Supplemental CON Application Form

**Establishment of Cardiac Services**

Conn. Gen. Stat. § 19a-638(a)(9)

**Applicant:**

**Project Name**:

# Affidavit

Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Position – CEO or CFO)

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 of the Connecticut General Statutes, and that all facts contained in this Certificate of Need application are true and correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Subscribed and sworn to before me on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Clear Public Need**
	1. The record in this docket will include, in addition to other materials, the most recent American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines. The Applicants may submit any comments in response to this evidence, which they deem appropriate.
	2. If applicable to the proposal (e.g., establishment of catheterization lab without a cardiac surgical program), provide a copy of a signed agreement between the applicant and a tertiary care facility. Identify patient selection guidelines, the process and protocols involved in the transfer of a patient requiring cardiac surgery and joint quality assurance reviews and joint training.
	3. Provide the names of the local emergency medical service (“EMS”) providers relevant to the proposal. Has the applicant held any discussions with local EMS providers regarding the proposed service? If yes, provide detail regarding the content and result of the discussion. If no, explain why it was not necessary to contact any local EMS providers.
2. **Historical/Projected Volume**
	1. If applicable, provide (in tables below) the historical cardiac patient/procedure volume (e.g., Cardiac catheterization, Primary and Elective Percutaneous Coronary Intervention) for three full years and the current year-to-date by town/zip code, inpatient/outpatient and by physician as applicable to the proposal. When completing the tables, please adhere to the following:
		1. For CFY periods 6 months or greater, report annualized volume, identify the months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the months covered;
		2. Fill in years. In a footnote, identify the period covered by the applicant’s FY (e.g., July 1-June 30, calendar year, etc.).

**Table a**

**Cardiac Catheterization** Historical Patient Volume by Zip Code

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Town** | **Zip Code** | **PSA or SSA** | **Actual Patient Volume****(Last 3 Completed FYs)** | **CFY Volume\*** |
| **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

**Table B**

**Primary PCI** Historical Patient Volume by Zip Code

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Town** | **Zip Code** | **PSA or SSA** | **Actual Patient Volume****(Last 3 Completed FYs)** | **CFY Volume\*** |
| **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

**Table C**

**elective PCI** Historical **Patient Volume** by Zip Code

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Town** | **Zip Code** | **PSA or SSA** | **Actual Patient Volume****(Last 3 Completed FYs)** | **CFY Volume\*** |
| **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

**Table D**

Cardiac Historical **Patient/Procedure Volume** by Inpatient/Outpatient

|  |  |  |
| --- | --- | --- |
| **Service** | **Actual Volume****(Last 3 Completed FYs)** | **CFY Volume\*** |
| **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| Patients | Procedures | Patients | Procedures | Patients | Procedures | Patients | Procedures |
| **Inpatient:**Cardiac CathsPrimary PCIElective PCI |  |  |  |  |  |  |  |  |
| **Outpatient:**Cardiac CathsElective PCI |  |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

**Table E**

Cardiac Historical **Patient/Procedure Volume** by Unique Physician Identifier

|  |  |  |
| --- | --- | --- |
| **Unique Physician Identifier** | **Actual Volume****(Last 3 Completed FYs)** | **CFY Volume\*** |
| **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| Patients | Procedures | Patients | Procedures | Patients | Procedures | Patients | Procedures |
| **Physician A:**Cardiac CathsPrimary PCIElective PCI |  |  |  |  |  |  |  |  |
| **Physician B:**Cardiac CathsPrimary PCIElective PCI |  |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

* 1. In the tables below, provide the projected cardiac volumes (three full years) by town, inpatient/outpatient and by physician as applicable to the proposal. If the first year of the proposal is only a partial year, provide the partial year utilization and indicate the months included in a footnote.

**Table F**

Cardiac Projected **Patient/Procedure Volume** by Inpatient/Outpatient

|  |  |
| --- | --- |
| **Service** | **Projected Volume** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| Patients | Procedures | Patients | Procedures | Patients | Procedures | Patients | Procedures |
| **Inpatient:**Cardiac CathsPrimary PCIElective PCI |  |  |  |  |  |  |  |  |
| **Outpatient:**Cardiac CathsElective PCI |  |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

**Table G**

Cardiac Projected **Patient/Procedure Volume** by Unique Physician Identifier

|  |  |
| --- | --- |
| **Unique Physician Identifier** | **Projected Volume** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| Patients | Procedures | Patients | Procedures | Patients | Procedures | Patients | Procedures |
| **Physician A:**Cardiac CathsPrimary PCIElective PCI |  |  |  |  |  |  |  |  |
| **Physician B:**Cardiac CathsPrimary PCIElective PCI |  |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

* 1. Utilizing Tables H through J below, provide the historical/projected payer mix for cardiac patient volume by service category. Ensure that volumes are consistent with the totals projected in Tables D through G. If the first operational year is a partial year, provide the anticipated volume and indicate the months that were included.

**TABLE H**

**CARDIAC CATHETERIZATION HISTORICAL/PROJECTED PAYER MIX**

|  |  |  |
| --- | --- | --- |
| **Payer** | **Most Recently Completed****FY \_\_\_\_** | **Projected** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| **Patients** | **%** | **Patients** | **%** | **Patients** | **%** | **Patients** | **%** | **Patients** | **%** |
| Medicare |  |  |  |  |  |  |  |  |  |  |
| Medicaid |  |  |  |  |  |  |  |  |  |  |
| TRICARE |  |  |  |  |  |  |  |  |  |  |
| **Total Government** |  |  |  |  |  |  |  |  |  |  |
| Commercial Insurers |  |  |  |  |  |  |  |  |  |  |
| Uninsured |  |  |  |  |  |  |  |  |  |  |
| Workers Compensation |  |  |  |  |  |  |  |  |  |  |
| **Total Non-Government** |  |  |  |  |  |  |  |  |  |  |
| **Total Payer Mix** |  |  |  |  |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

**TABLE I**

**PRIMARY PCI HISTORICAL/PROJECTED PAYER MIX**

|  |  |  |
| --- | --- | --- |
| **Payer** | **Most Recently Completed****FY \_\_\_\_** | **Projected** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| **Patients** | **%** | **Patients** | **%** | **Patients** | **%** | **Patients** | **%** | **Patients** | **%** |
| Medicare |  |  |  |  |  |  |  |  |  |  |
| Medicaid |  |  |  |  |  |  |  |  |  |  |
| TRICARE |  |  |  |  |  |  |  |  |  |  |
| **Total Government** |  |  |  |  |  |  |  |  |  |  |
| Commercial Insurers |  |  |  |  |  |  |  |  |  |  |
| Uninsured |  |  |  |  |  |  |  |  |  |  |
| Workers Compensation |  |  |  |  |  |  |  |  |  |  |
| **Total Non-Government** |  |  |  |  |  |  |  |  |  |  |
| **Total Payer Mix** |  |  |  |  |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

**TABLE J**

**ELECTIVE PCI HISTORICAL/PROJECTED PAYER MIX**

|  |  |  |
| --- | --- | --- |
| **Payer** | **Most Recently Completed****FY \_\_\_\_** | **Projected** |
| **Partial FY \_\_\_\_\*** | **FY \_\_\_\_** | **FY \_\_\_\_** | **FY \_\_\_\_** |
| **Patients** | **%** | **Patients** | **%** | **Patients** | **%** | **Patients** | **%** | **Patients** | **%** |
| Medicare |  |  |  |  |  |  |  |  |  |  |
| Medicaid |  |  |  |  |  |  |  |  |  |  |
| TRICARE |  |  |  |  |  |  |  |  |  |  |
| **Total Government** |  |  |  |  |  |  |  |  |  |  |
| Commercial Insurers |  |  |  |  |  |  |  |  |  |  |
| Uninsured |  |  |  |  |  |  |  |  |  |  |
| Workers Compensation |  |  |  |  |  |  |  |  |  |  |
| **Total Non-Government** |  |  |  |  |  |  |  |  |  |  |
| **Total Payer Mix** |  |  |  |  |  |  |  |  |  |  |

**\*Months include \_\_\_\_\_\_\_\_\_**

* 1. If applicable, for the most recently completed fiscal year, identify the number of:
		1. Patients with a diagnosis of ST-segment elevation acute myocardial infarction (AMI) that presented at the Hospital’s emergency room.
		2. Doses of thrombolytic medication, issued through its pharmacy, to patients with a diagnosis of AMI.
	2. Please identify the number of physicians that will be providing coverage for the proposed program. Explain whether the physicians will be full time with the proposed program or also providing coverage at other hospitals.