



## **Office of Health Care Access Certificate of Need Application**

### **Final Decision**

**Hospital:** Hospital of Saint Raphael

**Docket Number:** 06-30765-CON

**Project Title:** Proposal to Establish and Operate an Emergency Services Satellite in North Haven

**Statutory Reference:** Sections 19a-638 and 19a-639 of the Connecticut General Statutes

**Filing Date:** March 9, 2007

**Hearing Date:** May 2, 2007

**Intervenors:** MidState Medical Center  
Permanent Commission on the Status of Women

**Hearing Officer:** Cristine A. Vogel, Commissioner

**Decision Date:** July 6, 2007

**Default Date:** July 7, 2007

**Staff Assigned:** Laurie K. Greci

**Project Description:** The Hospital of Saint Raphael ("Hospital") proposes to establish and operate an emergency services satellite in North Haven, at a total capital expenditure of \$9,064,145.

**Nature of Proceedings:** On March 9, 2007, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from the Hospital of Saint Raphael ("Hospital") proposing to establish and operate an emergency services satellite in

North Haven, at a total capital expenditure of \$9,064,145. The Hospital is a health care facility or institution as defined by Section 19a-630 of the Connecticut General Statutes (“C.G.S.”).

A notice to the public concerning OHCA’s receipt of the Hospital’s Letter of Intent (“LOI”) was published on June 19, 2006, in *The New Haven Register*. On September 28, 2006, the Hospital requested an extension of its LOI for the proposal of 30 days. On September 28, 2006, OHCA extended the date that the Hospital must file its CON application from October 11, 2006, to November 10, 2006.

Pursuant to Sections 19a-638 and 19a-639, C.G.S., a public hearing regarding the CON application was scheduled to be held on April 12, 2007. On March 20, 2007, the Applicant was notified of the date, time, and place of the hearing. On March 24, 2007, a notice to the public announcing the hearing was published in *The New Haven Register*. On April 9, 2007, DePaul Health Services Corporation and New Haven Radiology Associates, P.C. d/b/a North Haven Diagnostic Imaging, LLC withdrew the CON application, identified as OHCA Docket Number 06-30772-CON, proposing to establish an imaging center in North Haven. Subsequent to the withdrawal of the Docket Number 06-30772-CON, on April 11, 2007, the Hospital requested permission to modify the CON application to include information on the provision of imaging services at the proposed emergency services satellite and to postpone the hearing for 30 days to allow for such modification.

Pursuant to Section 19a-638(b), C.G.S., the default date of the 90 day review period for the CON application was extended by 30 days, from June 7, 2007, to July 7, 2007. OHCA deemed it appropriate to postpone the hearing until May 2, 2007. 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 Sections 19a-638 and 19a-639, C.G.S.

By petition dated April 2, 2007, The Permanent Commission on the Status of Women requested Intervenor status regarding the Hospital’s CON application. On April 5, 2007, the Presiding Officer designated The Permanent Commission on the Status of Women as an Intervenor with limited rights of participation.

By petition dated April 5, 2007, MidState Medical Center requested Intervenor status regarding the Hospital’s CON application. On April 9, 2007, the Presiding Officer designated MidState Medical Center as an Intervenor with full rights of cross-examination.

OHCA’s authority to review, approve, modify, or deny this proposal is established by Section 19a-639, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

## Findings of Fact

### Clear Public Need

#### Impact of the Proposal on the Hospital's Current Utilization Statistics Proposal's Contribution to the Quality of Health Care Delivery in the Region Proposal's Contribution to the Accessibility of Health Care Delivery in the Region

1. Hospital of Saint Raphael ("Hospital") is an acute-care hospital located at 1450 Chapel Street, New Haven, Connecticut. *(November 9, 2006, Initial CON Submission, page 174)*
2. The Hospital proposes to establish and operate an emergency services satellite ("satellite ED") on 375 Washington Avenue in North Haven. The satellite ED will operate 24 hours day and 7 days per week. *(November 9, 2006, Initial CON Submission, page 2)*
3. The Hospital's proposed service area for the satellite ED is listed in the following table:

**Table 1: Proposed Service Area for the Satellite ED**

Service Area	Towns
Primary	<i>Hamden, North Haven, North Branford, and Wallingford</i>
Secondary	New Haven Area and East Shore: <i>New Haven, West Haven, East Haven, Branford, Clinton, Guilford, and Madison</i>
	Northern: <i>Cheshire and Meriden</i>
	Housatonic Valley: <i>Ansonia, Bethany, Derby, Milford, Orange, Oxford, Seymour, Shelton, and Woodbridge</i>

*(November 3, 2006, Initial CON Submission, pages 12 and 356  
and February 20, 2007, Completeness Response, page 13)*

4. The Hospital stated that the selected site for the satellite ED is a centralized location where the four primary service area towns lie within a five-mile radius of the selected site. *(November 9, 2006, Initial CON Submission, page 14)*
5. The Hospital has based the need for the satellite ED on the following:
  - a. Increasing utilization of the Hospital's main campus Emergency Department ("main ED");
  - b. Capacity constraints at the main ED; and
  - c. Bringing critical health care services closer to residents of the service area.*(November 9, 2006, Initial CON Submission, page 3)*

6. The following table reports the total visits by patient type to the Hospital's main ED by fiscal year:

**Table 3: Main ED Visits by Patient Type**

	<b>FY 2002</b>	<b>FY 2003</b>	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 2006</b>
Main ED Visits for Patients Admitted as an Inpatient	13,542	13,574	14,286	14,766	14,775
Main ED Outpatient Visits	34,772	35,555	37,802	39,946	37,240
<b>Total Visits</b>	<b>48,314</b>	<b>49,129</b>	<b>52,088</b>	<b>54,712</b>	<b>52,015</b>

(November 9, 2006, Initial CON Submission, page 5 and 17 and  
February 20, 2007, Completeness Submission, page 1)

7. The following table reports the total visits by payer type to the Hospital's main ED from FY 2003 to FY 2006:

**Table 4: Main ED Visits by Payer Type**

<b>Number of Patient Visits by Payer</b>	<b>FY 2003</b>	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 2006</b>
Medicare	16,611	17,531	18,159	17,683
Medicaid	12,584	14,528	15,872	14,502
Uninsured	5,031	5,223	5,430	4,491
All Other*	14,903	14,806	15,251	15,339
<b>Total</b>	<b>49,129</b>	<b>52,088</b>	<b>54,712</b>	<b>52,015</b>

\* Includes commercial payers, other government payers, and workmen's compensation.

(November 9, 2006, Initial CON Submission, page 5 and  
February 20, 2007, Completeness Submission, page 2)

8. The following table reports the number of visits to the main ED by patient town of residence in Hospital's primary service area:

**Table 5: Main ED Visits by Patient Town of Residence in Hospital's PSA**

	<b>FY 2003</b>	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 2006</b>
Hamden	6,032	6,471	6,712	6,664
North Haven	1,955	2,075	2,121	2,195
Wallingford	892	920	990	983
North Branford	839	902	782	763
<b>Subtotal</b>	<b>9,718</b>	<b>10,368</b>	<b>10,605</b>	<b>10,605</b>
Other Towns	39,411	41,720	44,107	41,410
<b>Total</b>	<b>49,129</b>	<b>52,088</b>	<b>54,712</b>	<b>52,015</b>

(February 20, 2007, Completeness Submission, page 3)

9. The Hospital stated that in addition to population growth and increasing utilization, other issues contribute to the overcrowding conditions at the main ED:
  - a. Increasing acuity level of patients presenting to the main ED;
  - b. Increasing psychiatric patient volume and the lack of adequate placement opportunities for psychiatric patients.

(November 9, 2006, Initial CON Submission, page 6)
10. The Hospital stated that the acuity level of patients presenting to the main ED has been steadily increasing over the past three years. Higher acuity patients require a higher intensity of care and generally utilize more ancillary services, such as computer tomography (“CT”) scans, magnetic resonance imaging (“MRI”), and ultrasound scans. These patients typically have a much longer length of stay within the main ED, tying up the ED beds and resources for longer periods of time which results in longer wait times and higher walkout<sup>1</sup> rates. (November 9, 2006, Initial CON Submission, page 6)
11. At the end of 2006, the Hospital’s walkout rate was 5.9%, resulting in the loss of 3,388 cases. Based on the first five months it is expected that the annualized number of walkouts for FY 2007 will be 3,487. (April 24, 2007, David Benfer, Revised Prefiled Testimony, pages 7 and 8)
12. The Hospital stated that behavioral health patients frequently occupy a significant number of the Hospital’s main ED beds. Psychiatric patients presenting to the main ED often have lengths of stay of forty-eight (48) hours or more while waiting for an inpatient psychiatric bed to open at the Hospital or another facility. (November 9, 2006, Initial CON Submission, page 8)
13. The Hospital’s market share, based on inpatient discharges from each town within the primary service area, is reported in the following table:

**Table 7: Hospital of Saint Raphael’s Inpatient Discharges for Persons from within the Primary Service Area**

	<b>Town</b>	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 2006</b>
<b>Inpatient Discharges</b>	Hamden	3,448	3,477	3,676
	North Branford	594	507	536
	North Haven	1,453	1,407	1,483
	Wallingford	795	864	883
<b>Percent of Hospital’s Total Inpatient Discharges</b>	Hamden	13.6%	13.9%	14.5%
	North Branford	2.3%	2.0%	2.1%
	North Haven	5.7%	5.6%	5.8%
	Wallingford	3.1%	3.4%	3.5%

(OHCA Acute Care Hospital Inpatient Discharge Database for FYs 2004, 2005, 2006)

<sup>1</sup> Walkout rate refers to the percentage of patients that present to an ED but leave before receiving treatment.

14. The following table reports the hospitals that had inpatient discharges from within the primary service area:

**Table 8: Number and Percent of Inpatient Discharges by Town and by Hospital for the Primary Service Area**

Inpatient Discharges	Town	FY 2004		FY 2005		FY 2006	
		No.	%	No.	%	No.	%
<b>Hospital of Saint Raphael</b>	Hamden	3,448	46.2%	3,477	46.8%	3,676	46.4%
	North Branford	594	38.9%	507	33.4%	536	32.9%
	North Haven	1,453	50.6%	1,407	49.4%	1,483	49.4%
	Wallingford	795	16.7%	864	16.7%	883	17.6%
<b>MidState Medical Center</b>	Hamden	57	0.8%	68	0.9%	50	0.6%
	North Branford	46	3.0%	32	2.1%	34	2.1%
	North Haven	95	3.3%	96	3.4%	120	4.0%
	Wallingford	2,267	47.6%	2,532	49.1%	2,324	46.3%
<b>Yale-New Haven Hospital</b>	Hamden	3,577	47.9%	3,561	47.9%	384	4.9%
	North Branford	785	51.4%	902	59.5%	966	59.2%
	North Haven	1,187	41.4%	1,213	42.6%	1,251	41.6%
	Wallingford	1,105	23.2%	1,130	21.9%	1,201	23.9%
<b>All Others Combined</b>	Hamden	385	5.2%	322	4.3%	3,807	48.1%
	North Branford	102	6.7%	76	5.0%	95	5.8%
	North Haven	135	4.7%	133	4.7%	151	5.0%
	Wallingford	592	12.4%	633	12.3%	615	12.2%

*(OHCA Acute Care Hospital Inpatient Discharge Database for FYs 2004, 2005, and 2006)*

15. The following table reports the percent of inpatient discharges for patients residing within the proposal's four town primary service area for all admission sources and those admitted through a hospital's emergency department:

**Table 9: Percent Inpatient Discharges by Admission Source  
for the Proposed Four Town Primary Service Area**

<b>Hospital</b>	<b>All Admission Sources</b>			<b>ED Admits Only</b>		
	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 2006</b>	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 2006</b>
Yale-New Haven	40%	40%	41%	38%	39%	41%
Saint Raphael	38%	37%	37%	41%	39%	39%
MidState Medical Center	15%	16%	14%	18%	19%	17%
Hartford	2%	1%	2%	1%	0%	0%
Milford	1%	1%	1%	-	-	-
Saint Francis	1%	1%	0%	-	-	-
Middlesex Memorial	1%	1%	1%	1%	1%	0%
Other*	3%	3%	3%	2%	2%	2%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

\* Includes 23 other hospital within the State of CT

Source: CT Office of Health Care Access Acute Care Discharge Database

16. The Hospital reported that it has 94 affiliated physicians in Hamden, 24 in North Haven, 2 in North Branford, and 8 in Wallingford. (February 20, 2007, Completeness Response, pages 46 to 50)
17. The Hospital has projected the following number of visits at the main ED and at satellite ED from 2006 through 2010:

**Table 10: Projected ED Visits by Location and Fiscal Year**

<b>Location</b>	<b>Patient Type</b>	<b>Fiscal Year</b>			
		<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
Satellite ED	Non-admit	0	9,121	9,855	10,567
	Admit	0	1,042	1,117	1,204
	<b>Total</b>	<b>0</b>	<b>10,162</b>	<b>10,972</b>	<b>11,771</b>
Main ED	Non-admit	38,419	37,077	37,642	37,606
	Admit	14,573	13,967	14,614	15,142
	<b>Total</b>	<b>52,992</b>	<b>51,043</b>	<b>52,256</b>	<b>52,748</b>
Combined	Non-admit	38,419	46,197	47,497	48,174
	Admit	14,573	15,008	15,730	16,346
	<b>Grand Total</b>	<b>52,992</b>	<b>61,206</b>	<b>63,228</b>	<b>64,519</b>

(November 9, 2006, Initial CON Submission, page 8)

18. The satellite ED will provide diagnostic computed tomography (“CT”) scanning, diagnostic radiology (x-ray), and ultrasound imaging services. New Haven Radiology Associates will provide professional services at the satellite ED. *(April 24, 2007, Modified CON Submission, page 8)*
19. The Hospital projects the imaging volumes at the satellite ED:

**Table 11: Projected Imaging Volume by Fiscal Year**

Scan Type	Patient Type	Fiscal Year		
		2008	2009	2010
CT Scans	Non-admitted	1,077	1,162	1,149
	Admitted	69	26	405
	<b>Total CT Scans</b>	<b>1,145</b>	<b>1,423</b>	<b>1,544</b>
X-rays	Non-admitted	3,152	3,399	3,361
	Admitted	218	828	1,283
	<b>Total X-rays</b>	<b>3,370</b>	<b>4,227</b>	<b>4,644</b>
Ultrasound	Non-admitted	163	176	174
	Admitted	11	43	67
	<b>Total Ultrasound</b>	<b>175</b>	<b>219</b>	<b>241</b>

*(April 24, 2007, Modified CON Submission, page 7)*

20. Paul Gustafson, Chairman of the Strategic and Financial Planning Committee of the Hospital, testified that:
  - a. The Hospital’s proposal is a key component of the revenue growth plan; and
  - b. The proposal will decompress the main ED and provide services to all in the communities that the Hospital serves.*(May 30, 2007, Paul Gustafson, Hearing Testimony)*
21. David Benfer, President and Chief Executive Officer of the Hospital, testified that:
  - a. Critical access to care is needed by expanding services to the North Haven, Hamden, North Branford, and Wallingford where 20% of the main ED visits originate and is 14 miles from the next emergency provider;
  - b. The Hospital will be able to improve access and expand services to meet the growing demand;
  - c. 75% of the visits to the ED are government insured or uninsured;
  - d. The Hospital has experienced turnover with respect to the leadership in the ED in the past five years;
  - e. The decrease in volume from FY 2005 to FY 2006 was during a leadership transition where the acting chair of the ED took another position and the Hospital was actively looking for a new chair;
  - f. Lack of leadership led to decreased volume and an increase in walkout rate;
  - g. The number of board-certified emergency physicians and registered nurses has increased;



- h. The decline in the number of ED visits from 2005 to 2006 is attributable to a leadership transition when the acting chairman of the ED went to another hospital;
  - i. The Hospital employed a new Chairman of Emergency Medicine, Dr. Ronald Thomas, who is well-experienced in satellite emergency services;
  - j. With Dr. Thomas's leadership, the processes in the main ED were changed, including the staffing;
  - k. The reduction of the inpatient length of stay from 5.6 to 5.1 days has freed up 18 additional inpatient beds;
  - l. The time of admission from the presentation at the ED to an inpatient bed has been reduced by 20%;
  - m. The changes made still cannot address the demand volume; and
  - n. ED is the major way patients access other services at the Hospital.  
*(May 30, 2007, David Benfer, Hearing Testimony)*
22. David Benfer testified that the Hospital did not assess the population for the need for a primary care center in the service area open 7 days a week, 10 hours a day, to truly address the needs of the community. *(May 30, 2007, David Benfer, Hearing Testimony)*
23. David Benfer also testified regarding the affordability of the proposed satellite ED to patients as opposed to a primary care center. He stated that it is a full service ED that would be more costly to the patient because of the initial cost (i.e. co pay) to the patient (as opposed to a primary care center). *(May 30, 2007, David Benfer, Hearing Testimony)*
24. Ronald Thomas, M.D., the Hospital's Chair of Emergency Department, testified that:
- a. The ED has implemented "Express Care", an area for fast-tracking patients presenting with lower acuity or less severe illness quickly;
  - b. The "Express Care" began operations four months ago and has been successful in reducing wait times;
  - c. The Hospital has established an electronic bed control system designed to promptly and efficiently identify available inpatient beds;
  - d. The Hospital will increase its bed capacity by 16 beds in the Verdi Building within several months<sup>2</sup>;
  - e. Under the Hospital's strategic plan, an additional 32 beds will be used as swing beds to accommodate the upgrading and refurbishing of other units in the Hospital;
  - f. Psychiatric patients requiring a safe environment will be transferred to the main ED where the resources are available; and
  - g. Telemetry beds, psychiatric beds and child psychiatric bed capacities are issues that lead to overcrowding.  
*(May 30, 2007, Dr. Thomas, Hearing Testimony)*

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<sup>2</sup> Under OHCA Docket Number 04-30417-CON the Hospital was authorized on September 20, 2005 to build-out its Verdi Low Roof Building on the main campus to increase its staffed bed capacity by 48 medical/surgical beds.

25. Paul Storiato, Vice-President and Chief Financial Officer for the Hospital and the Saint Raphael Healthcare System, testified that:
- The projected losses for the Hospital System in FY 2007 is expected to be significantly less than the budgeted loss of \$9.6 million<sup>3</sup>;
  - The Hospital filed a Hardship Fund Application August 2006 due to the operating loss of over \$5,000,000 in FY 2006 and a projected operating loss of \$9,000,000 in FY 2007; and
  - Convenience is an issue and time waiting in a main ED is significantly longer in a main ED than a satellite ED;
- (May 30, 2007, Paul Storiato, Hearing Testimony)
26. Lucille Janatka, President and Chief Executive Officer of MidState Medical Center (“MMC”) testified that:
- The satellite ED is just 14 minutes from MMC;
  - The Applicant’s proposal will have a significantly adverse impact on MMC;
  - The Hospital based its projected ED volume on the state rate of 421 visits per thousand in population when actual data for the proposed service area is 274 visits per thousand persons; and
  - High acuity of ED visits is one reason why EDs are overcrowded.
- (May 30, 2007, Lucille Janatka, Hearing Testimony)
27. Fred F. Tilden, MD, Medical Director of MMC, testified that:
- Every Emergency Department in Connecticut is seeing more patients than it was designed to serve;
  - Overcrowding in EDs is caused primarily by not having enough inpatient beds available;
  - MMC’s ED was intended to handle 28,000 ED visits per year;
  - ED visits at MMC in 2006 were 51,000;
  - MMC has 130 inpatient beds and 28 ED beds; and
  - MMC operates two walk-in facilities, one in Meriden, and another in Wallingford.
- (May 30, 2007, Dr. Tilden, Hearing Testimony)
28. Karen Goyette, of MMC, testified that the primary service area towns for MMC are Cheshire, Meriden, Southington, and Wallingford.
- (May 30, 2007, Karen Goyette, Hearing Testimony)
29. MidState Medical Center (“MMC”) reported that it has 75 affiliated physicians in Wallingford, and one affiliated physician in North Haven. (May 17, 2007, MMC Late File Submission, pages 7 to 9)

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<sup>3</sup> The actual loss in FY 2006 for the Hospital was \$9,318,000. Source: Hospital’s Audited Financial Statements

30. MMC reported the following non-admit visits at their main ED by fiscal year:

**Table 12: MMC Non-admit ED Visits by Fiscal Year**

<b>Residence</b>	<b>Fiscal Year</b>			
	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007 (1<sup>st</sup> Qtr)</b>
Wallingford	7,039	7,138	7,322	1,856
North Haven	501	505	492	124
North Branford	198	199	197	55
Hamden	270	346	333	79
Other Towns in Connecticut	31,246	32,022	33,410	8,249
Out-of-State	1	1	1	0
Total	39,255	40,211	41,755	10,363*

\* Annualized Total Visits = 41,452.

(May 17, 2007, MMC Late File Submission, pages 7 to 9)

31. The Hospital did not provide any documentation on:
- An assessment of the need for primary or urgent care access in the proposed primary service area;
  - Alternative site options on the main Hospital campus for addressing the increasing number of higher acuity cases and psychiatric patients presenting to the main ED;
  - Patient volumes treated in its Express Care;
  - An assessment of the impact of additional inpatient bed capacity; or
  - Cost-effectiveness of the proposed satellite ED.

**Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on the  
Applicant's 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**

32. The Hospital's CON proposed total capital expenditure of \$9,064,145 for the proposal consists of the following:

**Table 13: Proposed Total Capital Expenditure Components**

<b>Category</b>	<b>Proposed Expenditure</b>
Construction/Renovation	\$4,861,839
Major Medical Equipment (Purchase)	1,993,287
Medical Equipment (Purchase)	1,420,487
Non-Medical Equipment (Purchase)	788,532
<b>Total Capital Expenditure</b>	<b>\$9,064,145</b>

*(April 24, 2007, Modified CON Submission, page 2)*

33. The construction includes the interior fit out of a 12,500 square foot area in a new building shell provided by a developer. The capital expenditure of \$4,861,839 for the construction includes the following components:

**Table 14: Hospital's Capital Expenditures for Construction**

<b>Category</b>	<b>Proposed Expenditure</b>
Building Work for New Construction	\$3,831,532
Architectural and Engineering	\$220,000
Contingency	\$810,307
<b>Total Construction Expenditure</b>	<b>\$4,861,839</b>

*(April 24, 2007, Modified CON Submission, page 3)*

34. The Hospital proposes to purchase the following imaging equipment:

**Table 15: Hospital's Capital Expenditures for Imaging Equipment**

<b>Item</b>	<b>Cost</b>
Toshiba Aquilion 64-slice CT Scanner	\$1,592,112
Toshiba Aplio XV Ultrasound System	146,910
Shimadzu RadSpeed Radiographic Unit	75,000
Fuji FCR Carbon X Unit (2)	118,750
Mobile Radiographic Unit	36,000
TycoOptivantage DH Contract Injector	24,515
<b>Total</b>	<b>\$1,993,287</b>

*(April 24, 2007, Modified CON Submission, page 14)*

35. As a result of the withdrawal of CON Docket Number 06-30772-CON, the Hospital modified the initial CON application to include the provision of imaging services in the satellite ED. The total capital expenditure for the proposal increased by \$3,285,161, from \$5,778,984 to \$9,064,145. The satellite ED will occupy 12,500 square feet, an increase of 2,500 square feet from the originally proposed 10,000 square feet. The Hospital also included additional staffing of four (4) full-time equivalents (“FTE”) for CT scanning and 0.5 FTE to perform diagnostic x-rays and ultrasound scans for the first two years of operations. In the third year the staffing will increase by 1.0 FTE. *(April 24, 2007, Modified CON Submission, pages 1 and 6)*
36. The Hospital proposes to fund 50% of the proposal from its operating funds and 50% with a 15 year conventional loan at an interest rate of 7.5%. *(November 9, 2006, Initial CON Submission, page 36)*
37. The Hospital’s incremental financial projections for revenue gains from operations associated for the satellite ED are presented in the following table:

**Table 16: The Hospital’s Incremental Financial Projections  
for the Satellite ED Only**

<b>Description</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>
Revenue from Operations*	\$6,373,278	\$7,155,831	\$7,984,008
Total Operating Expense	6,180,857	7,531,251	8,077,407
<b>Gain from Operations*</b>	<b>\$ 192,421</b>	<b>\$(375,420)</b>	<b>\$ (93,399)</b>
Equivalent Full Time Employees	41.7	45.8	49.0

\* Includes a portion of admission net revenue to reflect patient visits that result in inpatient admission to the Hospital.

*(May 16, 2007, Late File, Revised Financial Pro Forma)*

38. The Hospital’s incremental financial projections for revenue gains from operations associated with the CON proposal, including the satellite ED and the main ED, are presented in the following table:

**Table 17: The Hospital’s Incremental Financial Projections  
for the Satellite and Main Emergency Departments**

<b>Description</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>
Revenue from Operations*	\$ 5,284,272	\$10,075,660	\$13,726,193
Total Operating Expense**	6,427,177	9,964,517	12,132,407
<b>Gain from Operations</b>	<b>\$(1,142,905)</b>	<b>\$ 111,143</b>	<b>\$ 1,593,786</b>
Equivalent Full Time Employees	41.7	45.8	49.0

\* Per visit net revenue of \$500 for outpatient and approximately \$9,000 for inpatient, with an average per unit of \$733.

\*\* Includes \$537,397 for depreciation expense and \$334,140 for interest expense in FY 2008.

*(May 16, 2007, Late File, Revised Financial Pro Forma)*

39. The Hospital will be responsible for the billing of the technical fee associated with emergency and imaging services provided at the satellite ED. Professional fees for imaging services will be billed by New Haven Radiology Associates. *(April 24, 2007, Modified CON Submission, page 1)*
40. The initial year operating loss of \$1,142,906 is due to the \$537,397 in depreciation expense related to the construction of the facility and the equipment purchase, interest expense of \$334,140 and other operating expenses related to the initial start-up of the satellite ED. *(April 24, 2007, Modified CON Submission, page 7)*
41. The Hospital reported the following actual payer mix for the main campus ED in FY 2005 and the projected payer mix for the satellite ED:

**Table 18: Hospital's Actual Main ED and Projected Satellite ED Projected Payer Mix**

Payer	Payer Mix	
	Actual	Projected
	FY 2005	FYs 2008, 2009, and 2010
Medicare	62.4%	57%
Medicaid	9.9%	4.4%
CHAMPUS or TriCare	0.1%	0.0%
<b>Total Government Payers</b>	<b>72.4%</b>	<b>61.4%</b>
Commercial Insurers	24.5%	34.0%
Uninsured	1.3%	1.0%
Workers Compensation	1.8%	3.6%
<b>Total Non-Government Payers</b>	<b>27.6%</b>	<b>38.6%</b>
<b>Total Payer Mix</b>	<b>100%</b>	<b>100%</b>

*(February 20, 2007, Completeness Response, page 382)*

42. The Hospital anticipates that the satellite ED will begin operations by March 1, 2008. *(November 9, 2006, Initial CON Submission, page 34)*
43. The Hospital stated that the proposal is not expected to affect existing providers as the proposal seeks to address capacity constraints that exist at the Hospital's main ED. Through a shift of current and projected emergency services volumes the Hospital states that the satellite ED will primarily serve the four town primary service area where there are no current providers of emergency services. *(November 9, 2006, Initial CON Submission, page 24)*
44. There is no State Health Plan in existence at this time. *(November 9, 2006, Initial CON Submission, page 2)*
45. The proposal is consistent with Hospital's long-range plan. *(November 9, 2006, Initial CON Submission, page 2)*

46. The Hospital's proposal will not change the Hospital's teaching and research responsibilities. *(November 9, 2006, Initial CON Submission, page 30)*
47. The proposal will not result in any change to the Applicant's patient/physician mix. *(November 9, 2006, Initial CON Submission, page 30)*
48. The Hospital has improved productivity and contained costs through energy conservation, group purchasing, reengineering, and the application of technology. *(November 9, 2006, Initial CON Submission, page 19)*
49. The Hospital has sufficient technical and managerial competence to provide efficient and adequate service to the public. *(November 9, 2006, Initial CON Submission, Attachment 7)*
50. The Hospital's rates are sufficient to cover the proposed capital expenditure and operating costs. *(May 16, 2007, Late File, Revised Financial Pro Forma)*

## Rationale

The Office of Health Care Access (“OHCA”) approaches community and regional need for the proposed service on a case by case basis. Certificate of Need (“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 proposed services.

The Hospital of Saint Raphael (“Hospital”), an acute-care hospital located at 1450 Chapel Street, New Haven, Connecticut, proposes to establish and operate an emergency services satellite (“satellite ED”) at 375 Washington Avenue, North Haven. The Hospital’s proposed primary service area for the satellite ED includes the towns of Hamden, North Branford, North Haven, and Wallingford. The Hospital stated that the satellite ED is needed due to the increasing utilization of the Hospital’s main campus Emergency Department (“main ED”), the capacity constraints at the main ED, and bringing health care services closer to residents of the service area. The Hospital stated that the increasing acuity level of patients presenting to the main ED and the increasing psychiatric patient volume have contributed to the overcrowding conditions at the main ED.

Higher acuity patients require a higher intensity of care and generally utilize more ancillary services, such as computer tomography (“CT”) scans, magnetic resonance imaging, and ultrasound scans. These patients typically have a much longer length of stay within the main ED, tying up the ED beds and resources for longer periods of time which results in longer wait times and higher walkout rates for other patients. The Hospital also stated that behavioral health patients frequently occupy a significant number of the Hospital’s main ED beds. Psychiatric patients presenting to the main ED often have lengths of stay of forty-eight (48) hours or more while waiting for an inpatient psychiatric bed to open at the Hospital or another facility. Under the Hospital’s proposal, the higher acuity patients, as well as the psychiatric patients, would still be diverted to the Hospital’s main ED.

In June 2006, the Hospital employed a new chair for its Emergency Department, Dr. Ronald Thomas. Prior to Dr. Thomas, the Hospital had an acting chair. At the hearing, David Benfer, the Hospital’s President and Chief Executive Officer, testified that the Hospital has experienced turnover with respect to the leadership in the main ED in the past five years. The decrease in volume from FY 2005 to FY 2006 was during a leadership transition where the acting chair of the ED left the Hospital and the Hospital was looking for a new chair. Mr. Benfer also testified that the lack of leadership led to the decreased volume and an increase in walkout rate. Mr. Benfer testified that the Hospital had not conducted an assessment of the need for primary or urgent care access in the proposed primary service area. He also acknowledged the higher cost to the patient who visits the satellite ED, as opposed to a primary care center.



Under Dr. Thomas's leadership, the main ED implemented a fast track area, referred to as "Express Care", four months ago. The Hospital stated that the new process has reduced waiting times, but provided no information on the volume of patients treated in the "Express Care" versus a regular main ED visit. It appears that the benefits of the organizational, managerial, and process changes made over the past year in the main ED are only now beginning to be realized.

One of the reasons for the overcrowding of EDs is not having enough inpatient beds available. Mr. Benfer testified that the reduction of the inpatient length of stay from 5.6 to 5.1 days has freed up 18 additional inpatient beds. The Hospital is expected to add from sixteen (16) to forty-eight (48) additional staffed inpatient beds with its Verdi Low Roof building project. However, it is not yet clear what impact these additional beds will have on the main ED's throughput, i.e. the number of patients that can be registered, evaluated, treated, and either discharged or admitted within a specified unit of time. As part of the Hospital's strategic plan to refurbish other inpatient units, many of these new beds will be used as "swing" beds. Use of these beds as swing beds will not add the full 48 inpatient bed capacity to the Hospital.

The Hospital's proposal has a total capital expenditure of \$9,064,145. The Hospital projects an incremental loss from operations of \$1,142,905 in FY2008, the first year of operations. Much of the loss is due to the depreciation expense associated with the construction costs and the purchase of the imaging equipment. The Hospital projects incremental gains from operations of \$111,143 and \$1,593,786 in FY 2009 and FY 2010, respectively.

OHCA is aware that emergency departments throughout Connecticut are experiencing volumes beyond what the facilities were designed to handle. However, the struggle with patient throughput is not singularly related to volume. The lack of efficient throughput at the Hospital is related to:

- delays in the admission of patients to an inpatient bed;
- delays in referring behavioral health patients to an appropriate resource whether that resource be an inpatient bed or a community-based outpatient program;
- overall management issues that are recently being addressed; and
- the lack of a fast-tracking process in the main ED for rapid assessment, treatment, and discharge until only recently.

The Hospital failed to produce sufficient evidence showing that the proposed satellite ED is the most cost-effective solution to the overcrowding of its main ED. The Hospital provided no substantive information to demonstrate that the Hospital considered alternative site locations on the main campus to alleviate the overcrowding of the main ED with patients of higher acuity. It appears that with the current leadership and management of the main ED, the opening of additional beds and the improved throughput measures (such as the Express Care), the Hospital will realize an improvement in access. The Hospital has not proven that there is a need for the full service satellite ED, as opposed to a primary care center, or that it is more cost-effective for the consumers of the service.

## **Order**

Based upon the foregoing Findings and Rationale, the Certificate of Need application of the Hospital of Saint Raphael to establish and operate an emergency services satellite in North Haven, at a total capital expenditure of \$9,064,145 is hereby DENIED.

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

July 6, 2007

Signed by Cristine A. Vogel  
Commissioner

CAV:lkg