certificate of Need Application, 08-31178-CON, Pre-Closing Amended and Restated Certificate of Incorporation or Schedule 1.1 of HHCC and WCMH Integration Agreement, Article V)*
12. HHCC shall have the following powers and rights as set forth in Section 1.3 of Schedule 1.2:
 - (a) The sole power to elect and remove, with or without cause members of the WCMH Board.
 - (b) Review and approve, disapprove, or modify annual operating and capital budgets; significant proposed programs and expenditures, the purchase of significant operating or capital assets not contemplated in an approved budget or plan; and the borrowing of any sum in excess of \$1,000,000 with a stated term of greater than one year.
 - (c) Approve, disapprove, modify or direct the implementation of strategic plans, programmatic plans; health care standards of care; utilization review; and program coordination with other entities or persons in HHCC's health care system.
 - (d) Approve or disapprove any voluntary dissolution, merger or consolidation of WCMH or the sale, pledging, leasing or transfer of any substantial amount of WCMH's assets or the creation or acquisition of any significant subsidiary or affiliate corporation, significant contracts which WCMH in its discretion may refer to HHCC for review or approval; the selection of certified public accountants for WCMH; the filing of any Certificate of Need application for an expenditure or program outside of WCMH's ordinary business.
 - (e) Approve or establish guidelines or parameters for governing WCMH's participation in managed care contracts. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of HHCC and WCMH Integration Agreement, page 4)*
13. When WCMH is integrated into HHCC there will be no change in ownership of WCMH's affiliated entities except that HHCC will become the sole member of WCMH as set forth Section 1.2 of Schedule 1.2 and the affiliated entities will remain unchanged as listed in Schedule 2.2 of the Integration Agreement. *(September 18, 2008, Initial Certificate of Need Application, Schedule 1.2 of the*

Integration Agreement, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008, Prefile Testimony and Response to OHCA Interrogatories)

14. WCMH shall maintain its Board of Corporators (“Corporators”) consisting of no more than 150 members who are adults who either work or reside in the towns listed in Section 2.4 of Schedule 1.2, but it will serve only in an advisory capacity to WCMH’s Board. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of the HHCC and WCMH Integration Agreement, page 4)*
15. The Independent Practice Association which owns fifty percent of Windham Physician-Hospital Organization, Inc., supports the proposed Integration of WCMH into HHCC. *(September 18, 2008, Initial Certificate of Need Application, Testimony of Windham Community Memorial Hospital, January 6, 2009, Public Hearing)*
16. The Applicants state that historically, WCMH has had a close relationship with Hartford Hospital and with respect to medical staff referrals for tertiary level services as well as for other programmatic collaboration. This relationship has included successful clinical efforts in oncology, cardiology and emergency medicine. It has also assisted in allowing WCMH to participate in National Institutes of Health (“NIH”) clinical research trials and other research projects. *(September 18, 2008, Initial Certificate of Need Application, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, page 5)*
17. According to the Applicants:
 - (a). In spring 2006, a strategic partnership agreement was signed by the Boards of both organizations,
 - (b). In January 2007, the leadership of WCMH, including the Board, Administration and Medical Staff embarked upon a comprehensive strategic planning process. Principles for affiliation were identified and given the longstanding relationship of both institutions, formal discussions were pursued with HHCC. Concurrently with the formal adoption of the revised strategic plan in early summer 2007, actions were implemented by both administrations and boards to develop an agreement. These agreements were approved in August of 2007,
 - (c). Formal votes of WCMH were taken in the spring of 2008 and the Corporators of WCMH took a vote in June 2008, approving this affiliation and the documents necessary for implementation. *(September 18, 2008, Initial Certificate of Need Application, pages 2-3)*
18. The Applicants stated that:
 - (a). The day to day operations of WCMH will remain the responsibility of the WCMH Board of Directors, the Chief Executive Office and administrative staff,
 - (b) The reserve powers of the agreement require WMCH to get approval from HHCC for certain fundamental decisions that will be subject to HHCC’s or the members approval (e.g., annual budgets, major capital purchases exceeding certain capital thresholds, and Certificate of Need projects), and
 - (c) No consolidation of services are planned at this time. However, it is possible in accordance with further development of the HHCC integrated Health Care delivery system

that certain services will not be duplicated at each member entity. It is also anticipated that certain administrative, management and technical services may be consolidated more immediately in order to achieve economies of scale and enhanced quality of service.
(November 3, 2008, Responses to OHCA's Completeness Letter, page 3)

19. According to the Applicants, WCMH will be integral to HHCC plan to advance the quality of Health Care delivered to residents in the region served by WCMH. *(November 3, 2008, Responses to OHCA's Completeness Letter, page 4)*
20. As set forth in Section 8.3 of the Integration Agreement, the HHCC Board of Directors will continue to be the principal policy making and decision making body for the System. Accordingly, WCMH management will have system accountability together with internal reporting relationships. *(September 18, 2008, Initial Certificate of Need Application, Section 8.3 of the Integration Agreement, page 21)*
21. The following utilization data is related to WCMH, as reported in the Patient Census Report of September 2008:

	2008	2007
Total WCMH Admissions	5,744	5,742
Medical-Surgical Service	4,724	4,651
Emergency Dept. Visits	29,054	26,822

(Patient Census Report, September, 2008)

22. WCMH stated that through the proposed integration, it will be better able to recruit primary care physicians and to explore development of primary care group sites in key locations throughout WCMH's service area. *(December 30, 2008, Prefile Testimony of Mr. Richard A. Brvenik, President and Chief Executive Officer of WCMH, pages 5-6)*
23. The Applicants state that the direct benefits of the integration to HHCC include the following opportunities:
- (a). Additional opportunities for Clinical research,
 - (b). Teaching,
 - (c) Implementation of quality initiatives,
 - (d) Shared best practices,
 - (e) Volume purchasing,
 - (f) Consolidation of certain administrative services,
 - (g) Deployment of expensive technologies throughout the system,
 - (h) Spreading of risk, and
 - (i) Recruitment of medical talent by virtue of system size and coordinated efforts.
- (November 3, 2008, Responses to OHCA's Completeness Letter, page 2)*

24. According to the Applicants, benefits of the integration to be derived by WCMH include the following opportunities:

- (a) Improved ability to recruit physicians,
 - (b) Increase market share in secondary service area communities,
 - (c) Access managed care contracting expertise,
 - (d) Purchase select clinical and administrative services,
 - (e) Achieve economies of scale,
 - (f) Improve the balance sheet by refinancing existing debt,
 - (g) Increase the services and technology offered locally,
 - (h) Decrease the out-migration of patients,
 - (i) Improved ability to access capital at a lower cost, and
 - (j) Reduce operating costs by being able to utilize the purchasing power of HHCC.
- (September 18, 2008, Initial Certificate of Need Application, page 4)*

**Financial Feasibility 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 Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines**

25. The projected three-year incremental revenue from operations, total operating expense and losses/gains from operations associated with the proposed integration are presented in the table below:

Table 3: WCMH's Incremental Financial Projections

Description	FY 2009	FY 2010	FY 2011
Incremental Revenue from Operations	\$0	\$0	\$0
Incremental Total Operating Expense	\$(600,000)	\$(600,000)	\$(600,000)
Incremental Gain from Operations	\$600,000	\$600,000	\$600,000
Revenue Over/(Under) Expenses	\$600,000	\$600,000	\$600,000

(September 18, 2008, Initial Certificate of Need Application, Financial Attach. I, number 12.C (i))

26. At a minimum is projected to save WCMH \$600,000 annually for FYs 2009-2011. The annual savings is primarily due to better financial terms attributable to WCMH's new affiliation with HHCC. *(CON Application, 08-31178-CON, Pro Forma Attachment I, Appendix M and Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, Public Hearing, page 5)*

27. HHCC's current payer mix and projected with the CON proposal is as follows:

Table 4: Current and Three-Year Projected Payer Mix with the CON Proposal

<i>Total HHCC</i>	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare	40%	40%	40%	40%
Medicaid (includes other medical assistance)	12%	12%	12%	12%
TRICARE and CHAMPUS	3%	3%	3%	3%
Total Government	55%	55%	55%	55%
Commercial Insurers*	45%	45%	45%	45%
Uninsured (1)				
Workers Compensation (1)				
Total Non-Government	45%	45%	45%	45%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity

(1) Included in Commercial Insurers

(September 18, 2008, Initial Certificate of Need Application, page 17)

28. WCMH's current payer mix and projected payer mix with the CON proposal is as follows:

Table 5: Current and Three-Year Projected Payer Mix with the CON Proposal

<i>Total WCMH</i>	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	58%	58%	58%	58%
Medicaid *(includes other medical assistance)	20%	20%	20%	20%
TRICARE and CHAMPUS				
Total Government	78%	78%	78%	78%
Commercial Insurers*	21%	21%	21%	21%
Uninsured	1%	1%	1%	1%
Workers Compensation				
Total Non-Government	22%	22%	22%	22%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity

(1) Included in Commercial Insurers

Based on hospital discharges

(September 18, 2008, Initial Certificate of Need Application, page 17)

29. WCMH stated that the most recent data indicate the payer mix for WCMH as a percent of gross revenue is: Medicare 39%, Medicaid 17%, commercial insurance 40% and self-pay 4%, which is significantly less positive than that of the average Connecticut acute care hospital. (December 30, 2008, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital)

30. WCMH stated given the demographics of its patients, financial analyses and forecasts showed that as a free-standing hospital, WCMH would be hard pressed to achieve an operating gains of even 1% in future years, accordingly financial analysts seek operating margins in the range of 4-5% to

assure future viability and institutional financial health. *(December 30, 2008, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital)*

31. WCMH stated that it is a safety net provider for the region it serves. In order to sustain this role WCMH felt it needed to strengthen its long-term financial stability. Consequently becoming a part of HHCC was viewed as critical to its long-term financial stability. *(CON Application, 08-31178-CON, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008, Response to OHCA Interrogatories, pages 1 & 2)*

32. Richard A. Brevnik, President and Chief Executive Officer of WCMH, stated that in order to achieve its institutional goals, WCMH required an estimated \$43 million dollars in capital over five year period covering, FY 2007 through 2012. The required capital would be earmarked for the following purposes:
 - a. Refinancing of WCMH's pension fund;
 - b. Refinancing of WCMH's Long-Term Debt;
 - c. Physician recruitment;
 - d. Facility upgrades; and
 - e. Acquiring other medical technologies.*(CON Application, 08-31178-CON, Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, Public Hearing)*

33. There is no State Health Plan in existence at this time. *(September 18, 2008, Initial Certificate of Need Application, page 2)*

34. The Applicants stated that this proposal is consistent with each of their respective long-range plans. *(September 18, 2008, Initial Certificate of Need Application, page 2)*

35. The Applicants have improved productivity and contained costs in the past year through the application of new technology, undertaking energy conservation measures and employing group purchasing methods. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

36. The proposal will not result in any change to the Applicants' teaching or research responsibilities. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

37. There are no distinguishing characteristics of the Applicants' patient/physician mix that makes the proposal unique. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

38. The Applicants have sufficient technical and managerial competence and expertise to provide efficient and adequate service to the public. *(September 18, 2008, Initial Certificate of Need Application, pages 10-11 and Appendix D)*

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.

Windham Community Memorial Hospital, Inc. (WCMH”) and Hartford Health Care Corporation, Inc. (“HHCC”) propose the integration of WCMH into HHCC, thereby, making WCMH a wholly owned subsidiary of HHCC, similar to Hartford Hospital and MidState Medical Center. WCMH has historically had a close relationship with Hartford Hospital (a subsidiary of HHCC) and its medical staff for referral for tertiary level services, as well as for other programmatic collaboration. Even though the Applicants are not planning any consolidation of service at this time, further development of HHCC integrated Health Care delivery system in the future will lead to certain services not being duplicated at each member entity of HHCC.

This partnership between the Applicants has been in place since January of 2007 and was formalized in June of 2008. As a result of this proposed integration, there will be no change in ownership of WCMH’s affiliated entities, as they will continue to operate under WCMH. HHCC will become the sole member of WCMH as set forth in the written agreements provided to this agency. The day to day operations of WCMH will remain the responsibility of the WCMH Board of Directors, the Chief Executive Officer and Administrative Staff; however, the reserve powers of the agreement between the Applicants require WCMH to get approval from HHCC for certain fundamental decisions which will be subject to HHCC’s or the members approval.

This proposal will improve the quality of health care delivered to patients in the region. This proposal will allow WCMH to improve its ability to recruit physicians, improve its managed care contracts, refinance its existing debt, access to capital at lower cost and reduce its overall operating costs. HHCC will intern have opportunities for additional clinical research, shared best practices and deploy expensive technologies through the system. It appears to OHCA that this proposal is mutually beneficial for both Applicants. WCMH’s utilization has stayed steady or increased between FY 2007 and 2008 for total admissions, medical surgical services and emergency department, leading OHCA to believe that the financial challenges appear to be more related to the patient mix. WCMH will be an integral part of HHCC’s plan to advance the quality of health care delivery to its patients in the region and the Applicants testified that they will improve access to primary care services. The Applicants, also stated that currently they will not be terminating any services; however, OHCA realizes that in the future the reduction of duplicative services may be necessary to further strengthen the financial viability of the system.

WCMH projects gains from operations, incremental to the proposal of \$600,000 for FYs 2009-2011, the first three years of the proposal, which is a result of WCMH’s relationship with HHCC which aided in restructuring of WCMH’s existing debt. This proposal provides longer term financial viability to the system of care. HHCC is projecting gains from operations, incremental to the proposal of

\$1,850,960, \$1,942,000 and \$1,238,000, for FYs 2009-2010. WCMH and HHCC's financial projections and volumes upon which they are based appear to be reasonable and achievable.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Windham Community Memorial Hospital (“WCMH” or “Hospital”) and Hartford Health Care Corporation, Inc. (“HHCC”) (together referred to as “Applicants”) for the integration of WCMH into HHCC with no associated capital expenditure, is hereby **Approved**, subject to the following conditions:

1. This authorization expires on January 31, 2010. Should the Applicants proposal not be completed (i.e. final agreement are executed) by that date, the Applicants must seek further approval from OHCA to complete the project beyond that date.
2. Within 60 days of the completion of the integration of WCMH into HHCC, the Applicants shall file with OHCA; a full copy of any and all signed, dated and completed final integration agreements including attachments indicating the integration of WCMH into HHCC has occurred.
3. If in the future there is any change in the ownership structure of WCMH or its affiliates or any change in control of WCMH, the Applicants shall file a CON Determination Form with OHCA.
4. If in the future there is any change in WCMH service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.
5. As there is no associated capital expenditure with this proposal, in the event that the Applicants learn of potential costs associated with this proposal, the Applicants shall notify OHCA immediately

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

Signed by Commissioner Vogel on January 29, 2009

Date

Cristine A. Vogel
Commissioner

Exhibit 2



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 30, 2015

Dennis O'Brien, Esq.
120 Bolivia Street
Willimantic, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Attorney O'Brien:

Thank you for your letter of September 25, 2015 regarding the determination issued by the Office of Health Care Access ("OHCA") under Docket Number 15-32026-DTR.

OHCA understands and appreciates your concerns. In making its determination OHCA's jurisdiction is limited by Conn. Gen. Stat. § 19a-638; specifically § 19a-638(a)(5) in this matter. § 19a-638(a)(5) mandates that a certificate of need be filed when a hospital is proposing to terminate inpatient or outpatient services offered by the hospital. The information provided by Windham Hospital in its 2020 form, and further confirmed via written communications between OHCA and Windham Hospital, the services currently being offered in the critical care unit will continue to be offered in the new progressive care unit. While Windham Hospital may be reducing the extent to which services are being offered, it is not terminating any services. OHCA's jurisdiction does not extend to reductions in the hours a particular service is offered or the number of beds used to offer that service.¹ Therefore, OHCA has no legal basis upon which it can require Windham Hospital to file a certificate of need application.

At your convenience, the complete record of this matter can be viewed on OHCA's website at <http://www.ct.gov/dph/ohca>.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kim Martone".

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

¹ Conn. Gen. Stat. § 19a-638(a)(12) requires a certificate of need for an increase in the licensed bed capacity of a health care facility. However, Windham Hospital is not seeking an increase in its licensed bed capacity.

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308

Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

Exhibit 3



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 9, 2015

Janette Edwards
Director Planning & Business Development
Windham Community Memorial Hospital
112 Mansfield Avenue
Windham, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Edwards:

On September 4, 2015, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Windham Community Memorial Hospital ("Petitioner") with respect to the alignment of clinical services at Windham Hospital.

Windham Hospital is a licensed nonprofit hospital and part of Hartford HealthCare Corporation. Windham Hospital currently provides inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23-bed medical-surgical unit, and a 12-bed critical care unit ("CCU"). The Petitioner is proposing to implement a progressive care unit ("PCU") in place of its CCU and reduce the number of beds in the PCU to four (4). The medical services currently provided in the CCU will continue to be provided in the new PCU to the same patient population. Also, there is no proposed change to the Petitioner's license.

Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), a certificate of need is required for the "termination of inpatient or outpatient services offered by a hospital..." The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a **CON is not required** for the Petitioner's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone".

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

Exhibit 4

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, February 24, 2015 3:59 PM
To: Hansted, Kevin
Cc: Greer, Leslie
Subject: FW: OHCA Determination
Attachments: OHCA Determination 02 24 2015.pdf

Importance: High

From: Johnson, Michelle [<mailto:Michelle.Johnson@wchn.org>]
Sent: Tuesday, February 24, 2015 3:43 PM
To: Martone, Kim
Cc: Herlihy, Sally
Subject: OHCA Determination
Importance: High

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached a Determination Request on behalf of Western Connecticut Health Network, Inc. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

The original document will be sent to the OHCA offices by mail.

Thank you.

Michelle Johnson
Executive Assistant to Senior Administrators
Western Connecticut Health Network

203-739-4935



This transmittal is intended for a particular addressee(s). If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, copying or distribution or dissemination is strictly prohibited. If you suspect that you have received this transmittal in error, please notify Western Connecticut Health Network immediately by email reply to the sender, and delete the transmittal and any attachments.

READER BEWARE: Internet e-mail is inherently insecure and occasionally unreliable. Please contact the sender if you wish to arrange for secure communication or to verify the contents of this message.



**State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020**

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner
Full Legal Name	The Danbury Hospital
Doing Business As	New Milford Hospital
Name of Parent Corporation	Western Connecticut Health Network, Inc. (WCHN)
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	24 Hospital Avenue Danbury, CT 06810
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP
Contact Person at Facility , including Title/Position: This Individual at the facility will be the	Sally F. Herlihy, MBA, FACHE VP, Planning

Petitioner's Designee to receive all correspondence in this matter.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	24 Hospital Avenue Danbury, CT 06811
Contact Person's Telephone Number	203-739-4903
Contact Person's Fax Number	203-739-1974
Contact Person's e-mail Address	sally.herlihy@wchn.org

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Alignment of Clinical Services
- b. Estimated Total Project Cost: \$0
- c. Location of proposal, identifying Street Address, Town and Zip Code: New Milford Hospital, 21 Elm Street, New Milford, CT 06776
- d. List each town this project is intended to serve: Existing communities (no changes)
- e. Estimated starting date for the project: March 2015

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and the target population to be served.

Overview

WCHN's mission is to "improve the health of every person we serve through the efficient delivery of excellent, innovative and compassionate care." In furtherance of this mission, we endeavor to provide the right care, at the right place and the right time. WCHN has been considering the appropriate management of the continuum of critical care patients at the New Milford Hospital (NMH) campus and the appropriate utilization of the recently opened new Critical Care Unit at the Danbury Hospital campus (DH) which features the latest medical technology and life-saving equipment, along with round-the-clock access to the specialists (neurologists, cardiologists, nephrologists, infectious diseases, etc.) required to deliver their care. Since 2009 (well before NMH's affiliation with WCHN), NMH has been transferring the most critically-ill patients from NMH to DH based on determinations by the NMH medical staff that DH offered critically-ill and injured patients a higher level of care. WCHN now desires to efficiently address the clinical needs of NMH's inpatients by consolidating its CCU beds within a progressive care unit located within NMH's 3-East medical-surgical unit. There is no proposed change to the DH license (see Exhibit 1).

Background

At NMH, the inpatient clinical care is currently provided in two locations, a 35-bed medical surgical unit located on its third-floor (referred to as "3-East"), and an 8-bed critical care unit located on the second floor of the same building (called the "CCU"). The average daily census ("ADC") at NMH for medical surgical patients during FY14 was 20 patients, with an ADC of only 2 patients in the CCU throughout FY14 and current FY15 (Q1) and no material change in activity from FY13. The CCU is operating at 25% occupancy (2 of the 8 available beds) and there is an average length of stay of 4.0 days. The CCU beds located on the second floor have separate staffing, and are underutilized, resulting in inefficiency.

Discussion

Based on the patient-complexity and historical utilization of the CCU at NMH, NMH proposes to implement a progressive care unit on its third floor, within its medical-surgical unit on 3-East. This efficient management of clinical and operational resources supports the provision of the right care, in the right location, at the right time. This approach also bridges the gap between a critical care unit complexity level of service and the care provided on the current medical-surgical unit:

- The American Association of Critical Care Nurses ("AACN") recognizes progressive care as part of the continuum of critical care.
- Per AACN, progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with high potential for becoming unstable and require an increased intensity of care.
 - Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

The patients who have been treated on the second floor in the CCU satisfy the definition of progressive care patients. There will be no change in the clinical care provided for these patients with co-location of the progressive care unit within the 3-East medical-surgical unit:

- The co-location of patients on 3-East will offer additional nursing resources and efficiencies to better address patient needs.
- The patients will be managed with the same level of technology that currently exists in the separate CCU. The centralized monitoring will be relocated and the unit will be upgraded with wireless monitoring, ensuring the same standard of care with no reduction in capabilities.
- DH's new state of the art ICU opened in October 2014. It is staffed by intensivists, specially trained to address the complex medical needs of critically ill patients and supported by a variety of specialists not available at NMH.

We respectfully request confirmation that consolidation of the second floor CCU at NMH with the third floor 3-East medical surgical unit will not require a CON.

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: The Danbury Hospital

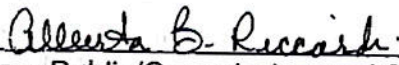
Project Title: Alignment of Clinical Services

I, Dan DeBarba, EVP, Western Connecticut Health Network, Inc., and President, The Danbury Hospital, being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.



Signature Date 2/24/15

Subscribed and sworn to before me on 2-24-15



Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2019

Exhibit I
The Danbury Hospital License

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0039

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Danbury Hospital of Danbury, CT d/b/a The Danbury Hospital is hereby licensed to maintain and operate a General Hospital.

The Danbury Hospital is located at 24 Hospital Avenue, Danbury, CT 06810.

The maximum number of beds shall not exceed at any time:

26 Bassinets
430 General Hospital Beds

This license expires September 30, 2015 and may be revoked for cause at any time.

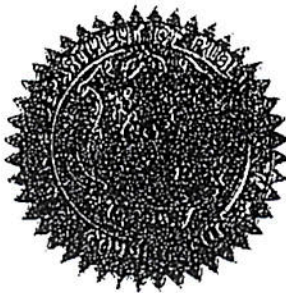
Dated at Hartford, Connecticut, October 1, 2013.

Satellites:

- *New Milford Hospital Campus, 21 Elm Street, New Milford, CT
- *New Milford Hospital Behavioral Health Services, 23 Poplar Street, New Milford, CT
- Center for Child and Adolescent Treatment Services, 152 West Street, Danbury, CT
- Community Center for Behavioral Health (ADH-PHP), 152 West Street, Danbury, CT
- The Pediatric Health Center, 70 Main Street, Danbury, CT
- Seifert & Ford Community Health Center, 70 Main Street, Danbury, CT
- Ridgefield Surgical Center, 901 Ethan Allen Highway, Ridgefield, CT

License revised to reflect:

*Added (2) satellites and increase of 85 General Beds because The Danbury Hospital merged and took over New Milford Hospital effective 10/1/14.



Jewel Mullen

Jewel Mullen, MD, MPH, MPA
Commissioner

Greer, Leslie

From: Hansted, Kevin
Sent: Friday, February 27, 2015 9:15 AM
To: Greer, Leslie
Cc: Martone, Kim
Subject: FW: Determination Report 15-31981-DTR

Leslie, please add the below to the record.
Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

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From: Herlihy, Sally [mailto:Sally.Herlihy@wchn.org]
Sent: Friday, February 27, 2015 8:47 AM
To: Hansted, Kevin
Subject: RE: Determination Report 15-31981-DTR

Dear Attorney Hansted,

The medical services provided in the CCU at New Milford Hospital will continue to be provided in the progressive care unit without any change. Some examples of these services follow:

- Unstable Non-invasive ventilation i.e. CPAP or BIPAP
- Hemodynamic instability due to hypovolemia, hemorrhage, sepsis, or other cause
- Central nervous system depression that threatens to compromise airway and protective reflexes
- Severe impairment of renal function or severe electrolyte abnormalities
- Patients requiring extended post-operative care
- Extended intra-operative time and vigorous fluid resuscitation with the probability of fluid shifts and massive third spacing
- Patients requiring frequent assessments(solid organ injury or abdominal pain with the possibility of emergent surgery)
- Patients with delirium tremens requiring continuous Ativan drip without respiratory failure requiring intubation
- Patients requiring continuous observation and pulse oximetry due to upper airway disease such as epiglottitis or tumor
- Possible intra-operative events (i.e. ST changes, arrhythmias, etc.) which are asymptomatic and hemodynamically stable
- Arrhythmias that are hemodynamically stable (IE. atrial fibrillation/flutter, supra ventricular tachycardia)

- Angina pectoris, that is hemodynamically stable but requires intravenous nitroglycerin for prophylaxis of the angina
- Mild to moderate congestive heart failure without signs/symptoms of shock
- Hypertensive urgency without evidence of end-organ damage
- Drug drips appropriate for PCU management as defined by the institutional critical care committee.
- Patients requiring initiation of and maintenance intravenous infusions of anti-arrhythmics, and vasoactive inotropic medications.
- Patients with a tracheostomy tube requiring aggressive pulmonary toileting or requiring arterial blood gases than once per eight hours. Suctioning is provided every 4 hours or less.
- Hemodynamically stable patients with evidence of compromised gas exchanges and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or continuous positive airway pressure
- Post-op patients after being fully recovered in PACU and meeting all other CSD criteria
- Patients requiring monitoring for seizure activity (should be controlled with anticonvulsant medication)
- Patient requiring vital signs, lab tests, neuro checks, peripheral pulse checks, I & O no more often than every two hours routinely. Exceptions: a) patient' s receiving blood products and B) certain IV infusions, and C) Dilantin loading doses may have more frequent vital signs
- Patient requiring monitoring for obstructive sleep apnea

Please reach out if you require additional information.

Sincerely,
Sally

Sally F. Herlihy, FACHE

Vice President, Planning

Western Connecticut Health Network

203-739-4903

From: Hansted, Kevin [<mailto:Kevin.Hansted@ct.gov>]

Sent: Thursday, February 26, 2015 11:44 AM

To: Herlihy, Sally

Subject: Determination Report 15-31981-DTR

Dear Ms. Herlihy,

I am in recent of your determination request concerning the consolidation of New Milford Hospital's CCU beds into a progressive care unit. Please provide a list of medical services currently provided in the CCU along with a list of the medical services proposed to be offered in the progressive care unit.

Thank you,

Kevin T. Hansted

Staff Attorney

Department of Public Health

Office of Health Care Access

410 Capitol Ave., MS #13HCA

P.O. Box 340308

Hartford, CT 06134

Phone: 860-418-7044

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

March 11, 2015

Sally F. Herlihy, MBA, FACHE
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Determination Report Number 15-31981-DTR
Alignment of Clinical Services at New Milford Hospital

Dear Ms. Herlihy:

On February 24, 2015, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Western Connecticut Health Network, Inc. ("Petitioner") with respect to the alignment of clinical services at New Milford Hospital ("NMH").

NMH is a licensed nonprofit hospital and part of the Western Connecticut Health Network, Inc. NMH currently provides inpatient critical care in two locations, a 35-bed medical surgical unit located on its third-floor, and an 8-bed critical care unit ("CCU") located on the second floor of the same building. NMH is proposing to implement a progressive care unit on its third floor, within its medical surgical unit. The medical services currently provided in the CCU will continue to be provided in the new progressive care unit without any change.

Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), as amended by P.A. 14-168, a certificate of need is required for the "termination of inpatient or outpatient services offered by a hospital..." The Petitioner has represented that the proposed progressive care unit will offer the same clinical care services that are currently offered in the CCU and the medical surgical unit will remain operational once the progressive care unit is opened. As a result, no termination of services is taking place. Therefore, a **CON is not required** for the Petitioner's proposal.

Sincerely,

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

* * * COMMUNICATION RESULT REPORT (MAR. 11. 2015 1:28PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FILE MODE	MAR. 11. 2015 1:28PM OPTION	ADDRESS	RESULT	PAGE
952 MEMORY TX		912037391974	OK	2/2

REASON FOR ERROR
 E-1) HANG UP OR LINE FAIL
 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



STATE OF CONNECTICUT
 DEPARTMENT OF PUBLIC HEALTH
 OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Sally F. Herlihy

FAX: 203 739-1974

AGENCY: WCHN

FROM: OHCA

DATE: 3/11/15 Time: _____

NUMBER OF PAGES: 2
(including transmittal sheet)

Comments:
 Determination for Report Number 15-31981-DTR is attached.

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
 P.O.Box 340308
 Hartford, CT 06134

Exhibit 5

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

Progressive Care Fact Sheet

Background

In the early 1970s, major medical center recruiters placed advertisements for both critical care and progressive care nurses in *Heart and Lung*. Initially, progressive care units housed post myocardial infarction patients requiring cardiac monitoring, but not requiring intensive care and observation. With the changing healthcare environment, the acuity of patients admitted to hospitals steadily increased and caused an increase in the demand for critical care beds. With the increased demand and decreased availability of critical care beds, patients were often transferred from critical care units while still requiring an increased level of nursing care and vigilance. Patients admitted to critical care units five to ten years ago are now routinely admitted to progressive care.

Progressive care is the term the American Association of Critical-Care Nurses (AACN) uses to collectively describe areas that are also referred to as Intermediate Care Units, Direct Observation Units, Step-down Units, Telemetry Units, or Transitional Care Units as well as to define a specific level of patient care. AACN recognizes the need to define and identify the special needs of progressive care nurses. In 2008, the Certification Corporation convened a progressive care nursing study of practice. The study of practice determined the scope of practice, populations served, the core competencies and basic knowledge and skill requirements of progressive care nurses and provided a foundation for development of certification exams. Progressive care nurses across the country participated in the study of practice.

Definition

The American Association of Critical-Care Nurses recognizes progressive care as part of the continuum of critical care. AACN is dedicated to creating a healthcare system driven by the needs of patients and families where critical care nurses make their optimal contribution. The AACN Synergy Model for Patient Care is the conceptual framework that actualizes the vision. It defines nursing practice based on the needs of the patient and the characteristics of the nurse to attain optimal patient outcomes.

Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care. Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

Progressive Care Patient Location

AACN's Synergy Model assists in defining the progressive care patient. The Synergy Model identifies patients based on the characteristics and needs that they present and not on the location of the bed they occupy. As in critical care, the geographic domain of progressive care is expanding. Care provided to progressive care patients is not limited by geography but is based on the needs and required interventions of the patient. While specific progressive care units can be identified, patients requiring progressive care nursing can be located throughout the hospital.

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

According to the Synergy Model, stability, complexity, vulnerability, resiliency, predictability, resource availability, participation in care and participation in decision making are the patient characteristics that describe patient function. The nurse characteristics that typically represent comprehensive nursing practice include clinical judgment, advocacy, caring practices, collaboration, systems thinking, response to diversity, clinical inquiry and learning facilitation. The framework, therefore, takes into account the unpredictability of the progressive care patient and, based on the patient's and family's needs, the competencies of the progressive care nurse. Progressive care can be very specialized, with care focused on a specific system such as cardiac, or more generalized, as in the care of patients with multi-system problems.

Educational Requirements

Progressive care nursing has expanded beyond the basic cardiac telemetry that marked its beginning and now encompasses many of the same technologies and therapies that were once limited to critical care units. To meet the changing needs of the patient, nurses caring for progressive care patients must demonstrate competencies that are influenced by ever changing technology. Progressive care nurses must demonstrate the following core competencies:

- Cardiac monitoring techniques and lead placement.
- Basic & advanced life support.
- Basic dysrhythmia interpretation and treatment, including ST segment and QTc interpretation.
- Drug dosage calculation, continuous medication infusion administration, and patient monitoring for medication effects.
- Titration of selected vasoactive medications such as nitroglycerin.
- Monitoring patients using standardized procedures for pre, intra, and post procedures (i.e., cardioversion, TEE, cardiac catheterization with PCI, bronchoscopy, EGD, PEG placement, chest tube insertion)
- Invasive arterial pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Non-Invasive hemodynamic pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Recognition of the signs and symptoms of cardiopulmonary emergencies and initiate standardized interventions to stabilize the patient awaiting transfer to critical care including cardioversion, defibrillation and transcutaneous pacing. Seek assistance as needed.
- Monitoring normal and abnormal diagnostic test results.
- Interpretation of ABGs and communicating findings.
- Recognition of indications for and management of patients requiring non-invasive O2 delivery systems including oral airways, blpap, and nasal CPAP
- Assessment of the ventilated patient to assure delivery of the prescribed treatment and patient response including tracheostomy care, and continuous and Intermittent SpO₂ monitoring.

AMERICAN
ASSOCIATION
of CRITICAL-CARE
NURSES

- Managing patients with chest tubes.
- Assisting with thoracentesis and chest tube insertion.
- Administering medications for procedural sedation and monitor patient's response.
- Assessing, monitoring and managing patients with stroke, seizure disorders and intracranial hemorrhage.
- Managing and titrating insulin infusions.
- Recognition of indications for and complications of enteral and parental nutrition
- Assessing, monitoring and managing patients requiring renal therapeutic interventions; e.g. hemodialysis, peritoneal dialysis, stents, continuous bladder irrigation, and urostomies
- Management of patients with complex wounds with fistulas, drains, and vacuum-assisted closure devices.
- Recognition of signs and symptoms of behavioral emergencies (e.g. delirium and dementia, mood disorders and substance abuse).
- Evaluating the family's need for enhanced involvement in care to facilitate the transition from hospital to home.

Reference List

AACN Scope and Standards for Acute and Critical Care Nursing Practice. AACN, Aliso Viejo, CA. 2008.

American College of Critical Care Medicine of the Society of Critical Care Medicine: Guidelines on admission and discharge for adult intermediate care units, 1997.

Exhibit 6

Greer, Leslie

From: Martone, Kim
Sent: Thursday, September 03, 2015 1:25 PM
To: Hansted, Kevin
Cc: Olejarz, Barbara; Greer, Leslie; Riggott, Kaila; Roberts, Karen
Subject: FW: Letter of Determination
Attachments: Windham Form 2020 FINAL 9.3.2015.pdf

From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, September 03, 2015 12:55 PM
To: Martone, Kim
Subject: Letter of Determination

Ms. Martone:

Please find attached a Certificate of Need Determination Form, Form 2020, detailing Windham Hospital's proposal for the alignment of its critical care unit as a progressive care unit.

The original copy is following via FedEx.

Sincerely,

Janette Edwards

This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, or an employee or agent responsible for delivering the message to the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message, including any attachments.

September 3, 2015

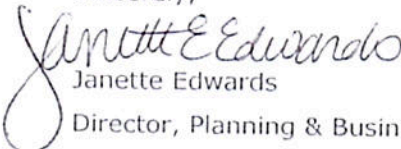
Ms. Kimberly Martone
Director, Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capital Avenue, MS#13 HCA
Hartford, CT 06106

Dear Ms. Martone:

Please find enclosed a Certificate of Need Determination Form, Form 2020 detailing Windham Community Memorial Hospital's proposal for the alignment of its Critical Care Unit as a Progressive Care Unit.

Please don't hesitate to contact me for if you require further information.

Sincerely,


Janette Edwards

Director, Planning & Business Development



State of Connecticut Office of Health Care Access CON Determination Form Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner
Full Legal Name	Windham Community Memorial Hospital
Doing Business As	Windham Hospital
Name of Parent Corporation	Hartford HealthCare Corporation
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	112 Mansfield Avenue, Windham, CT 06226
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP
Contact Person at Facility, including Title/Position: This Individual at the facility will be the	Janette Edwards, Director Planning & Business Development

Petitioner's Designee to receive all correspondence in this matter.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	112 Mansfield Avenue, Windham, CT 06226
Contact Person's Telephone Number	860-456-6800
Contact Person's Fax Number	860-456-6838
Contact Person's e-mail Address	Janette.edwards@hhchealth.org

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Alignment of Critical Care Unit as a Progressive Care Unit
- b. Estimated Total Project Cost: \$0
- c. Location of proposal, identifying Street Address, Town and Zip Code:
Windham Hospital, 112 Mansfield Avenue, Windham, CT 06226
- d. List each town this project is intended to serve:
Existing service area (no changes in communities currently served).
- e. Estimated starting date for the project: Upon OHCA's approval of this determination request.

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and the target population to be served.

The mission of Windham Community Memorial Hospital (“Windham”) is “to enhance the lives and well being of people in the communities we serve by providing quality health care.” In furtherance of its mission, Windham is committed to providing access to the right care, in the right location, and at the right time. To achieve this goal, Windham is proposing to provide services to patients who have historically received care in its critical care unit (“CCU”) in a new progressive care unit (“PCU”) without changing the clinical care provided to these patients.

Windham is a 130 bed hospital and currently delivers inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23- bed medical-surgical unit, and a 12-bed unit historically referred to as the CCU.

The average daily census at Windham for FY 2015 through July is 35 patients for the entire hospital. The following generally describes the types of patients cared for in the CCU during this period:

- Average daily census for critical care patients was 2.06 or 17% of total patients treated on the CCU with a 1.9 day average length of stay (these patients can be treated in PCU);
- Average daily census for intermediate level of care (“ILC”) patients in the CCU was 1.5 or 12.5% of total patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Average daily census for uncomplicated medical surgical patients was 5.16 or 43% of patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Overall, the CCU operates at 72.5% occupancy with only 17% needing CCU/PCU services.

Windham experienced a decline in critical care patient volume and length of stay for patients cared for in its CCU in recent years and these patients could be cared for in a PCU:

- 2013: 365, average length of stay 3.13 days
- 2014: 366, average length of stay 2.6 days
- 2015: 332 through July, average length of stay 1.9 days

Based on historical utilization and patient acuity to date, Windham proposes to address the clinical needs of its patients currently cared for in its CCU by transitioning the current 12-bed CCU to a 4-bed PCU. The proposed PCU will serve the same Windham patients who were previously treated in its CCU. Patients who will be admitted to the PCU will continue to be patients who require medical and nursing care beyond general inpatient level of services.

According to the American Association of Critical Care Nurses, progressive care is part of the continuum of critical care. The following may be applicable to PCU level patients:

- The patient has a persistent unstable status requiring continuous bedside cardiac and/or respiratory monitoring with frequent blood pressure monitoring as outlined in the PCU;
- The patient requires acute and/or complex medical monitoring as outlined in the PCU;

- The patient requires complex nursing treatment regimen; and
- The patient requires medication therapy requiring a higher level of assessment and intervention.¹

PCU patients typically include patients that have a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability and an increased ability to participate in their care.² In the last five years, patients who have been treated in the Windham CCU have met the definition for PCU level of care. The patients requiring progressive care will be managed with the same technology and staff competency levels that currently exist in the CCU. The only change will be that there will no longer be a dedicated physical space with 12 beds, which is clearly not needed based upon census for the last three years. Accordingly, this proposal will not change the clinical care provided to patients after the transition to the proposed PCU.

Should Windham patients cared for in the PCU require tertiary care services not available at Windham, these patients would continue to be transferred like they are from the CCU today. For example, Hartford Hospital is available to receive these patients and currently does receive these patients. The Windham Paramedic Program is readily available for necessary transport of these patients if the need arises during an inpatient stay. All full-time paramedics employed by the Windham Paramedic Program are critical care transport certified, or are in the process of receiving certification as a CCEMT-P or FP-C³. This is unique among paramedic transport services, and it ensures the highest level of care is available to Windham's patients during transport.

While the level of services currently provided to patients in the CCU will not change as a result of the transition to the PCU, it will allow space that is currently being underutilized to be utilized more efficiently and more responsively to the clinical needs of the community.

The services provided in the CCU will continue to be provided in the PCU. Please see Exhibit 1 for a list of the services currently provided to patients in the CCU, which will remain after the transition to a PCU.

There is no proposed change to the Windham license, attached as Exhibit 2.

Based upon the foregoing, Windham Hospital respectfully requests confirmation that the alignment of its Critical Care Unit to a Progressive Care Unit will not require a CON.

¹ CriticalCareNurse Vol 31, No. 3, JUNE 2011

² CriticalCareNurse Vol 31, No. 3, JUNE 2011

³ In the case of those paramedics who are also on the LifeStar flight crew. These certifications are granted by The Board for Critical Care Transport Certification.

Exhibit 1

Services provided at Windham CCU will continue at the PCU and will include:

- Management of sudden acute event on admitted medical surgical patient;
- Short term ventilator support (post anesthetic or otherwise);
- Hemodynamic instability due to hypovolemia, hemorrhage, sepsis, or other cause;
- Central nervous system depression that threatens to compromise airway and protective reflexes;
- Management of renal or electrolyte abnormalities;
- Extended intra-operative time and vigorous fluid resuscitation with the probability of fluid shifts and massive third spacing;
- Patients with delirium tremens requiring continuous sedative infusions without respiratory failure requiring intubation;
- Patients requiring continuous observation and pulse oximetry due to upper airway disease;
- Monitoring possible intra-operative cardiac events (i.e. ST changes, arrhythmias, etc.) which are asymptomatic and patient is hemodynamically stable;
- Arrhythmias that are hemodynamically stable (IE. atrial fibrillation/flutter, supra ventricular tachycardia);
- Angina pectoris that is hemodynamically stable but requires intravenous nitroglycerin for prophylaxis of the angina;
- Mild to moderate congestive heart failure without signs/symptoms of shock;
- Hypertensive conditions without evidence of end-organ damage;
- Patients requiring initiation of and maintenance intravenous infusions of anti-arrhythmics, and vasoactive inotropic medications;
- Patients with a tracheostomy tubes requiring aggressive pulmonary toileting or requiring arterial blood gases;
- Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or continuous positive airway pressure;
- Post-op patients after being fully recovered in PACU and meeting all other CSD criteria; and
- Patients requiring monitoring for seizure activity or obstructive sleep apnea.

WINDHAM LICENSE

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0061

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Windham Community Memorial Hospital, Inc. of Willimantic, CT d/b/a Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is hereby licensed to maintain and operate a General Hospital.

Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is located at 112 Mansfield Avenue, Willimantic, CT 06226.

The maximum number of beds shall not exceed at any time:

14 Bassinets
130 General Hospital Beds

This license expires **September 30, 2015** and may be revoked for cause at any time.

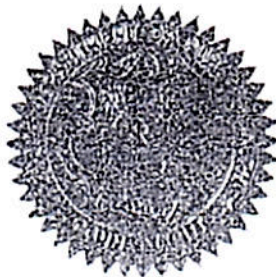
Dated at Hartford, Connecticut, October 1, 2013.

Satellites:

Windham Middle School Health Center, 123 Quarry Street, Willimantic, CT
Windham High School Wellness Center, 355 High Street, Willimantic, CT
*Charles Barrows STEM Academy School-Based Health Center, 141 Tuckie Road, N. Windham, CT

License revised to reflect:

*Added (1) Satellite effective 8/26/13



Handwritten signature of Jewel Mullen in cursive.

Jewel Mullen, MD, MPH, MPA
Commissioner

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Windham Community Memorial Hospital

Project Title: Alignment of Critical Care Unit as a Progressive Care Unit

I, David A. Whitehead, President of Windham Community Memorial Hospital, being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.

David A. Whitehead 09/03/15
Signature Date

Subscribed and sworn to before me on 9/3/15

Mary E. Vega
Notary Public/Commissioner of Superior Court

My commission expires: 4/30/16

Greer, Leslie

From: Hansted, Kevin
Sent: Wednesday, September 09, 2015 9:57 AM
To: Greer, Leslie
Subject: FW: Determination #15-32026-DTR

Leslie, please add the below to the record.

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, September 03, 2015 4:27 PM
To: Hansted, Kevin
Subject: RE: Determination #15-32026-DTR

Attorney Hansted,

I am confirming that the services currently provided to patients on the CCU will not change as a result of the transition to a PCU.

Please let me know if you require any further information.

Janette Edwards

From: Hansted, Kevin [<mailto:Kevin.Hansted@ct.gov>]
Sent: Thursday, September 03, 2015 1:49 PM

To: Edwards, Janette
Subject: Determination #15-32026-DTR

Dear Ms. Edwards,

I am in receipt of your determination request regarding the alignment of the Critical Care Unit ("CCU") as a Progressive Care Unit ("PCU") at Windham Hospital. Can you confirm for me that all of the services that are currently offered in the CCU will be offered in the PCU?

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 9, 2015

Janette Edwards
Director Planning & Business Development
Windham Community Memorial Hospital
112 Mansfield Avenue
Windham, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Edwards:

On September 4, 2015, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Windham Community Memorial Hospital ("Petitioner") with respect to the alignment of clinical services at Windham Hospital.

Windham Hospital is a licensed nonprofit hospital and part of Hartford HealthCare Corporation. Windham Hospital currently provides inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23-bed medical-surgical unit, and a 12-bed critical care unit ("CCU"). The Petitioner is proposing to implement a progressive care unit ("PCU") in place of its CCU and reduce the number of beds in the PCU to four (4). The medical services currently provided in the CCU will continue to be provided in the new PCU to the same patient population. Also, there is no proposed change to the Petitioner's license.

Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), a certificate of need is required for the "termination of inpatient or outpatient services offered by a hospital..." The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a **CON is not required** for the Petitioner's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone".

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

* * * COMMUNICATION RESULT REPORT (SEP. 9. 2015 2:22PM) * * *

FAX HEADER:

TRANSMITTED/STORED : SEP. 9. 2015 2:21PM
FILE MODE OPTION

ADDRESS

RESULT

PAGE

270 MEMORY TX

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OK

2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-3) NO ANSWER

E-2) BUSY
E-4) NO FACSIMILE CONNECTION



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANETTE EDWARDS
FAX: 860 456 6838
AGENCY: WINDHAM COMMUNITY MEMORIAL HOSPITAL
FROM: OHCA
DATE: 9/9/15 Time: _____
NUMBER OF PAGES: 2
(including transmittal sheet)

Comments: Attached is the determination regarding Report Number 15-32026-DTR
Regarding Alignment of Clinical Services at Windham Hospital

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Exhibit 7



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info@ccrnreview.com

Member Access:

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Frequently Asked Questions

What does CCRN Mean?

CCRN is a board certification that can be obtained by nurses who care for patients in the acute and/or critical care settings. CCRN is a registered trademark and does not stand for "Critical Care Registered Nurse" but rather is affirmation of certification that a registered nurse (RN) or advanced practice registered nurse (APRN) has met the American Association of Critical-Care Nurses (AACN) eligibility requirements and has successfully passed the CCRN examination.

CCRN certification is granted by AACN. Registered nurses, who have not successfully obtained certification or those with CCRN certification that has lapsed or become inactive, are not authorized to use the CCRN credentials.

What is CCRN Certification?

CCRN certification is a board certification granted by AACN Certification Corporation. It validates that a registered nurse has achieved a level of knowledge in nursing necessary to care for patients in the acute and/or critical care setting. CCRN certification denotes that the registered nurse is qualified in the clinical component, as well as, has met the rigorous certification requirements set forth by AACN necessary to achieve board certification status.

Why should I obtain a CCRN certification?

Obtaining your CCRN certification allows you to enhance and maintain an up-to-date knowledge in acute and critical care nursing necessary to provide safe and effective care for acutely ill patients. CCRN certification confirms that you have achieved a higher level of clinical knowledge and that you are committed to promoting excellence in nursing. In addition, most hospitals, facilities, and organizations offer incentives for nurses who obtain and maintain board certification status.

How do I prepare for the CCRN?

The adult CCRN review online program, (featured by Laura Gasparis), is a comprehensive review program designed to thoroughly prepare the RN or APRN working in the acute and/or critical care settings.

setting for the adult CCRN certification exam. The training is offered entirely online and may be accessed from any internet-based computer. The learner will have the ability to review course materials at his or her own pace, anytime, anywhere. In addition, we strongly recommend that clinicians complete all of the CCRN review practice exam questions and review the test plan in the CCRN Handbook by AACN. The CCRN examination handbook can be found at www.aacn.org/wd/certifications/docs/ccrn-exam-handbook.pdf

What are the current CCRN examination requirements?

Candidates must have an unrestricted/valid RN or APRN license in the United States

Candidates must meet one of the following clinical requirements in order to take the CCRN exam

- Option 1: Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely and critically ill patients during the previous 2 years, with 875 of those hours accrued in the recent year preceding application.

OR

- Option 2: Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely and/or critically ill patients, with 144 of those hours accrued in the most recent year preceding application.
- Eligible hours are those spent caring for one patient population (adult, pediatric or neonatal) that aligns with the exam for which you are applying.
- Hours must be completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice, as evidenced by Magnet Status or Joint Commission International accreditation.
- For more information about CCRN exam eligibility, please refer to the CCRN Exam Handbook <http://www.aacn.org/wd/certifications/docs/ccrn-exam-handbook.pdf>

Who is eligible to sit for the CCRN certification exam?

The CCRN exam is for nurses who work at the bedside of acutely and/or critically ill patients in such as ICUs, CCUs, respiratory ICUs, surgical ICUs, medical/surgical ICUs, cardiac/surgical ICU, neuro/neurosurgical ICUs, PICUs, NICUs, critical care transport/flight, trauma units, emergency departments and in nurse anesthesia – or in other units as appropriate.

Final determination of eligibility is not based on unit type but on patient acuity, as patient placement varies by facility and bed availability.

When is the CCRN exam offered?

The CCRN exam is offered via computer-based testing year-round, Monday through Saturday at more than 175 testing centers across the United States.

What are the application fees for the CCRN examination?

- CCRN Computer-Based Exam (initial exam): AACN Members \$225.00 and Nonmembers \$330.00
- CCRN Retest Exam: AACN Members \$170.00 and Nonmembers \$275.00
- CCRN Renewal Exam: AACN Members \$170.00 and Nonmembers \$ 275.00

How do I register for the CCRN exam?

Online Application Process: Same day Processing

You can register for the adult CCRN examination online (for the computer-based test) at www.certcorp.org > Apply Online

Before you start online application process, please have the following information:

- RN or APRN license number and expiration date
- Name, address, phone number, and email address of your clinical supervisor or professional colleague (RN or physician) whom you can verify your practice eligibility
- Valid credit card (Visa, MasterCard, Discover, or American Express)

Paper Application Process: Allow 2-3 weeks for Processing

Paper applications are required for candidates applying with a group, for paper and pencil exam for testing outside the United States.

Complete the application process in the CCRN exam handbook on pages 41-42 and the honor statement on page 43. Be sure to complete all requested information on application and include application fees in the form of check, money order, or credit card.

We strongly recommend that you thoroughly review the materials outlined in our CCRN online program and review the CCRN exam handbook set forth by AACN. The CCRN examination handbook can be found at www.aacn.org/wd/certifications/docs/ccrn-exam-handbook.pdf.

How long is the CCRN Exam?

The CCRN is a 3-hour timed exam, consisting of 150 questions; 125 of the questions are scored and 25 questions are used to gather statistical data for future exams. The exam questions are based on AACN Synergy's Model for Patient Care. For details, please refer to the CCRN exam handbook.

After I take the CCRN exam, how soon will I know if I passed the exam?

Candidates who complete the computer-based exam will receive their results and final score immediately upon test completion. Those who complete the exam via paper and pencil should receive their results by regular mail within three to four weeks after testing.

Once I have successfully passed the CCRN examination, when does my certification expire?

CCRN certification is valid for a period of 3-years and may be renewed every 3 years by re-taking the CCRN exam or by meeting the requirements of the renewal by Synergy CERP (Continuing Education Recognition Points) program during the 3-year certification period.

What if I don't pass the CCRN exam on the first attempt, can I re-take the exam?

Yes, candidates who do not pass the CCRN exam are eligible to re-take the exam for a discount retest fee up to four times in a 12-month period.

How do I renew my CCRN?

You may seek to renew your CCRN certification every 3 years by re-taking/passing the CCRN exam by Synergy CERP, or you may choose inactive status.

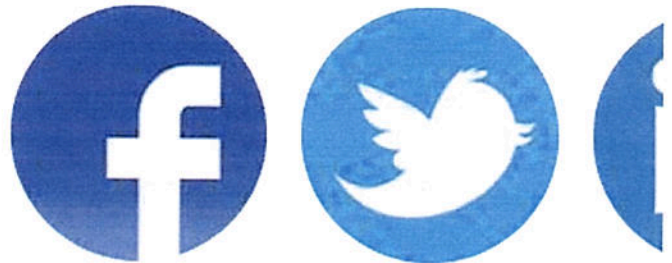
Eligibility for Renewal:

- You must have maintained a valid/unrestricted RN or APRN license in the United States. Unrestricted license, meaning that your license was not subjected to formal discipline by the state board of nursing during the 3-year certification renewal period.

- Completion of 432 hours of direct bedside care of acutely and/or critically ill patients or APRN within the 3-year certification period, with 144 of those hours being completed in the 12-month period preceding the scheduled renewal date.

- Eligible hours are those hours spent caring for the patient populations (i.e., adult, pediatric neonatal) in which your current certification is held.

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Exhibit 8

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.			PAGE: 1 OF: 1
TITLE: Critical Care Unit Admission, Transfer, and Discharge Criteria Policy (combined policies)		SCOPE: Hospital - Clinical	
EFFECTIVE: 6/07	REVIEW: Triennially	REVIEWED: 7/2010	REVISED: 11/07, 11/09
REVIEWED BY: Critical Care Unit Committee		APPROVED BY: Medical Director, Critical Care Unit	

PURPOSE: To establish Admission, Transfer and Discharge criteria and timeliness of orders for the Critical Care Unit

POLICY:

1. **CRITERIA**

- a. **Admission** - Patients are admitted to the CCU based on their need for medical and nursing care beyond conventional services, and the need for select acute and/or complex medical diagnostic or treatment regimens. Examples include:
 - i. Acute Myocardial Infarction (AMI), Life threatening arrhythmias
 - ii. Continuous drug infusion for anti-arrhythmic and/or vasopressor intervention
 - iii. Acute Pulmonary Edema, Respiratory Failure requiring invasive Mechanical Ventilation
 - iv. Acute/Potential evolving System(s) Failure
 - v. Diabetic Ketoacidosis (DKA) with DKA insulin drip
 - vi. Invasive Hemodynamic Monitoring

- b. **Transfer and/or Discharge** - Patient no longer requires the scope of services provided in the CCU. Examples include:
 - i. Myocardial Infarction is ruled out and cardiovascular status is stable
 - ii. Angina, Congestive Heart Failure (CHF), arrhythmias are stable or resolved
 - iii. Extubated, ABGs within normal limits, Respiratory Failure resolved.
 - iv. System(s) Failure resolved
 - v. DKA resolved and DKA insulin drip discontinued
 - vi. No invasive hemodynamic monitoring required for assessment/ diagnostic parameters
 - vii. Renal function improved, no longer requiring acute interventions
 - viii. Patient/Family requesting no further acute interventions
 - ix. Services required are not available at WCMH

2. There are no direct admissions to the CCU. All patients must be evaluated in the Emergency Department.

3. Any patient with a critical illness, who requires admission or transfer to the CCU, must be evaluated by the Attending Physician within 2 hours, with appropriate orders written.

4. It is the responsibility of the attending or covering physician to assess the patient and write complete transfer orders into and out of the CCU.

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.		PAGE: 1 OF: 1	
TITLE: Intermediate Care Guidelines for patients in the Critical Care Unit: Admissions, Down-grades, Transfer, and Discharge Criteria Policy		SCOPE: Hospital - Clinical	
EFFECTIVE: 9/09 (New Policy)	REVIEW: Triennially	REVIEWED:	REVISED:
REVIEWED BY: Critical Care Unit Committee		APPROVED BY: Medical Director, Critical Care Unit	

PURPOSE: The Intermediate Level of Care designation is reserved for patients who require monitoring due to a moderate or potentially severe physiologic instability, requiring necessary technical support, but not artificial life support. Intermediate care is reserved for patients who require less care than standard intensive care but more than what is available on the medical-surgical units.

POLICY:

1. CRITERIA

- a. Admissions, CCU down grades or transfers into the CCU:** Patients who require an Intermediate Level of Care designation may include:
- i. Cardiac
 - 1. Low probability of myocardial infarct (MI); rule-out MI
 - 2. Hemodynamically stable MI, arrhythmia
 - 3. Mild to moderate CHF (Class I, II)
 - 4. Hypertensive urgency without evidence of end-organ damage
 - ii. Pulmonary
 - 1. Medically stable ventilator patient for weaning or chronic care
 - 2. Hemodynamically stable, compromised gas exchange/underlying disease that is at risk for worsening respiratory insufficiency
 - 3. Frequent vital signs or aggressive pulmonary physiotherapy
 - iii. Neurologic
 - 1. Established, stable stroke with frequent vitals signs, neurologic assessment or frequent suctioning and turning
 - 2. Patients with chronic but stable neurologic or neuromuscular disorders who require frequent nursing intervention
 - iv. Drug Ingestion/Overdose
 - 1. Any patient requiring frequent neurologic, pulmonary, or cardiac monitoring for drug ingestion or overdose who is hemodynamically stable.
 - v. Gastrointestinal (GI) Disorders
 - 1. GI bleed with minimal orthostatic hypotension, responsive to fluid therapy
 - 2. Variceal bleeding without evidence of bright red blood by gastric aspirate and stable vital signs.
 - 3. Acute liver failure with stable vital signs
 - vi. Endocrine
 - 1. Diabetic Ketoacidosis (DKA) in early regulation phase (recovery from DKA) requiring constant intravenous infusions of insulin and/or frequent injections of regular Insulin with appropriate monitoring

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.		PAGE: 2 OF: 1	
TITLE: Intermediate Care Guidelines for patients in the Critical Care Unit: Admissions, Down-grades, Transfer, and Discharge Criteria Policy		SCOPE: Hospital - Clinical	
EFFECTIVE: 9/09 (New Policy)	REVIEW: Triennially	REVIEWED:	REVISED:
REVIEWED BY: Critical Care Unit Committee		APPROVED BY: Medical Director, Critical Care Unit	

vii. Surgical

1. Post-operative patient following major surgery who is hemodynamically stable but requires fluid resuscitation and transfusion due to fluid shifts

viii. Miscellaneous

1. Treated and resolving sepsis without evidence of shock or secondary organ failure
2. Patients requiring closely titrated fluid management
3. Patients requiring frequent nursing observations or extensive time (> 60 minutes) for wound management

b. Transfer and/or Discharge - Patient no longer requires the Intermediate scope of services provided in the CCU. Examples include:

- i. Patient physiologic status is stabilized and need for intensive monitoring is not necessary; patient can be cared for on general medical-surgical unit
- ii. Patient physiological status has deteriorated and active life support is required or highly likely; the patient will be transferred to a CCU level of care.
- iii. Patient/Family requesting no further acute interventions
- iv. Services required are not available at WCMH

2. There are no direct admissions to the CCU for the Intermediate Level of Care. All patients must be evaluated in the Emergency Department. Nursing discretion should be used when transporting a patient from the ED to the CCU (monitoring patient during transport).
3. It is the responsibility of the attending or covering physician to assess the patient and write complete transfer orders into and out of the CCU.

References:

Guidelines on Admissions and Discharges for Adult Intermediate Care Unit (1998). Critical Care Medicine, 26(3), 607 – 610.

Meyer, M. (2003). Avoid PCU Bottlenecks With Proper Admission and Discharge Criteria. Nursing Management, 3(6), 31 – 35.



Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access
410 Capital Avenue, MS#13HCA
PO Box 340308
Hartford, CT 06134

Re: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Martone,

In response to your letter dated October 8, 2015, on behalf of Windham Community Memorial Hospital ("Windham," or "WCMH"), I am writing to confirm the accuracy of all statements and representations made by Windham in connection with the above-referenced submission.

The Request for Determination submitted to the Office of Health Care Access ("OHCA") on September 3, 2015, is in alignment with the Final Decision Order for Docket No. 08-31178-CON, "Windham Community Memorial Hospital & Hartford HealthCare Corporation" (**Exhibit 1**). Condition 4 of the Order states "if in the future there is any change in WCMH service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA." Notwithstanding the Final Decision Order for Docket No. 08-31178, the only reason that Windham requested the above-referenced Determination was because there was precedent in the State wherein another hospital requested a Determination in connection with the transition of critical care services to a progressive care unit ("PCU"). See Exhibit 4. As stated in the September 30, 2015, letter from OHCA to Attorney Dennis O'Brien, "although Windham is reducing the extent to which critical care services are being offered, it is not terminating any services" (**Exhibit 2**).

This is further supported by OHCA's September 9 determination that no Certificate of Need ("CON") was required to transition to a PCU model of care (**Exhibit 3**). This determination states, "Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), a certificate of need is required for the 'termination of inpatient or outpatient services offered by a hospital...' The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a *CON is not required* for the Petitioner's proposal."

OHCA had made the same determination for previous proposals. Specifically, this same determination applied for Certificate of Need Determination Report Number 15-31981-DTR, "Alignment of Clinical Services at New Milford Hospital" (**Exhibit 4**). In that Request for Determination, New Milford Hospital proposed to transition its critical care unit ("CCU") to a progressive care unit to better manage its patient population and bridge the gap between a critical care unit and the care delivered within its current medical-surgical units. As in the case of Windham Hospital, New Milford stated it would maintain the same level of care and competencies post progressive care unit transition and, also like Windham would not be terminating any inpatient services currently provided.

In addition, and as requested by OHCA, Windham Hospital leadership has carefully reviewed all of the documentation submitted by various individuals to OHCA in opposition to OHCA's decision confirming that Windham did not need a CON in connection with its alignment of its existing critical care unit as a progressive care unit. While we truly appreciate the feedback and the commitment that these individuals have all demonstrated on behalf of Windham, we do not agree with their position that Windham has terminated a service.

As stated in the September 3rd submission, the same level of service that Windham provides today to patients cared for in its space designated as the critical care unit will continue to be provided to Windham's patients, but within a progressive care model (See **Exhibit 6** for the list of services filed in the original request for Determination by Windham Hospital). Clinical competencies will not be reduced, and services appropriate for the acuity level of patients treated by Windham will continue to be provided.

The need to transition the critical care unit to a progressive care unit at Windham was precipitated by a declining average daily census for critical care patients, as well as the patient acuity treated in the clinical space to date. The American Association of Critical Care Nurses ("AACN") "Progressive Care Fact Sheet" (**Exhibit 5**) cites progressive care as a part of the continuum of critical care, and "patients admitted to critical care units five to ten years ago are now routinely admitted to progressive care." The AACN defines progressive care as care delivered to patients who "fall along the less acute end" of the critical care spectrum. Additionally, the AACN describes progressive care nursing competencies as encompassing many of the "same technologies and therapies that were once limited to critical care units." The critical care patients treated in the Windham critical care unit meet the definition of progressive care patients.

Windham cannot provide the same level of care that is provided by tertiary and quaternary hospitals. Tremendous resources are required to provide such critical care, including the latest medical technology and life-saving equipment; 24/7 staffing by board certified intensivists, specifically trained to address complex medical needs of critically ill patients, and supported by a variety of specialists not available at Windham Hospital, and certified critical care nurses, referred to as "CCRN^s."¹ Windham is capable, and well equipped, however, to treat patients requiring lower-acuity critical care and progressive care services, as evidenced by its "Intermediate Care Guidelines for patients in the Critical Care Unit: Admissions, Down-grades, Transfers, and Discharge Criteria Policy" and its "Critical Care Unit

¹ CCRN certification is a credential granted by AACN Certification Corporation (**Exhibit 7**). CCRNs meet specific standards, including holding a current and unencumbered licensure as an RN or APRN and clinical practice requirements; eligibility is granted upon passing an exam which is accredited by the National Commission for Certifying Agencies. The AACN states "the CCRN exam is for nurses who work at the bedside of acutely and/or critically ill patients in areas such as ICUs, CCUs, respiratory ICUs, surgical ICUs, medical/surgical ICUs, cardiac/surgical ICUs, neuro/neurosurgical ICUs, PICUs, NICUs, critical care transport/flight, trauma units, emergency departments and in nurse anesthesia — or in other units as appropriate. Final determination of eligibility is *not based on unit type but on patient acuity*, as patient placement varies by facility and bed availability" [emphasis added]. No registered nurses currently employed by Windham Hospital hold the CCRN certification simply because Windham nurses do not have the type of experience that would qualify them to achieve or maintain certification.

Admission, Transfer, and Discharge Criteria Policy” (**Exhibit 8**). Windham’s definition of intermediate care is consistent with the AACN definition of progressive care, and this fact has not changed. The progressive care unit at Windham will attain efficient management of resources and operational efficiencies which are vital to the sustainability of Windham, while still enabling the provision of the right care, at the right time, in the right place for patients.

Based on historical utilization and patient-complexity (as represented in the original Determination submitted to OHCA) Windham will address the clinical needs of its critical care patients, and create sustainable operational efficiencies, by transitioning the current 12-bed unit historically referred to as the critical care unit at Windham Hospital to a unit that includes four progressive-care beds and eight medical/surgical beds. Windham Hospital is creating a progressive care unit where the critical care unit currently exists.

In summary, the level of care that Windham currently provides falls along the less acute end of the critical care spectrum and that is exactly what will continue to be provided in a progressive care unit. Based on OHCA’s Determination, the transition is currently underway. Windham, not unlike New Milford Hospital, has appropriately allocated its limited resources in the most efficient manner so that it can continue to best serve the community’s health needs.

If you have any further questions, please let me know.

Sincerely,



David A. Whitehead

President

Windham Community Memorial Hospital


cc: Joan Feldman, Esq.

Affidavit

Petitioner: Windham Community Memorial Hospital

Project Title: Alignment of Critical Care Unit as a Progressive Care Unit (15-32026-DTR)

I, David A. Whitehead, President of Windham Community Memorial Hospital, being duly sworn, depose and state that the information provided in the enclosed letter is true and accurate to the best of my knowledge.


Signature

10/22/15
Date

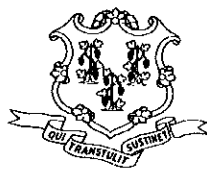
Subscribed and sworn to before me on October 22, 2015



Notary Public/Commissioner of Superior Court

My commission expires: 11/30/2017

Exhibit 1



Office of Health Care Access Certificate of Need Application

Final Decision

Applicants: Windham Community Memorial Hospital,
Inc. and Hartford Health Care
Corporation, Inc.

Docket Number: 08-31178-CON

Project Title: Integration of Windham Community
Memorial Hospital, Inc. into Hartford
Health Care Corporation, Inc.

Statutory Reference: Sections 19a-638, C.G.S.

Filing Date: November 3, 2008

Public Hearing Date: January 6, 2009

Decision Date: January 29, 2009

Default Date: February 1, 2009

Staff: Tillman Foster
Steven W. Lazarus
Sharon Malinowski

Project Description: Windham Community Memorial Hospital, Inc. (“WCMH” or “Hospital”) and Hartford Health Care Corporation, Inc. (“HHCC”) propose the integration of WCMH into HHCC, with no associated capital expenditure.

Nature of Proceedings: On November 3, 2008, the Office of Health Care Access (“OHCA”) received the completed Certificate of Need (“CON”) Application of WCMH and HHCC for the integration of WCMH into HHCC, with no associated capital expenditure. WCMH and HHCC

(collectively known as the “Applicants”) are considered to be health care facilities or institutions for purposes of this CON as defined by Section 19a-630 of the Connecticut General Statutes (“C.G.S.”).

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on January 6, 2008. On December 8, 2008, the Applicants were notified of the date, time, and place of the hearing. On December 6, 2008, notices to the public announcing the hearing were published in *The Hartford Courant* and on December 8, 2008, in *The Chronicle*.

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., the Presiding Officer heard testimony from the Applicants and their witnesses.

OHCA’s authority to review and approve, modify or deny this proposal 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

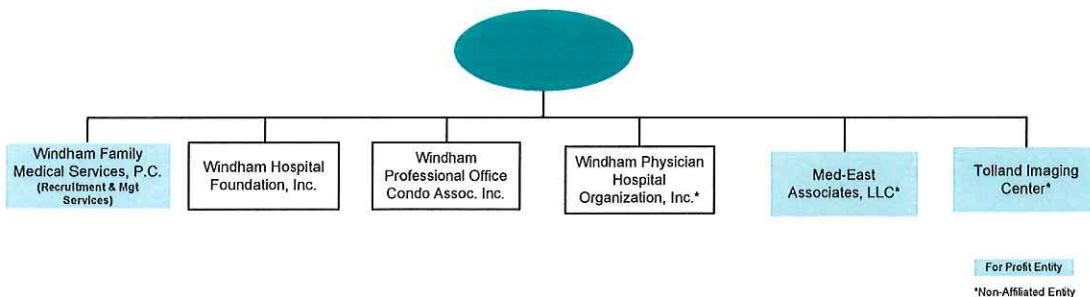
Clear Public Need

Impact on the Applicants’ Current Utilization Statistics Contribution of the Proposal to the Accessibility and Quality of Health Care Delivery in the Region

1. Windham Community Memorial Hospital, Inc. (“WCMH” or “Hospital”) is a Connecticut corporation located at 112 Mansfield Avenue, Willimantic, Connecticut and operates a 144 licensed bed acute care hospital. (*CON Application, 08-31178-CON, HHCC and WCMH Integration Agreement, Appendix B, and Office of Health Care Access, Hospital Reporting System, FY 2007, Report 400*)
2. Hartford Health Care Corporation (“HHCC”) located at 80 Seymour Street, Hartford, Connecticut, is the parent corporation of Hartford Hospital, in Hartford and MidState Medical Center in Meriden. (*November 3, 2008, CON Application, page 1 and Office of Health Care Access, Hospital Reporting System, FY 2007, Report 400*)

3. WCMH and HHCC (“Applicants”) are proposing the integration of WCMH into HHCC, with no associated capital expenditure. *(June 2, 2008, Letter of Intent and November 3, 2008, CON Application, pages 1-8)*
4. Under the proposed integration WCMH will become a wholly-owned subsidiary of HHCC similar to Hartford Hospital and MidState Medical Center. *(June 2, 2008, Letter of Intent)*
5. The organization chart of WCMH and its affiliates before integration with HHCC is as follows:

Chart One: WCMH Organization Chart Prior to Integration into HHCC:



Source: CON Application DN 08-31178-CON, Proposed Integration Agreement, Schedule 2.2

6. The following table lists affiliated and non-affiliated entities currently under WCMH (prior to the proposed the integration):

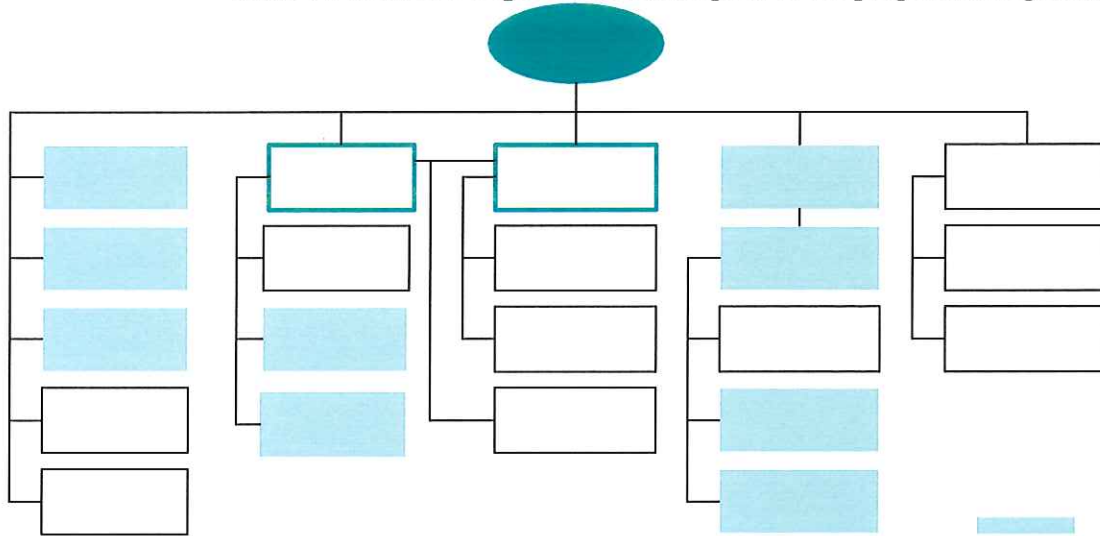
Table 1: Affiliated and Non-Affiliated WCMH Entities

Affiliated Entities		
Entity	WCMH Ownership Percentage	
Windham Family Medical Services, P.C.	One Hundred Percent	
Windham Hospital Foundation, Inc.	One Hundred Percent	
Windham Professional Office Condominium Association, Inc.	One Hundred Percent	
Non-Affiliated Entities		
Windham Physician – Hospital Organization, Inc.	Fifty Percent	
Med-East Associates, LLC	Fifty Percent	
Tolland Imaging Center, LLC	Fifteen Percent	
Health Connecticut, LLC (Connecticut Hospital Association Entity)	WCMH one of 18 Hospital owners	

Note: “Affiliated” entities are describe as having greater than 50% WCMH ownership;
 “Non-Affiliated” are described as having 50% or less WCMH ownership
(CON Application, 08-31178-CON, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008 Prefile Testimony, Response to OHCA Interrogatories, page 127 and January 6, 2009, Applicants Public Hearing Testimony)

7. The organization chart of HHCC before integration with WCMH is as follows:

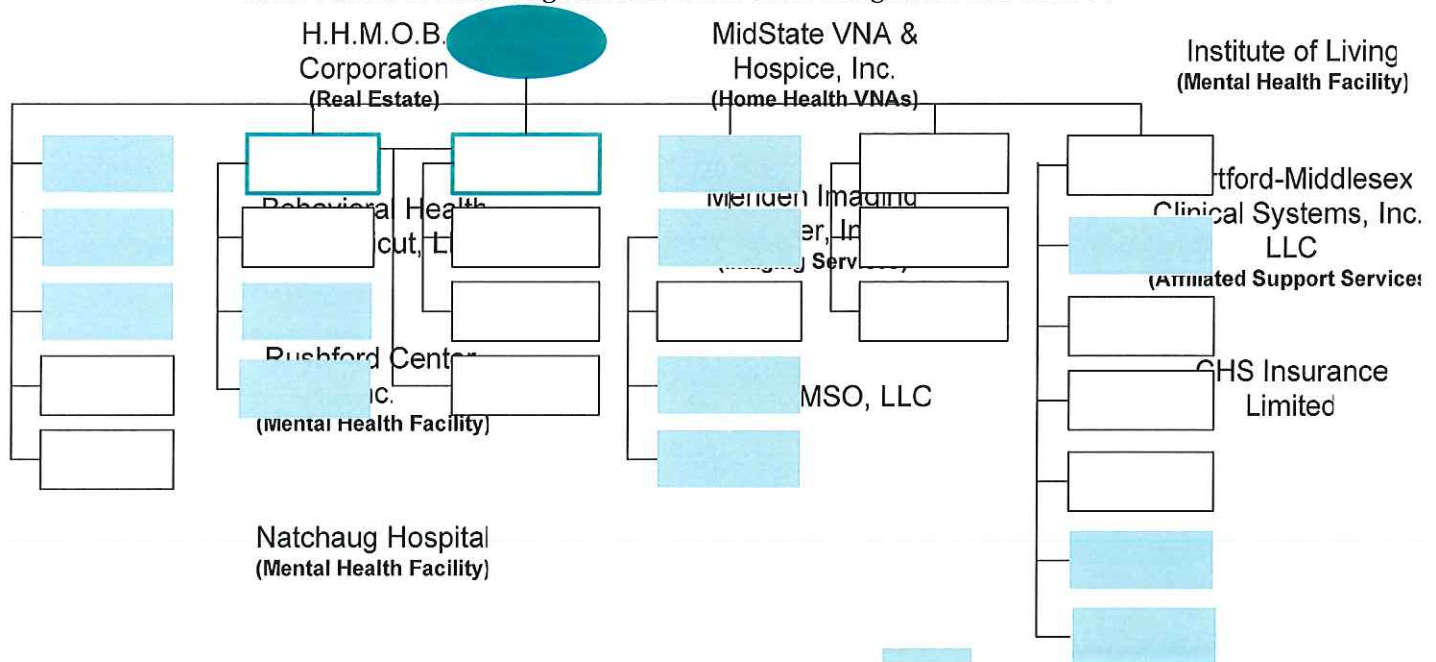
Chart Two: HHCC Organization Chart prior to the proposed Integration:



Source: Hartford Hospital, Docket Number 07-005AR, FY 2007 Annual Reporting

8. The proposed organization chart of WCMH and its affiliated entities after integration into HHCC as Hartford Hospital (Jefferson House) follows:

Chart Three: WCMH Organization Chart After Integration into HHCC:



Sources: CON Application DN 08-31178-CON, Proposed Integration Agreement, Schedule 2.2 and Hartford Hospital, Docket Number 07-005AR, FY 2007 Annual Reporting

9. As of Integration Agreement's closing date, the Board of Directors of WCMH will consist of eighteen (18) individuals, three (3) of which are ex-officio, serving on the WCMH Board of Directors as set forth in Schedule 1.3 of the Integration Agreement. *(CON Application, 08-31178-CON, December 30, 2008, Prefile Testimony and Response to OHCA Interrogatories, HHCC and WCMH Integration Agreement, page 126)*
10. Section 3.1 of the Pre-Closing Amended and Restated Bylaws (or Schedule 1.2 of Integration Agreement) sets forth that the WCMH Board shall not consist of any more than 18 directors, and only HHCC shall have the exclusive right to elect directors or fill any vacancy on WCMH's Board. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of HHCC and WCMH Integration Agreement, page 4)*
11. Under Article V of the Pre-Closing Amended and Restated Certificate of Incorporation WCMH shall operate under the management of its Board of Directors having all the necessary corporate power and authority to own, lease and use its properties and to operate its businesses as now being conducted as set forth in Clause 2.2 of the Integration Agreement. *(September 18, 2008, Initial Certificate of Need Application, 08-31178-CON, Pre-Closing Amended and Restated Certificate of Incorporation or Schedule 1.1 of HHCC and WCMH Integration Agreement, Article V)*
12. HHCC shall have the following powers and rights as set forth in Section 1.3 of Schedule 1.2:
 - (a) The sole power to elect and remove, with or without cause members of the WCMH Board.
 - (b) Review and approve, disapprove, or modify annual operating and capital budgets; significant proposed programs and expenditures, the purchase of significant operating or capital assets not contemplated in an approved budget or plan; and the borrowing of any sum in excess of \$1,000,000 with a stated term of greater than one year.
 - (c) Approve, disapprove, modify or direct the implementation of strategic plans, programmatic plans; health care standards of care; utilization review; and program coordination with other entities or persons in HHCC's health care system.
 - (d) Approve or disapprove any voluntary dissolution, merger or consolidation of WCMH or the sale, pledging, leasing or transfer of any substantial amount of WCMH's assets or the creation or acquisition of any significant subsidiary or affiliate corporation, significant contracts which WCMH in its discretion may refer to HHCC for review or approval; the selection of certified public accountants for WCMH; the filing of any Certificate of Need application for an expenditure or program outside of WCMH's ordinary business.
 - (e) Approve or establish guidelines or parameters for governing WCMH's participation in managed care contracts. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of HHCC and WCMH Integration Agreement, page 4)*
13. When WCMH is integrated into HHCC there will be no change in ownership of WCMH's affiliated entities except that HHCC will become the sole member of WCMH as set forth Section 1.2 of Schedule 1.2 and the affiliated entities will remain unchanged as listed in Schedule 2.2 of the Integration Agreement. *(September 18, 2008, Initial Certificate of Need Application, Schedule 1.2 of the*

Integration Agreement, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008, Prefile Testimony and Response to OHCA Interrogatories)

14. WCMH shall maintain its Board of Corporators (“Corporators”) consisting of no more than 150 members who are adults who either work or reside in the towns listed in Section 2.4 of Schedule 1.2, but it will serve only in an advisory capacity to WCMH’s Board. *(September 18, 2008, Initial Certificate of Need Application, Pre-Closing Amended and Restated Bylaws or Schedule 1.2 of the HHCC and WCMH Integration Agreement, page 4)*
15. The Independent Practice Association which owns fifty percent of Windham Physician-Hospital Organization, Inc., supports the proposed Integration of WCMH into HHCC. *(September 18, 2008, Initial Certificate of Need Application, Testimony of Windham Community Memorial Hospital, January 6, 2009, Public Hearing)*
16. The Applicants state that historically, WCMH has had a close relationship with Hartford Hospital and with respect to medical staff referrals for tertiary level services as well as for other programmatic collaboration. This relationship has included successful clinical efforts in oncology, cardiology and emergency medicine. It has also assisted in allowing WCMH to participate in National Institutes of Health (“NIH”) clinical research trials and other research projects. *(September 18, 2008, Initial Certificate of Need Application, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, page 5)*
17. According to the Applicants:
 - (a). In spring 2006, a strategic partnership agreement was signed by the Boards of both organizations,
 - (b). In January 2007, the leadership of WCMH, including the Board, Administration and Medical Staff embarked upon a comprehensive strategic planning process. Principles for affiliation were identified and given the longstanding relationship of both institutions, formal discussions were pursued with HHCC. Concurrently with the formal adoption of the revised strategic plan in early summer 2007, actions were implemented by both administrations and boards to develop an agreement. These agreements were approved in August of 2007,
 - (c). Formal votes of WCMH were taken in the spring of 2008 and the Corporators of WCMH took a vote in June 2008, approving this affiliation and the documents necessary for implementation. *(September 18, 2008, Initial Certificate of Need Application, pages 2-3)*
18. The Applicants stated that:
 - (a). The day to day operations of WCMH will remain the responsibility of the WCMH Board of Directors, the Chief Executive Office and administrative staff,
 - (b) The reserve powers of the agreement require WMCH to get approval from HHCC for certain fundamental decisions that will be subject to HHCC’s or the members approval (e.g., annual budgets, major capital purchases exceeding certain capital thresholds, and Certificate of Need projects), and
 - (c) No consolidation of services are planned at this time. However, it is possible in accordance with further development of the HHCC integrated Health Care delivery system

that certain services will not be duplicated at each member entity. It is also anticipated that certain administrative, management and technical services may be consolidated more immediately in order to achieve economies of scale and enhanced quality of service. *(November 3, 2008, Responses to OHCA's Completeness Letter, page 3)*

19. According to the Applicants, WCMH will be integral to HHCC plan to advance the quality of Health Care delivered to residents in the region served by WCMH. *(November 3, 2008, Responses to OHCA's Completeness Letter, page 4)*
20. As set forth in Section 8.3 of the Integration Agreement, the HHCC Board of Directors will continue to be the principal policy making and decision making body for the System. Accordingly, WCMH management will have system accountability together with internal reporting relationships. *(September 18, 2008, Initial Certificate of Need Application, Section 8.3 of the Integration Agreement, page 21)*
21. The following utilization data is related to WCMH, as reported in the Patient Census Report of September 2008:

	2008	2007
Total WCMH Admissions	5,744	5,742
Medical-Surgical Service	4,724	4,651
Emergency Dept. Visits	29,054	26,822

(Patient Census Report, September, 2008)

22. WCMH stated that through the proposed integration, it will be better able to recruit primary care physicians and to explore development of primary care group sites in key locations throughout WCMH's service area. *(December 30, 2008, Prefile Testimony of Mr. Richard A. Brvenik, President and Chief Executive Officer of WCMH, pages 5-6)*
23. The Applicants state that the direct benefits of the integration to HHCC include the following opportunities:
- (a). Additional opportunities for Clinical research,
 - (b). Teaching,
 - (c) Implementation of quality initiatives,
 - (d) Shared best practices,
 - (e) Volume purchasing,
 - (f) Consolidation of certain administrative services,
 - (g) Deployment of expensive technologies throughout the system,
 - (h) Spreading of risk, and
 - (i) Recruitment of medical talent by virtue of system size and coordinated efforts.
- (November 3, 2008, Responses to OHCA's Completeness Letter, page 2)*

24. According to the Applicants, benefits of the integration to be derived by WCMH include the following opportunities:

- (a) Improved ability to recruit physicians,
- (b) Increase market share in secondary service area communities,
- (c) Access managed care contracting expertise,
- (d) Purchase select clinical and administrative services,
- (e) Achieve economies of scale,
- (f) Improve the balance sheet by refinancing existing debt,
- (g) Increase the services and technology offered locally,
- (h) Decrease the out-migration of patients,
- (i) Improved ability to access capital at a lower cost, and
- (j) Reduce operating costs by being able to utilize the purchasing power of HHCC.
(September 18, 2008, Initial Certificate of Need Application, page 4)

**Financial Feasibility 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 Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines**

25. The projected three-year incremental revenue from operations, total operating expense and losses/gains from operations associated with the proposed integration are presented in the table below:

Table 3: WCMH’s Incremental Financial Projections

Description	FY 2009	FY 2010	FY 2011
Incremental Revenue from Operations	\$0	\$0	\$0
Incremental Total Operating Expense	\$(600,000)	\$(600,000)	\$(600,000)
Incremental Gain from Operations	\$600,000	\$600,000	\$600,000
Revenue Over/(Under) Expenses	\$600,000	\$600,000	\$600,000

(September 18, 2008, Initial Certificate of Need Application, Financial Attach. I, number 12.C (i))

26. At a minimum is projected to save WCMH \$600,000 annually for FYs 2009-2011. The annual savings is primarily due to better financial terms attributable to WCMH’s new affiliation with HHCC. *(CON Application, 08-31178-CON, Pro Forma Attachment I, Appendix M and Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, Public Hearing, page 5)*

27. HHCC's current payer mix and projected with the CON proposal is as follows:

Table 4: Current and Three-Year Projected Payer Mix with the CON Proposal

<i>Total HHCC</i>	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare	40%	40%	40%	40%
Medicaid (includes other medical assistance)	12%	12%	12%	12%
TRICARE and CHAMPUS	3%	3%	3%	3%
Total Government	55%	55%	55%	55%
Commercial Insurers*	45%	45%	45%	45%
Uninsured (1)				
Workers Compensation (1)				
Total Non-Government	45%	45%	45%	45%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity

(1) Included in Commercial Insurers

(September 18, 2008, Initial Certificate of Need Application, page 17)

28. WCMH's current payer mix and projected payer mix with the CON proposal is as follows:

Table 5: Current and Three-Year Projected Payer Mix with the CON Proposal

<i>Total WCMH</i>	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	58%	58%	58%	58%
Medicaid *(includes other medical assistance)	20%	20%	20%	20%
TRICARE and CHAMPUS				
Total Government	78%	78%	78%	78%
Commercial Insurers*	21%	21%	21%	21%
Uninsured	1%	1%	1%	1%
Workers Compensation				
Total Non-Government	22%	22%	22%	22%
Total Payer Mix	100%	100%	100%	100%

* Includes managed care activity

(1) Included in Commercial Insurers

Based on hospital discharges

(September 18, 2008, Initial Certificate of Need Application, page 17)

29. WCMH stated that the most recent data indicate the payer mix for WCMH as a percent of gross revenue is: Medicare 39%, Medicaid 17%, commercial insurance 40% and self-pay 4%, which is significantly less positive than that of the average Connecticut acute care hospital. (December 30, 2008, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital)

30. WCMH stated given the demographics of its patients, financial analyses and forecasts showed that as a free-standing hospital, WCMH would be hard pressed to achieve an operating gains of even 1% in future years, accordingly financial analysts seek operating margins in the range of 4-5% to

assure future viability and institutional financial health. *(December 30, 2008, Prefile Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital)*

31. WCMH stated that it is a safety net provider for the region it serves. In order to sustain this role WCMH felt it needed to strengthen its long-term financial stability. Consequently becoming a part of HHCC was viewed as critical to its long-term financial stability. *(CON Application, 08-31178-CON, Schedule 2.2 of HHCC and WCMH Integration Agreement, December 30, 2008, Response to OHCA Interrogatories, pages 1 & 2)*

32. Richard A. Brevnik, President and Chief Executive Officer of WCMH, stated that in order to achieve its institutional goals, WCMH required an estimated \$43 million dollars in capital over five year period covering, FY 2007 through 2012. The required capital would be earmarked for the following purposes:
 - a. Refinancing of WCMH's pension fund;
 - b. Refinancing of WCMH's Long-Term Debt;
 - c. Physician recruitment;
 - d. Facility upgrades; and
 - e. Acquiring other medical technologies.*(CON Application, 08-31178-CON, Testimony of Richard A. Brevnik, President and Chief Executive Officer of Windham Community Memorial Hospital, January 6, 2009, Public Hearing)*

33. There is no State Health Plan in existence at this time. *(September 18, 2008, Initial Certificate of Need Application, page 2)*

34. The Applicants stated that this proposal is consistent with each of their respective long-range plans. *(September 18, 2008, Initial Certificate of Need Application, page 2)*

35. The Applicants have improved productivity and contained costs in the past year through the application of new technology, undertaking energy conservation measures and employing group purchasing methods. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

36. The proposal will not result in any change to the Applicants' teaching or research responsibilities. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

37. There are no distinguishing characteristics of the Applicants' patient/physician mix that makes the proposal unique. *(September 18, 2008, Initial Certificate of Need Application, page 12)*

38. The Applicants have sufficient technical and managerial competence and expertise to provide efficient and adequate service to the public. *(September 18, 2008, Initial Certificate of Need Application, pages 10-11 and Appendix D)*

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.

Windham Community Memorial Hospital, Inc. (WCMH”) and Hartford Health Care Corporation, Inc. (“HHCC”) propose the integration of WCMH into HHCC, thereby, making WCMH a wholly owned subsidiary of HHCC, similar to Hartford Hospital and MidState Medical Center. WCMH has historically had a close relationship with Hartford Hospital (a subsidiary of HHCC) and its medical staff for referral for tertiary level services, as well as for other programmatic collaboration. Even though the Applicants are not planning any consolidation of service at this time, further development of HHCC integrated Health Care delivery system in the future will lead to certain services not being duplicated at each member entity of HHCC.

This partnership between the Applicants has been in place since January of 2007 and was formalized in June of 2008. As a result of this proposed integration, there will be no change in ownership of WCMH’s affiliated entities, as they will continue to operate under WCMH. HHCC will become the sole member of WCMH as set forth in the written agreements provided to this agency. The day to day operations of WCMH will remain the responsibility of the WCMH Board of Directors, the Chief Executive Officer and Administrative Staff; however, the reserve powers of the agreement between the Applicants require WCMH to get approval from HHCC for certain fundamental decisions which will be subject to HHCC’s or the members approval.

This proposal will improve the quality of health care delivered to patients in the region. This proposal will allow WCMH to improve its ability to recruit physicians, improve its managed care contracts, refinance its existing debt, access to capital at lower cost and reduce its overall operating costs. HHCC will intern have opportunities for additional clinical research, shared best practices and deploy expensive technologies through the system. It appears to OHCA that this proposal is mutually beneficial for both Applicants. WCMH’s utilization has stayed steady or increased between FY 2007 and 2008 for total admissions, medical surgical services and emergency department, leading OHCA to believe that the financial challenges appear to be more related to the patient mix. WCMH will be an integral part of HHCC’s plan to advance the quality of health care delivery to its patients in the region and the Applicants testified that they will improve access to primary care services. The Applicants, also stated that currently they will not be terminating any services; however, OHCA realizes that in the future the reduction of duplicative services may be necessary to further strengthen the financial viability of the system.

WCMH projects gains from operations, incremental to the proposal of \$600,000 for FYs 2009-2011, the first three years of the proposal, which is a result of WCMH’s relationship with HHCC which aided in restructuring of WCMH’s existing debt. This proposal provides longer term financial viability to the system of care. HHCC is projecting gains from operations, incremental to the proposal of

\$1,850,960, \$1,942,000 and \$1,238,000, for FYs 2009-2010. WCMH and HHCC's financial projections and volumes upon which they are based appear to be reasonable and achievable.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Windham Community Memorial Hospital ("WCMH" or "Hospital") and Hartford Health Care Corporation, Inc. ("HHCC") (together referred to as "Applicants") for the integration of WCMH into HHCC with no associated capital expenditure, is hereby **Approved**, subject to the following conditions:

1. This authorization expires on January 31, 2010. Should the Applicants proposal not be completed (i.e. final agreement are executed) by that date, the Applicants must seek further approval from OHCA to complete the project beyond that date.
2. Within 60 days of the completion of the integration of WCMH into HHCC, the Applicants shall file with OHCA; a full copy of any and all signed, dated and completed final integration agreements including attachments indicating the integration of WCMH into HHCC has occurred.
3. If in the future there is any change in the ownership structure of WCMH or its affiliates or any change in control of WCMH, the Applicants shall file a CON Determination Form with OHCA.
4. If in the future there is any change in WCMH service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.
5. As there is no associated capital expenditure with this proposal, in the event that the Applicants learn of potential costs associated with this proposal, the Applicants shall notify OHCA immediately

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

Signed by Commissioner Vogel on January 29, 2009

Date

Cristine A. Vogel
Commissioner

Exhibit 2



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 30, 2015

Dennis O'Brien, Esq.
120 Bolivia Street
Willimantic, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Attorney O'Brien:

Thank you for your letter of September 25, 2015 regarding the determination issued by the Office of Health Care Access ("OHCA") under Docket Number 15-32026-DTR.

OHCA understands and appreciates your concerns. In making its determination OHCA's jurisdiction is limited by Conn. Gen. Stat. § 19a-638; specifically § 19a-638(a)(5) in this matter. § 19a-638(a)(5) mandates that a certificate of need be filed when a hospital is proposing to terminate inpatient or outpatient services offered by the hospital. The information provided by Windham Hospital in its 2020 form, and further confirmed via written communications between OHCA and Windham Hospital, the services currently being offered in the critical care unit will continue to be offered in the new progressive care unit. While Windham Hospital may be reducing the extent to which services are being offered, it is not terminating any services. OHCA's jurisdiction does not extend to reductions in the hours a particular service is offered or the number of beds used to offer that service.¹ Therefore, OHCA has no legal basis upon which it can require Windham Hospital to file a certificate of need application.

At your convenience, the complete record of this matter can be viewed on OHCA's website at <http://www.ct.gov/dph/ohca>.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kim Martone".

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

¹ Conn. Gen. Stat. § 19a-638(a)(12) requires a certificate of need for an increase in the licensed bed capacity of a health care facility. However, Windham Hospital is not seeking an increase in its licensed bed capacity.

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308

Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

Exhibit 3



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 9, 2015

Janette Edwards
Director Planning & Business Development
Windham Community Memorial Hospital
112 Mansfield Avenue
Windham, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Edwards:

On September 4, 2015, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Windham Community Memorial Hospital ("Petitioner") with respect to the alignment of clinical services at Windham Hospital.

Windham Hospital is a licensed nonprofit hospital and part of Hartford HealthCare Corporation. Windham Hospital currently provides inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23-bed medical-surgical unit, and a 12-bed critical care unit ("CCU"). The Petitioner is proposing to implement a progressive care unit ("PCU") in place of its CCU and reduce the number of beds in the PCU to four (4). The medical services currently provided in the CCU will continue to be provided in the new PCU to the same patient population. Also, there is no proposed change to the Petitioner's license.

Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), a certificate of need is required for the "termination of inpatient or outpatient services offered by a hospital..." The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a *CON is not required* for the Petitioner's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim M.", with a stylized flourish at the end.

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

Exhibit 4

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, February 24, 2015 3:59 PM
To: Hansted, Kevin
Cc: Greer, Leslie
Subject: FW: OHCA Determination
Attachments: OHCA Determination 02 24 2015.pdf

Importance: High

From: Johnson, Michelle [<mailto:Michelle.Johnson@wchn.org>]
Sent: Tuesday, February 24, 2015 3:43 PM
To: Martone, Kim
Cc: Herlihy, Sally
Subject: OHCA Determination
Importance: High

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached a Determination Request on behalf of Western Connecticut Health Network, Inc. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

The original document will be sent to the OHCA offices by mail.

Thank you.

Michelle Johnson
Executive Assistant to Senior Administrators
Western Connecticut Health Network

203-739-4935



This transmittal is intended for a particular addressee(s). If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, copying or distribution or dissemination is strictly prohibited. If you suspect that you have received this transmittal in error, please notify Western Connecticut Health Network immediately by email reply to the sender, and delete the transmittal and any attachments.

READER BEWARE: Internet e-mail is inherently insecure and occasionally unreliable. Please contact the sender if you wish to arrange for secure communication or to verify the contents of this message.



**State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020**

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner
Full Legal Name	The Danbury Hospital
Doing Business As	New Milford Hospital
Name of Parent Corporation	Western Connecticut Health Network, Inc. (WCHN)
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	24 Hospital Avenue Danbury, CT 06810
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP
Contact Person at Facility , including Title/Position: This Individual at the facility will be the	Sally F. Herlihy, MBA, FACHE VP, Planning

Petitioner's Designee to receive all correspondence in this matter.	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	24 Hospital Avenue Danbury, CT 06811
Contact Person's Telephone Number	203-739-4903
Contact Person's Fax Number	203-739-1974
Contact Person's e-mail Address	sally.herlihy@wchn.org

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Alignment of Clinical Services
- b. Estimated Total Project Cost: \$0
- c. Location of proposal, identifying Street Address, Town and Zip Code: New Milford Hospital, 21 Elm Street, New Milford, CT 06776
- d. List each town this project is intended to serve: Existing communities (no changes)
- e. Estimated starting date for the project: March 2015

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and the target population to be served.

Overview

WCHN's mission is to "improve the health of every person we serve through the efficient delivery of excellent, innovative and compassionate care." In furtherance of this mission, we endeavor to provide the right care, at the right place and the right time. WCHN has been considering the appropriate management of the continuum of critical care patients at the New Milford Hospital (NMH) campus and the appropriate utilization of the recently opened new Critical Care Unit at the Danbury Hospital campus (DH) which features the latest medical technology and life-saving equipment, along with round-the-clock access to the specialists (neurologists, cardiologists, nephrologists, infectious diseases, etc.) required to deliver their care. Since 2009 (well before NMH's affiliation with WCHN), NMH has been transferring the most critically-ill patients from NMH to DH based on determinations by the NMH medical staff that DH offered critically-ill and injured patients a higher level of care. WCHN now desires to efficiently address the clinical needs of NMH's inpatients by consolidating its CCU beds within a progressive care unit located within NMH's 3-East medical-surgical unit. There is no proposed change to the DH license (see Exhibit 1).

Background

At NMH, the inpatient clinical care is currently provided in two locations, a 35-bed medical surgical unit located on its third-floor (referred to as "3-East"), and an 8-bed critical care unit located on the second floor of the same building (called the "CCU"). The average daily census ("ADC") at NMH for medical surgical patients during FY14 was 20 patients, with an ADC of only 2 patients in the CCU throughout FY14 and current FY15 (Q1) and no material change in activity from FY13. The CCU is operating at 25% occupancy (2 of the 8 available beds) and there is an average length of stay of 4.0 days. The CCU beds located on the second floor have separate staffing, and are underutilized, resulting in inefficiency.

Discussion

Based on the patient-complexity and historical utilization of the CCU at NMH, NMH proposes to implement a progressive care unit on its third floor, within its medical-surgical unit on 3-East. This efficient management of clinical and operational resources supports the provision of the right care, in the right location, at the right time. This approach also bridges the gap between a critical care unit complexity level of service and the care provided on the current medical-surgical unit:

- The American Association of Critical Care Nurses ("AACN") recognizes progressive care as part of the continuum of critical care.
- Per AACN, progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with high potential for becoming unstable and require an increased intensity of care.
 - Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

The patients who have been treated on the second floor in the CCU satisfy the definition of progressive care patients. There will be no change in the clinical care provided for these patients with co-location of the progressive care unit within the 3-East medical-surgical unit:

- The co-location of patients on 3-East will offer additional nursing resources and efficiencies to better address patient needs.
- The patients will be managed with the same level of technology that currently exists in the separate CCU. The centralized monitoring will be relocated and the unit will be upgraded with wireless monitoring, ensuring the same standard of care with no reduction in capabilities.
- DH's new state of the art ICU opened in October 2014. It is staffed by intensivists, specially trained to address the complex medical needs of critically ill patients and supported by a variety of specialists not available at NMH.

We respectfully request confirmation that consolidation of the second floor CCU at NMH with the third floor 3-East medical surgical unit will not require a CON.

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: The Danbury Hospital

Project Title: Alignment of Clinical Services

I, Dan DeBarba, EVP, Western Connecticut Health Network, Inc., and President, The Danbury Hospital, being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.



Signature



Date

Subscribed and sworn to before me on 2-24-15



Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2019

Exhibit I
The Danbury Hospital License

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0039

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Danbury Hospital of Danbury, CT d/b/a The Danbury Hospital is hereby licensed to maintain and operate a General Hospital.

The Danbury Hospital is located at 24 Hospital Avenue, Danbury, CT 06810.

The maximum number of beds shall not exceed at any time:

26 Bassinets
430 General Hospital Beds

This license expires September 30, 2015 and may be revoked for cause at any time.

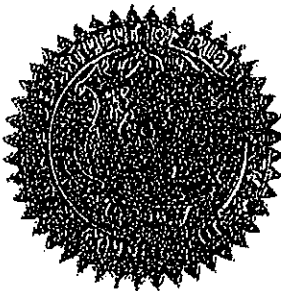
Dated at Hartford, Connecticut, October 1, 2013.

Satellites:

*New Milford Hospital Campus, 21 Elm Street, New Milford, CT
*New Milford Hospital Behavioral Health Services, 23 Poplar Street, New Milford, CT
Center for Child and Adolescent Treatment Services, 152 West Street, Danbury, CT
Community Center for Behavioral Health (ADH-PHP), 152 West Street, Danbury, CT
The Pediatric Health Center, 70 Main Street, Danbury, CT
Seifert & Ford Community Health Center, 70 Main Street, Danbury, CT
Ridgefield Surgical Center, 901 Ethan Allen Highway, Ridgefield, CT

License revised to reflect:

*Added (2) satellites and increase of 85 General Beds because The Danbury Hospital merged and took over New Milford Hospital effective 10/1/14.



Jewel Mullen

Jewel Mullen, MD, MPH, MPA
Commissioner

Greer, Leslie

From: Hansted, Kevin
Sent: Friday, February 27, 2015 9:15 AM
To: Greer, Leslie
Cc: Martone, Kim
Subject: FW: Determination Report 15-31981-DTR

Leslie, please add the below to the record.
Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

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From: Herlihy, Sally [mailto:Sally.Herlihy@wchn.org]
Sent: Friday, February 27, 2015 8:47 AM
To: Hansted, Kevin
Subject: RE: Determination Report 15-31981-DTR

Dear Attorney Hansted,

The medical services provided in the CCU at New Milford Hospital will continue to be provided in the progressive care unit without any change. Some examples of these services follow:

- Unstable Non-invasive ventilation i.e. CPAP or BIPAP
- Hemodynamic instability due to hypovolemia, hemorrhage, sepsis, or other cause
- Central nervous system depression that threatens to compromise airway and protective reflexes
- Severe impairment of renal function or severe electrolyte abnormalities
- Patients requiring extended post-operative care
- Extended intra-operative time and vigorous fluid resuscitation with the probability of fluid shifts and massive third spacing
- Patients requiring frequent assessments (solid organ injury or abdominal pain with the possibility of emergent surgery)
- Patients with delirium tremens requiring continuous Ativan drip without respiratory failure requiring intubation
- Patients requiring continuous observation and pulse oximetry due to upper airway disease such as epiglottitis or tumor
- Possible intra-operative events (i.e. ST changes, arrhythmias, etc.) which are asymptomatic and hemodynamically stable
- Arrhythmias that are hemodynamically stable (IE. atrial fibrillation/flutter, supra ventricular tachycardia)

- Angina pectoris, that is hemodynamically stable but requires intravenous nitroglycerin for prophylaxis of the angina
- Mild to moderate congestive heart failure without signs/symptoms of shock
- Hypertensive urgency without evidence of end-organ damage
- Drug drips appropriate for PCU management as defined by the institutional critical care committee.
- Patients requiring initiation of and maintenance intravenous infusions of anti-arrhythmics, and vasoactive inotropic medications.
- Patients with a tracheostomy tube requiring aggressive pulmonary toileting or requiring arterial blood gases than once per eight hours. Suctioning is provided every 4 hours or less.
- Hemodynamically stable patients with evidence of compromised gas exchanges and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or continuous positive airway pressure
- Post-op patients after being fully recovered in PACU and meeting all other CSD criteria
- Patients requiring monitoring for seizure activity (should be controlled with anticonvulsant medication)
- Patient requiring vital signs, lab tests, neuro checks, peripheral pulse checks, I & O no more often than every two hours routinely. Exceptions: a) patient' s receiving blood products and B) certain IV infusions, and C) Dilantin loading doses may have more frequent vital signs
- Patient requiring monitoring for obstructive sleep apnea

Please reach out if you require additional information.

Sincerely,
Sally

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

From: Hansted, Kevin [<mailto:Kevin.Hansted@ct.gov>]
Sent: Thursday, February 26, 2015 11:44 AM
To: Herlihy, Sally
Subject: Determination Report 15-31981-DTR

Dear Ms. Herlihy,

I am in recent of your determination request concerning the consolidation of New Milford Hospital's CCU beds into a progressive care unit. Please provide a list of medical services currently provided in the CCU along with a list of the medical services proposed to be offered in the progressive care unit.

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

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message. If I have sent you this message in error, please notify me immediately by return email and promptly delete this message and any attachments from your computer system. We do not waive attorney-client or work product privilege by the transmission of this message.



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

March 11, 2015

Sally F. Herlihy, MBA, FACHE
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Determination Report Number 15-31981-DTR
Alignment of Clinical Services at New Milford Hospital

Dear Ms. Herlihy:

On February 24, 2015, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Western Connecticut Health Network, Inc. ("Petitioner") with respect to the alignment of clinical services at New Milford Hospital ("NMH").

NMH is a licensed nonprofit hospital and part of the Western Connecticut Health Network, Inc. NMH currently provides inpatient critical care in two locations, a 35-bed medical surgical unit located on its third-floor, and an 8-bed critical care unit ("CCU") located on the second floor of the same building. NMH is proposing to implement a progressive care unit on its third floor, within its medical surgical unit. The medical services currently provided in the CCU will continue to be provided in the new progressive care unit without any change.

Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), as amended by P.A. 14-168, a certificate of need is required for the "termination of inpatient or outpatient services offered by a hospital..." The Petitioner has represented that the proposed progressive care unit will offer the same clinical care services that are currently offered in the CCU and the medical surgical unit will remain operational once the progressive care unit is opened. As a result, no termination of services is taking place. Therefore, a **CON is not required** for the Petitioner's proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Kimberly R. Martone".

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

* * * COMMUNICATION RESULT REPORT (MAR. 11. 2015 1:28PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FILE MODE	MAR. 11. 2015 OPTION	1:28PM	ADDRESS	RESULT	PAGE
952	MEMORY TX		912037391974	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-3) NO ANSWER

E-2) BUSY
E-4) NO FACSIMILE CONNECTION



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Sally F. Herlihy

FAX: 203 739-1974

AGENCY: WCHN

FROM: OHCA

DATE: 3/11/15 Time: _____

NUMBER OF PAGES: 2
(including transmittal sheet)

Comments: Determination for Report Number 15-31981-DTR is attached.

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Exhibit 5

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

Progressive Care Fact Sheet

Background

In the early 1970s, major medical center recruiters placed advertisements for both critical care and progressive care nurses in *Heart and Lung*. Initially, progressive care units housed post myocardial infarction patients requiring cardiac monitoring, but not requiring intensive care and observation. With the changing healthcare environment, the acuity of patients admitted to hospitals steadily increased and caused an increase in the demand for critical care beds. With the increased demand and decreased availability of critical care beds, patients were often transferred from critical care units while still requiring an increased level of nursing care and vigilance. Patients admitted to critical care units five to ten years ago are now routinely admitted to progressive care.

Progressive care is the term the American Association of Critical-Care Nurses (AACN) uses to collectively describe areas that are also referred to as Intermediate Care Units, Direct Observation Units, Step-down Units, Telemetry Units, or Transitional Care Units as well as to define a specific level of patient care. AACN recognizes the need to define and identify the special needs of progressive care nurses. In 2008, the Certification Corporation convened a progressive care nursing study of practice. The study of practice determined the scope of practice, populations served, the core competencies and basic knowledge and skill requirements of progressive care nurses and provided a foundation for development of certification exams. Progressive care nurses across the country participated in the study of practice.

Definition

The American Association of Critical-Care Nurses recognizes progressive care as part of the continuum of critical care. AACN is dedicated to creating a healthcare system driven by the needs of patients and families where critical care nurses make their optimal contribution. The AACN Synergy Model for Patient Care is the conceptual framework that actualizes the vision. It defines nursing practice based on the needs of the patient and the characteristics of the nurse to attain optimal patient outcomes.

Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care. Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care.

Progressive Care Patient Location

AACN's Synergy Model assists in defining the progressive care patient. The Synergy Model identifies patients based on the characteristics and needs that they present and not on the location of the bed they occupy. As in critical care, the geographic domain of progressive care is expanding. Care provided to progressive care patients is not limited by geography but is based on the needs and required interventions of the patient. While specific progressive care units can be identified, patients requiring progressive care nursing can be located throughout the hospital.

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

According to the Synergy Model, stability, complexity, vulnerability, resiliency, predictability, resource availability, participation in care and participation in decision making are the patient characteristics that describe patient function. The nurse characteristics that typically represent comprehensive nursing practice include clinical judgment, advocacy, caring practices, collaboration, systems thinking, response to diversity, clinical inquiry and learning facilitation. The framework, therefore, takes into account the unpredictability of the progressive care patient and, based on the patient's and family's needs, the competencies of the progressive care nurse. Progressive care can be very specialized, with care focused on a specific system such as cardiac, or more generalized, as in the care of patients with multi-system problems.

Educational Requirements

Progressive care nursing has expanded beyond the basic cardiac telemetry that marked its beginning and now encompasses many of the same technologies and therapies that were once limited to critical care units. To meet the changing needs of the patient, nurses caring for progressive care patients must demonstrate competencies that are influenced by ever changing technology. Progressive care nurses must demonstrate the following core competencies:

- Cardiac monitoring techniques and lead placement.
- Basic & advanced life support.
- Basic dysrhythmia interpretation and treatment, including ST segment and QTc Interpretation.
- Drug dosage calculation, continuous medication infusion administration, and patient monitoring for medication effects.
- Titration of selected vasoactive medications such as nitroglycerin.
- Monitoring patients using standardized procedures for pre, intra, and post procedures (i.e., cardioversion, TEE, cardiac catheterization with PCI, bronchoscopy, EGD, PEG placement, chest tube insertion)
- Invasive arterial pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Non-Invasive hemodynamic pressure monitoring including equipment setup and troubleshooting, monitoring and recognition of signs and symptoms of patient instability.
- Recognition of the signs and symptoms of cardiopulmonary emergencies and initiate standardized interventions to stabilize the patient awaiting transfer to critical care including cardioversion, defibrillation and transcutaneous pacing. Seek assistance as needed.
- Monitoring normal and abnormal diagnostic test results.
- Interpretation of ABGs and communicating findings.
- Recognition of indications for and management of patients requiring non-invasive O2 delivery systems including oral airways, bIPAP, and nasal CPAP
- Assessment of the ventilated patient to assure delivery of the prescribed treatment and patient response including tracheostomy care, and continuous and Intermittent SpO₂ monitoring.

AMERICAN
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of CRITICAL-CARE
NURSES

- Managing patients with chest tubes.
- Assisting with thoracentesis and chest tube insertion.
- Administering medications for procedural sedation and monitor patient's response.
- Assessing, monitoring and managing patients with stroke, seizure disorders and intracranial hemorrhage.
- Managing and titrating insulin infusions.
- Recognition of indications for and complications of enteral and parental nutrition
- Assessing, monitoring and managing patients requiring renal therapeutic interventions; e.g. hemodialysis, peritoneal dialysis, stents, continuous bladder irrigation, and urostomies
- Management of patients with complex wounds with fistulas, drains, and vacuum-assisted closure devices.
- Recognition of signs and symptoms of behavioral emergencies (e.g. delirium and dementia, mood disorders and substance abuse).
- Evaluating the family's need for enhanced involvement in care to facilitate the transition from hospital to home.

Reference List

AACN Scope and Standards for Acute and Critical Care Nursing Practice, AACN, Aliso Viejo, CA. 2008.

American College of Critical Care Medicine of the Society of Critical Care Medicine: Guidelines on admission and discharge for adult intermediate care units, 1997.

Exhibit 6

Greer, Leslie

From: Martone, Kim
Sent: Thursday, September 03, 2015 1:25 PM
To: Hansted, Kevin
Cc: Olejarz, Barbara; Greer, Leslie; Riggott, Kaila; Roberts, Karen
Subject: FW: Letter of Determination
Attachments: Windham Form 2020 FINAL 9.3.2015.pdf

From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, September 03, 2015 12:55 PM
To: Martone, Kim
Subject: Letter of Determination

Ms. Martone:

Please find attached a Certificate of Need Determination Form, Form 2020, detailing Windham Hospital's proposal for the alignment of its critical care unit as a progressive care unit.

The original copy is following via FedEx.

Sincerely,

Janette Edwards

This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, or an employee or agent responsible for delivering the message to the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message, including any attachments.

September 3, 2015

Ms. Kimberly Martone
Director, Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capital Avenue, MS#13 HCA
Hartford, CT 06106

Dear Ms. Martone:

Please find enclosed a Certificate of Need Determination Form, Form 2020 detailing Windham Community Memorial Hospital's proposal for the alignment of its Critical Care Unit as a Progressive Care Unit.

Please don't hesitate to contact me for if you require further information.

Sincerely,



Janette Edwards

Director, Planning & Business Development



**State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020**

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner
Full Legal Name	Windham Community Memorial Hospital
Doing Business As	Windham Hospital
Name of Parent Corporation	Hartford HealthCare Corporation
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	112 Mansfield Avenue, Windham, CT 06226
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP
Contact Person at Facility, including Title/Position: This Individual at the facility will be the	Janette Edwards, Director Planning & Business Development

Petitioner's Designee to receive all correspondence in this matter.

Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail

112 Mansfield Avenue, Windham, CT 06226

Contact Person's Telephone Number

860-456-6800

Contact Person's Fax Number

860-456-6838

Contact Person's e-mail Address

Janette.edwards@hhchealth.org

SECTION II. GENERAL PROPOSAL INFORMATION

- a. Proposal/Project Title: Alignment of Critical Care Unit as a Progressive Care Unit
- b. Estimated Total Project Cost: \$0
- c. Location of proposal, identifying Street Address, Town and Zip Code:
Windham Hospital, 112 Mansfield Avenue, Windham, CT 06226
- d. List each town this project is intended to serve:
Existing service area (no changes in communities currently served).
- e. Estimated starting date for the project: Upon OHCA's approval of this determination request.

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.
2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.
3. Identify the current population served and the target population to be served.

The mission of Windham Community Memorial Hospital (“Windham”) is “to enhance the lives and well being of people in the communities we serve by providing quality health care.” In furtherance of its mission, Windham is committed to providing access to the right care, in the right location, and at the right time. To achieve this goal, Windham is proposing to provide services to patients who have historically received care in its critical care unit (“CCU”) in a new progressive care unit (“PCU”) without changing the clinical care provided to these patients.

Windham is a 130 bed hospital and currently delivers inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23- bed medical-surgical unit, and a 12-bed unit historically referred to as the CCU.

The average daily census at Windham for FY 2015 through July is 35 patients for the entire hospital. The following generally describes the types of patients cared for in the CCU during this period:

- Average daily census for critical care patients was 2.06 or 17% of total patients treated on the CCU with a 1.9 day average length of stay (these patients can be treated in PCU);
- Average daily census for intermediate level of care (“ILC”) patients in the CCU was 1.5 or 12.5% of total patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Average daily census for uncomplicated medical surgical patients was 5.16 or 43% of patients treated on the CCU (these patients do not require CCU/PCU level of care);
- Overall, the CCU operates at 72.5% occupancy with only 17% needing CCU/PCU services.

Windham experienced a decline in critical care patient volume and length of stay for patients cared for in its CCU in recent years and these patients could be cared for in a PCU:

- 2013: 365, average length of stay 3.13 days
- 2014: 366, average length of stay 2.6 days
- 2015: 332 through July, average length of stay 1.9 days

Based on historical utilization and patient acuity to date, Windham proposes to address the clinical needs of its patients currently cared for in its CCU by transitioning the current 12-bed CCU to a 4-bed PCU. The proposed PCU will serve the same Windham patients who were previously treated in its CCU. Patients who will be admitted to the PCU will continue to be patients who require medical and nursing care beyond general inpatient level of services.

According to the American Association of Critical Care Nurses, progressive care is part of the continuum of critical care. The following may be applicable to PCU level patients:

- The patient has a persistent unstable status requiring continuous bedside cardiac and/or respiratory monitoring with frequent blood pressure monitoring as outlined in the PCU;
- The patient requires acute and/or complex medical monitoring as outlined in the PCU;

- The patient requires complex nursing treatment regimen; and
- The patient requires medication therapy requiring a higher level of assessment and intervention.¹

PCU patients typically include patients that have a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability and an increased ability to participate in their care.² In the last five years, patients who have been treated in the Windham CCU have met the definition for PCU level of care. The patients requiring progressive care will be managed with the same technology and staff competency levels that currently exist in the CCU. The only change will be that there will no longer be a dedicated physical space with 12 beds, which is clearly not needed based upon census for the last three years. Accordingly, this proposal will not change the clinical care provided to patients after the transition to the proposed PCU.

Should Windham patients cared for in the PCU require tertiary care services not available at Windham, these patients would continue to be transferred like they are from the CCU today. For example, Hartford Hospital is available to receive these patients and currently does receive these patients. The Windham Paramedic Program is readily available for necessary transport of these patients if the need arises during an inpatient stay. All full-time paramedics employed by the Windham Paramedic Program are critical care transport certified, or are in the process of receiving certification as a CCEMT-P or FP-C³. This is unique among paramedic transport services, and it ensures the highest level of care is available to Windham's patients during transport.

While the level of services currently provided to patients in the CCU will not change as a result of the transition to the PCU, it will allow space that is currently being underutilized to be utilized more efficiently and more responsively to the clinical needs of the community.

The services provided in the CCU will continue to be provided in the PCU. Please see Exhibit 1 for a list of the services currently provided to patients in the CCU, which will remain after the transition to a PCU.

There is no proposed change to the Windham license, attached as Exhibit 2.

Based upon the foregoing, Windham Hospital respectfully requests confirmation that the alignment of its Critical Care Unit to a Progressive Care Unit will not require a CON.

¹ CriticalCareNurse Vol 31, No. 3, JUNE 2011

² CriticalCareNurse Vol 31, No. 3, JUNE 2011

³ In the case of those paramedics who are also on the LifeStar flight crew. These certifications are granted by The Board for Critical Care Transport Certification.

Exhibit 1

Services provided at Windham CCU will continue at the PCU and will include:

- Management of sudden acute event on admitted medical surgical patient;
- Short term ventilator support (post anesthetic or otherwise);
- Hemodynamic instability due to hypovolemia, hemorrhage, sepsis, or other cause;
- Central nervous system depression that threatens to compromise airway and protective reflexes;
- Management of renal or electrolyte abnormalities;
- Extended intra-operative time and vigorous fluid resuscitation with the probability of fluid shifts and massive third spacing;
- Patients with delirium tremens requiring continuous sedative infusions without respiratory failure requiring intubation;
- Patients requiring continuous observation and pulse oximetry due to upper airway disease;
- Monitoring possible intra-operative cardiac events (i.e. ST changes, arrhythmias, etc.) which are asymptomatic and patient is hemodynamically stable;
- Arrhythmias that are hemodynamically stable (IE. atrial fibrillation/flutter, supra ventricular tachycardia);
- Angina pectoris that is hemodynamically stable but requires intravenous nitroglycerin for prophylaxis of the angina;
- Mild to moderate congestive heart failure without signs/symptoms of shock;
- Hypertensive conditions without evidence of end-organ damage;
- Patients requiring initiation of and maintenance intravenous infusions of anti-arrhythmics, and vasoactive inotropic medications;
- Patients with a tracheostomy tubes requiring aggressive pulmonary toileting or requiring arterial blood gases;
- Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or continuous positive airway pressure;
- Post-op patients after being fully recovered in PACU and meeting all other CSD criteria; and
- Patients requiring monitoring for seizure activity or obstructive sleep apnea.

WINDHAM LICENSE

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0061

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Windham Community Memorial Hospital, Inc. of Willimantic, CT d/b/a Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is hereby licensed to maintain and operate a General Hospital.

Windham Community Memorial Hospital, Inc. and Hatch Hospital Corporation is located at 112 Mansfield Avenue, Willimantic, CT 06226.

The maximum number of beds shall not exceed at any time:

14 Bassinets
130 General Hospital Beds

This license expires September 30, 2015 and may be revoked for cause at any time.

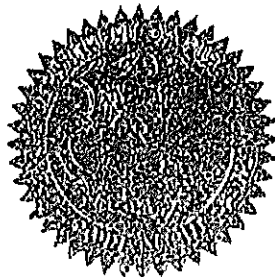
Dated at Hartford, Connecticut, October 1, 2013.

Satellites:

Windham Middle School Health Center, 123 Quarry Street, Willimantic, CT
Windham High School Wellness Center, 355 High Street, Willimantic, CT
*Charles Barrows STEM Academy School-Based Health Center, 141 Tuckio Road, N. Windham, CT

License revised to reflect:

*Added (1) Satellite effective 8/26/13



Handwritten signature of Jewel Mullen in cursive.

Jewel Mullen, MD, MPH, MPA
Commissioner

Greer, Leslie

From: Hansted, Kevin
Sent: Wednesday, September 09, 2015 9:57 AM
To: Greer, Leslie
Subject: FW: Determination #15-32026-DTR

Leslie, please add the below to the record.

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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From: Edwards, Janette [<mailto:Janette.Edwards@hhchealth.org>]
Sent: Thursday, September 03, 2015 4:27 PM
To: Hansted, Kevin
Subject: RE: Determination #15-32026-DTR

Attorney Hansted,

I am confirming that the services currently provided to patients on the CCU will not change as a result of the transition to a PCU.

Please let me know if you require any further information.

Janette Edwards

From: Hansted, Kevin [<mailto:Kevin.Hansted@ct.gov>]
Sent: Thursday, September 03, 2015 1:49 PM

To: Edwards, Janette
Subject: Determination #15-32026-DTR

Dear Ms. Edwards,

I am in receipt of your determination request regarding the alignment of the Critical Care Unit ("CCU") as a Progressive Care Unit ("PCU") at Windham Hospital. Can you confirm for me that all of the services that are currently offered in the CCU will be offered in the PCU?

Thank you,

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 9, 2015

Janette Edwards
Director Planning & Business Development
Windham Community Memorial Hospital
112 Mansfield Avenue
Windham, CT 06226

RE: Certificate of Need Determination Report Number 15-32026-DTR
Alignment of Clinical Services at Windham Hospital

Dear Ms. Edwards:

On September 4, 2015, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request on behalf of Windham Community Memorial Hospital ("Petitioner") with respect to the alignment of clinical services at Windham Hospital.

Windham Hospital is a licensed nonprofit hospital and part of Hartford HealthCare Corporation. Windham Hospital currently provides inpatient care on three (3) inpatient units, including a 30-bed medical-surgical unit, a 23-bed medical-surgical unit, and a 12-bed critical care unit ("CCU"). The Petitioner is proposing to implement a progressive care unit ("PCU") in place of its CCU and reduce the number of beds in the PCU to four (4). The medical services currently provided in the CCU will continue to be provided in the new PCU to the same patient population. Also, there is no proposed change to the Petitioner's license.

Pursuant to Conn. Gen. Stat. § 19a-638(a)(5), a certificate of need is required for the "termination of inpatient or outpatient services offered by a hospital..." The Petitioner has represented that the proposed PCU will offer the same clinical care services that are currently offered in the CCU. As a result, no termination of services is taking place. Therefore, a **CON is not required** for the Petitioner's proposal.

Sincerely,

Kimberly R. Martone
Director of Operations

C: Rose McLellan, License and Applications Supervisor, DPH, DHSR

An Equal Opportunity Provider

(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308

Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

* * * COMMUNICATION RESULT REPORT (SEP. 9. 2015 2:22PM) * * *

FAX HEADER:

TRANSMITTED/STORED : SEP. 9. 2015 2:21PM	FILE MODE	OPTION	ADDRESS	RESULT	PAGE
270	MEMORY TX		98604566838	OK	2/2

REASON FOR ERROR
 E-1) HANG UP OR LINE FAIL
 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



STATE OF CONNECTICUT
 DEPARTMENT OF PUBLIC HEALTH
 OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANETTE EDWARDS

FAX: 860 456 6838

AGENCY: WINDHAM COMMUNITY MEMORIAL HOSPITAL

FROM: OHCA

DATE: 9/9/15 Time: _____

NUMBER OF PAGES: 2
(including transmittal sheet)

Comments: Attached is the determination regarding Report Number 15-32026-DTR Regarding Alignment of Clinical Services at Windham Hospital

PLEASE PHONE Barbara K. Olejarsz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
 P.O. Box 340308
 Hartford, CT 06134

Exhibit 7



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info@ccrnreview.com

Member Access:

User Name



Frequently Asked Questions

What does CCRN Mean?

CCRN is a board certification that can be obtained by nurses who care for patients in the acute and/or critical care settings. CCRN is a registered trademark and does not stand for "Critical Care Registered Nurse" but rather is affirmation of certification that a registered nurse (RN) or advanced practice registered nurse (APRN) has met the American Association of Critical-Care Nurses (AACN) eligibility requirements and has successfully passed the CCRN examination.

CCRN certification is granted by AACN. Registered nurses, who have not successfully obtained certification or those with CCRN certification that has lapsed or become inactive, are not authorized to use the CCRN credentials.

What is CCRN Certification?

CCRN certification is a board certification granted by AACN Certification Corporation. It validates that a registered nurse has achieved a level of knowledge in nursing necessary to care for patients in the acute and/or critical care setting. CCRN certification denotes that the registered nurse is qualified in the clinical component, as well as, has met the rigorous certification requirements set forth by AACN necessary to achieve board certification status.

Why should I obtain a CCRN certification?

Obtaining your CCRN certification allows you to enhance and maintain an up-to-date knowledge in acute and critical care nursing necessary to provide safe and effective care for acutely ill patients. CCRN certification confirms that you have achieved a higher level of clinical knowledge and that you are committed to promoting excellence in nursing. In addition, most hospitals, facilities, and organizations offer incentives for nurses who obtain and maintain board certification status.

How do I prepare for the CCRN?

The adult CCRN review online program, (featured by Laura Gasparis), is a comprehensive review program designed to thoroughly prepare the RN or APRN working in the acute and/or critical care settings.

setting for the adult CCRN certification exam. The training is offered entirely online and may be accessed from any internet-based computer. The learner will have the ability to review course materials at his or her own pace, anytime, anywhere. In addition, we strongly recommend that clinicians complete all of the CCRN review practice exam questions and review the test plan in the CCRN Handbook by AACN. The CCRN examination handbook can be found at www.aacn.org/wd/certifications/docs/ccrn-exam-handbook.pdf

What are the current CCRN examination requirements?

Candidates must have an unrestricted/valid RN or APRN license in the United States

Candidates must meet one of the following clinical requirements in order to take the CCRN exam

- Option 1: Practice as an RN or APRN for 1,750 hours in direct bedside care of acutely and critically ill patients during the previous 2 years, with 875 of those hours accrued in the recent year preceding application.

OR

- Option 2: Practice as an RN or APRN for at least 5 years with a minimum of 2,000 hours in direct bedside care of acutely and/or critically ill patients, with 144 of those hours accrued in the most recent year preceding application.
- Eligible hours are those spent caring for one patient population (adult, pediatric or neonatal) that aligns with the exam for which you are applying.
- Hours must be completed in a U.S.-based or Canada-based facility or in a facility determined to be comparable to the U.S. standard of acute/critical care nursing practice, as evidenced by Magnet Status or Joint Commission International accreditation.
- For more information about CCRN exam eligibility, please refer to the CCRN Exam Handbook <http://www.aacn.org/wd/certifications/docs/ccrn-exam-handbook.pdf>

Who is eligible to sit for the CCRN certification exam?

The CCRN exam is for nurses who work at the bedside of acutely and/or critically ill patients in such as ICUs, CCUs, respiratory ICUs, surgical ICUs, medical/surgical ICUs, cardiac/surgical ICU neuro/neurosurgical ICUs, PICUs, NICUs, critical care transport/flight, trauma units, emergency departments and in nurse anesthesia – or in other units as appropriate.

Final determination of eligibility is not based on unit type but on patient acuity, as patient placement varies by facility and bed availability.

When is the CCRN exam offered?

The CCRN exam is offered via computer-based testing year-round, Monday through Saturday through 175 testing centers across the United States.

What are the application fees for the CCRN examination?

- CCRN Computer-Based Exam (initial exam): AACN Members \$225.00 and Nonmembers \$330.00
- CCRN Retest Exam: AACN Members \$170.00 and Nonmembers \$275.00
- CCRN Renewal Exam: AACN Members \$170.00 and Nonmembers \$ 275.00

How do I register for the CCRN exam?*Online Application Process: Same day Processing*

You can register for the adult CCRN examination online (for the computer-based test) at www.certcorp.org Apply Online

Before you start online application process, please have the following information:

- RN or APRN license number and expiration date
- Name, address, phone number, and email address of your clinical supervisor or professional colleague (RN or physician) whom can verify your practice eligibility
- Valid credit card (Visa, MasterCard, Discover, or American Express)

Paper Application Process: Allow 2-3 weeks for Processing

Paper applications are required for candidates applying with a group, for paper and pencil exam for testing outside the United States.

Complete the application process in the CCRN exam handbook on pages 41-42 and the honor statement on page 43. Be sure to complete all requested information on application and include application fees in the form of check, money order, or credit card.

We strongly recommend that you thoroughly review the materials outlined in our CCRN online program and review the CCRN exam handbook set forth by AACN. The CCRN examination handbook can be found at www.aacn.org/wd/certifications/docs/ccrn-exam-handbook.pdf.

How long is the CCRN Exam?

The CCRN is a 3-hour timed exam, consisting of 150 questions; 125 of the questions are scored and the remaining 25 questions are used to gather statistical data for future exams. The exam questions are based on AACN Synergy's Model for Patient Care. For details, please refer to the CCRN exam handbook.

After I take the CCRN exam, how soon will I know if I passed the exam?

Candidates who complete the computer-based exam will receive their results and final score immediately upon test completion. Those who complete the exam via paper and pencil should receive their results by regular mail within three to four weeks after testing.

Once I have successfully passed the CCRN examination, when does my certification expire?

CCRN certification is valid for a period of 3-years and may be renewed every 3 years by re-taking the CCRN exam or by meeting the requirements of the renewal by Synergy CERP (Continuing Education Recognition Points) program during the 3-year certification period.

What if I don't pass the CCRN exam on the first attempt, can I re-take the exam?

Yes, candidates who do not pass the CCRN exam are eligible to re-take the exam for a discount retest fee up to four times in a 12-month period.

How do I renew my CCRN?

You may seek to renew your CCRN certification every 3 years by re-taking/passing the CCRN exam by Synergy CERP, or you may choose inactive status.

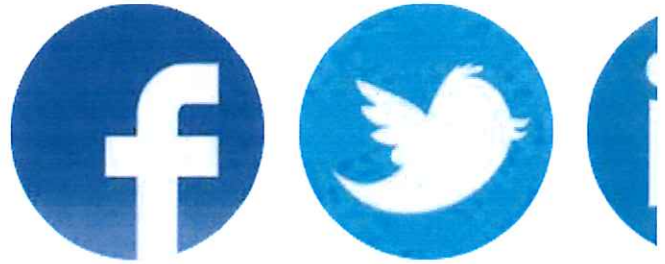
Eligibility for Renewal:

- You must have maintained a valid/unrestricted RN or APRN license in the United States. Unrestricted license, meaning that your license was not subjected to formal discipline by the state board of nursing during the 3-year certification renewal period.

- Completion of 432 hours of direct bedside care of acutely and/or critically ill patients or APRN within the 3-year certification period, with 144 of those hours being completed in the 12-month period preceding the scheduled renewal date.

- Eligible hours are those hours spent caring for the patient populations (i.e., adult, pediatric neonatal) in which your current certification is held.

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Exhibit 8

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.			PAGE: 1 OF: 1
TITLE: Critical Care Unit Admission, Transfer, and Discharge Criteria Policy (combined policies)		SCOPE: Hospital - Clinical	
EFFECTIVE: 6/07	REVIEW: Triennially	REVIEWED: 7/2010	REVISED: 11/07, 11/09
REVIEWED BY: Critical Care Unit Committee		APPROVED BY: Medical Director, Critical Care Unit	

PURPOSE: To establish Admission, Transfer and Discharge criteria and timeliness of orders for the Critical Care Unit

POLICY:

1. CRITERIA

- a. **Admission** - Patients are admitted to the CCU based on their need for medical and nursing care beyond conventional services, and the need for select acute and/or complex medical diagnostic or treatment regimens. Examples include:
 - i. Acute Myocardial Infarction (AMI), Life threatening arrhythmias
 - ii. Continuous drug infusion for anti-arrhythmic and/or vasopressor intervention
 - iii. Acute Pulmonary Edema, Respiratory Failure requiring invasive Mechanical Ventilation
 - iv. Acute/Potential evolving System(s) Failure
 - v. Diabetic Ketoacidosis (DKA) with DKA insulin drip
 - vi. Invasive Hemodynamic Monitoring

- b. **Transfer and/or Discharge** - Patient no longer requires the scope of services provided in the CCU. Examples include:
 - i. Myocardial Infarction is ruled out and cardiovascular status is stable
 - ii. Angina, Congestive Heart Failure (CHF), arrhythmias are stable or resolved
 - iii. Extubated, ABGs within normal limits, Respiratory Failure resolved.
 - iv. System(s) Failure resolved
 - v. DKA resolved and DKA insulin drip discontinued
 - vi. No invasive hemodynamic monitoring required for assessment/ diagnostic parameters
 - vii. Renal function improved, no longer requiring acute interventions
 - viii. Patient/Family requesting no further acute interventions
 - ix. Services required are not available at WCMH

2. There are no direct admissions to the CCU. All patients must be evaluated in the Emergency Department.

3. Any patient with a critical illness, who requires admission or transfer to the CCU, must be evaluated by the Attending Physician within 2 hours, with appropriate orders written.

4. It is the responsibility of the attending or covering physician to assess the patient and write complete transfer orders into and out of the CCU.

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.		PAGE: 1 OF: 1	
TITLE: Intermediate Care Guidelines for patients in the Critical Care Unit: Admissions, Down-grades, Transfer, and Discharge Criteria Policy		SCOPE: Hospital - Clinical	
EFFECTIVE: 9/09 (New Policy)	REVIEW: Triennially	REVIEWED:	REVISED:
REVIEWED BY: Critical Care Unit Committee		APPROVED BY: Medical Director, Critical Care Unit	

PURPOSE: The Intermediate Level of Care designation is reserved for patients who require monitoring due to a moderate or potentially severe physiologic instability, requiring necessary technical support, but not artificial life support. Intermediate care is reserved for patients who require less care than standard intensive care but more than what is available on the medical-surgical units.

POLICY:

1. CRITERIA

- a. **Admissions, CCU down grades or transfers into the CCU:** Patients who require an Intermediate Level of Care designation may include:
 - i. Cardiac
 1. Low probability of myocardial infarct (MI); rule-out MI
 2. Hemodynamically stable MI, arrhythmia
 3. Mild to moderate CHF (Class I, II)
 4. Hypertensive urgency without evidence of end-organ damage
 - ii. Pulmonary
 1. Medically stable ventilator patient for weaning or chronic care
 2. Hemodynamically stable, compromised gas exchange/underlying disease that is at risk for worsening respiratory insufficiency
 3. Frequent vital signs or aggressive pulmonary physiotherapy
 - iii. Neurologic
 1. Established, stable stroke with frequent vitals signs, neurologic assessment or frequent suctioning and turning
 2. Patients with chronic but stable neurologic or neuromuscular disorders who require frequent nursing intervention
 - iv. Drug Ingestion/Overdose
 1. Any patient requiring frequent neurologic, pulmonary, or cardiac monitoring for drug ingestion or overdose who is hemodynamically stable.
 - v. Gastrointestinal (GI) Disorders
 1. GI bleed with minimal orthostatic hypotension, responsive to fluid therapy
 2. Variceal bleeding without evidence of bright red blood by gastric aspirate and stable vital signs.
 3. Acute liver failure with stable vital signs
 - vi. Endocrine
 1. Diabetic Ketoacidosis (DKA) in early regulation phase (recovery from DKA) requiring constant intravenous infusions of insulin and/or frequent injections of regular Insulin with appropriate monitoring

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.		PAGE: 2 OF: 1	
TITLE: Intermediate Care Guidelines for patients in the Critical Care Unit: Admissions, Down-grades, Transfer, and Discharge Criteria Policy		SCOPE: Hospital - Clinical	
EFFECTIVE: 9/09 (New Policy)	REVIEW: Triennially	REVIEWED:	REVISED:
REVIEWED BY: Critical Care Unit Committee		APPROVED BY: Medical Director, Critical Care Unit	

vii. Surgical

1. Post-operative patient following major surgery who is hemodynamically stable but requires fluid resuscitation and transfusion due to fluid shifts

viii. Miscellaneous

1. Treated and resolving sepsis without evidence of shock or secondary organ failure
2. Patients requiring closely titrated fluid management
3. Patients requiring frequent nursing observations or extensive time (> 60 minutes) for wound management

b. **Transfer and/or Discharge** - Patient no longer requires the Intermediate scope of services provided in the CCU. Examples include:

- i. Patient physiologic status is stabilized and need for intensive monitoring is not necessary; patient can be cared for on general medical-surgical unit
- ii. Patient physiological status has deteriorated and active life support is required or highly likely; the patient will be transferred to a CCU level of care.
- iii. Patient/Family requesting no further acute interventions
- iv. Services required are not available at WCMH

2. There are no direct admissions to the CCU for the Intermediate Level of Care. All patients must be evaluated in the Emergency Department. Nursing discretion should be used when transporting a patient from the ED to the CCU (monitoring patient during transport).
3. It is the responsibility of the attending or covering physician to assess the patient and write complete transfer orders into and out of the CCU.

References:

Guidelines on Admissions and Discharges for Adult Intermediate Care Unit (1998). Critical Care Medicine, 26(3), 607 – 610.

Meyer, M. (2003). Avoid PCU Bottlenecks With Proper Admission and Discharge Criteria. Nursing Management, 3(6), 31 – 35.