Proposed Final Decision

Applicant: **Windham Community Memorial Hospital, Inc.**
112 Mansfield Avenue
Willimantic, CT 06226

Docket Number: **20-32394-CON**

Project Title: **Termination of inpatient or outpatient services (inpatient obstetrics services) by a hospital (Windham Hospital)**

I. Project Description

Windham Community Memorial Hospital, Inc. (the "Applicant," "Hospital," or "WH") seeks authorization to terminate inpatient obstetrics services ("Services") at its main hospital campus located at 112 Mansfield Avenue, Willimantic, Connecticut 06226.

II. Procedural History

The Applicant published notice of its intent to file a Certificate of Need ("CON") application in *The Chronicle* (Willimantic) on July 8, 9 and 10, 2020. On September 3, 2020, the Health Systems Planning unit ("HSP") of the Office of Health Strategy ("OHS") received the CON application from the Applicant for the above-referenced project and deemed the application complete with an intent to hold a public hearing on February 25, 2021.

On March 10, 2020, Governor Ned Lamont issued an emergency declaration of public health and civil preparedness in response to the COVID-19 global pandemic.[1] On March 14, 2020, Governor Lamont issued Executive Order 7B, which, in relevant part, waived in-person meeting requirements under the Freedom of Information Act to mitigate the spread of COVID-19.[2] Thereafter, Public Act 21-2 was enacted, Section 149 of which authorized public agencies to hold a public meeting solely or in part using electronic equipment until April 30, 2022, and established requirements and procedures for holding such meetings.

On September 8, 2021, Executive Director Victoria Veltri designated Attorney Joanne Yandow to be the Hearing Officer in this proceeding. On September 10, 2021, the Applicant was notified of the date, time, and place of the public hearing. On September 10, 2021, a notice to the public announcing the hearing was published in *The Chronicle* (Willimantic). On September 27, 2021, OHS published notice in *The Chronicle* (Willimantic) announcing the rescheduled virtual public

[1] Declaration of Public Health and Civil Preparedness Emergencies. Governor Ned Lamont, March 10, 2020, https://www.cga.ct.gov/ph/tfs/20200311_Public%20Health%20Emergency%20Committee/Declaration-of-civil-preparedness-and-public-health-emergency.pdf
[2] Executive Order 7B. Governor Ned Lamont, March 14, 2020, https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7B.pdf (extended through May 28, 2021 via Executive Order 12B)

hearing on November 10, 2021, and the hearing was held on said date. On December 14, 2021, Executive Director Victoria Veltri redesignated Attorney Daniel Csuka as the Hearing Officer.

OHS convened the public hearing pursuant to Connecticut General Statutes ("C.G.S.") § 19a-639a(e)[3] and in accordance with Executive Order 7B and Section 149 of Public Act 21-2. The proceedings were conducted pursuant to the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes). Attorney Csuka closed the hearing record on March 17, 2022. The undersigned attests to having reviewed the record in its entirety.

III. Provisions of Law

The proposal constitutes the termination of inpatient or outpatient services offered by a hospital pursuant to C.G.S. § 19-638(a)(5). OHS considered the factors set forth in C.G.S. § 19a-639(a), in rendering its decision.

CON applications are decided on a case-by-case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727 (2013).

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[3] Sufficient requests for hearing were submitted pursuant to C.G.S. § 19a-639a(e). *See* Exhibit E – Public Comment, pp. 53-68.

Findings of Fact

Introduction and Background[4]

1. Windham Hospital is licensed by the Connecticut Department of Public Health ("DPH") to operate as a one-hundred and thirty (130) bed and fourteen (14) bassinet acute care general hospital with a main campus located at 112 Mansfield Avenue, Willimantic, Connecticut ("CT" or the "State") 06226. Ex. A – Application, pp. 12, 55

2. The Hospital's parent corporation is Hartford HealthCare ("HHC"), and as a member of HHC it provides inpatient, outpatient, and rehabilitative services to the residents of northwestern CT. Ex. A – Application, pp. 9, 12

3. The Applicant seeks regulatory approval from OHS to terminate inpatient obstetrics services ("OB Services" or labor and delivery services ["L&D Services"]) at its main campus (the "Proposal"). Ex. A – Application, pp. 11-16

4. The Windham OB unit is staffed by a physician specializing in obstetrics and gynecology (OB/GYN) and registered nurses (RNs) with some deliveries requiring on call anesthesiologists and/or neonatal providers. Ex. A – Application, p. 14; Ex. E, pp. 98-99

5. WH's fiscal year is October 1st – September 30th. Ex. A – Application, p. 29

6. Since at least 2014, WH has experienced difficulty recruiting and retaining physician coverage. Ex. E – WH Response to CL#1, pp. 98-100

7. In a June 23, 2015 publication titled "East Region Transition Plan," WH stated that it: (1) was "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 in time," with such "cornerstone services" including, but not being limited to, "[w]omen's health," and (2) "would continue to work collaboratively to enable access to the specialty care services that [its] affiliation with Hartford HealthCare makes possible." Ex. F – Public Comment, pp. 179, 182-185; Ex. DD – Hearing Transcript, pp. 191-192 (Arvind Shaw)

8. After OHS determined on September 9, 2015 that WH's conversion of its Critical Care Unit ("CCU") to a Progressive Care Unit ("PCU") did not require CON authorization, and the conversion occurred thereafter, WH was no longer capable of safely performing vaginal births after cesarean section ("VBAC") services.[5] Ex. F – Public Comment, pp. 278-279; Ex. R – WH Prefile, p. 346

9. In 2017, the Hospital engaged Sindhu K. Srinivas, M.D., a practicing obstetrician, maternal fetal medicine specialist, and the Director of Obstetrical Services at the Hospital of the

[4] Use of header descriptions in this document are for organizational purposes only and are not intended as restrictions on the use of information in relation to the CON statutory criteria.
[5] Office of Health Strategy. CON Determination – Docket No. 15-32026-DTR. Available at: https://portal.ct.gov/media/OHS/ohca/CONDeterminations/Determinations_2015/1532026DTRpdf.pdf

University of Pennsylvania, to conduct a review of its labor and delivery service. Following her review, Dr. Srinivas issued a report that recommended WH consider closing its labor and delivery service. Ex. A – Application, pp. 14, 49-53

10. The plan to terminate the Hospital's OB Services was introduced to the Hospital's Board of Directors ("BoD") at the November 2019 BoD meeting. Ex. Y – WH Late File, p. 372; Ex. DD – Hearing Transcript, pp. 118-120 (Donna Handley)

11. The plan was presented and unanimously approved by the BoD at the June 16, 2020 meeting. Ex. R – WH's Response to Order for Prefiled Testimony and Issues, p. 330; Ex. Y – WH Late File, p. 372

12. The last birth at WH occurred on June 16, 2020. Ex. Y – WH Late File, p. 367; Ex. DD – Hearing Transcript, pp. 107 (Donna Handley), 59-60 (David Kalla, MD)

13. In late June 2020, the Hospital began meeting with community stakeholders to discuss the termination of obstetric services. Ex. E – WH Response to CL#1, p. 103; Ex. H – WH Response to CL#2, pp. 124-126

14. On July 8, 9 and 10, 2020, the Applicant published notice of its intent to file a CON application for the Proposal. Ex. A – Application, pp. 1-3; Ex. D – WH Response to Inquiry, pp. 3

15. The following is a timeline of actions taken by the Hospital to secure provider coverage between 2014 and June 2020:

    - In 2014, Mansfield OB GYN terminated its contract with the Hospital due to a lack of clinical resources necessary to support a full range of obstetric and gynecological services, and difficulty with call coverage.
    - In 2015, Mansfield OB GYN stopped delivering babies at the Hospital.
    - Between 2014 – 2016, the Hospital contracted with locum tenens physicians for deliveries and call coverage.
    - In 2016, the Hospital hired Eugene Rozenshteyn, MD for primary OB delivery service coverage and also contracted with a private physician group from Norwich – OB GYN Services – to provide supplemental call coverage.
    - In 2019, OB GYN Services notified the Hospital that it would be terminating its contract to provide call coverage for evenings and weekends effective December 31, 2019.
    - Beginning January 2020, the Hospital contracted with individual physicians from OB GYN Services, but the coverage was insufficient to cover the vacation and paid time off for Dr. Rozenshteyn.
    - From January 1, 2020 through June 2020 the Hospital asserts that it exhausted all options for call coverage, which included reaching out to the other private practice that services the area, Mansfield OB/GYN Associates, who were not interested in providing call coverage at the Hospital.

    Ex. D – WH Response to Inquiry, pp. 1-2; Ex. E – WH Response to CL#1, pp. 98-100; Ex. Y – WH Late File, p. 402; Ex. DD – Hearing Transcript, p. 24 (Kalla)

16. Even though it was brought to the Applicant's attention that physicians affiliated with UConn Health's Family Practice Residency Program ("UConn Health") and Day Kimball Hospital ("DKH") could potentially provide call coverage, WH did not contact either one because it decided on its own that neither provided a viable long-term solution. Ex. F – Public Comment, pp. 32-33; Ex. G – OHS CL#2, p. 2; Ex. H – WH Response to CL#2, pp. 126-127

17. With regard to UConn, the Applicant determined that since residents require in-hospital attending physician presence and it was experiencing difficulty recruiting attending physicians, this was not an option. In addition, the American College of Obstetrics and Gynecology ("ACOG") Guideline for perinatal care establishes thirty (30) minutes as the time within which an emergency cesarean section needs to be performed, and since UConn Health is a 45-minute drive from Windham Hospital, and many UConn residents likely live even further. Ex. H – WH Response to CL#2, pp. 126-127

18. With regard to DKH, the Applicant determined that the private physician practice that provides call coverage there provides services to a different service area and patient population, and the practice does not have sufficient physician resources required to provide ongoing, consistent coverage as a long-term, permanent solution. Ex. H – WH Response to CL#2, pp. 126-127

19. According to the Applicant, due to low and declining patient volume, it has been unable to maintain adequate nursing resources, and that despite efforts to recruit both employed and agency staff the Hospital has been unsuccessful in recruiting additional staff because nurses want to work at a busy obstetrics unit. Ex. D – WH Response to Inquiry, pp. 1; Ex. E – WH Response to CL#1, pp. 99-100

20. The Applicant's plans for the termination of services and transition for the community include: (1) planning for emergency deliveries; (2) transportation planning (including choosing where to deliver); (3) Emergency Medical Services (EMS) coordination; and (4) expanding and enhancing access to women's health services. Ex. A – Application, p. 15

21. The Applicant's proposed investment in the expansion and enhancement of women's health services includes: pre- and post-natal care; upgrading mammography services, including 3D technology; gynecologic and urogynecologic oncology; women's cardiology; primary care, general surgery, and pulmonology. Ex. A – Application, pp. 11, 15-16; Ex. R – WH Prefile, pp. 295-298

22. Even if the Proposal is not approved, the Hospital intends to maintain its other women's health services, such as its prenatal clinic. Ex. A – Application, p. 15; Ex. D – WH Response to Inquiry, p. 4

Relationship to the Statewide Health Care Facilities and Services Plan (the "Plan")[6]

23. In 2015, 44.2% of the WH Service Area ("WHSA") was considered "rural." WH Community Health Needs Assessment ("CHNA") 2015, p. 33[7]

24. In 2021, 49.8% of Windham County's population was defined as living in "rural areas."[8] WH CHNA 2021, p. 8

25. The Applicant has repeatedly stated and implied that it is in a "rural" location. Ex. A – Application, pp. 14, 21, 25; Ex. R – WH Prefile, p. 203; Ex. DD – Transcript, p. 42 (Rodis); *but see* Ex. R – WH Prefile, p. 258; Ex. DD – Transcript, p. 236 (Kalla)

26. A "rural hospital" is one where the delivery volume is less than 200 births per year.[9] Ex. A – Application, pp. 21, 50; Ex. H – WH Response to CL#2, pp. 121-122; Ex. R – WH Prefile, pp. 203, 321

27. According to the Applicant, Windham County's population is more than double that of a "rural county" according to the National Center for Health Statistics ("NCHS"). Ex. R – WH Prefile, p. 258

28. The Applicant constitutes a rural hospital. WH CHNA 2015, p. 33; WH CHNA 2021, p. 8; Ex. A – Application, pp. 14, 21, 25, 50; Ex. H – WH Response to CL#2, pp. 121-122; Ex. R – WH Prefile, p. 203, 321; Ex. DD – Transcript, p. 42 (Rodis); *but see* Ex. R – WH Prefile, p. 258; Ex. DD – Transcript, p. 236 (Kalla)

29. Among high income countries, the United States consistently faces the worst rates of pregnancy- and childbirth-related deaths. Ex. F – Public Comment, p. 278 [10]

30. In the United States, maternal mortality disproportionately affects birthing people of color regardless of socioeconomic status, as well as birthing people in rural areas. Ex. F – Public Comment, p. 278 [11]

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[6] Connecticut's first and only full Statewide Health Care Facilities and Services Plan was published in 2012. Subsequently, supplements to the Plan were published in 2014, 2016, 2018, and 2020. They can all be accessed online at https://portal.ct.gov/OHS/Services/Health-Systems-Planning/Facilities-Plan-and-Inventory.

[7] The WH CHNA 2015 defines "rural" as it relates to "urban": "Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban." WH CHNA 2015, pp. 5-6

[8] This statistic was based on an analysis of SparkMap, which is a product of the Center for Applied Research and Engagement Systems (CARES) and hosted by the University of Missouri.

[9] Kozhimannil, K., Thao V., Hung, P. Tilden, E., Caughey, A., Snowden, J. (2016) Association between Hospital Birth Volume and Maternal Morbidity among Low-Risk Pregnancies in Rural, Urban and Teaching Hospitals the United States. Am J Perinatol. 2016 May ; 33(6): 590–599. Published online 2016 Jan 5. doi: 10.1055/s-0035-1570380. Obtained from HHS Public access website, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4851580/

[10] UNICEF Data. Monitoring the Situation of Women and Children. Available at: https://data.unicef.org/topic/maternalhealth/maternal-mortality/

[11] America's Health Rankings. Health of Women and Children. Available at: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_b/state/ALL

31. In the United States, there is a significant racial and ethnic disparity in maternal mortality, with black women being three to four (3 to 4) times more likely to die from pregnancy-related causes. Ex. F – Public Comment, p. 258 [12]

32. Over the last decade in the United States, there has been an increase in the rural Latino/a population, so hospital closures/converted closures in rural areas have had a greater impact on this population. Ex. F – Public Comment, p. 279 [13]

33. Black, Indigenous, Latino/a, and other people of color in Connecticut are more likely to work wage-based jobs, have less wealth, suffer from chronic health conditions such as asthma and diabetes, and experience pregnancy-related deaths. Ex. F – Public Comment, p. 279 [14, 15, 16]

34. Windham is a town of 24,425 residents, 53% of whom are people of color. This is greater than the statewide population, 37% of which is comprised of people of color. Ex. F – Public Comment, p. 279 [17]

35. At $47,481, Windham's median household income is the lowest of the towns in Windham County and well below the statewide median income of $78,444. Ex. F – Public Comment, p. 279 [18]

36. In the Town of Windham, 32% of Latino/a households live below the poverty level, compared to 29% of the entire Windham County Latino/a population and 11% of the entire Windham County population. Ex. F – Public Comment, p. 279 [19]

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[12] Patridge, J., Balayla, J., Holcroft, C., Abenhaim, H. Inadequate prenatal care utilization and risks of infant mortality and poor birth outcome: a retrospective analysis of 28,729,765 U.S. deliveries over 8 years. Am J Perinatol. 2012 Nov;29(10):787-93. Available at: https://www.researchgate.net/publication/230573498_Inadequate_Prenatal_Care_Utilization_and_Risks_of_Infant_Mortality_and_Poor_Birth_Outcome_A_Retrospective_Analysis_of_28729765_US_Deliveries_over_8_Years?msclkid=bbc1d6b8c28011ecac7c65e44981a2b7

[13] Brookings, Mapping rural America's diversity and demographic change. Retrieved from https://www.brookings.edu/blog/theavenue/2021/09/28/mapping-rural-americas-diversity-and-demographic-change/

[14] Seaberry, C., Davila, K., Abraham, M. (2021). Equity Report. New Haven, CT: DataHaven. Retrieved from https://ctdatahaven.org/sites/ctdatahaven/files/DataHaven%20Health%20Equity%20Connecticut%20061820.pdf

[15] Centers for Disease Control and Prevention, African American Health
Creating equal opportunities for health. Retrieved from https://www.cdc.gov/vitalsigns/aahealth/index.html#:~:text=The%20death%20rate%20for%20African%20Americans%20decreased%2025%25%20from%201999,high%20blood%20pressure%20than%20whites

[16] John Hopkins Center for Health Equity, The State of Black America. Retrieved from https://soba.iamempowered.com/sites/soba.iamempowered.com/files/Johns%20Hopkins%20Report%20PDF%20Download%20SOBA%202020.pdf

[17] Seaberry, C., Davila, K., Abraham, M. (2021). Windham Equity Report. New Haven, CT: DataHaven, Page 2, Executive Summary. Retrieved from https://www.ctdatahaven.org/sites/ctdatahaven/files/windham_profile_v1.pdf

[18] Seaberry, C., Davila, K., Abraham, M. (2021). Windham Equity Report. New Haven, CT: DataHaven, Page 13. Retrieved from https://www.ctdatahaven.org/sites/ctdatahaven/files/windham_profile_v1.pdf

[19] Seaberry, C., Davila, K., Abraham, M. (2021). Windham Equity Report. New Haven, CT: DataHaven, Page 14, Table 7. Retrieved from https://www.ctdatahaven.org/sites/ctdatahaven/files/windham_profile_v1.pdf

37. Research on the effects of rural obstetrics unit closures on birth outcomes in North Carolina found that rural labor and delivery unit closures disproportionately affected people enrolled in Medicaid. Ex. F – Public Comment, p. 279 [20]

38. Uninsured birthing people in Connecticut are three to four times (3x-4x) more likely to die of pregnancy-related complications than their insured counterparts. Ex. F – Public Comment, p. 280 [21]

39. Inequities in health insurance coverage further exacerbate inequities in birth outcomes as people of color are more likely to be uninsured. Ex. F – Public Comment, p. 280 [22]

40. The Town of Windham has a higher rate of uninsured adults ages 19-64 (10%) than the statewide average (8%). Ex. F – Public Comment, p. 280 [23]

41. In 2016, 11,195 (45%) residents in the Town of Windham were enrolled in Medicaid. Ex. F – Public Comment, p. 280 [24]

42. Most of the women who gave birth at WH were Medicaid recipients. Ex. R – WH Prefile, pp. 200, 213, 324

[20] Sullivan, M.H., Denslow, S., Lorenz, K., Dixon, S., Kelly, E. and Foley, K.A. (2021), Exploration of the Effects of Rural Obstetric Unit Closures on Birth Outcomes in North Carolina. The Journal of Rural Health, 37: 373-384. https://doi.org/10.1111/jrh.12546

[21] Connecticut Department of Public Health. *Healthy People 2020 State Health Assessment*. Retrieved from https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/SHA-Chapters/3_MICH-chapter_CT_SHA_Report_Final060520-3.pdf;content

[22] Racial Disparities in Maternal and Infant Health: An Overview. Retrieved from https://www.kff.org/report-section/racialdisparities-in-maternal-and-infant-health-an-overview-issue-brief/

[23] Seaberry, C., Davila, K., Abraham, M. (2021). Windham Equity Report. New Haven, CT: DataHaven, Page 16, Figure 15. Uninsured rate among adults ages 19–64 by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates Retrieved from https://www.ctdatahaven.org/sites/ctdatahaven/files/windham_profile_v1.pdf

[24] Access Health CT and Medicaid enrollment by town, Connecticut Health Foundation. Retrieved from https://www.cthealth.org/wp-content/uploads/2018/07/2018-Town-Totals.pdf

43. In FY19, WH's labor and delivery payer mix was 81 (82%) Medicaid, 10 (10%) self-pay, and 8 (8%) commercial:

APPLICANT'S CURRENT & PROJECTED PAYER MIX [indicate location]

Payer	Most Recently Completed FY 2019		Projected					
			FY ____		FY ____		FY ____	
	Volume: (indicate type)	%	Volume: (indicate type)	%	Volume: (indicate type)	%	Volume: (indicate type)	%
Medicare	0.0	0.0%						
Medicaid	**81**	82.0						
TRICARE								
Total Government	**81**	**82.0%**						
Commercial Insurers	8	8.0						
Uninsured								
Self-pay	10	10.0						
Workers Compensation								
Total Non-Government	**18**	**18.0%**						
Total Payer Mix	**99**	**100%**						

Ex. A – Application, pp. 32-33

44. WH's overall historical payer mix for the four (4) most recently completed fiscal years is reflected in the following table. WH's average payer mix for those years was 1,447.25 (66.5%) Medicaid, 326 (15.25%) self-pay, and 348.5 (15.75%) commercial.

HISTORICAL PAYER MIX [indicate location]

Payer	Most Recently Completed FY2019		Actual Payer Mix [indicate location] (Last 3 Completed FYs)					
			FY 2018		FY 2017		FY 2016	
	Volume [indicate type]:	%	Volume [indicate type]:	%	Volume [indicate type]:	%	Volume [indicate type]:	%
Medicare	94	4	47	2	47	2	21	1
Medicaid	1,518	68	1,497	67	1,335	68	1,439	63
TRICARE	0	0	7	0	4	0	2	0
Total Government	1,612	72	1,552	70	1,385	70	1,462	64
Commercial Insurers	341	15	338	15	259	13	456	20
Uninsured								
Self-pay	290	13	329	15	331	17	354	16
Workers Compensation	0		0		0		0	
Total Non-Government	631	28	667	30	590	30	810	36
Total Payer Mix	2,243	100	2,219	100	1,975	100	2,272	100

Ex. E – WH Response to CL#1, pp. 119-120

45. In Connecticut, about 64% of pregnancy-related deaths were those of Black and Latino/a people, despite these groups accounting for just 45% of live births from 2015-2017. Ex. F – Public Comment, p. 278 [25]

[25] Maternal Mortality in Connecticut: Maternal Mortality Review Committee Data, 2015-2017, page vii. Available at: https://portal.ct.gov/-/media/DPH/Maternal-Mortality/CT-MMR-Evaluation-Report-2015-2017-FINAL-PRINT.pdf

Demonstration of Need

46. WH provided the following table to describe the population that will be served by the Proposal:

Windham Hospital Primary Service Area Female Population Demographic - Projections by Age Cohort						
1. Female Demographic: Age 15 - 49 years	**Current State (%)**	**Projected State (%)**	**Current Female Population (2019)**	**Projected Female Population (2024)**	**+/- Projected Δ**	**% Projected Δ**
Female Age Segmentation (15-49)	55%	54%	21,055	21,053	(2)	-0.01%
Total Female (15-49) Population						
2. Female Demographic: Age 0 - 85+ years	**Current State (%)**	**Projected State (%)**	**Current Female Population (2019)**	**Projected Female Population (2024)**	**+/- Projected Δ**	**% Projected Δ**
Female Age Segmentation (All Ages)	3.8%	3.9%	1,452	1,517	65	5%
Pop female < 5 yrs	3.9%	3.6%	1,488	1,390	(98)	-7%
Pop female 5-9 yrs	4.5%	4.1%	1,723	1,577	(146)	-9%
Pop female 10-14 yrs	13.3%	13.0%	5,103	5,016	(87)	-2%
Pop female 15-19 yrs	16.8%	15.7%	6,413	6,093	(320)	-5%
Pop female 20-24 yrs	6.0%	6.1%	2,304	2,351	47	2%
Pop female 25-29 yrs	4.9%	5.4%	1,858	2,084	226	12%
Pop female 30-34 yrs	4.7%	4.9%	1,797	1,914	117	7%
Pop female 35-39 yrs	4.3%	4.6%	1,665	1,793	128	8%
Pop female 40-44 yrs	5.0%	4.7%	1,915	1,802	(113)	-6%
Pop female 45-49 yrs	5.6%	4.9%	2,149	1,917	(232)	-11%
Pop female 50-54 yrs	6.3%	5.5%	2,419	2,117	(302)	-13%
Pop female 55-59 yrs	5.8%	5.7%	2,233	2,205	(28)	-1%
Pop female 60-64 yrs	4.5%	4.9%	1,707	1,906	199	12%
Pop female 65-69 yrs	3.6%	4.1%	1,367	1,584	217	16%
Pop female 70-74 yrs	2.6%	3.3%	1,009	1,271	262	26%
Pop female 75-79 yrs	1.9%	2.5%	729	957	228	31%
Pop female 80-84 yrs	2.5%	3.2%	956	1,230	274	29%
Pop female 85+ yrs						
	100.0%	**100.0%**	**38,282**	**38,731**	**437**	**1%**
Total Female Population						
Market definition: '06226, 06235, 06237, 06238, 06249, 06250, 06251, 06256, 06266, 06268, 06269, 06280						
Town in market definition: Windham, Mansfield, Lebanon, Columbia, Coventry and Chaplin						
Source:Advisory Board Demographic Profile						

Table C- Primary Service Area Demographics

Ex. A – Application, pp. 18, 33-34

47. There were 171 fewer births at WH between FY14 and FY15 (376 to 205), a 45.5% decrease in one year's time:

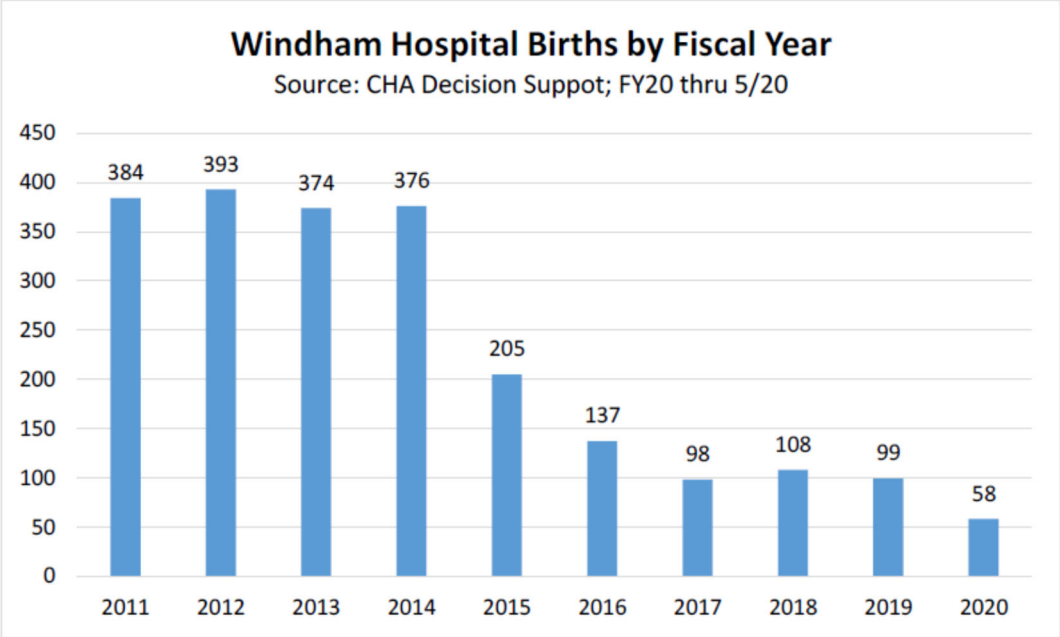
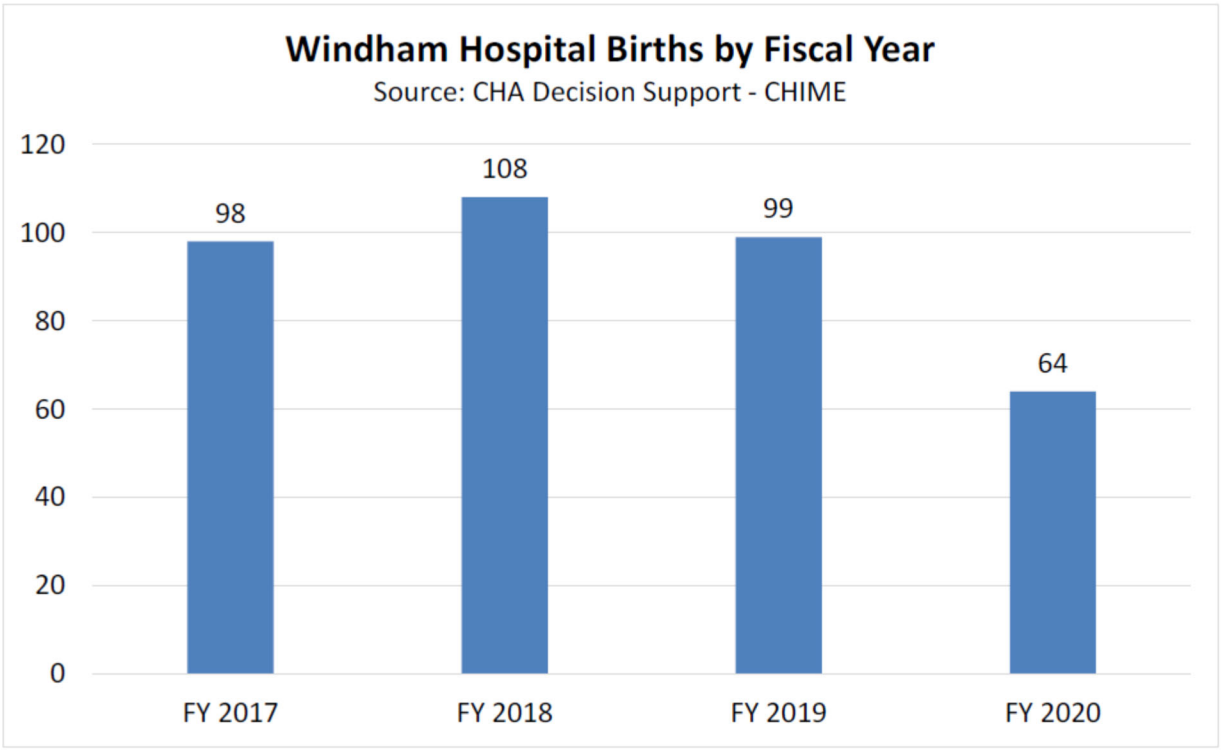


Chart 1- Windham Hospital Obstetric Volume
Source, CHIME

Ex. A – Application, pp. 13-14[26]

[26] This chart is an image captured directly from the Application. As such, the typographical error ("suppot") is not the agency's, but rather the Applicant's.

48. The following table reflects updated and corrected data, demonstrating that there were sixty-four (64) rather than fifty-eight (58) deliveries at the Hospital in FY20:



Source: CHIME Decision Support

Ex. A – Application, p. 13; Ex. Y – WH Late File, p. 367

49. "Diversion" has two different meanings in the context of the Proposal. It can mean the planned redirection of patients resulting from the interruption of obstetric services at WH, or it can mean an emergent diversion that occurs in the course of a medical event.[27] Ex. D – WH Response to Inquiry, p. 2

50. Between January 1, 2020 and October 20, 2020, WH's planned diversion resulted in a total of thirty-three (33) patients being redirected to other hospitals – specifically Backus Hospital ("BH"): two (2) between February 15th – February 24th; four (4) between March 20th – April 1st; one (1) between April 10th – April 19th; twenty-eight (28) between June 20th – October 20th. Ex. E – WH Response to CL#1, p. 104-105

[27] WH indicates that "diversion" could imply an "emergent medical diversion as defined by the Office of Emergency Medical Services," but the OEMS statutes and regulations do not define such a "diversion," nor did the Applicant supply one. For purposes of this decision, I distinguish between the two by labeling one as "planned diversion" and the other as "emergent diversion" even though these may not be correct terms of art.

51. Although there was a very small decline in the number of births by women originating in towns within the Applicant's PSA between FY17-FY20, there were still 498 births in FY20:

Patient Origin	FY17	FY18	FY19	FY20	FYTD November 2021
WINDHAM	227	251	235	219	11
COVENTRY	95	96	114	90	28
MANSFIELD	81	68	71	76	11
LEBANON	49	68	52	59	4
COLUMBIA	42	37	32	35	12
CHAPLIN	14	21	10	19	2
Total	**508**	**541**	**514**	**498**	**68**

Table A: Number of Births by Town

Ex. H – WH's Response to CL#2, p. 123

52. During FY20, 52 (10.4%) of the total deliveries originating from the PSA occurred at Windham Hospital, with the majority occurring at Manchester Memorial Hospital ("MMH") (231 or 46.3%), followed by BH (84 or 16.9%) and Hartford Hospital ("HH") (55 or 11%).

Hospital	FY17	FY18	FY19	FY20	FYTD November 2021
Total	**508**	**541**	**514**	**498**	**68**
Manchester Memorial	252	242	237	231	37
Backus	30	58	42	84	15
Hartford	59	74	62	55	7
Windham	84	87	90	52	0
Saint Francis	38	28	30	30	2
UConn John Dempsey	15	22	20	15	3
Middlesex	10	7	13	11	0
Day Kimball	6	5	5	7	3
L+M	4	9	6	5	0
Hospital of Central CT	2	4	3	4	0
Yale New Haven	5	3	2	2	1
Johnson Memorial	2	2	3	1	0
Griffin	0	0	0	1	0
MidState	1	0	0	0	0
Charlotte Hungerford	0	0	1	0	0
Rockville General	0	0	0	0	0

Table B: Primary Service Area Deliveries by Hospital

Ex. H – WH's Response to CL#2, p. 124

53. A total of ninety-one (91) women from the Windham Women's Health Clinic delivered at BH in FY21. Ex. Y – WH Late File, p. 368

54. WH's conversion of its Critical Care Unit (CCU) to a Progressive Care Unit (PCU) in approximately September 2015 played a role in WH transferring VBAC procedures to other hospitals. Ex. F – Public Comment, pp. 278-279; Ex. R – WH Prefile, p. 346

55. Some of the decline in the number of births at the Hospital is due to the planned diversion of laboring patients to other hospitals rather than such patients voluntarily choosing different hospitals. Ex. F – Public Comment, pp. 1, 191; *see also* Ex. D – WH Response to OHS Inquiry, p. 2; Ex. E – WH Response to CL#1, pp. 102-105

56. If its Proposal is approved, the Hospital plans to continue prenatal and post-partum care for mothers and babies as well as women's health services including urogynecology, gynecologic oncology, cardiology, and mammography. Ex. A – Application, p. 15-17

57. Analysis of survey data in the WH 2021 CHNA indicates that significant health needs in the community served by WH include: access to health care services; limited transportation resources; gaps in insurance coverage and overall affordability; numerous racial and ethnic health and economic disparities, associated with systemic racism and language barriers, among other contributing factors; and poverty and other Social Determinants of Health, including affordable housing, levels of educational achievement, and food insecurity. Ex. F – Public Comment (Attorney General of Connecticut), p. 195, citing WH 2021 CHNA, p. 4; Ex. DD – Hearing Transcript, p. 198

Access

58. In the United States, hospital closures/converted closures in rural areas have decreased access to services, such as obstetrics care, further contributing to difficulties in maternal care. Ex. F – Public Comment, p. 279 [28, 29, 30]

59. The lack of adequate access to labor and delivery facilities and services for women in rural areas has led to documented increases in out-of-hospital births, births in hospitals without obstetrics services, and poorer birth outcomes. Ex. F – Public Comment, pp. 279-280 [31]

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[28] Facilities that no longer provide specific patient care, but continue to provide some healthcare services [e.g., primary care, Rural Emergency Hospital (REH), skilled nursing care]. Retrieved from https://www.shepscenter.unc.edu/programsprojects/rural-health/rural-hospital-closures/

[29] America's Health Rankings. Health of Women and Children. Retrieved from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_b/state/ALL

[30] Health Resources & Services Administration, Rural Hospital Programs. Retrieved from https://www.hrsa.gov/ruralhealth/rural-hospitals

[31] Centers for Medicare & Medicaid Services (CMS), Improving Access to Maternal Health Care in Rural Communities Issue Brief. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf

60. Transportation issues for low-income residents disproportionately impact people of color. Ex. F – Public Comment, pp. 47, 280 [32, 33]

61. In the United States, a majority of pregnancy-related deaths are preventable and many are the result of lack of access to care. Ex. F – Public Comment, p. 278 [34]

62. In 2021, the Connecticut Department of Economic and Community Development ("DECD") ranked Windham "Connecticut's most fiscally and economically distressed municipality based on population, unemployment, poverty, educational attainment, and property value." Ex. F – Public Comment, pp. 194-195, 198, 261 [35]

63. Windham has ranked in the top twenty-five (25) of CT towns based on the above distress categories for over ten (10) years. Ex. F – Public Comment (Attorney General of Connecticut), pp. 194-195

64. The Applicant's primary service area ("PSA")[36] for its inpatient services consists of the northwestern towns of Chaplin, Columbia, Coventry, Lebanon, Mansfield, and Windham. Ex. A – Application, pp. 19-20

65. According to the WH 2021 CHNA, the Hospital Service Area consisting of Chaplin, Columbia, Coventry, Hampton, Lebanon, Mansfield, Scotland, and Windham accounted for approximately sixty percent (60%) of inpatient volumes and seventy-one percent (71%) of emergency department visits. WH 2021 CHNA, p. 3

66. WH 2021 CHNA indicates that "virtually all interviewees identified transportation as a significant issue" with limited transportation resources affecting access to primary health services, adherence to treatment plans, and ability to access basic needs. WH 2021 CHNA, p. 10

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[32] Centers for Medicare & Medicaid Services (CMS), Improving Access to Maternal Health Care in Rural Communities Issue Brief. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf, p. 23

[33] Kozhimannil, K. B., Interrante, J. D., Henning-Smith, C., & Admon, L. K. (2019). Rural-Urban differences in Severe Maternal morbidity and mortality in The US, 2007–15. Health Affairs, 38(12), 2077–2085. https://doi.org/10.1377/hlthaff.2019.00805

[34] Pregnancy-Related Deaths Happen Before, During, and Up to a Year After Delivery, Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/media/releases/2019/p0507-pregnancy-related-deaths.html

[35] https://portal.ct.gov/DECD/Content/About_DECD/Research-and-Publications/02_Review_Publications/Distressed-Municipalities; *see also* https://portal.ct.gov/DEEP/Environmental-Justice/Environmental-Justice-Communities#Map

[36] A PSA is defined as the "geographic area (by town), for the service location in the application, consisting of the lowest number of contiguous zip codes from which the applicant draws at least 75% of its patients for this service at such location." https://portal.ct.gov//media/OHS/ohca/Publications/2012/OHCAStatewideFacilitiesandservicespdf.pdf, p. 149

67. A detailed travel assessment of travel times between Windham Hospital and area hospitals broken down by mode of transportation (car vs. ambulance) and routes is set forth below:

Transportation from Windham Hospital to Area Hospital by Car

	Backus Hospital	Manchester Memorial Hospital	Day Kimball Hospital	Hartford Hospital
Distance	16.1 miles	19.0 miles	25.9 miles	28.0 miles
Travel Time	26 minutes	30 minutes	43 minutes	43 minutes
Best/Fastest Route	CT-32, Route 2	CT-32, CT-6 W, CT-44 W, CT-83	CT-6 East, CT-97, CT-44 E	CT-6 W, I-384 W, I-84 W, CT-2
Description	CT-32: 2 lane state highway CT-2: 4 lane state highway	CT-32: 2 lane state highway CT-6 W: 2 lane state highway, four lanes wide in some sections CT-44 W: 2 lane state highway, four lanes wide in some sections	US-6 East: Four lanes in many sections before turning into 2 lanes CT-97: 2 lane north-south state highway CT-44 E: Multi-lane in many areas	US-6 W: four lanes in many sections I-384 W: interstate highway, 4 lane expressway I-84 W: multi-lane highway CT-2: multi-lane highway

Source: Google Maps

Transportation from Windham Hospital to Area Hospital by Ambulance

	Backus Hospital*	Manchester Memorial Hospital	Day Kimball Hospital	Hartford Hospital
Distance	16.1 miles	19.0 miles	25.9 miles	28.0 miles
Travel Time	22 minutes	26 minutes	35 minutes	36 minutes
Best/Fastest Route	CT-32, Route 2	CT-32, CT 6 West, CT-44, CT-83	High Street, S. Frontage, CT-6 East, CT-198, CT-44	CT-6W, CT-44W,I-384W, I-84W, Exit-54 (CT-2)
Description	CT-32 2 lane state highway CT-2 4 lane state highway	CT-32: 2 lane state highway CT-6 West: 2 lane state highway, some portions are 4 lane CT-44 W: 2 lane state highway, four lanes wide in some sections	High Street: 2 lane city street S. Frontage: 2 lane city street CT-6 East: four lanes in many sections CT-198: 2 lane state road CT-44: multi-lane in many areas	US-6 W: 4 lanes in sections US-44: brief travel 4 lanes I-384 W: 4 lane highway I-84: multi-lane highway

Source: Apple Maps

Note: The travel time is based on the national average of time saved by utilizing a light and siren transport mode. However, based on EMS experience at Windham Hospital, ambulance travel times can vary based on time of day, weather, traffic, and experience of ambulance drivers and can be less than what is reported above.

Ex. Y – WH Late File, p. 377

68. Travel time of twenty (20) minutes or more by car is associated with an increased risk of mortality and adverse outcomes in women at term, which should be considered in connection with plans to centralize obstetric care. Ex. F – Public Comment, p. 257 [37]

69. Between the cessation of services on June 16, 2020 and November 2, 2021, approximately 71% of women who delivered (or received emergency care) at BH arrived by car, with less than 20% requesting or requiring ambulance transport. Ex. R – WH Prefile, pp. 185-186

70. WH has adopted the ACOG Guideline for perinatal care that establishes 30 minutes as the time within which a person should start an emergency cesarean section procedure. Ex. H – WH Response to CL#2, p. 127; Ex. R – WH Prefile, pp. 207, 210-211

71. If the Proposal is approved, the Applicant intends to provide transportation via local ambulance service at no cost to patients who are in labor or who need immediate medical assistance for a related reason provided the patient has made arrangements in advance with the receiving physician at the other hospital and their admission is expected. Ex. E, pp. 100-101

[37] https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/j.1471-0528.2010.02816.x BJOG International Journal of Obstetrics and Gynaecology Dec. 2010.

72. Between the hours of 9 AM and 11 PM, ambulances are available via dispatch and it takes approximately 10-15 minutes for one to arrive at WH. Alternatively, if an ambulance is needed sooner, the Willimantic Fire Department is capable of responding within 5 minutes. Ex. R – WH Prefile, p. 211; Ex. DD – Transcript, pp. 44 (Rodis), 163-164 (Pedchenko)

73. Ambulance rides from Willimantic to either MMH or BH can be dangerous – especially in winter – and travel can be blocked if there is an accident, which is one reason why WH has a helipad and uses helicopters. Ex. F – Public Comment, p. 256, 261; Ex. DD – Transcript, pp. 145-146 (Johnson), 209 (Rosenblatt)

74. Helicopters cannot be used in certain weather conditions. Ex. F – Public Comment, p. 261; Ex. DD – Transcript, pp. 145-146 (Johnson), 209 (Rosenblatt)

75. There is evidence that the OB unit did not receive the same level of attention and funding after Hartford HealthCare acquired WH in 2009, and that registered nurses in the OB unit were transferred to other areas of the Hospital prior to the cessation of OB Services in June 2020. Ex. F – Public Comment, pp. 1, 218-219, 252-254; *but see* Ex. D – WH Response to Inquiry, p. 5

Quality

76. Windham County is ranked last in the state in most health outcomes and leads the state in health disparities. Ex. F – Public Comment, p. 180 [38]

77. There are no specific national guidelines regarding the provision of inpatient obstetrics and patient volume. The ACOG has not opined on volume thresholds that should be maintained by hospitals, physicians, or other providers. Ex. H – WH Response to CL#2, p. 121 (and p. 23 of PDF); *see also* Ex. F – Public Comment, p. 44

78. Researchers stratify hospitals into deciles based on delivery volume, with Decile 1 being the lowest annual volume and Decile 10 being the highest annual volume. Ex. A – Application, pp. 14, 49-53; Ex. H – WH Response to CL#2, p. 20 (of PDF)

79. Women delivering at either very low volume hospitals (Deciles 1 and 2) or very high volume hospitals (Deciles 9 and 10) both have higher complication rates. Ex. H – WH Response to CL#2, pp. 18-36 (of PDF)

80. Studies examining the relationship between volume and complication rate exclude transfer patients because transfer patients are more complex than patients admitted through other routes, and administrative data do not adequately capture this excess complexity leading to potentially biased results. It is unclear what effect transfers have on the correlation between volume and risk of complication. Ex. H – WH Response to CL#2, pp. 19, 38, 43 (of PDF)

81. Dr. Srinivas's report presented literature about the correlation between low-volume obstetric services and increased birth complications and morbidity. Ex. A – Application, pp. 14, 49-53

[38] *See* https://www.countyhealthrankings.org/app/connecticut/2021/rankings/windham/county/outcomes/overall/snapshot

82. According to Dr. Srinivas and the cited 2012 study by Kyser et al.,[39] Windham Hospital would fall within Decile 1 in terms of vaginal and caesarian delivery volumes, which is associated with the higher rates of composite morbidity including hemorrhage, perineal lacerations, infections, operative complications and mortality.[40] Ex. A – Application, pp. 14, 49-53

83. The Applicant's proposed hospitals to provide OB Services – BH and MMH – are considered intermediate volume hospitals and are in Deciles 5 and 6, respectively. These deciles are associated with modestly lowered odds of adverse outcomes with the effect particularly notable for cesarean deliveries. Ex. H – WH Response to CL#2, pp. 4, 18-36; *see* Ex. A – Application, pp. 14, 49-53

84. The decline in rural hospitals offering obstetric services has contributed to a rise in health risks and mortality in some of the country's most medically underserved areas. Ex. F – Public Comment, pp. 43, 48 [41]

85. The lack of access to maternal health services in rural communities resulting from factors including obstetric department closures "can result in a number of negative maternal health outcomes including premature birth, low-birth weight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression." Ex. F – Public Comment, pp. 43, 47, 197 [42]

86. The impact of the loss of accessible obstetric services and increased distance to travel to care "has been associated with increased risk of non-indicated induced Cesarean section (which can lead to more complications), postpartum hemorrhage, prolonged hospital stay, and/or postpartum depression." Ex. F – Public Comment, pp. 43, 45-46, 198 [43]

87. In rural counties, the absence of active L&D units is associated with a significant increase in perinatal mortality. Ex. F – Public Comment, pp. 43, 47-48, 198 [44]

88. Between June 2020 and November 2021, there was at least one (1) but possibly two (2) deliveries on the road while women were traveling to BH, and in both cases the women and their babies needed to go to Hartford for follow up care. Ex. F – Public Comment, p. 261; Ex. R – WH Prefile, pp. 186 (Kalla), 212 (Borgida)

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[39] Kyser, K. L., Lu, X., Santillan, D. A., Santillan, M. K., Hunter, S. K., Cahill, A. G., & Cram, P. (2012). The association between hospital obstetrical volume and maternal postpartum complications. American journal of obstetrics and gynecology, 207(1), 42.e1–42.17. https://doi.org/10.1016/j.ajog.2012.05.010

[40] Adverse outcomes of childbirth included in this study hemorrhage, severe perineal lacerations (3rd- or 4th-degree lacerations), operative complications, infection, thrombotic complications, and death. Ex. A – Application, p. 50

[41] Rural Maternity Care Losses Lead to Childbirth Risks, Modern Healthcare (March 9, 2018), available at https://www.modernhealthcare.com/article/20180309/NEWS/180309894/rural-maternity-care-losses-lead-to-childbirth-risks

[42] Improving Access to Maternal Health Care in Rural Communities, Issue Brief, CMS (Sept. 3, 2019), available at https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf

[43] Available at https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2020-maternal-obstetric-care-challenges.pdf

[44] Effect of Access to Obstetrical Care in Rural Alabama on Perinatal, Neonatal, and Infant Outcomes: 2003-2017, Annals of Family Medicine (Sept. 2020), available at: https://www.annfammed.org/content/annalsfm/18/5/446.full.pdf

89. Between June 20, 2020 and November 8, 2020, there were no quality-related incidents related to the Hospital's planned diversion of laboring patients to other hospitals. Ex. E – WH Response to CL#1, p. 104

Financial Soundness

90. The Proposal does not require any capital expenditure and WH does not anticipate any financial losses resulting from the termination of OB Services. Ex. A – Application, pp. 29, 31

91. The Hospital projects that its total full-time equivalent (FTE) employee count would decrease from 485 to 475 if the Proposal is approved. Ex. A – Application, p. 96 (Financial Worksheet A)

92. The Hospital projects that it will save approximately $2.5 million each year on salaries and wages, fringe benefits, and physicians fees, if the Proposal is approved. Ex. A – Application, p. 96 (Financial Worksheet A)

93. The Applicant testified that the costs of transporting WH patients to area hospitals for labor and delivery services would use restricted Hatch building funds currently in the Windham Hospital Foundation; however, in the Applicant's response to the late file request, WH indicated it "will use operating income to fund all transportation costs for as long as necessary." Ex. DD, Hearing Transcript, p. 138; Ex. Y – WH Late File, p. 378

Cost to Consumers

94. Historically, WH has delivered a minimal number of babies whose mothers were either commercially insured or self-pay. Ex. A – Application, p. 33; Ex. Y – WH Late File, pp. 373-374

95. A comparison of the costs of delivery between WH and BH utilizing FY20 blended commercial rates data indicates that normal vaginal deliveries cost 15.3% more at BH than WH, and c-section deliveries cost 6.5% more at BH than WH:

Windham Hospital / Backus Hospital				
FY 2020 Labor and Delivery				
Overall Average Blended Commercial Rate				
		Backus Hospital	Windham Hospital	Difference
Maternity- Normal Vaginal Delivery		$ 11,944	$ 10,362	$ 1,582
Maternity C-Section Delivery		$ 16,412	$ 15,407	$ 1,005
Source: HHC Internal data / payor contracts				

Ex. Y – WH Late File, p. 373-374

96. With regard to cost of OB Services for self-pay patients, the Applicant indicated that both WH and BH generally deliver a minimal number of self-pay patients. Costs to these patients are governed by the FY20 Hartford HealthCare Financial Assistance Plan/Uninsured Notification Policy which provided fifty-six percent (56%) and sixty-one percent (61%) discounts at WH and BH, respectively.

FY 2020 Average Cost of Delivery Self-Pay / Uninsured Patients		
	Backus	Windham
Average Charges	$ 10,958	$ 10,182
# of Patients	5	3
Uninsured Discount	61%	56.0%
Discounted Self-Pay Cost	$ 4,274	$ 4,480
Source: Epic data		

Ex. Y – WH Late File, pp. 374-375

97. Medicaid coverage for childbirth is the same regardless of the hospital at which a patient chooses to deliver and there are no out-of-pocket costs associated with the delivery. Ex. R – WH Prefile, p. 326

98. WH's proposed transportation program applies to patients, their families, and other support persons, but only applies to "transportation to the receiving hospital." Ex. A – Application, p. 15; Ex. E – WH Response to CL#1, pp. 100-101, 107; Ex. R – WH Prefile, pp. 184-185, 320, 326

Existing Providers

99. There are twenty-four (24) Connecticut hospitals reporting OB volume data from FY17-FYTD20, of which fifteen (15) reported at least one delivery within that time period. Ex. A – Application, p. 17

100. In order of travel distance and time from WH, the area hospitals capable of serving patients seeking OB Services are BH, MMH, DKH, and HH. Ex. A – Application, p. 17; Ex. Y – WH Late File, pp. 377-378

101. The following table demonstrates the available volume capacity at three (3) of the four (4) closest hospitals to WH between the start of Connecticut hospitals' 2019 fiscal year and the end of May 2020, which is the month preceding the month in which WH ceased providing OB Services:

PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Accepting Transfers/Referrals Provider(s)				Terminating Service	
Provider Name	Provider Address	Total Capacity	Available Capacity (b)	*Inpatient Cases* FY 2019	*Inpatient Cases* CFYTD 2020*
William W. Backus Hospital	326 Washington Street Norwich, CT 06360	1,000	138		
Hartford Hospital	80 Seymour Street Hartford, Ct 06106	3,900	362		
Manchester Hospital	71 Haynes Street Manchester, CT 06040	1,467 (a)	109		
Total		6,367	609	99	58

*Months include: October 2019 through May 2020 (8 months)

(a) Total capacity based on 5 year high volume as provided in Table C above.
(b) Available capacity calculated as the difference between total capacity and FYTD 20 annualized volume as provided in Table C above.

Ex. A – Application, p. 42

102. The maximum capacity of the BH OB unit alone is projected to be 1,825 over the next three years based on fifteen (15) staffed beds, and since FY17, deliveries at BH have not exceeded 917 per year. Ex. Y – WH Late File, p. 368

Miscellaneous

103. At the hearing, the Hearing Officer took administrative notice of the following: The Plan; the OHS acute-care hospital discharge database; the Hospital Reporting System ("HRS") financial data, bed-need methodology; the HRS report 400; the hospital inpatient bed utilization by department; the All Payer Claims Database ("APCD") claims data; Connecticut Vital Statistics Registration reports for the years 2010 to 2019, provisional; and the Windham Hospital CHNAs for the years 2015, 2018 and 2021. Ex. DD – Hearing Transcript, p. 6

Discussion

The Hospital has failed to establish that six (6) of the eight (8) applicable statutory criteria set forth in C.G.S. § 19a-639 are met. Therefore, for the reasons described below, the Applicant has failed to carry its burden of demonstrating that a CON should be approved for this Proposal.

A. C.G.S. § 19a-639(a)(1): Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the OHS

Subsection (a)(1) is *not applicable* because OHS has not yet established policies and standards as regulations.

B. C.G.S. § 19a-639(a)(2): The relationship of the proposed project to the state-wide health care facilities and services plan

The Applicant has *not demonstrated* that the Proposal is consistent with the Plan.

The mission of OHS is "to implement comprehensive, data driven strategies that promote equal access to high quality health care, control costs and ensure better health for the people of Connecticut." In furtherance of this mission, the legislature tasked OHS with preparing the Plan because OHS's planning and regulatory responsibilities "are intended to increase accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services."[45]

When asked in the application to describe how the Proposal aligns with the Plan, WH stated:

> As identified in the Statewide Health Care Facilities and Services Plan (2014 Supplement), the Applicant has identified this proposal as a vehicle to ensure the continued provision of high quality, safe obstetrics services and improved access to other women's health services.[46]

In its November 9, 2021 response to a November 5, 2021 letter submitted by Arvind Shaw, CEO of Generations Family Health Center, Inc.,[47] WH reiterated that closure of labor and delivery is consistent with the Plan because it would improve the quality and safety of obstetric services for the women who would otherwise deliver their babies at WH.[48] The Applicant does not specifically address the Plan in any other part of the record.

As evidenced by the agency's mission and the Executive Summary of the Plan, quality is an important consideration but it is certainly not the only one. Also important are the Plan's goals of accessibility, continuity of care (and its relationship to quality of healthcare services), the avoidance of duplication of services, financial stability, and cost containment. And inextricably

[45] *See* C.G.S. § 19a-634; Plan (2012), p. ix (Executive Summary)
[46] Ex. A – Application, pp. 22-23
[47] Ex. F – Public Comment, pp. 177-185
[48] Ex. V – WH Response to Generations (11/9/21), p. 362

intertwined with these goals is the Plan's emphasis on identifying persons at risk and vulnerable populations, and taking action to improve health equity across the state.[49]

While the Applicant's Proposal aligns with the Plan's goals of avoiding duplication of services (*see* Section I below), for the reasons set forth below in Sections E, F, I and J of this Proposed Final Decision, the Applicant has failed to demonstrate that the Proposal aligns with the Plan's goals of improving quality, accessibility, continuity of care (and its relationship to quality of healthcare services), financial stability, and cost containment.

As to health equity, the negative impact on Medicaid recipients and indigent persons (addressed below) alone is a sufficient basis to determine that the Proposal is not consistent with the Plan. Putting this aside, however , the data also demonstrates that the Proposal's negative impact on access to Medicaid recipients and indigent persons would exacerbate racial and ethnic healthcare inequities at the state, county, and town levels. Black, Indigenous, Latino/a, and other people of color in Connecticut are more likely to work wage-based jobs, have less wealth, suffer from chronic health conditions such as asthma and diabetes, and experience pregnancy-related deaths. FF 33. Windham is a town of 24,425 residents, 53% of whom are people of color; this is greater than the statewide population, 37% of which is comprised of people of color. FF 34. In addition, in the Town of Windham, 32% of Latino/a households live below the poverty level, compared to 29% of the entire Windham County Latino/a population and 11% of the entire Windham County population. FF 36. Inequities in health insurance coverage further exacerbate inequities in birth outcomes as people of color are more likely to be uninsured. FF 39. The Town of Windham has a higher rate of uninsured adults ages 19-64 (10%) than the statewide average (8%) (FF 40), and uninsured birthing people in Connecticut are three to four times (3x-4x) more likely to die of pregnancy-related complications than their insured counterparts. FF 38. In Connecticut, about 64% of pregnancy-related deaths were those of Black and Latino/a people, despite these groups accounting for just 45% of live births from 2015-2017. FF 45.

Accordingly, WH has failed to establish this criterion is met.

C. C.G.S. § 19a-639(a)(3): Whether there is a clear public need for the health care facility or services proposed by the Applicant

Subsection (a)(3) is *not applicable* because there cannot be clear public need for a termination of services.

D. C.G.S. § 19a-639(a)(4): Whether the Applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the Applicant

The Applicant *has demonstrated* that the Proposal is financially feasible.

The Applicant has a well-established parent company – Hartford HealthCare. FF 2. The Applicant asserts that the Proposal does not require any capital expenditure and WH does not anticipate any financial losses resulting from the termination of OB Services. FF 90. However, the Applicant

[49] Plan (2012), pp. 81-88; Plan (2014 Supplement), pp. 6, 50-80; Plan (2016 Supplement), pp. 5, 64-102

does anticipate implementing a transportation program at no cost to patients in order to assist them with accessing services at other hospitals (FF 71). WH testified that the costs of transporting WH patients to area hospitals for labor and delivery services would use restricted Hatch building funds currently in the Windham Hospital Foundation; however, in the Applicant's response to the late file request, it indicated it "will use operating income to fund all transportation costs for as long as necessary." FF 93. It is also unclear how the Applicant's proposed investment in the expansion and enhancement of women's health services will impact the financial feasibility of the project. FF 20-21.

Nevertheless, an additional consideration is that the Hospital projects its total full-time equivalent (FTE) employee count would decrease from 485 to 475 if the Proposal is approved, which the Hospital expects will allow it to save approximately $2.5 million each year on salaries and wages, fringe benefits, and physicians fees. FF 91, 92. Accordingly, any financial loss attributable to institution of the proposed transportation program and expansion of women's health services would likely be offset by gains resulting from fewer employees.

Therefore, the Applicant has demonstrated that this criterion is met.

E. **C.G.S. § 19a-639(a)(5): Whether the Applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons**

The Applicant *has not satisfactorily demonstrated* that the Proposal will improve quality, accessibility, and cost effectiveness of health care delivery in the region, particularly for Medicaid recipients and indigent persons.

Quality:

The Applicant has presented an incomplete analysis of how rurality affects quality in the context of this Application. Here, rurality impacts quality in two ways: by diminishing the volume of deliveries and by limiting access to care. The Applicant has addressed only the first – how diminished volume negatively impacts quality. Applicant's failure to address rurality's impact on patients' access to care, and by extension, the quality of health care, neglects a component necessary to a full evaluation of whether quality would be improved by the Proposal.

With respect to the Applicant's narrow focus on volume as the factor driving health outcomes, there are no specific national guidelines regarding the provision of inpatient obstetrics and patient volume and the ACOG has not opined on volume thresholds that should be maintained by hospitals, physicians or other providers. FF 77. However, WH provided ample evidence that very low delivery volume leads to higher complication rates. The Applicant supplied the report of Dr. Srinivas, who presented literature about the correlation between low-volume obstetric services and increased birth complications and morbidity. FF 9, 81. According to Dr. Srinivas and the cited 2012 study by Kyser et al., Windham Hospital would fall within Decile 1 in terms of vaginal and caesarian delivery volumes, which is associated with the higher rates of composite morbidity including hemorrhage, perineal lacerations, infections, operative complications and mortality. FF

82. The Applicant's proposed hospitals to provide OB Services – BH and MMH – are considered intermediate volume hospitals and are in Deciles 5 and 6, respectively. These deciles are associated with modestly lowered odds of adverse outcomes with the effect particularly notable for cesarean deliveries. FF 78, 83.

But there are reasons to question the significance of Dr. Srinivas's report to this Application. First, the existence of the report itself does little to support the Proposal since it, like the Application, was narrowly focused on the impact that volume has on health outcomes and ignores the role that access plays. Additionally, the fact that Dr. Srinivas's own research seems to focus on volume could indicate that WH knew Dr. Srinivas, if selected as the consultant, would recommend termination of WH's OB Services at the conclusion of her analysis.

Beyond this, it is unclear whether Dr. Srinivas's conclusion is correct that WH would in fact be in Decile 1. Despite WH's statements that obstetric volumes at the Hospital declined over the past several years,[50] the number of births remained relatively consistent – around 100 per year – between 2017 and the present. The Applicant delivered 98 babies in 2017, 108 in 2018, and 99 in 2019. FF 47-48. WH reports that it delivered sixty-four (64) babies and redirected via planned diversion approximately thirty-three (33) patients in FY20. FF 47-50. Therefore, if the Applicant had not ceased providing OB Services, at least approximately 97 patients would have delivered their babies at WH in FY20. This is just two (2) less than were delivered in FY19 (99) and one (1) less than was delivered in FY17 (98). FF 47-48. In addition, although there was a very small decline in the number of births by women originating in towns within the Applicant's PSA between FY17-FY20 (508, 541, 514, 498), the numbers remained mostly consistent. FF 51. Given the fact that births in the Hospital's PSA remained fairly stable, it is likely that the number of diversions would have been higher if women had not learned of the Hospital's cessation of OB Services (FF 13-14)[51] and began making alternate arrangements to deliver elsewhere as WH began to require. FF 49, 55.

One of the main studies that the Applicant and Dr. Srinivas relied on found that while it is true that women delivering at low volume hospitals have higher complication rates, so do women delivering at high volume hospitals (FF 79), so volume should not be the only factor looked at when assessing quality. Also important, some studies examining the relationship between volume and complication rate exclude transfer patients because transfer patients are more complex than patients admitted through other routes, and administrative data do not adequately capture this excess complexity leading to potentially biased results. FF 80. It is unclear what effect transfers have on the correlation between volume and risk of complication. FF 80. Moreover, there is a continuity of care concern with respect to two of the four nearest hospitals (MMH and DKH) since those are not part of the Hartford HealthCare system.

Lastly, it is worth noting that there may not even be an "emerging body of clinical research that suggests that patients who deliver at low-volume hospitals are at greater risk for certain adverse events such as post-partum hemorrhage."[52] The support provided for this is limited and self-referring. Each of the WH submissions (Exs. H and R) cite the 2016 Kozhimannil article, the

[50] Ex. A – Application, pp. 12, 39
[51] *See also* Ex. A – Application, pp. 1-3
[52] Ex. H – WH Response to CL#2, p. 2; Ex. R – WH Prefile, p. 321

2019 Bozzuto article, the 2012 Kyser article, and the 2011 Kanakiraman article. Srinivas' 2017 WH report cites three (3) of these four (4) articles and the fourth she was a co-author on. All four (4) of the remaining articles Srinivas cites in her report were published between 2010-2014, and she co-authored one of them. (Lorch 2014).

Volume aside, diminished access also plays a significant role in obstetric outcomes. As a preliminary matter, the Applicant has failed to demonstrate that Windham County does not constitute a rural county or that WH is not a rural hospital. FF 23-28. According to the Applicant, Windham County's population is more than double that of a "rural county" according to the NCHS, but fails to provide evidence about the metrics NCHS utilizes for defining "rural," either via provision of URL or attached document. FF 27. And despite this claim, the Applicant itself repeatedly stated and implied that it is in a "rural" location. FF 25. In 2015, 44.2% of the WHSA was considered "rural." FF 23. In 2021, 49.8% of Windham County's population was defined as living in "rural areas." FF 24. One article that the Applicant routinely relied on in support of its volume argument actually defines "rural hospital" as being one where the delivery volume is less than 200 births per year, which WH clearly falls within. FF 26.

Numerous articles in the record demonstrate that the decline in rural hospitals offering obstetric services has contributed to a rise in health risks and mortality in medically underserved areas. FF 84. The lack of access to maternal health services in rural communities resulting from factors including obstetric department closures "can result in a number of negative maternal health outcomes including premature birth, low-birth weight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression." FF 85. The impact of the loss of accessible obstetric services and increased distance to travel to care "has been associated with increased risk of non-indicated induced Cesarean section (which can lead to more complications), postpartum hemorrhage, prolonged hospital stay, and/or postpartum depression." FF 86. In rural counties, the absence of active L&D units is associated with a significant increase in perinatal mortality. FF 87.

While we know that between June 20, 2020 and November 8, 2020, there were no quality-related incidents that stemmed from the Hospital's planned diversion of laboring patients to other hospitals (FF 89), we also know that between June 2020 and November 2021 there was at least one (1) but possibly two (2) deliveries on the road while women were traveling to BH, and in both cases the women and their babies needed to go to Hartford for follow up care. FF 88.

For all of the foregoing reasons, the Applicant has failed to demonstrate that quality would be improved with the termination of OB Services.

Accessibility:

The Plan recognizes that transportation is one of the top barriers to care in rural areas.[53] It is well-documented in the United States that a majority of pregnancy-related deaths are preventable, and many deaths are caused by lack of access to care. FF 61. Not only this, but lower income residents are the ones at greatest risk for facing transportation obstacles. FF 57, 62-63, 66. In 2021, the Connecticut DECD ranked Windham "Connecticut's most fiscally and economically

[53] Plan (2012), p. 88

distressed municipality based on population, unemployment, poverty, educational attainment, and property value." FF 62. Windham has ranked in the top twenty-five (25) of CT towns based on the above distress categories for over ten (10) years. FF 63. At $47,481, Windham's median household income is the lowest of the towns in Windham County and well below the statewide median income of $78,444. FF 35.

The Applicant's PSA for its inpatient services consists of the northwestern towns of Chaplin, Columbia, Coventry, Lebanon, Mansfield, and Windham. FF 64. According to the WH 2021 CHNA, the Hospital Service Area consisting of Chaplin, Columbia, Coventry, Hampton, Lebanon, Mansfield, Scotland, and Windham accounted for the majority of its inpatient volumes and emergency department visits. FF 65. The WH 2021 CHNA indicated that "virtually all interviewees identified transportation as a significant issue" with limited transportation resources affecting access to primary health services, adherence to treatment plans, and ability to access basic needs. FF 66.

Travel distances and times by car from Windham Hospital to the four (4) nearest hospitals (BH, MMH, DKH, and HH) are: 16.1 miles (26 minutes), 19 miles (30 minutes), 25.9 miles (43 minutes), and 28 miles (43 minutes), respectively. FF 67. Travel distances are the same by ambulance, but travel times for these hospitals are: 22 minutes, 26 minutes, 35 minutes, and 36 minutes, respectively. FF 67.

If the Proposal is approved, the Applicant intends to provide transportation via local ambulance service at no cost to patients who are in labor or who need immediate medical assistance for a related reason provided the patient has made arrangements in advance with the receiving physician at the other hospital and their admission is expected. FF 71. Between the hours of 9 AM and 11 PM, ambulances are available via dispatch and it takes approximately 10-15 minutes for one to arrive at WH. Alternatively, if an ambulance is needed sooner, the Willimantic Fire Department is capable of responding within 5 minutes. FF 72. In other words, the best case scenario is that it would take a patient twenty-seven (27) minutes from arrival at WH to get to a different hospital even by ambulance. But this does not take into account travel time from wherever the laboring individual happens to be to the hospital. Nor does it take into account other variables that can increase the time it would take to get to a hospital, such as not knowing whether she is in active labor and not being able to access personal transportation. In addition, ambulance rides from Willimantic to either MMH or BH can be dangerous – especially in winter – and travel can be blocked if there is an accident, which is one reason why WH has a helipad and uses helicopters. FF 73-74. But helicopters cannot be used in certain weather conditions. FF 74.

WH has adopted the ACOG Guideline for perinatal care that establishes 30 minutes as the time within which a person should start an emergency cesarean section procedure. FF 17. But even so, travel time of 20 minutes or more by car is associated with an increased risk of mortality and adverse outcomes in women at term, and it is recommended that this be considered in connection with plans to centralize obstetric care. FF 68.

But looking beyond access in the context of quality, data provided suggests that laboring mothers likely have a strong preference for either their own vehicles or for avoiding the use of ambulances. Between the hospital's cessation of services on June 16, 2020 and November 2,

2021, approximately 71% of women who delivered (or received emergency care) at BH arrived by car, with less than 20% requesting or requiring ambulance transport. FF 69. In other words, the provision of transportation services would have a negligible effect on maintaining, much less improving, access anyway.

For all of the foregoing reasons, the Applicant has failed to demonstrate that accessibility of L&D Services would be improved with the termination of OB Services.

Cost Effectiveness:

Historically, WH has delivered a minimal number of babies whose mothers were either commercially insured or self-pay. FF 94. However, it does appear that the costs of delivering a baby at BH are higher than at WH. A comparison of the costs of delivery between WH and BH utilizing FY20 blended commercial rates data indicates that normal vaginal deliveries cost 15.3% more at BH than WH, and c-section deliveries cost 6.5% more at BH than WH. FF 95. With regard to cost of OB Services for self-pay patients, the Applicant indicated that both WH and BH generally deliver a minimal number of self-pay patients. FF 96. Costs to these patients are governed by the FY20 Hartford HealthCare Financial Assistance Plan/Uninsured Notification Policy which provided fifty-six percent (56%) and sixty-one percent (61%) discounts at WH and BH, respectively. FF 96. Medicaid coverage for childbirth is the same regardless of the hospital at which a patient chooses to deliver and there are no out-of-pocket costs associated with the delivery. FF 97.

WH's proposed transportation program applies to patients, their families, and other support persons, but only applies to "transportation to the receiving hospital." FF 98. In other words, the costs of any other transportation, including even the trip home, are not covered, and would be higher given the greater distance between the delivering hospitals and the patients' homes. This is particularly problematic if, for example, the mother experiences complications during birth and must remain in the hospital for an extended period of time. Patients, their families, and other support persons, would be forced to choose between the costs of traveling a greater distance between Windham County and the other hospital, the costs of lodging closer to the other hospital, or simply not spending time with the mother.

Also problematic is the fact that the Applicant itself seems unclear on how the transportation program will be funded. WH testified that the costs of transporting WH patients to area hospitals for labor and delivery services would use restricted Hatch building funds currently in the Windham Hospital Foundation, which would have no impact on operational revenue; however, in the Applicant's response to the late file request, it indicated it "will use operating income to fund all transportation costs for as long as necessary." FF 93. The first would presumably have no impact on cost to consumers, while the second would presumably result in the hospital having to find some way to offset the losses attributable to the program by increasing costs for patients. Therefore, the financial impact the transportation program will have on cost to patients cannot be adequately assessed.

Due to the slight differences in costs of delivery as well as the higher costs associated with transportation, the Applicant has failed to demonstrate that the Proposal would be more cost-effective.

As the Applicant has failed to establish each of the three prongs, it has failed to establish that this criterion is met by the Proposal.

F. **C.G.S. § 19a-639(a)(6): The Applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons**

The Applicant *has not met this criterion* because it has not satisfactorily demonstrated that there would be no change in the provision of health care services to the relevant patient populations and payer mix, including access to services by Medicaid recipients and indigent persons.

As a starting point, WH appears to provide services to Medicaid recipients and indigent persons at a higher rate than those populations are present in the community. The Town of Windham currently has a higher rate of uninsured adults ages 19-64 (10%) than the statewide average (8%). FF 40. In 2016, only 11,195 (45%) residents in the Town of Windham were enrolled in Medicaid. FF 41. In contrast to this, the percentage of WH's patients that are Medicaid recipients is approximately 66.5%. FF 44. Thus, any termination of a service at WH is likely to impact Medicaid recipients in the community to a greater extent than any other patient population.

Looking specifically at WH though, most of the women who give birth at WH are Medicaid recipients. FF 42-43. In FY19, WH's labor and delivery payer mix was 81 (82%) Medicaid, 10 (10%) self-pay, and 8 (8%) commercial. FF 43. In contrast to this, the averages for WH's overall historical payer mix for the four (4) most recently completed fiscal years were 1,447.25 (66.5%) Medicaid, 326 (15.25%) self-pay, and 348.5 (15.75%) commercial. FF 44. Therefore, L&D patients were 15.5% more likely to be Medicaid beneficiaries and 6.5% less likely to have commercial insurance coverage than the hospital population as a whole.

When taken together with the analysis and conclusion set forth in Section E above that accessibility will not be improved and will actually be harmed by the Proposal, it is clear that there will be a change in healthcare services, and that Medicaid recipients and indigent persons will be negatively affected by the termination at a disproportionately higher rate than the hospital population as a whole.

G. **C.G.S. § 19a-639(a)(7): Whether the Applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services**

Subsection (a)(7) is *not applicable* because there is no population that can be served by the termination of services, and even if there was, there cannot be need for a termination of services.

H. C.G.S. § 19a-639(a)(8): The utilization of existing health care facilities and health care services in the service area of the Applicant

The Applicant *has demonstrated* that utilization of existing health care facilities and health care services in the Applicant's service area supports this Application.

In order of travel distance and time from WH, the area hospitals capable of serving patients seeking OB Services are BH, MMH, DKH, and HH. FF 67, 100. At least three (3) of these four (4) hospitals have available volume capacity and are able to absorb approximately six hundred (600) more patients. FF 101-102. BH alone has the capacity to absorb all of WH's deliveries. FF 101-102.

Accordingly, WH has satisfactorily established that other existing health care facilities can adequately handle its OB Services volume.

I. C.G.S. § 19a-639(a)(9): Whether the Applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities

The Applicant *has demonstrated* that the Proposal will not result in an unnecessary duplication of services or facilities.

Between FY17 – FYTD20, there were twenty-four (24) Connecticut hospitals reporting OB volume data, of which fifteen (15) reported at least one delivery within that time period. FF 99. In order of travel distance and time from WH, the area hospitals capable of serving patients seeking OB Services are BH, MMH, DKH, and HH. FF 67, 100. Available data from three (3) of the four (4) closest hospitals to WH demonstrates that they have availability to absorb all of the WH volume if the Proposal is approved. FF 101-102. BH alone has the capacity to absorb all of WH's deliveries. FF 101-102.

Accordingly, WH has satisfactorily established that other existing health care facilities can adequately handle its OB Services volume and that there will not be any duplication of services or facilities.

J. C.G.S. § 19a-639(a)(10): Whether an Applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers

The Applicant *has not demonstrated* that there is good cause for its reducing access to services by Medicaid recipients and indigent persons.

The Applicant provides a number of reasons why it believes good cause exists to reduce access to services by Medicaid recipients or indigent persons. They can fairly be summarized as follows: (1) a declining birth volume indicates that the service is no longer as crucial to the community as other more utilized services; (2) the negative impact of low birth volume on quality; (3) adequate access due to proximity of nearby hospitals and implementation of a

transportation program; (4) inability to adequately staff the L&D unit; and (5) enhancement to other women's services.

As to (1), despite WH's statements that obstetric volumes at the Hospital declined over the past several years,[54] the number of births remained relatively consistent – around 100 per year – between 2017 and the present. The Applicant delivered 98 babies in 2017, 108 in 2018, and 99 in 2019. FF 47-48. WH reports that it delivered sixty-four (64) babies and diverted approximately thirty-three (33) patients in FY20. FF 47-50. Therefore, if the Applicant had not ceased providing OB Services, at least approximately 97 patients would have delivered their babies at WH in FY20. This is just two (2) less than were delivered in FY19 (99) and one (1) less than was delivered in FY17. FF 47-48. In addition, although there was a very small decline in the number of births by women originating in towns within the Applicant's PSA between FY17-FY20 (508, 541, 514, 498), the numbers remained mostly consistent. FF 51. Given the fact that births in the Hospital's PSA remained fairly stable, one can assume that the number of diversions would likely have been higher than reported if women had not learned of the Hospital's cessation of OB Services (FF 13-14)[55] and began making alternate arrangements to deliver elsewhere as WH began to require. FF 49, 55.

As to (2), as described above in Section E, the Applicant has failed to demonstrate that the negative impact of low birth volumes outweighs the negative impact of restricting access when it comes to quality, much less that there would be an improvement in quality, therefore this reason does not constitute good cause. As to (3), also as described above in Section E, the Applicant has not only failed to demonstrate that access to OB Services would be improved, but also has failed to demonstrate that adequate access would be maintained if the Proposal is approved. Therefore, this reason does not constitute good cause.

With respect to (4), while it does appear that the Hospital made some effort to obtain coverage for several years (FF 6, 15), it did not pursue all avenues available to it. Even after it was brought to the Applicant's attention that the UConn Family Practice Residency Program and DKH might be able to provide coverage assistance, WH did not bother to contact either one. FF 16. Instead, the Hospital simply assumed they were not options[56]:

- With regard to UConn, the Applicant determined that since residents require in-hospital attending physician presence and it was experiencing difficulty recruiting attending physicians, this was not an option. FF 17. In addition, the ACOG Guideline for perinatal care establishes thirty (30) minutes as the time within which an emergency cesarean section needs to be performed, and since UConn Health is a 45-minute drive from Windham Hospital, and many UConn residents likely live even further. FF 17, 70. Importantly, though, the Hospital didn't bother to contact UConn to discuss either concern. Instead, the Hospital appears to have relied on assumptions and one doctor's personal experience with UConn residents.[57]

[54] Ex. A – Application, pp. 12, 39
[55] *See also* Ex. A – Application, pp. 1-3
[56] FF 16-18.
[57] Ex. R – WH Prefile, pp. 206-207 (Borgida)

- As to DKH, the Applicant determined that the private physician practice that provides call coverage there provides services to a different service area and patient population, and the practice does not have sufficient physician resources required to provide ongoing, consistent coverage as a long-term, permanent solution. FF 18. Rather than contacting DKH, WH speaks of it in indefinite terms premised upon what is known historically to be accurate.[58] The Hospital also asserts that DKH covers a different service area despite being closer to WH than HH, which in FY20 delivered 55 (11%) of the babies originating from WH's PSA. FF 52. It is close enough to serve as a potential source for coverage assistance.

WH's failure to contact UConn Health and DKH foreclosed even the possibility of obtaining coverage from either one, and more importantly also foreclosed the possibility of a collaborative effort from area providers to fill the Hospital's need for coverage. Even if this had not been the case, the Hospital repeatedly spoke only in general terms about staffing rather than providing specific evidence (e.g., job postings, responses to job postings, efforts to retain staffing such as via financial incentives, etc.) (FF 15, 19), so no findings can be made about step-by-step actions that were taken to recruit and retain staff.

With respect to (5), the Applicant's proposed investment in the expansion and enhancement of women's health services includes: pre- and post-natal care; upgrading mammography services, including 3D technology; gynecologic and urogynecologic oncology; women's cardiology; primary care, general surgery, and pulmonology. FF 21. While the investment in the expansion and enhancement of women's health services would be a positive step forward and would no doubt assist Medicaid recipients and indigent persons in accessing those important services, it is not sufficient to constitute good cause for reducing access to other crucial services received by Medicaid recipients or indigent persons. It is not as if closure of one service line will open up a new, more beneficial service line for women – the Hospital would simply be maintaining a "cornerstone" service. FF 22, 56.

Accordingly, the Applicant *has not demonstrated* that this criterion is met.

K. C.G.S. § 19a-639(a)(11): Whether the Applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region

The Applicant *has not satisfactorily demonstrated* that the Proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region. Without the approval of the Proposal, patients would have the option of choosing to deliver at any one of four or five different hospitals: Windham Hospital, MMH, BH, DKH, and HH. FF 52, 67, 101. If the Proposal is approved, there would be one (1) less health care provider in the area providing OB Services. This necessarily means less diversity of health care providers and less patient choice in the geographic region. Accordingly, this criterion is not met.

[58] Ex. R – WH Prefile, pp. 206-207 (Borgida)

L. C.G.S. § 19a-639(a)(12): Whether the Applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care

Subsection (a)(12) is *not applicable* because there is no consolidation that would result from the Proposal.

Conclusion

The Applicant has failed to meet its burden of proof in satisfying the statutory requirements of C.G.S. § 19a-639. Specifically, the Applicant failed to satisfy the five (5) of the eight (8) applicable criteria set forth in C.G.S. § 19a-639(a), to wit: (2) consistency with the Plan, (5) improvement of quality, access, and cost effectiveness of the Proposal, (6) no change in the provision of health care services to the relevant patient populations and payer mix, (10) good cause for reducing access to services by Medicaid recipients or indigent persons, and (11) no negative impact on the diversity of health care providers and patient choice. The Applicant has demonstrated that the Proposal meets Subsections (4), (8), and (9). Subsections (1), (3), (7) and (12) are not applicable.

Based upon the foregoing Findings of Fact, Conclusions of Law and Discussion, I respectfully recommend that the Certificate of Need application of Windham Hospital to terminate obstetric services be **DENIED**.

Respectfully Submitted,

July 5, 2022
Date

Daniel J. Csuka, Esq.
Hearing Officer