Greer, Leslie

From: Herlihy, Sally <Sally.Herlihy@wchn.org>
Sent: Monday, August 12, 2013 3:57 PM
To: Greer, Leslie; Lazarus, Steven
Subject: WCHN CON Submission
Attachments: OHCA WCHN Single License CON Application 08 12 2013.pdf

Please find attached a PDF file for a CON submission for Western Connecticut Health Network, Inc.
The original document, including an Affidavit and the Filing Fee are being sent Federal Express to the OHCA office.
Thank you.

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

Executive Assistant: Michelle Johnson
Voice: (203) 739-4935
Email: michelle.johnson@wchn.org

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

This transmittal is intended for a particular addressee(s). If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, copying or distribution or dissemination is strictly prohibited. If you suspect that you have received this transmittal in error, please notify Western Connecticut Health Network immediately by email reply to the sender, and delete the transmittal and any attachments.

READER BEWARE: Internet e-mail is inherently insecure and occasionally unreliable. Please contact the sender if you wish to arrange for secure communication or to verify the contents of this message.

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

RECEIVED
AUG 12 2013
OFFICE OF
HEALTH CARE ACCESS

August 12, 2013

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

Re: Western Connecticut Health Network, Inc. CON Request

Dear Ms. Martone,

Pursuant to Section 19a-638, C.G.S., please find enclosed a Certificate of Need for Western Connecticut Health Network, Inc., to merge The Danbury Hospital and New Milford Hospital, Inc. under a single general hospital license with two campuses.

If you have any questions that the attached submission does not answer, please contact me so that we may provide whatever additional information you need in your deliberations. I can be reached directly at 203-739-4903, or sally.herlihy@wchn.org.

Thank you,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

(Note: Submitted via email to Leslie.greer@ct.gov and Steven.lazarus@ct.gov, with original copy and Filing Fee mailed to OHCA).

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☒ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: _____ **Check No.:** _____
OHCA Verified by: _____ **Date:** _____

☒ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☒ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☒ **Attached are completed Financial Attachments I and II.**

N/A Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders. – sent via email

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to the following email addresses: steven.lazarus@ct.gov **and** leslie.greer@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

N/A The following have been submitted on a CD – PDF sent via email

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL • NEW MILFORD HOSPITAL

Accounts Payable Telephone: 203-739-7169

Wachovia Bank of Delaware, NA
62-22/311

Check No. 830033

Check Date
06/12/2013

PAY *Five Hundred AND 00/100*

Check Amount
$ ********500.00

TO THE ORDER OF
TREASURER STATE OF CT
410 CAPITOL AVE
HARTFORD, CT 06134

12592

⑈00830033⑈ ⑆031400225⑆ 2079960001550⑈

PUBLIC NOTICES

STATE OF CONNECTICUT
COUNTY OF FAIRFIELD
CITY OF DANBURY

U-HAUL OF LOWER HUDSON VALLEY, 300 WINDSOR HIGHWAY, NEW WINDSOR, NY 12553, HEREBY GIVES NOTICE TO ALL INTERESTED PARTIES THAT THE CONTENTS OF STORAGE UNITS LOCATED 75 DIVISION ST. DANBURY, CT 06810, WILL BE SOLD TO THE HIGHEST BIDDER DUE TO THE NONPAYMENT OF RENT AS STATED IN THE RENTAL AGREEMENT. THE CONTENTS OF THESE UNITS CONSISTS OF FURNITURE, HOUSEHOLD GOODS, AND OTHER MISCELLANEOUS PROPERTY.

THE SALE OF THIS PROPERTY WILL BE HELD AT U-HAUL OF MIDTOWN, 75 DIVISION ST. DANBURY, CT 06810, ON JULY 18TH, 2013 AT 10:00 A.M.

B004 TIFFANY FORD
BB01 JERMAINE HUGHES
C010 SOUFIANE OULED-AMOR
C018 DEBORAH WADE
D505 LAURENCE YEOU-MONTHE
D906 JENNIFER KERN
DD22 CHRIS ROBERTS
E026 VICTORIA BOOTH
H005 EDUARDO RIBEIRO
H016 DEBORAH WADE
H017 JENNIFER KERN
J013 JIM REAGAN
L003 JOLINE FERNANDEZ
L012 STEVEN RISI
L014 CINDY THORNE

WARNING
NOTICE OF SPECIAL TOWN MEETING
OF THE TOWN OF BETHEL, CONNECTICUT

The Legal Voters of the Town of Bethel, Connecticut, and those persons entitled to vote therein, are notified to assemble at a Special Town Meeting to be held in the Clifford J. Hurgin Municipal Center - Meeting Room A, 1 School Street, Bethel, Connecticut 06801 on Wednesday, July 10, 2013 at 7:00 p.m. for the following purposes, to wit:

1.)To consider and take action upon a recommendation of the Bethel Board of Selectmen and approved by the Bethel Board of Finance to sell all of the assets of the Bethel Water System which includes certain real property to Aquarion Water Company of Connecticut pursuant to an Asset Purchase Agreement dated effective as of April 29, 2013 for the purchase price of Seven Million Two Hundred Thousand ($7,200,000.00) Dollars.

Pursuant to Connecticut General Statute § 7-7, the Bethel Board of Selectmen by resolution on July 2, 2013 have removed this Item No. 1, the sale of the assets of the Bethel Water System from vote by the body of this Special Town Meeting and adjourned this vote to a Town wide machine vote to be held on the date as established by this body of the Special Town Meeting between the hours of twelve o'clock noon (12:00) PM and eight o'clock (8:00) PM unless the body of this Special Town Meeting approves earlier hours for the opening of the Town wide machine vote pursuant to Connecticut General Statute § 7-7.

A copy of said Agreement for the sale of the Bethel Water System assets is available for review during normal business hours at the Office of the First Selectman of Bethel, Clifford J. Hurgin Municipal Center, 1 School Street, Bethel, CT.

2.)To consider and take action upon a recommendation of the Bethel Board of Selectmen and approved by the Bethel Board of Finance to accept the transfer of ownership of 119,940 (0.92) SQ.FT.-2.74 acres of real property as open space from T. D. And Sons, Inc. which real property is located at Knollwood Drive and Rotella Drive adjacent to other land of the Town of Bethel. The transfer of real property fulfills the requirements of a resubdivision approval for Knollwood Drive and Granite Drive by the Bethel Planning & Zoning Commission.

A copy of said map depicting the real property to be transferred is available for review during normal business hours at the Office of the First Selectman of Bethel, Clifford J. Hurgin Municipal Center, 1 School Street, Bethel, CT.

3.) To take any and all action legally necessary or appropriate to accomplish the above intended results.

Dated at Bethel, CT this 2nd day of July, 2013.

BETHEL BOARD OF SELECTMEN

Matthew S. Knickerbocker, First Selectman
Richard C. Straiton, Selectman
Paul R. Szatkowski, Selectman

NOTICE OF PUBLIC HEARING ON
PROPOSED FARE AND SERVICE CHANGES

The Housatonic Area Regional Transit (HARTransit) invites public comment on proposed changes to fares and bus services. Proposals include:
•Raising the base fare for fixed route from $1.25 to $1.50 with other fixed route fare classes increasing proportionately;
•Elimination of the Danbury Trolley route;
•Increasing the minimum eligible age for senior half fare to 65, and
•Raising the minimum eligible age for senior SweetHART Dial-A-Ride to 65.
These changes, if approved by the HARTransit Board of Directors, are proposed to take effect on September 1, 2013. Hearings will take place at the following dates and locations:

Tuesday, August 6, 2:00pm
Bethel Senior Center, 1 School St., Bethel

Wednesday, August 7, 4:00pm
New Milford Town Hall, 10 Main St. New Milford

Thursday, August 8, 4:00pm
HARTransit, 62 Federal Rd., Danbury

Written comments may be submitted to HARTransit, 62 Federal Road, Danbury, CT 06810 until Friday, August 9, 2013. For information, contact HARTransit at (203)744-4070 or info@hartransit.com.

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and Danbury Hospital (DH) [illegible] submit the following Certificate of Need application to the CT Office of Health Care Access:
Applicants: Western Connecticut Health Network, Inc. (WCHN) which includes The Danbury Hospital (DH) and New Milford Hospital, Inc. (NMH)
Addresses: WCHN and DH are located at 24 Hospital Avenue, Danbury, CT. NMH is located at 21 Elm Street, New Milford, CT.
Proposal: This proposal involves consolidating the operations of DH and NMH [illegible] [illegible] the health and well-being of people in the communities it serves [illegible]
Capital Expenditure: $0

GENERAL HELP WANTED

PROCESSING OPERATOR - FT
Chemical filling dept- 2nd Shift

GENERAL HELP WANTED

RECEIVING DEPARTMENT
If you are an organized, self-starter

PUBLIC NOTICES

LEGAL NOTICE

The Superior Court has found that the persons listed below own property seized in connection with a drug offense. Pursuant to General Statutes § 54-36h, the State of Connecticut has petitioned for forfeiture of the property. The State hereby gives notice that unless the owners appear to contest the forfeiture, the State will move the Court to enter a default and judgment, resulting in forfeiture of the property.

The Court has ordered a hearing on the State's Petition for July 25, 2013 at 11:15 a.m., at the Superior Court, G.A. 3 Danbury, 146 White Street, Danbury, CT 06810.

This case is pending:
CV13-4016375-S: State v. $16,625.00 in U.S. Currency (Kenneth Wright)
By: CHRISTOPHER MALANY
Supervisory Assistant State's Attorney
Asset Forfeiture Bureau
Office of the Chief State's Attorney
Tel.# (860) 258-5810

LEGAL NOTICE

NOTICE IS HEREBY GIVEN that on June 18, 2013 a demolition application was filed in the Brookfield Building Dept. by Bohan Contracting having an address at 74 Mygatt Rd New Preston CT for the following address and action:

235 Federal Rd Permit # 201300564, demolition of a commercial building

Said notice is on file in the Town of Brookfield Land Use Office.

Dated this 2nd day of July 2013
Brookfield Building Department

STATE OF CONNECTICUT
JUVENILE MATTERS
SUPERIOR COURT,
DANBURY, CT
NOTICE TO: DEREK WILSON of parts unknown.
A petition has been filed seeking: Commitment of minor child of the above named or vesting of custody and care of said child of the above named in a lawful, private or public agency or a suitable and worthy person.
The petition whereby the court's decision can impact your parental rights, if any, regarding the minor child will be heard on 7/10/13 at 10:15 am at SCJM, 71 Main Street, Danbury, CT 06810.
It is therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the Danbury News-Times, 333 Main Street, Danbury, CT, a newspaper having a circulation in the town of Danbury.
Judge Donna Nelson Heller
Antoinette Real, Clerk, 6/27/13.
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is to be held.

SCHOOLS & JOB TRAINING

AMERICAN RED CROSS

CNA/NURSE ASSISTANT TRAINING

Day & Evening Classes
Flexible Payment Plan

Offered at:

American Red Cross
7 Park Lawn Drive
Bethel, CT
(located near Target)
203-702-1200

American Red Cross
1057 Broad Street 3rd Flr.
Bpt., CT 203- 328-0951

Financial aid available for qualified applicants

Approved by the CT Commissioner of Higher Education and CT Department of Public Health

CAREER TRAINING

* Certified Nurse's Aid
* Patient Care Technician Level I-II
* Phlebotomy

Day, Evenings and Weekends

BRANFORD HALL
CAREER INSTITUTE
155 Main Street, Suite 302
Danbury, CT 06810
203-797-1461

SITUATIONS WANTED

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE
DANBURY PROBATE COURT

NOTICE TO CREDITORS

ESTATE OF
CLAIRE LORRAINE LUNDQUIST
AKA Claire L. Hornig
(13-0367)

The Hon. Dianne E. Yamin, Judge of the Court of Probate, Danbury Probate District, by decree dated June 27, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Jessica E. Regan, Assistant Clerk

The fiduciary is:

Eric Lundquist, 20 Agnes Drive, Manchester, CT 06042
Paul Lundquist, 148 Currituck Road, Newtown, CT 06470.

MERCHANDISE FOR SALE

ANTIQUE TABLETOP wooden pinball game works. 18 steel balls and stick. $100. 203-748-2774

AREA RUG Good cond. 5'6"L x 7'11"W. $29. 203-746-1711

BABY CAR SEAT
Britax Roundabout
Excellent Condition $50.00
203-775-6925

BABY HIGH CHAIR folds up. $19. call 203-743-3297

BASKETBALL CARD SET '90-91 NBA Hoops Series Complete Set 1-336 Mint, incl. Jordan $29. 203-791-4883

BED Queen Pillowtop Mattress & Boxspring. Brand New. Still in Plastic. Sacrifice $250. 203-557-0049

BEDROOM SET, Solid Wood, Queen Size, Boxspring, Mattress, Dresser, Chest, 2 Night Stands, Metal Frame Headboard. Custom Made By Stanley Woodworks. Excellent Condition, $450. 203-544-8750.

BEDROOM CHERRY solid sleighbed, dresser, mirror, chest, night stand. Cost $2500, Sacrifice $850. 203-557-0049

BED TABLE
asking $50. 203-731-0477

BEENIE BABY COLLECTION
TAGS IN PERFECT CONDITION
1997-2001 Vintage
Qty. over 400
Buy a few or the whole lot
Most $2.50 each
Many with matching McDonald's
$5.00
203-775-6925

BICYCLE: Women's Schwinn World Sport, 12 speeds, 27 inch. Excellent condition. $75. 203-744-2955.

BIKE RACK for minivan - carries 2 bikes. $45 BO. call 203-743-3297

BROWN HUTCH $75.
203-300-4709 New Milford

BUNK BEDS by Stanley Furniture. Twin w/ storage unit. Wooden convertible to two twin beds. Excellent condition & quality. $445. Call 203-258-8531.

CABINETS Glazed Maple. New, Never Installed. All Wood. Dovetail. Can add or subtract to Fit Kitchen. Cost $9000, sell $2500, Can Deliver. 203-247-9459.

CALCULATORS - DESK TOP WITH TAPE CASIO PR-260 12 DIGIT $20.00 203-775-6925

CALCULATORS - DESK TOP WITH TAPE CASIO DL-251 HEAVY DUTY 12 DIGIT $20.00 203-775-6925

CAMERA - CANNON 35MM EOS REBEL G QD $56.00

ALSO

CANNON 35MM EOS REBEL G11 $50.00

BOTH CAMERAS W/ MANUALS IN WORKING ORDER
203-775-6925

CAMPING LANTERN AM/FM RADIO WEATHER LOTS MORE. $50. 203-746-5046

CAR RAMPS for repairing cars, brakes, oil, etc. $20. 203-743-3297

CHAIR - IKEA PELLO HOLMBY
Natural light color fabric.
Great for dorm, kids room or den.
Very comfortable
$25.00 203-775-6925

CHINA CABINET, Oak, Excellent Condition. Please call 203-743-3196. Part of Set.

CHINA CLOSET Oak, Beveled glass. Exc. cond 47"Wx87" Hx20"D $190. 203-746-1711.

DINING ROOM TABLE CHAIRS, 6, Oak. Excellent Cond. Please call 203-743-3196. Part of Set.

DINING ROOM SERVER, Oak, quality Furniture. Please call 203-743-3196. Part of Set.

DINING ROOM TABLE Oak. Top Inlay, plus Extension Leaf for Table. Call 203-743-3196 Part of set.

DOLLY FLAT PLATFORM W/HANDLE. HEAVY DUTY, $69. 203-746-5046

DRESSER. 2 small dressers w/4 drawers, $20 each. Microwave $5. Call 203-512-3232

DRESSER with Mirror, great Condition. Please Call 203-743-3196.

DRUM SET 5 Piece inc. Zildjian & Paiste Cymbals & Sabian Hi-Hat $125 firm. 203-313-4836

END TABLES Pair of end tables, all wood brown fancy, very good cond. asking $50. 203-798-2210.

ENTERTAINMENT CENTER
48x32x19. $65. 203-746-5046

ATTENTION

EQUUS INDUCTIVE xenon timing light excellent condition $10 203-792-5557

FUR STOLES (2) mink - good condition, $25 each. call 203-743-3297

FUTON, $90 Call 203-512-3232

GAZEBO COVER
CANOPY TOP ONLY
TO FIT A
12' X 12' GAZEBO BEIGE
BRAND NEW $50.00
CALL 203-775-6925

GLASS PATIO TABLE, $10.
203-300-4709

Golf Clubs Ping i5i Stiff PW-3+Bag $75 203-313-4836

Golf Clubs Ram LH Junior SW-3 Hybrid+Bag $75 203-312-4836

GOLF PULL CART
PRO KENNEX
2 WHEEL
SUMMER IS HERE
AND SO IS GOLF SEASON
$35.00 203-775-6925

NEW AD!

Guardian adjustable Walker Model [illegible], with 5 in. wheels $30 203-792-5557

Guitar - Fender Telecaster and [illegible] Bag like new [illegible] 203-313-4836 $325.00

GUITAR AMP Peavey Classic 50 4X10 Kustom [illegible] 203-313-4836

HITCHCOCK: [illegible] chair and [illegible] [illegible] $150. [illegible]

HOOSIER CABINET. Two piece w/ 2 cabinets on top & a flour bin and sifter. 4 drawers on bottom, metal pull-out counter & 1 cabinet. Original finish. Some wood cracks on side. $375. 203-354-5521.

HOSPITAL BED
asking $100. 203-731-0477

SCHOOLS & JOB TRAINING

MERCHANDISE FOR SALE

HOT TUB: 2013 Model, 5/6 Pers. 45 Jets, all opt w/Cover. New in Pkg, never used. Full wrty. Orig. Cost $7400 sacrifice $2950. Can Deliver. 203-232-6778

ICE BOX, Old oak. $450. 203-746-1711

IKEA COAT, HAT & STORAGE RACK dark oak. Moving sale. $25. Call/text 203-458-0336

JOHN DEERE LEAF BAGGER
INCLUDES MANUAL

USE WITH RX, SX, SRX AND GX RIDING MOWERS AND LX LAWN TRACTOR.

NEEDS CLOTH BAGS
GOOD CONDITION
$50.00 203-775-6925

KENWOOD/BOSTON Acoustic Unity DVD Home theater Sys Awesome! $125 Mike 203-994-0663

KITCHEN TABLE AND SEATING
Country corner Kitchen nook. oak, exc. cond. storage benches, seats 5-6 $230.00 203-746-3569

LAMPS (2), Dark Green, Great Cond. Please Call 203-743-3196.

Lands End NEVER WORN Womens Knit Shorts PINK/TAN 14/16 203 746-8488 Both for $25.00

LAPTOP TABLE LIGHTWEIGHT, FOLDS FLAT, LED LIGHT, $15. 203-746-5046

LARGE PAINTING OF CASTLE w/frame 3' x 4' $25. 203-743-3297

LAWN MOWER: $25
Redding, CT. 203-938-3275

Lawn mower, self propelled, Sears, $100. 203-938-3275

LAWN SPREADER for seeding or fertilizing. $29 BO. call 203-743-3297

LEATHER RECLINER, $50.
Redding, CT 203-938-3275

LEATHER COAT WOMENS S/M
BEAUTIFUL COAT

BLACK, 3/4 LENGTH,
REMOVABLE LINER.
$50.00 203-775-6925

LIONEL TRAIN 3665 USAF BOX CAR MINUTEMAN

Unique car 1961-64 Roof opens & launching mech. elevates to firing position. Operates with O27 & O gauge Lionel (others)
Very clean, no yellowing, free of cracks, chips or breaks $200.00 or best offer 203-775-6925

LUGGAGE -
AMERICAN TOURISTER
HARDSIDED LUGGAGE
SUMMER & TRAVEL IS HERE
SET OF 4 PIECES -
27" PULLMAN, 24", 21" AND TOTE. BEIGE EXCELLENT FOR GOING TRAVEL OVER SEAS OR ANYWHERE
OR USE AS STORAGE

$100.00 FOR SET OF 4
203-775-6925

MAN'S LEATHER JACKET like new warm liner. $49 BO. 203-743-3297

MATCHING FLOOR LAMPS (2)
$50. 203-300-4709

MATTRESS & Boxspring.
King size Pillowtop set, brand new, still in plastic. Sacrifice $300. 203-557-0049

SCHOOLS & JOB TRAINING

Valley

CLASSES AVAILABLE TO LEARN

• PATIENT CARE TECHNICIAN IN 10 WEEKS
• CERTIFIED NURSING AIDE IN 4 WEEKS
• DENTAL ASSISTING IN 4 WEEKS
• PHLEBOTOMY
• EKG

DAY, EVENING & SAT. CLASSES

NEW Bridgeport Location: 4537 Main Street
The Brookside Professional Bldg.
91 Shrefts Dr., Waterbury
203-378-2210 • 1-800-886-8773
valleymedicalinstitute.com

• JOB ASSISTANCE •
EASY PAYMENT PLANS • AS LITTLE AS [illegible] DOWN

Training Direct

Train in 3 – 4 Weeks to Become:

Certified Nurse's Aide (Day and Classes Offered)

THE NEWS-TIMES

Classified

SOUTHERNCTJOBS.com

monster

203-330-6556 | classified@newstimes.com | Hours: 8:30 a.m. – 5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

FORECLOSURE SALE-
PUBLIC AUCTION
Docket No. DBD CV 12-6010675 S
Case Name: 1st Alliance Lending LLC v. Dean A. Grecco, et al
Property Address: 44 Putnam Park Road, Bethel, CT
Property Type: Residential
Date of Sale: July 13, 2013
Committee Name: Richard D. Arconti, Esq. Committee Phone Number: (203) 790-7747.
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE
The Zoning Board of Appeals of t

PUBLIC NOTICES

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and New Milford Hospital (NMH) will submit the following Certificate of Need application to the CT Office of Health Care Access:

Applicants: Western Connecticut Health Network, Inc. (WCHN) which includes The Danbury Hospital (DH) and New Milford Hospital, Inc. (NMH)

Addresses: WCHN and DH are located at 24 Hospital Avenue, Danbury, CT. NMH is located at 21 Elm Street, New Milford, CT.

Proposal: The proposed project is considering the acquisition of DH and NMH under a single license, as they are already governed by the same parent board of directors and have a unified mission to provide the health and well being of people in the communities it serves in a cost effective manner.

Capital Expenditure: $0

Town of Bethel, CT
LEGAL NOTICE
ZONING BOARD OF APPEALS
Notice is hereby given that the Zoning Board of Appeals of the

GENERAL HELP WANTED

SSS EARN CASH SSS
Be a Newspaper Carrier

GENERAL HELP WANTED

PUBLIC WORKS
Highway Superintendent
TOWN OF NEW MILFORD

The New Milford, CT Public Works Department is currently recruiting a Highway Superintendent to plan, coordinate, supervise and direct the work of subordinates in the maintenance construction and repair of streets, bridges, storm sewers, drainage systems and highway equipment.

Minimum qualifications include, High school diploma or equivalent required, Associate or Bachelor's degree in Civil Engineering or related field preferred. Min. of three years experience as a Public Works Supervisor with ten or more years of construction and construction management experience. Associate

ABSOLUTELY FREE

TELEVISION. Sony 34" Hi Def TV, exc. 720p picture, matching stand. FREE for the taking. 203-947-1730

HEATING AND FIREWOOD

Firewood Seasoned $200/cord locally. 2 or more cords $180. Guaranteed full cord. Call Rod Fitch 860-355-9476

UNSEASONED FIREWOOD all hardwood $175 cord split 2 cord min. 203-312-3864/203-470-8498

MERCHANDISE FOR SALE

AERATOR: 35" with 18 pronging wheels. Tractor ready! $60. Call Bob @ 203-778-4567

ALUMINUM FOLDING LAWN

MERCHANDISE FOR SALE

COACH Men's Leather Bound Portfolio Dark Brown Leather. Excellent Condition! $60. 203-912-3683

COACH Men's Leather Messenger Bag Dark Brown Leather. Excellent Condition! $90. 203-912-3683

COACH IPAD COVERS One Brown and One Black with COACH Logo. Exc Condition. $50. 203-912-3683

B8 | The News-Times

THE NEWS-TIMES

Classified

SOUTHERNCTJOBS.com

monster

203-330-6556 | classified@newstimes.com | Hours: 8:30 a.m. – 5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and New Milford Hospital (NMH) will submit the following Certificate of Need application to the CT Office of Health Care Access:

Applicants: Western Connecticut Health Network, Inc. (WCHN) which includes The Danbury Hospital (DH) and New Milford Hospital, Inc. (NMH)

Addresses: WCHN and DH are located at 24 Hospital Avenue, Danbury, CT. NMH is located at 21 Elm Street, New Milford, CT.

Proposal: The proposed project is considering the acquisition of DH and NMH under a single license, as they are already governed by the same parent board of directors and have a unified mission to provide the health and well being of people in the communities it serves in a cost effective manner.

Capital Expenditure: $0

GENERAL HELP WANTED

DISHWASHER
needed at BLUE COLONY DINER
Contact George 203-417-1269

DRIVER - Reliable person wanted for Recycle/Refuse collection route. 2 years Medium Truck driving experience required. Class driving record & drug test. Email resume to madina@abeglobal.net or fax to 203-227-1873.

SSS EARN CASH SSS

GENERAL HELP WANTED

PUBLIC WORKS
Highway Superintendent
TOWN OF NEW MILFORD

The New Milford, CT Public Works Department is currently recruiting a Highway Superintendent to plan, coordinate, supervise and direct the work of subordinates in the maintenance construction and repair of streets, bridges, storm sewers, drainage systems and highway equipment.

Minimum qualifications include, High school diploma or equivalent required, Associate or Bachelor's degree in Civil Engineering or related field preferred. Min. of three years

MERCHANDISE FOR SALE

ANTIQUE LIVERS, box of 12 assorted small liners. $25. 203-775-0174

ANTIQUE TABLETOP wooden pedestal base w/cast 18 steel bats and [illegible]

AREA RUG Gold color, 5'6" x 7'9". 203-775-4211

BABY CAR SEAT
Sidex Recaro Boost
Excellent Condition $80.00
203-454-9765

BABY HIGH CHAIR Solid op. $15. [illegible]

MERCHANDISE FOR SALE

DRUM SET 5 Piece Inc. Zildjian & Paiste Cymbals & Sabian Hi-Hat $125 firm. 203-313-4636

END TABLES Pair of end tables, all wood brown fancy, very good cond. asking $50. 203-798-0810.

ATTENTION

EQUUS INDUCTIVE xenon fixing light excellent condition $10 203-742-6567

FUR STOLES (2) mink - good condi-

AFFIDAVIT

Applicant: Western Connecticut Health Network, Inc.: The Danbury Hospital and New Milford Hospital, Inc.

Project Title: WCHN Single License: The Danbury Hospital and New Milford Hospital, Inc.

I, Steven H. Rosenberg, Senior Vice President and CFO, of Western Connecticut Health Network, Inc., being duly sworn, depose and state that The Danbury Hospital and New Milford Hospital, Inc.'s information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Steven Rosenberg
Signature

8/12/13
Date

Subscribed and sworn to before me on August 12, 2013

Alberta B. Ricciardi

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2014

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:	TBD
Applicant:	Western Connecticut Health Network, Inc.
Contact Person:	Sally F. Herlihy, MBA, FACHE
Contact Person's Title:	Vice President, Planning
Contact Person's Address:	24 Hospital Avenue Danbury, CT 06810
Contact Person's Phone Number:	203-739-4903
Contact Person's Fax Number:	203-739-1974
Contact Person's Email Address:	sally.herlihy@wchn.org
Project Town:	Danbury, CT, New Milford, CT
Project Name:	WCHN Single License: The Danbury Hospital and New Milford Hospital, Inc.
Statute Reference:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$0

Project Description: Service Termination

a. For each of the Applicant's programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.

In October 2010, with Docket No. 10-31560-CON, The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH") as well as their affiliated entities became wholly owned subsidiaries of a newly formed entity, Western Connecticut Health Network, Inc. ("WCHN"). As part of that transaction, the governing instruments of DH and NMH were revised so that both corporations have the same governance with the same sole member and the same directors. WCHN also has the same reserved powers / voting rights as to both NMH and DH.

DH is a 371-bed acute care hospital located at 24 Hospital Avenue, Danbury, CT. DH's total licensed bed capacity includes 345 general hospital beds and 26 bassinets. For DH, the following 6 towns account for 75% of its activity: Danbury, Bethel, Newtown, Ridgefield, Brookfield and Southbury, CT.

NMH is an 85-bed acute care hospital located at 21 Elm Street in New Milford, CT. NMH's total licensed bed capacity is 85 licensed beds with 0 bassinets. For NMH, the following 6 towns account for 75% of the inpatient activity currently at NMH: New Milford, Kent, Sherman, Brookfield, Danbury, and Washington, CT.

Individual hospital licenses for DH and NMH are enclosed as Exhibit A.

See Exhibit B for inpatient utilization of DH and NMH.

WCHN proposes to merge DH and NMH under a single general hospital license, with no associated capital expenditure in order to improve efficiency and allow for NMH to be compliant with ICD10 requirements by the October 1, 2014 deadline. WCHN understands that the Office of Health Care Access ("OHCA") considers a merger a termination of all services by one of the entities because only one license remains. There is no actual termination of any health care services as part of this Project. Similarly, no change in governance or control is contemplated as part of this Project. Upon accomplishment of the merger, the same services will be offered at the same locations.

This Project will involve the consolidation of DH and NMH into one licensed general hospital that is operationally and financially integrated with two campuses at the existing locations in Danbury, CT and New Milford, CT. No addition, replacement or termination of any health care functions or services at DH or NMH is contemplated as part of this Project. Immediately after the merger, the existing campuses will remain in operation, with inpatient services provided at both locations.

The primary service area ("PSA") for WCHN includes a population of 275,000 for residents in the following communities: Bethel, Bridgewater, Brookfield, Danbury, Kent, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman, Washington, CT (the "CT PSA"); and Brewster, Pawling, Patterson, and Wingdale, NY (the "NY PSA"). During FY 2012, 8 out of 10 residents in the CT PSA utilized either DH or NMH for their inpatient services and 1 out of 7 residents in the NY PSA utilized either facility for their inpatient care. Additionally, WCHN's secondary service area

("SSA") includes an estimated population of 165,000 residents in towns located adjacent to the PSA, including Southbury, CT. A map of WCHN's service area is enclosed as Exhibit C. The PSA and SSA of the proposed consolidated successor hospital will consist of the same towns currently served by both hospitals.

The purpose of the WCHN affiliation 2 ¾ years ago was to develop a regional health care delivery system (*OHCA Final Decision, 9/23/10, Docket No. 10-31560-CON, p.3*). In its decision, OHCA found that "the affiliation would improve the quality, accessibility and cost effectiveness of the health care delivery in the region" (*OHCA Final Decision, p.21*). This proposal involves further consolidation of the operations of DH and NMH, as the two organizations are already governed by the same parent and board of directors and have a unified mission to promote the health and well being of people in the communities it serves in a cost effective a manner. See the WCHN organizational chart in Exhibit D.

At the time of affiliation, the direction was to maintain two separate licenses for the individual hospitals. (*OHCA Final Decision, Finding of Fact #10, p 3).* However, since the affiliation in October 2010, the two hospitals have integrated operations to create consistent quality and a more cost effective delivery of care. A matrix organizational structure, which includes a service line executive and physician director, has been developed across service lines for WCHN (See Exhibit E). This structure ensures provision of a single standard of care for our patients, supported by ongoing alignment of policies and procedures and practices at both Hospitals.

This Project supports necessary further consolidation of DH and NMH in order for NMH to comply with ICD10 requirements, since NMH's existing Meditech system will not become compliant without a significant financial investment. Moreover, the maintenance of two different information technology (IT) platforms hinders operational, financial and clinical efficiencies within WCHN. Given the level of work that would be required to convert NMH's existing IT platform, the only viable solution to ensure NMH's compliance with ICD10 and enable billing to occur on October 1, 2014 is to integrate NMH's system with DH's and bill as one entity. By moving the 2 Hospitals to a single license with a single IT platform, WCHN would avoid incurring an estimated $3.2M in additional costs and would realize an operating savings of approximately $715K annually including savings associated with a reduction in redundant platforms, maintenance costs, licensing, and IT staff productivity. Without this Project NMH will be unable to bill under ICD 10 requirements, which will have a significant impact on the cash and financial position of NMH.

b. Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.

This Project involves a termination only in that the two separate general hospital licenses of DH and NMH will be merged into one general hospital license with operations at the same facilities existing prior to the merger on the two campuses at the existing locations in Danbury, CT and New Milford, CT. This Project does not involve the addition, replacement or termination of any health care functions or services at DH or NMH. The goal is to enhance the quality of care that is provided, while delivering it as efficiently and consistently as possible. NMH is a small, community hospital located in close proximity to DH, which currently faces a tremendous challenge to satisfy all requirements on a standalone basis. Operating with one license would reduce cost redundancies

and support consistency and quality in all the programs. A single license also enables savings to be achieved through economies of scale, thus reducing the cost of health care (such as a single approach to accreditation processes, Medical Staff credentialing and peer review, Medicare Cost Reporting, consolidating and standardizing IT system platforms and annual auditing). This merger of DH and NMH will strengthen both hospitals by working together to provide the right care, at the right place, at the right time, for the right price for the residents of the DH and NMH service areas.

c. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.

As noted, this request is not to terminate services at DH or NMH; rather it is a change to consolidate licenses to operate one acute care general hospital with two campuses. The ability to achieve synergies in activities, maintain and enhance quality, and realize cost-savings with streamlined operations has become a paramount concern for all hospitals. Government and commercial reimbursement rates have not kept pace with operating expenses and hospitals are constantly making adjustments to remain financially viable. Further compounding WCHN's ability to efficiently deliver quality care at the lowest cost are funding cuts from the recently approved State of Connecticut fiscal budget, which will reduce Medicaid reimbursements to the Network by $30M over the next two years. As a result, WCHN is carefully evaluating its ability to maintain access and offer community programs and to maintain staffs who have dedicated their lives to serving others, and continues to scrutinize its operations to find any opportunity to operate more efficiently to preserve our mission. The reductions in revenue are compounded by increases in costs associated with compliance with regulatory requirements such as ICD10 and the Accountable Care Act.

Pursuing a single license is one means of addressing the need for cost reduction while improving the quality of care provided to all of WCHN's patients through clinical, financial and operational integration. The immediate effect of a single license would be cost-avoidance related to a necessary one-time upgrade and testing of NMH's Meditech IT platform that is not compliant with ICD10 requirements. To avoid this unnecessary expense, the two Hospitals must move to a single license with a single IT platform.

A brief description of the billing process will highlight the complexity of the process and importance of operating under one billing entity.

- There are several key fields in billing systems that need to be separate when 2 hospitals are different entities. The first is the Medical Record Number of the patient. Each hospital bases the patient identification on a single master number which is the basis for the legal medical record and for billing purposes. One person would have one identifier for Danbury Hospital and another for New Milford Hospital. Each separate encounter within a hospital will also contain a unique account number for that patient, which is used for billing and identification of statistics for that visit. In addition, the tax identification number (TIN) is a separate number for each hospital. In billing and accounts receivable, electronic claims are submitted by each hospital using the Medical Record, Account and TIN. Payer systems process claims and return electronic remittances for payment using the same 3 numbers as keys. These payments are returned to a separate "lockbox" managed for each TIN for the individual hospital before applying the amount to specific medical record and account numbers.

Statistics required for Medicare cost reporting would also need to be separated under 2 licenses.

- Danbury Hospital currently uses Siemens' Invision Patient Management/Patient Accounting systems for managing patient financial information. This application can only function as a "single entity" system, and cannot accommodate multiple medical record numbers for one person and cannot process claims or accounts receivable for multiple TINs. To accommodate this for 2 separate hospitals operating on separate licenses, we will need to implement a separate version of the software on different hardware. All master tables, files, screens and coding logic would need to be rebuilt and tested. In addition, all clinical systems that are interfaced with the Patient Management and Accounting system would need to be built as a separate entity using the medical record and account numbers to process all clinical orders, results viewing, billing, and clinical documentation. The project would take approximately 1 year to build and test.

A Task Force comprised of WCHN leadership evaluated the impacts of upgrading the current Meditech platform at NMH to be compliant for ICD10 billing. This resulted in a recommendation to the Board of Directors in December 2012 and subsequent endorsement to pursue a single license. A Modification Request to Docket No. 10-31560-CON was submitted to OHCA in March 2013, which resulted in a May 31, 2013 decision that a CON would be required to pursue a single license (Docket No. 13-31560-MDF). WCHN has already invested $596K to support alignment of its IT systems to achieve efficiencies.

This Project is now submitted as a CON for OHCA review, and is time-sensitive to the ability to implement the new system by the October 1, 2014 deadline. As noted above, this consolidation to a single IT platform for the two hospitals will result in significant additional cost savings for the Network and is the only viable solution to ensure NMH's compliance with ICD10 and enable billing to occur on October 1, 2014.

d. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted.

The WCHN Board of Directors is comprised of the same individuals who serve on the DH NMH Boards. The Board Members understand the challenges facing NMH in complying with ICD10 and support this CON request as a solution to that problem as well as a natural evolution of the plan to provide the best services possible at the most reasonable cost for all of the patients in the WCHN service area. The Board adopted resolutions supporting this project and authorizing the operational activities necessary to develop a plan of merger and single licensure for DH and NMH at its meeting on December 6, 2012. A copy of such resolutions are attached as Exhibit F

There will be no impact or change in the governance or controlling body of NMH or DH as a result of this proposal to allow both hospitals to operate under a single license.

e. Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

It is in the public's interest to maintain the financial viability of NMH and to ensure that high quality health care is provided in the most efficient manner. By joining the two hospitals under one license, WCHN provides one high standard of care at both campuses and avoids a large out of pocket cost for a redundant IT infrastructure which would only foster silos and impede clinical and financial integration within the Network. It would allow WCHN to realize substantial cost savings at a time when hospital resources are already strained. The Table below demonstrates the financial impact of merging DH and NMH under one hospital license and IT infrastructure.

			Year 1	Year 2	Year 3
Dept	**Operating Expense**	**FTE**	**Annual Budget Impact**	**Annual Budget Impact**	**Annual Budget Impact**
Finance	Audit Fees		(175,000)	(175,000)	(175,000)
Finance	Consolidate Audit Preparations	(1.0)	(150,000)	(150,000)	(150,000)
Quality	CHA Fees		(18,000)	(18,000)	(18,000)
Quality	JCAHO Fees		(10,000)	(10,000)	(10,000)
Quality	Press Ganey Fees		(8,000)	(8,000)	(8,000)
Quality	Core Measures/VBP Fees		(27,000)	(27,000)	(27,000)
ITG	ITG Productivity Savings	(1.0)	(200,000)	(200,000)	(200,000)
ITG	Siemens System maintenance		173,028	181,679	190,763
ITG	Meditech System Maintenance		(300,446)	(313,021)	(326,151)
	Total	**(2.0)**	**(715,418)**	**(719,341)**	**(723,388)**
	Capital Impact				
ITG	Meditech Upgrade Capital Required		(3,160,902)		
ITG	Integration cost to single system		596,965		
	Total Capital Impact		**(2,563,937)**		

2. Termination's Impact on Patients and Provider Community

a. List all existing providers (name, address, services provided, hours and days of operation, and current utilization) of the services proposed for termination in the towns served by the Applicant, and in nearby towns.

WCHN currently consists of two hospitals and its affiliated entities. WCHN is a comprehensive health system that includes 24/7 acute care and emergency services, home health, behavioral health, diagnostic services, and outpatient surgical services; DH is a 371-bed acute care hospital

located at 24 Hospital Avenue, Danbury, CT, and NMH is an 85-bed acute care hospital located at 21 Elm Street in New Milford; CT. The estimated driving distance between the Danbury and New Milford campuses of the proposed successor hospital is 15.4 miles, and the estimated driving time is 20-25 minutes.

This proposal does not involve the addition, replacement or termination of any health care functions or services at DH or NMH. It would have no impact on any of the existing providers in the towns served by DH or NMH other than the realized benefits to DH, NMH and WCHN described in this application if the project is completed.

b. Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.

Access to the services currently provided by DH and NMH will be unaffected by this Project. There will be no change to the services provided by DH or NMH as a result of this proposal. NMH and DH will improve the overall quality of the services provided and the financial viability of the two hospitals.

c. For each provider to whom the Applicant proposes to transfer or refer clients, provide the current available capacity, as well as the total capacity and actual utilization for the current year and last completed year.

No transfer or referral of patients is contemplated as a result of this Project. Immediately following the merger, both hospitals would continue to provide the same services and the same capacity and utilization is anticipated to continue.

d. Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.

There will be no closure of a service location as a result of this merger.

e. Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.

Not applicable.

f. Describe how clients will be notified about the termination and transferred to other providers.

This proposal does not involve the addition, replacement or termination of any health care functions or services at DH or NMH. This change will be seamless to patients and the community.

3. Actual and Projected Volume

a. Provide volumes for the most recently completed FY by town.

The NMH total volume for FY 2012 is provided in descending order in the chart below:

	FY2012 Volume
New Milford- CT	31,983
Danbury- CT	3,230
Washington Depot- CT	2,608
Sherman- CT	2,386
Kent- CT	2,377
Brookfield Center- CT	2,063
Marble Dale- CT	1,867
Roxbury- CT	1,573
Bridgewater- CT	1,494
Wingdale- NY	1,368
Gaylordsville- CT	1,307
Cornwall Bridge- CT	999
Pawling- NY	809
Dover Plains- NY	707
Southbury- CT	644
South Kent- CT	593
Woodbury- CT	585
Torrington- CT	478
Bantam- CT	473
Litchfield- CT	401
Bethel- CT	352
Newtown- CT	313
All Other Towns	4,925
Total	63,535

b. Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for both number of visits and number of admissions, by service.

Table 1: Historical and Current Visits & Admissions

	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	2010	2011	2012	2013 YTD June
Inpatient:				
Medicine	1,515	1,579	1,538	1,072
Surgical	456	403	264	220
Obsetrics	270	267	245	58
Pediatrics	10	2	1	-
Newborn	261	264	243	55
Inpatient Total	2,512	2,515	2,291	1,405
Outpatient:				
Ambulatory IV	291	250	195	186
Cardiac Rehab	149	168	158	321
Cardiovascular	2,604	2,216	2,193	1,378
Cat Scan	1,960	1,765	1,865	1,315
Diabetes	58	50	74	25
Dietary/Nutrition	90	40	46	35
Emergency Room	16,238	16,459	16,210	11,308
Endoscopy	1,972	1,805	1,827	1,318
Laboratory	42,927	43,614	12,159	453
Outpt Psych	4,159	4,314	4,119	3,670
Nuclear Medicine	274	203	185	133
Lactation / Breast Feeding	12	39	29	4
Lithotripsy	38	49	56	43
Outpt Obstetrics	280	381	319	134
Oncology	3,942	3,680	3,178	2,266
One Day Surgery/ASU	2,617	2,336	2,178	1,559
Observation	481	557	586	539
Radiation Therapy	734	679	730	627
Radiology	7,293	6,924	7,242	5,208
Invasive Radiology	379	400	414	312
MRI	1,631	2,313	2,391	1,787
Primary Care Office	3,700	3,552	1	-
PET	2	1	10	-
Respiratory Therapy	56	115	113	70
Sleep Center	522	377	316	158
Speech Therapy	247	236	148	78
Women's Imaging	4,359	4,284	4,466	3,111
Misc other	137	71	36	18
Outpatient Total	97,152	96,878	61,244	36,056
Grand Total	**99,664**	**99,393**	**63,535**	**37,461**

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

** Identify each service type and add lines as necessary. Provide both number of visits and number of admissions for each service listed.

*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the tables above.

Inpatient volume has declined in both OB/Newborn from FY2012 to FY2013 as a direct result of the closing of the OB services at NMH. In addition, inpatient surgical volume has decreased due to a very active general surgeon that moved out of the community at the end of the first quarter of the fiscal year, impacting inpatient and one day surgery volumes.

Outpatient volume has experienced a decline overall related to several key changes. Oncology volume has seen a year over year decline. This is due to the loss of several key physicians. To date, physicians have been recruited and we anticipate the volume to return to historic levels. In addition, outpatient volume relating to both Primary Care Practice as well as the Outpatient Laboratory shows declines. This decline is not a loss of volume but a transition of volume associated with the integration. The Primary Care practice transitioned all billing functions from NMH and has been consolidated into the WCMG entity structure under WCHN. The Outpatient Laboratory service has declined due to the transition of the drawing station from NMH to a consolidated laboratory function with a satellite office at 120 Park Lane in New Milford.

d. For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:
   i. Average daily census;
   ii. Number of clients on the last day of the month;
   iii. Number of clients admitted during the month; and
   iv. Number of clients discharged during the month.

Not Applicable.

4. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

WCHN has strong leadership at the management level based on a great deal of depth and experience in health care in general, and hospitals in particular. A copy of the CV's for each of the following leaders from WCHN are attached in Exhibit G.

President & CEO, John Murphy, MD
Senior VP, COO, Danbury Hospital, Michael Daglio
Executive Director, Senior VP, New Milford Hospital, Deborah Weymouth
Senior VP, CFO & Treasurer, Steven Rosenberg
Senior VP, Human Resources, Phyllis Zappala
Chief Medical Officer, Matt Miller, MD
Senior VP Patient Care Services, CNO, Moreen Donahue, RN
General Counsel, Carolyn McKenna
Chief Risk & Compliance Officer, Joe Campbell

Chief Information Officer, Kathy DeMatteo
VP, Facilities, Morris Gross
VP, Marketing & Communications, Mark Schumann
VP, Quality & Patient Safety, Dawn Myles
VP, Planning, Sally Herlihy
Executive Director & VP Foundation, Grace Linhard

WCHN already provides system-wide management of both DH and NMH. The close proximity of the two hospitals allows for effective involvement of centralize WCHN management. In addition, Deborah Weymouth provides on-site administration at NMH and will continue to do so immediately after the merger is accomplished.

b. Explain how the proposal contributes to the quality of health care delivery in the region.

Although the two hospitals are already formally affiliated, creating a single license has significant implications for the two separate Medical Staffs and how they, together, can further enhance the quality and efficiency of healthcare for the region.

With separate licenses, there is a requirement for each hospital entity to have its own medical staff, with its own set of Bylaws and Medical Staff leadership. The latter is structured as a Medical Executive Committee and currently both hospitals maintain this separate structure. While there have already been efficiencies and standardization of care achieved across the region due to the opportunities presented through the formal affiliation, more formal synergies can be achieved by combining the medical staff under a single license: a single set of bylaws that wholly govern the medical staff---from initial appointment to setting a single standard for expectations of providers, to setting a single standard of care for all clinical conditions, to a formal and consistent peer review process, to reappointment based on unified standards and to a centralized oversight of the quality and safety of care rendered across the region.

The proposed consolidation will create one unified medical staff with the same policies, procedures, clinical pathways/order sets that support the delivery of one standard of high quality, cost-effective care. Under this single license the medical staff will have greater opportunity to coordinate care across the network --consistently, efficiently and under one standard. The implementation of a single electronic health record spanning both campuses will further enhance the quality and safety of health care delivery by improving communications across sites of care, including physician offices, emergency services, ambulatory centers and the inpatient environment. Access will be improved through better coordination between providers, emergency rooms, and hospitals.

Supporting the single standard of care concept is a Policy & Procedure project undertaken by WCHN and its affiliated hospitals in the summer of 2012. This initiative will align and simplify their collective policies and procedures. Driven by an executive steering committee and including over 150 staff representing every functional area of the two organizations, well over 6,000 policies were reviewed. Using a standard template these polices has now been consolidated into approximately 3,700 in total. As a direct result of this project, care and service practices have been standardized, variation has been reduced and training is streamlined. The policies will eventually be accessible from a single electronic site for easy 24/7 access by all staff in all locations. Overall the project has

the potential to deliver improved quality and reduced cost. Single licensure will ensure that the benefits of this project can be fully adopted in all care and service functions at both campuses.

Additional quality benefits of single license include:

- Allows for us to be on a shared medical record. Information will seamlessly be shared across the two hospitals without the inefficiencies of duplicative efforts (CMS requires separate medical records for separate CCN numbers).
- Increased coordination of care with all clinicians working off of the same admit information, med/allergy lists, care plans, etc.
- More efficient QA and Peer Review through (again) seamless access to information from any campus.
- Increased ability to perform quality analytics since all data is in the same database. Can truly look at care across sites without having to make adjustments for different data capture or coding.
- Efficiencies in Value Based Purchasing (VBP) data abstraction, since it is all from the same formatted medical records, and not multiple versions in multiple sites.

The collective impact of these efforts will contribute to the quality of health care delivery in the region.

c. Identify when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.

Activities supporting achievement of a single license have been explored and a work plan is under development (i.e. single medical staff structure, Medicare Conditions of Participation, IT integration schedules, etc.). Outreach will be pursued with the licensing division of DPH and the federal government simultaneously with this CON application, for execution immediately upon approval from OHCA.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

Non-profit tax exempt corporations.

b. Does the Applicant have non-profit status?
☒ Yes (Provide documentation) ☐ No

c. Financial Statements

i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

Audited Financial Statements for the most recently completed fiscal year for both DH and NMH are on file with OHCA.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

d. Submit a final version of all capital expenditures/costs.

Not Applicable.

e. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Not Applicable.

f. Demonstrate how this proposal will affect the financial strength of the state's health care system.

Continued operational and clinical integration will positively benefit the cost of delivery of health care through savings realized from the integration of duplicative functions, and enhanced IT functionality, particularly NMH's ability to bill with the new ICD10 requirements. Financial health of two hospitals in the region will support the financial health of the State's health care system.

6. **Financial Attachments I & II**

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

See Exhibit H for Financial Attachment I for both DH and NMH.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

Not Applicable, as this proposal is not adding or eliminating any new services. The financials provided reflect the shifting of all revenue and expenses existing at NMH into the DH financials (see Exhibit H).

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

See Exhibit I for the Financial Assumptions utilized in development of Financial Attachment I.

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

Not Applicable.

e. Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

Yes, NMH was being reimbursed by payers for all existing services. Reimbursement levels are not expected to change as we are not terminating any services with this Project.

f. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

Not Applicable.

g. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

We are not anticipating any projected incremental losses from this Project. This Project will demonstrate a savings as outlined.

h. Describe how this proposal is cost effective.

DH and NMH are operating as a unified entity, and additional efficiencies can be realized if there is a single license, including efficiencies achieved in financial operations (single audit and single charge master), IT conversion and preparation for ICD10 requirements. Savings can also be achieved through consolidation of accreditation surveys, organizational fees for participation in professional organizations and some service contracts that are billed to individual entities. These efforts will reduce further the duplication of work and positively benefit the cost of delivery of health care in the community.

Exhibit A

Hospital Licenses

STATE OF CONNECTICUT

Department of Public Health

License No. 0039

General Hospital

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

The Danbury Hospital of Danbury, CT. d/b/a The Danbury Hospital is hereby licensed to maintain and operate a General Hospital.

The Danbury Hospital is located at 24 Hospital Avenue, Danbury, CT 06810

The maximum number of beds shall not exceed at any time:
345 General Hospital beds
26 Bassinets

This license expires September 30, 2013 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2011. RENEWAL.

Satellites
Center for Child and Adolescent Treatment Services, 152 West Street, Danbury, CT
Community Center for Behavorial Health (ADH-PHP), 152 West Street, Danbury, CT
The Pediatric Health Center, 70 Main Street, Danbery, CT
Seifers & Ford Community Health Center, 70 Main Street, Danbury, CT
Ridgefield Surgical Center, 901 Ethan Allen Highway, Ridgefield, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0032

General Hospital

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

New Milford Hospital, Inc. of New Milford, CT d/b/a New Milford Hospital is hereby licensed to maintain and operate a General Hospital.

New Milford Hospital is located at 21 Elm Street, New Milford, CT 06776.

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

0 Bassinets
85 General Hospital Beds

This license expires **June 30, 2015** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, July 1, 2013. RENEWAL.

Satellite:
New Milford Hospital Community Mental Health Services, 23 Poplar Street, New Milford, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

Exhibit B

FY 2012 Hospital Dependency by Town

DANBURY HOSPITAL

	2012	% Total	Cum %
DANBURY	7,638	40.0%	40.0%
BETHEL	1,628	8.5%	48.5%
NEWTOWN	1,580	8.3%	56.8%
RIDGEFIELD	1,332	7.0%	63.8%
BROOKFIELD	1,210	6.3%	70.1%
SOUTHBURY	1,098	5.8%	75.9%
NEW MILFORD	927	4.9%	80.7%
NEW FAIRFIELD	893	4.7%	85.4%
REDDING	439	2.3%	87.7%
BREWSTER	225	1.2%	88.9%
WATERBURY	153	0.8%	89.7%
WOODBURY	152	0.8%	90.5%
PAWLING	126	0.7%	91.2%
SHERMAN	112	0.6%	91.7%
CARMEL	107	0.6%	92.3%
OXFORD	101	0.5%	92.8%
PATTERSON	79	0.4%	93.3%
NAUGATUCK	67	0.4%	93.6%
BRIDGEWATER	61	0.3%	93.9%
MAHOPAC	60	0.3%	94.2%
ROXBURY	57	0.3%	94.5%
MIDDLEBURY	55	0.3%	94.8%
KENT	53	0.3%	95.1%
ALL OTHER ZIPS (90)	935	4.9%	100.0%
Grand Total	19,088		

NEW MILFORD HOSPITAL

	2012	% Total	Cum %
NEW MILFORD	1,219	55.7%	55.7%
KENT	128	5.8%	61.5%
SHERMAN	96	4.4%	65.9%
BROOKFIELD	77	3.5%	69.4%
DANBURY	65	3.0%	72.4%
WASHINGTON	65	3.0%	75.3%
NEW PRESTON	61	2.8%	78.1%
BRIDGEWATER	55	2.5%	80.6%
ROXBURY	50	2.3%	82.9%
WINGDALE	46	2.1%	85.0%
PAWLING	38	1.7%	86.8%
CORNWALL BRIDGE	37	1.7%	88.4%
SOUTHBURY	32	1.5%	89.9%
BANTAM	30	1.4%	91.3%
DOVER PLAINS	25	1.1%	92.4%
WOODBURY	25	1.1%	93.6%
NEWTOWN	18	0.8%	94.4%
BETHEL	16	0.7%	95.1%
ALL OTHER ZIPS (34)	107	4.9%	100.0%
Grand Total	2,190		

Source: CHIME and HANYS

Exhibit C

WCHN Primary Service Area & Hospital Utilization

WCHN Primary Service Area

Population: 275,000

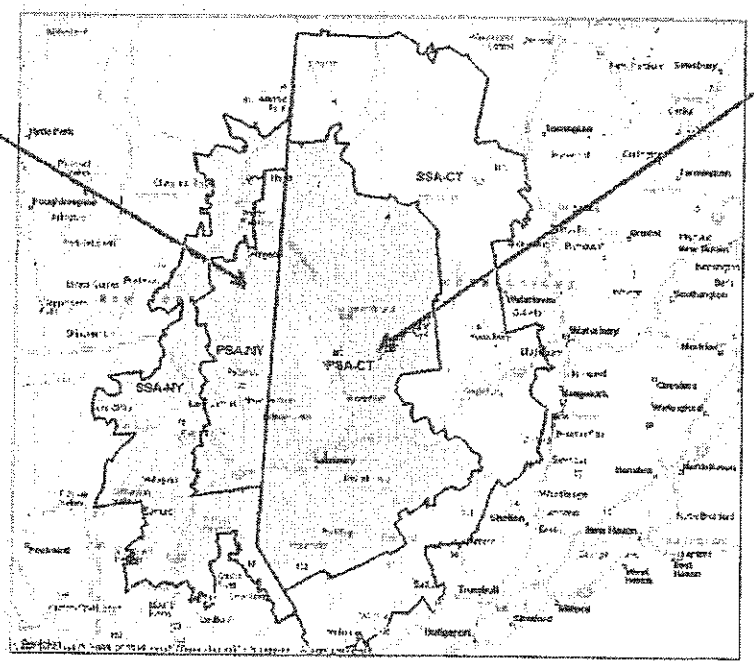
Primary - NY

RANK:

#3 Danbury Hospital
– 467 / 12.4%

#6 New Milford Hospital
– 86 / 2.3%

PSA-NY:
1 out of 7 individuals utilized DH or NMH



Primary – CT

RANK:

#1 Danbury Hospital
– 15,896 / 73.3%

#2 New Milford Hospital
– 1,871 / 8.6%

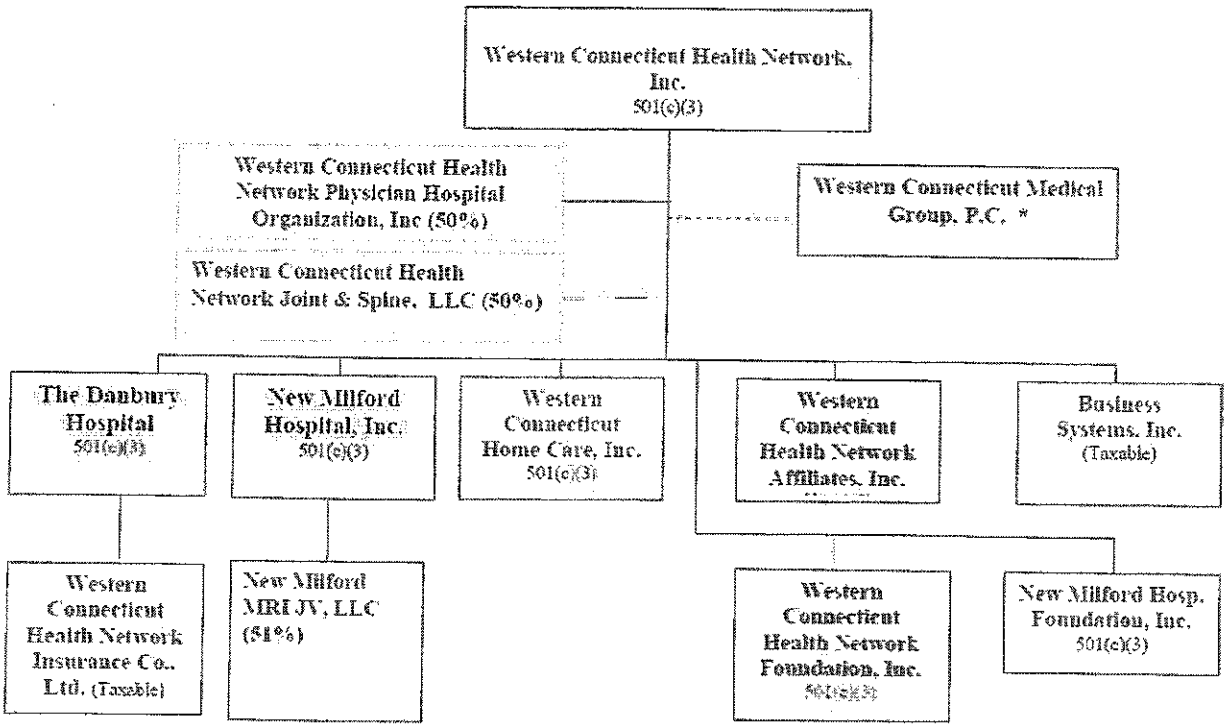
PSA-CT:
8 out of 10 individuals utilized DH or NMH

FY 2012

Source: CHIME and HANYS

Exhibit D

Current Organizational Chart for Western Connecticut Health Network, Inc – 2013



*Controlled entity via management agreement

Exhibit E

WCHN Matrix Organizational Chart

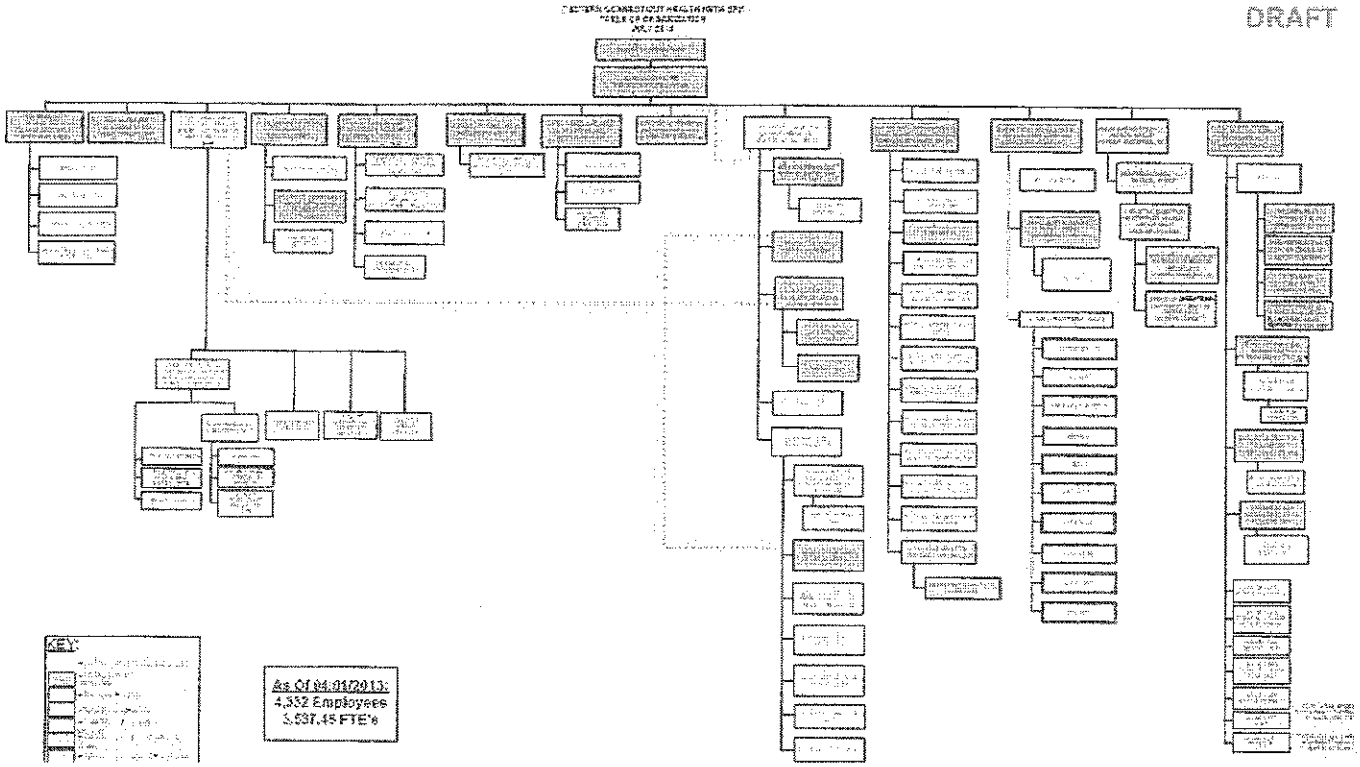


Exhibit F

WCHN Board of Directors Endorsement of Single License

WESTERN CONNECTICUT HEALTH NETWORK
BOARD OF DIRECTORS
December 6, 2012

Draft

A meeting of the Board of Directors of Western Connecticut Health Network, New Milford Hospital and Danbury Hospital was held on Thursday, December 6, 2012 at 8:00 a.m. in the Robinson Conference Room at New Milford Hospital. Chairman of the Board Jim Kennedy presided.

PRESENT:	A. Altorelli, M.D, A. Disney, S. Houldin, J. Kennedy, J. Murphy, MD., J. Patrick, J. Skrzypczak, B. White
VIA TELECONFERENCE:	D. Cyganowski, N. Culligan, and M.D. D. Kramer, M.D.
ABSENT:	R. Jabara.
GUESTS:	Lisa Boyle, Esq. – Robinson & Cole Bruce Barth, Esq. – Robinson & Cole (via teleconference)
ALSO PRESENT:	M. Daglio, C. McKenna, S. Rosenberg, D. Weymouth

CHAIRMAN'S REMARKS

Chairman Kennedy welcomed the directors and guests and noting that we had a quorum, began with the opening of the meeting of the WCHN Board of Directors to review the status of due diligence work being done towards the possible affiliation with Norwalk Hospital.

NEW MILFORD HOSPITAL

GENERAL CONSENT

Approvals Resolutions (attachments):

a. Licensure – New Milford

RESOLUTIONS TO BE CONSIDERED
FOR ADOPTION
AT THE MEETING OF THE GOVERNANCE COMMITTEE OF THE
BOARD OF DIRECTORS
OF
WESTERN CONNECTICUT HEALTH NETWORK, INC.

December 6, 2012

Licensure

WHEREAS, Western Connecticut Health Network, Inc. ("WCHN") is the sole member of The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH");

WHEREAS, the DH and NMH each operate separately licensed hospitals (the "Hospitals"); and

WHEREAS, the DH and NMH desire to authorize the operational activities necessary to present the board of directors of each entity with a plan to merge the two entities and operate the Hospitals as one licensed facility with two campuses.

NOW, THEREFORE, BE IT:

RESOLVED, that, WCHN, as the sole member of each of DH and NMH, hereby authorizes and directs the proper officers of DH and NMH, on behalf of each entity, to take all necessary and appropriate actions to develop a plan of merger and single licensure for DH and NMH, including without limitation engaging consultants and authorizing communications with the Connecticut Department of Health, the Centers for Medicare and Medicaid Services, and the Joint Commission, the taking of such action to be conclusive evidence of the necessity, appropriateness or desirability thereof.

Exhibit G

Curriculum Vitaes

Western Connecticut Health Network, Inc.
President & CEO, John Murphy, MD
Senior VP, COO, Danbury Hospital, Michael Daglio
Executive Director, Senior VP, New Milford Hospital, Deborah Weymouth
Senior VP, CFO & Treasurer, Steven Rosenberg
Senior VP, Human Resources, Phyllis Zappala
Chief Medical Officer, Matt Miller, MD
VP Patient Care Services, CNO, Moreen Donahue, RN
General Counsel, Carolyn McKenna
Chief Risk & Compliance Officer, Joe Campbell
Chief Information Officer, Kathy DeMatteo
VP, Facilities, Morris Gross
VP, Marketing & Communications, Mark Schumann
VP, Quality & Patient Safety, Dawn Myles
VP, Planning, Sally Herlihy
Executive Director & VP Foundation, Grace Linhard

Curriculum Vitae
John M. Murphy, M.D.

Professional Experience

Western Connecticut Health Network (formerly DHS) **July 2010 - PRESENT**
President & Chief Executive Officer
Responsible for direction of core strategic programs, objectives and the enhancement of operational excellence, growth and financial performance of the $750M integrated delivery network. Work in collaboration with physician and nursing leadership to align operational areas to support quality care, patient safety and service excellence initiatives of Danbury Hospital, New Milford Hospital, Western Connecticut Medical Group, Western Connecticut Home Care and associated subsidiaries and the surrounding communities

Danbury Health Systems (DHS), Danbury, CT **July 2008 – June 2010**
Executive Vice President (President /CEO Designee)

Associated Neurologists, P.C., Danbury, CT **1989- 2008**
Clinical neurologist with a particular interest in stroke, multiple sclerosis, and neurodegenerative disorders. I was active both clinically as well as administratively serving as the president of the group for 18 years and actively expanded the group to include clinical research, neurophysiology, neuropsychology and infusion therapy. In addition I was active in clinical research and both undergraduate as well as graduate medical education

Education
Fordham University, Bronx, NY
Major: Biology
Summa cum Laude (G.P.A. 4.0)
B.S., May 1981

UMDNJ -Rutgers Medical School
Piscataway, NJ
M.D., May 1985

Medical Training
1985-1986: Internship, Internal Medicine
UMDNJ-Rutgers Medical School
Middlesex General University Hospital
New Brunswick, NJ

1986-1988: Resident in Neurology

UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

1988-1989: Chief Resident in Neurology
UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

Professional Certifications
Fellow – American College of Physicians – Appointed 2012
Attending Neurologist – Danbury Hospital – 1989 – Present
Clinical Assistant Professor of Neurology – University of Vermont – 2010-Present
Fellow – American Academy of Neurology

Professional Organizations
American College of Healthcare Executives
Board of Directors – Voluntary Hospital Association (VHA)
Board of Trustees – Connecticut Hospital Association (CHA)
Board of Trustees – Union Savings Bank
Connecticut State Medical Society
Fairfield County Medical Society
Fairfield County Neurology Society
American Academy of Neurology

Curriculum Vitae
Michael J. Daglio

Professional Experience

Danbury Hospital, Danbury, CT **June 2004 –Present**

Senior Vice President and Chief Operating Officer ***October 2010 – present***

- Responsible for the following operational areas: Cardiovascular Service Line, Surgical Services, Cancer Center, Women's and Children's, Emergency Department, Radiology, Laboratory, Pharmacy, Facilities, Medical Education and Research.
- Provide senior level oversight of 7 direct reports and 1,400 indirect reports.
- Oversee Operating Budgets of $400,000,000 and manage capital budget of $30,000,000.
- Responsible for the post-merger integration of Danbury Hospital and New Milford Hospital operational and clinical departments.
- Developed a "Portfolio Review" process to identify cost reduction opportunities throughout the network. Achieved $18,000,000 in cost reduction in first twelve months of the program.
- Responsible for physician relations and physician acquisition strategy for key clinical services.
- Developed a "Staffing Management Council" to review all position requests for the Network. Reduced 140 positions through tighter controls, sharing of resources and more stringent approval process.

Vice President, Operations ***October 2007 – October 2010***

- Responsible for Medical Education and Research , the Cardiovascular, Radiology, Laboratory and Women's and Children's Service Lines, and The Emergency and Behavioral Health Departments
- Manage operating budget of $100,000,000 with gross revenues exceeding $350,000,000
- Manage average annual capital budget of $10,000,000 for service lines
- Provide senior level oversight of 10 Directors and a staff of 725 FTEs
- Leading $150,000,000 Hospital facility expansion project, including securing CON approval from the State
- Collaborate in partnerships with Chairmen and Physician Executives for the Service Lines
- Lead physician recruitment efforts and negotiate and execute physician contracts for service lines

Other Positions

- Danbury Hospital - Service Line Executive, Cardiovascular Services and Radiology Services- June 2004-October 2007
- Continuum Health Partners, New York, NY Director, Ambulatory Care - June 2001-June 2004
- Continuum Health Partners, New York, NY Assistant Director, Physician Initiatives Group– May 2000 – June 2001
- The George Washington University Hospital, Washington, DC Administrative Resident – May 1999-April 2000
- The George Washington University Hospital, Washington, DC Interim Administrative Director, Department of Medical Imaging – July 1998- May 1999
- The George Washington University Hospital, Washington, DC Project Coordinator, Department of Quality Management – July 1996 – July 1998

Education

The George Washington University – School of Business and Public Management, Washington, DC Masters of Health Administration, May 2000

The University of Hartford – West Hartford, CT
Bachelor of Arts, Secondary Education and Allied Health, May 1991

Professional Organizations

Danbury Hospital, Regional YMCA of Western Connecticut and the Pound Ridge Partnership – Pound Ridge, NY

Awards

2005 Recipient of the Fairfield County Business Journal's "40 under 40" award for extraordinary leadership qualities and outstanding professional accomplishments that have made a significant impact on my organization and Fairfield County, CT

Curriculum Vitae
Deborah Kinney Weymouth

Professional Experience

Executive Director, Senior Vice President, New Milford Hospital • New Milford, CT Western Connecticut Health Network, Danbury, CT	2011 – Present
Executive Vice President/Chief Operating Officer, Thompson Health • Canandaigua, NY	2009 – 2011
Chief Financial Officer/Senior Vice President, Thompson Health • Canandaigua, NY	2004 – 2009
Senior Vice President of Support Services, Thompson Health • Canandaigua, NY	1999 – 2004
Vice President of Operations, FFThompson Continuing Care Center • Canandaigua, NY	1995 – 1999
Vice President, Key Bank of New York • Rochester, NY	1992 – 1994
Chief Operating Officer, Concierge Services of America • Washington, D.C.	1990 – 1992
Vice President, Citicorp NA/Citibank • Los Angeles, CA and Phoenix, AZ	1985 – 1990
Vice President of Operations, Great Western Bank • Phoenix, AZ	1984 – 1985

Education

Fellow, American College of Healthcare Executives (FACHE)	2007
Master in Business Administration - Master of International Management / Finance Thunderbird Global Management School • Phoenix, AZ	1984
Bachelor of Science - Education and Rehabilitation, Cum Laude Springfield College • Springfield, MA	1979

Professional Certifications

Examiner, Malcolm Baldridge National Quality Award Program	2010-2011
Institute of Healthcare Improvement (IHI) Executive Hospital Operations	2009
Graduate of Citibank Global Credit Training Program • New York, NY	1987

Professional Organizations

Member, New Milford Economic Development Corporation Board	2012 – Present
Member, DNS-Connecticut Hospital Association Fee-Based Services Board	2011 – Present
Member, United Way of Western Connecticut Board	2011 – Present
Chair, CFO Committee - Rochester Regional Healthcare Association	2009-11
Member, Finance Committee – Healthcare Association of NY	2008-11
Member, Information Technology Committee – Healthcare Association of NY	2009-11
Member, Board of Directors- Rochester Healthcare Financial Management Association	2010
Financial Executive of the Year - Rochester Business Journal	2008
Associate of the Year - Thompson Health Shining Star Award	2006
Athena Award, Outstanding Female Leadership - Canandaigua Chamber of Commerce	2002
Lifetime Achievement Award - Canandaigua Chamber of Commerce	1999
Employee of the Year - Great Western Bank	1984
8 Time NCAA All-American Swimmer	1975-79

Curriculum Vitae
Steven H. Rosenberg

Professional Experience

November 2010 – Present **Senior Vice President-Chief Financial Officer-Treasurer**
Western Connecticut Health Network

March 1987 – November 2010 **Senior Vice President and Chief Financial Officer**
Saint Francis Hospital and Medical Center - Hartford, CT

Steven H. Rosenberg is the Senior Vice President-Chief Financial Officer-Treasurer of Western Connecticut Health Network in Danbury, Connecticut. Mr. Rosenberg oversees all financial operations including patient accounting & billing, information technology, materials management, payor relations, contract management, general accounting and financial reporting, payroll, accounts payable, budget, reimbursement and decision support. Danbury Hospital is a 371-bed regional medical center and teaching hospital associated with Yale University, UConn and University of Vermont. The hospital's Centers of Excellence include: cardiovascular services, cancer, weight loss surgery, orthopedic and spine care, digestive disorders and radiology and employs approximately 2,400 FTEs.

Prior to his arrival at the Western Connecticut Health Network, Mr. Rosenberg was Senior Vice President and Chief Financial Officer for Saint Francis Hospital and Medical Center in Hartford, CT. Their health system included a hospital with 619 licensed beds; a 60-bed acute rehabilitation hospital; a faculty practice plan, (Woodland Physician Associates), which employed 110 physicians; a joint laboratory service with Bristol and St. Mary's Hospitals; and a very successful Physician Hospital Organization, which was jointly owned by physicians and the hospital.

Education

University of Connecticut
Storrs, CT
Accounting, BS 1975

University of New Haven
West Haven, CT
MBA 1980

Professional Organizations

Member, Connecticut Hospital Association Committee on Finance
Member, The Healthcare Financial Management Association

Curriculum Vitae
Phyllis F. Zappala

Professional Experience:
In her progressive career spanning over 25 years in general industry and healthcare, Phyllis has served in numerous HR leadership roles with increasing responsibility. Phyllis is known for her expertise in directing rapid growth and change in healthcare, services and manufacturing environments. She has successfully used HR strategies to help organizations achieve their business goals.

Western Connecticut Health Network, Danbury CT – 1998-Present
Senior Vice President Human Resources 2008 to date
Vice President Human Resources 1998 to 2007
Western Connecticut Health Network, consisting of Danbury and New Milford hospitals and numerous subsidiaries, is a leading regional health care provider located in western Connecticut with nearly 5000 employees including a 250 member physician practice subsidiary.

Staveley Industries plc, Norwalk, CT - 1988-1998
A UK based publically traded company with services and manufacturing holdings in 15 countries
Senior Vice President Human Resources, North America 1994-1998
Vice President Human Resources 1988-1994

The Penn Central Corporation – 1978-1988
Vice President of Human Resources and Corporate Communications
services and manufacturing businesses
HR Director 1981-1984
HR Manager 1978-1981

Education
Undergraduate: Bachelors Degree, St. John's University

Professional Certifications
Certificate from the New York School of Industrial Relations at Cornell University

Professional Organizations
American Society for Healthcare Human Resources Administrators (ASHHRA)
Connecticut Hospital Association (CHA)
The HR Investment Center, a program of the Health Care Advisory Board in Washington, D.C.

Curriculum Vitae
Matthew Alan Miller, MD

Professional Experience

1980-94	Director, Medical Intensive Care Unit, Danbury Hospital
1980-94	Chief, Pulmonary/Critical Care, Danbury Hospital
1991-Present	Vice President for Medical Affairs, Danbury Hospital
1994-Present	President, Healthcare Partners (Danbury Physician Hospital Organization)
1996-Present	President, Foundation for Community Health Care, Inc.
2004-Present	Chief Medical Officer, Danbury Hospital

Education

1968	BA	Amherst College, Amherst, Massachusetts
1972	M.D.	New York University School of Medicine, New York, NY

Postdoctoral Training

1972-73	Intern, Internal Medicine, Bellevue Hospital, New York, NY
1973-75	Resident, Internal Medicine, Bellevue Hospital, New York, NY
1975-76	Chief Medical Resident, Bellevue Hospital, New York, NY
1976-78	Clinical and Research Fellow, Pulmonary Unit, Massachusetts General Hospital; Research Fellow, Harvard Medical School, Boston, MA

Licenses and Board Certifications

1975	Diplomat, American Board of Internal Medicine
1975	American Thoracic Society
1978	Diplomat, American Board of Internal Medicine in Pulmonary Disease
1981	Fellowship American College of Chest Physicians

Curriculum Vitae
Moreen Donahue, DNP, RN, NEA-BC, FAAN

Professional Experience

Sr. Vice President, Patient Care Services & Chief Nursing Officer	Western Connecticut Health Network, Danbury, CT	2010 - Present
Sr. Vice President, Patient Care Services & Chief Nursing Officer	Danbury Hospital, Danbury, CT	2006 - 2010
Sr. Vice President, Patient Care Services & Chief Nursing Officer	Greenwich Hospital, Greenwich, CT	2000 – 2005
Director, Home Care & Hospice	Greenwich Hospital, Greenwich, CT	1997 - 2000
Vice President, Patient Care Services	United Home Care, Fairfield, CT	1990 - 1997

Professional History
Four decades of progressive administrative responsibilities in a variety of health care settings

Education

BS (Nursing)	Boston College, Boston, MA
MS (Education)	State University of New York, Cortland, NY
MSN	Case Western Reserve University, Cleveland, OH
DNP	Case Western Reserve University, Cleveland, OH

Professional Certifications

Nurse Executive Advanced – Board Certified	2008 – 2013
Certified Nurse Administrator	2003 – 2008
Certified Home/Hospice Care Executive (CHCE)	1998 – 2002
Professional Educator (State of Connecticut)	Permanent Certificatio

Professional Organizations

American Academy of Nursing Fellowship	2011 – Present
American Organization of Nurse Executives	2007 – Present
American Organization of Nurse Executives – Connecticut	2007 - Present
Sigma Theta Tau International Honor Society of Nursing	2004 – Present
American College of Healthcare Executives	2002 - Present
American Nurses Association	2000 – Present
Connecticut Hospital Association Patient Care Executive Committee	2000 – Present
VHA Northeast CNO Network	2000 - Present

Curriculum Vitae
Kathleen DeMatteo

Professional Experience

July 2011 – Present	Western Connecticut Health Network, Danbury, CT Chief Information Officer

Current responsibilities include oversight of all Information Technology for WCHN including clinical and financial systems, infrastructure, customer service, networking, telecommunications and health information management.

Recent accomplishments include the following:

- Developed an Information Technology Strategic Plan to align with the WCHN Strategic Plan.
- Implemented an IT governance structure to ensure alignment with business priorities.
- Established a strategy to centralize IT resources from Danbury Hospital and New Milford Hospital and standardize infrastructure and applications for the two hospitals.

2004 – 2007	Saint Francis Care, Hartford, CT Chief Information Officer
1999 - 2004	Saint Francis Care, Hartford, CT Director, Information Technology

Education

BS	Occupational Therapy University of New Hampshire, Durham NH
MPH	Healthcare Policy and Administration New York Medical College, Valhalla NY

Professional Organizations

College of Healthcare Information Management Executives (CHIME)
Health Information Management Systems Society (HIMSS)

Curriculum Vitae
Carolyn L. McKenna, Esq.

Professional Experience

Western Connecticut Health Network, Inc., Danbury, CT ***April, 2011 - Present***
General Counsel. Provide legal support for a two-hospital regional health system with home care services, a multi-specialty physician group, research and a multiple joint ventures. Support all corporate transactions, contracting, regulatory issues, litigation oversight, governance, risk and compliance. Provide management oversight responsibility for Western Connecticut Health Network Insurance Company, Ltd., an offshore captive insurance company. Participate in strategic development as a senior team member.

Eastern Connecticut Health Network, Inc., Manchester, CT	2003 - 2011
CIGNA Healthcare, Bloomfield, CT	2002 - 2003
YALE NEW HAVEN HEALTH SERVICES CORP., New Haven, CT	1998 - 2002
UNITED HEALTHCARE, INC., Hartford, CT Associate General Counsel	1995 - 1998
QUINNIPIAC UNIVERSITY SCHOOL OF LAW, Hamden, CT	1998 - 2001
U.S. DISTRICT COURT, District of Connecticut	1993 - 1995
U.S. COURT OF APPEALS FOR THE SECOND CIRCUIT	1992 - 1993

Education

UNIVERSITY OF BRIDGEPORT SCHOOL OF LAW, Bridgeport, CT
(Note: This is now Quinnipiac University School of Law, Hamden, CT)
J.D., May 1992 (Rank: Top 4%)
Honors: *magna cum laude*; Dean's Scholarship recipient
Activities: *University of Bridgeport Law Review*, Managing Editor; Phi Delta Phi Honors Fraternity

UNIVERSITY OF VERMONT, Burlington, VT
B.A. in English May 1985

Professional Certifications

Member of Connecticut and District of Connecticut Bars

Professional Organizations

American Health Lawyers In House Legal Counsel
Healthcare Roundtable
Association of Corporate Counsel
Connecticut Health Lawyers Association

Curriculum Vitae
Joseph A. Campbell

Professional Experience

2001 to Present	Chief Risk & Compliance Officer – Western Connecticut Health Network
1989 – 2001	Chief Compliance Officer & Quality Executive – Greater Waterbury Health Network
1987 – 1989	Visiting Nurse Association of South Central Connecticut – Chief Financial Officer

Professional experience includes more than thirty years in the non-profit, healthcare industry in Connecticut; approximately ten years in Finance, ten years in Quality Management and fourteen years in Compliance.

Currently responsible for WCHN's Compliance Program that includes Regulatory Compliance, Revenue Compliance, Physician Coding Compliance, Internal Audit, Enterprise Risk and HIPAA Privacy.

The Chief Risk & Compliance Officer serves as a consultant to senior management in a matrix organization; is the key contact with outside regulators, i.e., DHHS Office of the Inspector General; U.S. Department of Justice; DHHS Office of Civil Rights; State of Connecticut Department of Social Services; and State of Connecticut Office of the Attorney General.

Education

B.S. Degree in Accounting/Business Administration
M.S. Degree in Healthcare Management
Rensselaer Polytechnic Institute

Professional Organizations

American College of Healthcare Executives
Health Care Compliance Association
Healthcare Financial Management Association
Institute of Internal Auditors

Professional Presentations

"The Role of Compliance in the Revenue Cycle"
Connecticut Chapter – Healthcare Financial Management Association, Uncasville, CT

"Retrospective Review of an OIG Self-disclosure"
American Health Lawyers Association/Healthcare Compliance Association, (AHLA/HCCA)
Fraud and Abuse Forum, Baltimore, MD

"Improving Internal Response to Audit & Compliance Situations"
Connecticut Hospital Association Annual Compliance Conference, Wallingford, CT

"Physician Responsibilities Under EMTALA"
National Association of Medical Staff Services, Las Vegas, NV

Curriculum Vitae
Morris Gross

Professional Experience

Danbury Hospital since 1975 in administration (38 years). During this time period has been responsible for almost all hospital departments, both clinical and support departments. Has held role of Vice President Facilities since 1992, and since October 2010 has been responsible for Facilities for Western Connecticut Health Network which includes both Danbury and New Milford Hospitals.

Since 1975, I have provided administrative support for all major construction projects including the Tower Project completed in 1979, the construction of the Stroock building, Cancer Center, Medical Arts Center building and Garage, and currently am responsible for the New North Tower project totaling 316,000 sq ft plus Blue Garage expansion. I am also responsible for the siting, development and ongoing facilities support for all offsite locations for Danbury and New Milford Hospitals as well as the development and implementation of the Master Facility Plan of both hospitals. In addition to construction and offsite development, I am currently administratively responsible for the Facilities division at Danbury and New Milford Hospitals including all plant operations, safety, security, environmental services, dietary, gift shops, and spiritual care.

Education

Undergraduate- University of Connecticut, Bachelors in Physical Therapy (1971)
Graduate- New York University, Masters in Health Administration within Graduate School of Public Administration (1975)

Professional Certifications

Licensed in Physical Therapy in Connecticut and New York
Fellow in the American College of Health Executives

Professional Organizations

Fellow in the American College of Healthcare Executives
Education Chairman for Connecticut for the American College of Healthcare Executives (since 1992)
On Board of Habitat for Humanity for Fairfield County

Other Areas of Interest

Member of Danbury Connecticut Lions Club since 1978

Curriculum Vitae:
D. Mark Schumann

Professional Experience:
April 2013-Present: Vice President, Marketing and Communications, WCHN
January 2010-April 2013: Principal, re-communicate
January 1984-January 2010: Managing Principal, Towers Perrin
June 1978-January 1984: Director, Public Relations/Advertising, Frontier Airlines

Education:
1977: Bachelor of Arts, Austin College, Sherman, Texas
1978: Master of Arts, University of Denver, Denver, Colorado

Professional Certifications:
Accredited Business Communicator, International Association of Business Communicators

Professional Organizations:
1978-Present: International Association of Business Communicators
Chair, 2009-2010

Other Areas of Interest:
September 1999-Present: Film Critic, Hersam Acorn Press, Connecticut

Curriculum Vitae
Dawn N. Myles

Professional Experience

12/08-Present — *Vice President, Quality and Patient Safety, Western Connecticut Health Network, Danbury, CT*
Direct the strategic planning and program implementation for quality improvement, patient safety/risk management, patient relations, volunteers, and infection control. Responsible for regulatory compliance programming and communication. Oversee initiatives with high impact on quality, patient safety, and efficiency.

10/97-12/08 — *Director of Performance Improvement/Chief Quality Officer, Danbury Hospital, Danbury CT*
Directed performance improvement, patient safety/risk management, patient relations, infection control, project management, and medical informatics functions. Responsible for clinical regulatory compliance functions. Oversaw participation in national quality programs, such as those sponsored by Leapfrog and the Institute for Healthcare Improvement

02/96-6/00 — *Director of Nursing & Quality Management, Behavioral Health, Danbury Hospital, Danbury, CT*
Supervised nursing practice in all inpatient and outpatient psychiatric and chemical dependency programs. Was directly responsible for daily operations on the inpatient psychiatric unit. Organized a system of orientation and cross training of service line nursing staff. Redesigned the Behavioral Health Quality Management program.

Education

01/95-09/96 — *M.S., Nursing, Clinical Nurse Specialist - Psychiatric/Mental Health Nursing, Pace University, Pleasantville, NY*
09/89-05/92 — *B.S., Nursing, Western Connecticut State University, Danbury, CT*
09/88-05/90 — *M.S., Counseling, Southern Connecticut State University, New Haven, CT*
09/84-05/88 — *B.A., Psychology/Communications, Western Connecticut State University, Danbury, CT*

Professional Certifications

Certified Professional in Healthcare Quality (CPHQ)
Certified Professional in Healthcare Risk Management (CPHRM)

Professional Organizations

American Society for Healthcare Risk Management
Connecticut Society for Healthcare Risk Management

Other Areas of Interest

Mentoring and Training

Curriculum Vitae
Sally F. Herlihy, MBA, FACHE

Professional Experience

2010 – Present Western Connecticut Health Network, Danbury, CT
2010 – Present, VP, Planning
2011– 2013 Interim VP, Marketing

Plans, organizes, directs and facilitates strategic planning processes, including creation of an overall WCHN Strategic Plan and monitoring implementation. Manages and coordinates planning across network entities, consults and informs leadership and service lines on business and strategic planning issues, including market share, market surveys, planning processes, future trends, and environmental assessments, and managing the regulatory/CON process. Directs community needs assessments, and collaborates in the strategic marketing planning for WCHN.

1985 – 2010 New Milford Hospital, Inc. New Milford, CT
2007 – 2010 VP, Regulatory Compliance
1997 – 2007 VP, Planning and Marketing
1988 – 1997 VP, General Services
1985 – 1988 Corporate Project Planner

1980 – 1985 The Seiler Corporation, Waltham, MA
1983-1985 Director, Food Services, New Milford Hospital, CT
1981-1983 Chief Dietitian, New Milford Hospital, CT
1980-1981 Clinical Dietitian, St. Elizabeth Hospital, Utica, NY

Education

1995 University of New Haven, New Haven, CT
MBA (concentration in Health Care Management)
1980 University of Connecticut, Storrs, CT
BS Degree, School of Allied Health (Clinical Dietetics)

Professional Certifications

1992 - Present American College of Health Care Executives
Fellow Status – 2007, recertified - 2010
Diplomate – 1998, recertified - 2006
Member – 1992

American Dietetic Association
Registered Dietitian – 1980 - 2000

Curriculum Vitae
Grace Linhard

Professional Experience
Executive Director & Vice President, WCHN Foundation
2011-present

Vice President, Danbury Hospital Development Fund
2004-2011

Chief Development Officer, Waterbury Hospital
1998-2004

- Fundraising professional for 20 years
  Experience in United Way system (4 years) and healthcare philanthropy (16 years)
- Currently overseeing $50 million campaign for WCHN
- Manage $10+ million annual fundraising effort for WCHN's two hospitals
- Oversee fundraising department with 13 staff members
- Work closely with WCHN leadership team, physician leaders, Boards of Directors and other volunteer committees to maximize fundraising potential
- Develop and execute fundraising goals/plans

Education
Stonehill College
BA, Communication/Journalism

Professional Organizations
Association of Fundraising Professionals
New England Association of Healthcare Professionals
Planned Giving Society of Connecticut

Volunteer Affiliations

Board Chairman	- Jane Doe No More, Inc.
Alumni Class Agent	- Stonehill College
Volunteer	- Church of the Nativity, Bethlehem
Fundraising Consultant/Volunteer	- Clube Uniao Portuguesa

Awards / Recognitions

2010 Conference Speaker	- Int'l Assn of Fundraising Professionals
2009 Conference Speaker	- NE Assn of Healthcare Professionals
2008 Leadership Graduate	- Danbury Chamber of Commerce
2002 Leadership Graduate	- Greater Waterbury Chamber of Commerce
2002 Conference Chairman	- Assn of Fundraising Professionals

Exhibit H

Financial Attachment 1

Danbury Hospital

6.A. Financial Attachment 1

(Dollars are in thousands)
Total Facility:

Description	FY2012 Actual Actuals	FY2013 Projected Actuals	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected Actuals	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected Actuals	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected Actuals	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$285,502	289,950	-	289,950	$296,458	47,040	$343,470	$316,014	49,844	$364,729	$327,328	50,221	$377,567
Medicare	170,894	172,609	-	172,609	176,721	15,657	192,413	175,191	15,842	191,003	177,643	15,026	192,641
Medicaid and Other Medical Assistance	35,801	37,262	-	37,262	37,861	5,344	43,205	37,405	5,349	42,774	37,516	4,976	42,491
Other Governmental	305	325	-	325	325	85	410	325	85	410	325	85	410
Total Net Patient Patient Revenue	$502,423	$500,146	$0	$500,146	$511,365	$71,167	$582,532	$529,035	$71,120	$598,915	$542,812	$74,090	$617,969
Other Operating Revenue	$23,127	$11,393	-	$11,393	$11,462	$850	$12,312	$10,649	$850	$11,499	$10,844	$850	$11,694
Revenue from Operations	$514,549	$519,539	$0	$519,539	$522,827	$72,017	$594,844	$539,684	$71,970	$610,414	$553,656	$74,940	$629,663
OPERATING EXPENSES													
Salaries and Fringe Benefits	$354,364	$364,995	-	$364,995	$376,055	49,670	$425,725	$385,236	49,859	$435,147	$375,283	49,835	$425,118
Professional / Contracted Services	85,287	85,938	-	85,938	87,057	9,772	96,829	88,128	9,693	97,068	89,362	9,073	98,434
Supplies and Drugs	77,261	80,299	-	80,299	82,708	9,895	92,603	85,150	9,175	94,325	87,745	10,478	98,223
Other Operating Expenses	61,366	61,367	-	61,367	61,466	10,176	71,642	60,736	13,188	73,924	63,057	10,153	73,210
Subtotal	$4,422,359	$4,451,599	$0	$4,451,599	$4,481,304	29,287	$4,510,591	$4,459,935	31,115	$4,540,228	$4,483,248	79,470	$4,562,918
Depreciation And Amortization	51,963	51,976	-	51,976	56,106	5,546	62,372	49,999	5,849	67,605	49,992	7,646	62,966
Interest Expense	4,155	5,237	-	5,237	4,627	258	4,885	5,837	258	6,095	5,026	259	5,563
Lease Expense	7,304	7,472	-	7,472	7,581	880	8,461	7,778	841	8,619	7,959	849	8,778
Total Operating Expenses	$4,485,784	$4,524,958	$0	$4,524,958	$4,609,727	979,497	$4,586,124	$4,563,779	74,899	$4,638,649	$4,541,954	$91,297	$4,633,140
Gain/(Loss) from Operations	$29,765	$28,495	$0	$28,495	$20,847	($4,946)	$15,015	$15,005	($4,929)	$7,954	$11,703	($16,777)	$5,073
Plus: Non-Operating Income	$14,227	$14,837		$14,837	$14,481	$0	$14,481	$14,395	$0	$14,395	$14,163	$0	$14,163
Income before provision for income taxes	$43,992	$43,332	$0	$43,332	$35,328	($4,946)	$29,496	$29,399	($4,929)	$22,349	$25,866	($16,777)	$19,236
Provision for Income taxes			-	$0		$0	$0		$0	$0		$0	$0
Revenue Over/(Under) Expense	$43,992	$43,332	$0	$43,332	$35,328	($4,946)	$29,496	$29,399	($4,929)	$22,349	$25,866	($16,777)	$19,236
FTEs	3,405.1	3,575.5	-	3,575.5	3,575.5	379.0	3,744.5	3,575.5	379.0	3,744.5	3,571.7	379.0	3,744.7
Volume Statistics: Inpatient Discharges	16,573	16,951		16,951	16,464	1,606	20,067	16,503	1,664	20,167	16,129	1,646	19,775
Outpatient Visits	450,413	454,038	-	454,038	465,973	47,648	493,621	467,717	47,668	493,385	478,469	48,020	497,489
Key Ratios:													
Op Margin	5.8%	4.8%		4.8%	3.8%		2.7%	2.4%		1.0%	2.1%		0.8%
Operating EBDA Margin	13.4%	13.4%		13.4%	13.4%		13.2%	13.1%		13.2%	13.5%		13.2%
Excess Margin	8.5%	7.5%		7.5%	6.8%		5.0%	5.1%		3.7%	4.6%		3.1%

New Milford Hospital

6.A. Financial Attachment I

(Dollars are in thousands)

Total Facility Description	FY 2012 Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$48,136	45,662	-	45,662	47,042	(47,042)	-	48,544	(48,544)	-	50,231	(50,231)	-
Medicare	24,342	19,222	-	19,222	18,687	(18,687)	$0	19,342	(18,342)	$0	19,099	(19,099)	$0
Medicaid and Other Medical Assistance	5,632	5,340	-	5,340	5,344	(5,344)	$0	5,349	(5,349)	$0	5,376	(5,376)	$0
Other Government	101	85	-	85	85	(85)	$0	85	(85)	$0	85	(85)	$0
Total Net Patient Patient Revenue	$78,711	$70,245	$0	$70,245	$71,157	($71,157)	$0	$72,820	($72,820)	$0	$74,780	($74,780)	$0
Other Operating Revenue	$1,101	$980	-	$980	$980	($980)	$0	$980	($980)	$0	$980	($980)	$0
Revenue from Operations	$79,212	$71,225	$0	$71,225	$72,137	($72,137)	$0	$73,799	($73,799)	$0	$75,759	($75,759)	$0
OPERATING EXPENSES													
Salaries and Fringe Benefits	$45,239	$40,419	-	$40,419	$41,329	(41,329)	$0	$42,269	(42,269)	$0	$43,209	(43,209)	$0
Professional / Contracted Services	12,196	8,713	-	8,713	8,887	(8,887)	-	9,085	(9,085)	-	9,246	(9,246)	-
Supplies and Drugs	10,415	9,589	-	9,589	9,878	(9,878)	-	10,173	(10,173)	-	10,475	(10,475)	-
Other Operating Expense	10,942	10,360	-	10,360	10,360	(10,360)	-	10,360	(10,360)	-	10,360	(10,360)	-
Subtotal	$78,792	$69,081	$0	$69,081	$70,452	($70,452)	$0	$71,886	($71,886)	$0	$73,294	($73,294)	$0
Depreciation/Amortization	5,827	5,862	-	5,862	6,162	(6,162)	-	7,162	(7,162)	-	8,162	(8,162)	-
Interest Expense	419	288	-	288	268	(268)	-	268	(268)	-	268	(268)	-
Lease Expense	447	824	-	824	832	(832)	-	841	(841)	-	849	(849)	-
Total Operating Expenses	$85,164	$76,035	$0	$76,035	$77,715	($77,715)	$0	$80,127	($80,127)	$0	$82,573	($82,573)	$0
Gain/(Loss) from Operations	($5,972)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
Plus: Non-Operating Income	$772	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income before provision for income taxes	($5,200)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
Provision for income taxes			-	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense	($5,200)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
FTEs	420.0	375.0	-	375.0	375.0	(375.0)	-	375.0	(375.0)	-	375.0	(375.0)	-
*Volume Statistics: Inpatient Discharges	2,069	1,922		1,922	1,903	(1,903)	-	1,884	(1,884)	-	1,865	(1,865)	-
Outpatient Visits	51,244	47,455	-	47,455	47,645	(47,645)	-	47,835	(47,835)	-	48,030	(48,030)	-
			-	-	-	-	-	-	-	-	-	-	-
Key Ratios:													
Op Margin	-7.5%	-6.5%		-6.5%	-7.7%		0.0%	-8.6%		0.0%	-9.0%		0.0%
Operating EB DA Margin	0.0%	1.9%		1.7%	1.3%		0.0%	1.5%		0.0%	2.1%		0.0%
Excess Margin	-6.6%	-6.8%		-6.8%	-7.7%		0.0%	-8.6%		0.0%	-9.0%		0.0%

Exhibit I

Financial Assumptions

Western CT Health Network - DH / NMH Single License

6.C. Financial Assumptions

Financial Assumptions With Project anticipate all revenue and expenses will shift from New Milford Hospitals financials to Danbury Hospitals financials statements (see incremental column). In addition, savings as a result of this project have been further incorporated as follows:

Current NMH Operating Expenses/FTEs by Projected By Year:

Dollars reflected in thousands	Year 1	Year 2	Year 3	
NMH Without Project Operating Income	($5,578)	($6,328)	($6,813)	
Savings Projected with Project:				
Salaries & Fringe Benefits	350	350	350	2.0 FTE Savings anticipated with system integration
Contracted Services	175	175	175	Audit Services
Other Operating Expense				
Software Expense	154	158	162	Savings with consolidation of software
Membership Dues	26	26	26	Savings with consolidation of membership dues
JCAHO	10	10	10	Reduction
Depreciation	513	513	513	Savings in capital costs from after Meditech upgrade (see below)
Total Savings	1,228	1,232	1,236	
Operating Income WITH PROJECT	(4,349)	(5,096)	(5,577)	

Depreciation Savings identified above is comprised of the following capital costs depreciated over 5yrs:

Cost to Upgrade Meditech Systems (reflected as savings)	3,161
Incremental implementation costs to move to single platform	(597)
Net Savings	2,564
Depreciation Exp over 5yrs	513

* Moving to a single platform avoids extensive capital investment as well as ongoing annual maintenance savings.

Overall Hospital Projections WITHOUT PROJECT were based on the assumptions outlined below:

Net Patient Revenue/Volumes:	Determined using historical payment experience and anticipated overall volume increases
Other Operating Revenue:	Assumes 0% increase annually
Salaries and Fringe Benefits:	Based on historic and planned expense combined with inflationary increases
Professional / Contracted Srvs:	Assumes 2% annual increase, based on projected trend
Supplies and Drugs:	Assumes 3% annual increase, based on historical data combined with inflationary increases
Other Op Expenses:	Based on historic trend
Depreciation:	Assumption is based on historic and planned annual capital spending
Interest:	Based on current interest of existing debt rolled forward annually.
Lease Expense:	Includes a 3% annual increase on expenses annually.
FTEs:	Includes increase in variable staffing required to support growth combined with conversion and productivity increases currently underway.

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

RECEIVED
AUG 15 2013
OFFICE OF
HEALTH CARE ACCESS

August 12, 2013

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

Re: Western Connecticut Health Network, Inc. CON Request

Dear Ms. Martone,

Pursuant to Section 19a-638, C.G.S., please find enclosed a Certificate of Need for Western Connecticut Health Network, Inc., to merge The Danbury Hospital and New Milford Hospital, Inc. under a single general hospital license with two campuses.

If you have any questions that the attached submission does not answer, please contact me so that we may provide whatever additional information you need in your deliberations. I can be reached directly at 203-739-4903, or sally.herlihy@wchn.org.

Thank you,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

(Note: Submitted via email to Leslie.greer@ct.gov and Steven.lazarus@ct.gov, with original copy and Filing Fee mailed to OHCA).

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☒ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 13-31859-CON **Check No.:** 830033
OHCA Verified by: SED **Date:** 8/15/13

☒ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☒ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☒ **Attached are completed Financial Attachments I and II.**

N/A Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders. – sent via email

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to the following email addresses: steven.lazarus@ct.gov **and** leslie.greer@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

N/A The following have been submitted on a CD – PDF sent via email

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL • NEW MILFORD HOSPITAL

Accounts Payable Telephone: 203-739-7169

Wachovia Bank of Delaware, NA
62-22/311

Check No. 830033

Check Date
08/12/2013

PAY *Five Hundred AND 00/100*

Check Amount
$ ********500.00

TO THE ORDER OF
TREASURER STATE OF CT
410 CAPITOL AVE
HARTFORD, CT 06134

12592

PUBLIC NOTICES

STATE OF CONNECTICUT
COUNTY OF FAIRFIELD
CITY OF DANBURY

U-HAUL OF LOWER HUDSON VALLEY, 300 WINDSOR HIGHWAY, NEW WINDSOR, NY 12553, HEREBY GIVES NOTICE TO ALL INTERESTED PARTIES THAT THE CONTENTS OF STORAGE UNITS LOCATED 75 DIVISION ST, DANBURY, CT 06810, WILL BE SOLD TO THE HIGHEST BIDDER DUE TO THE NONPAYMENT OF RENT AS STATED IN THE RENTAL AGREEMENT. THE CONTENTS OF THESE UNITS CONSISTS OF FURNITURE, HOUSEHOLD GOODS, AND OTHER MISCELLANEOUS PROPERTY.

THE SALE OF THIS PROPERTY WILL BE HELD AT U-HAUL OF MIDTOWN, 75 DIVISION ST, DANBURY, CT 06810, ON JULY 18TH, 2013 AT 10:00 A.M.

B004 TIFFANY FORD
B801 JERMAINE HUGHES
C010 SOUFIANE OULED-AMOR
D018 DEBORAH WADE
D005 LAURENCE YEGU-MONTHE
D006 JENNIFER KERN
DD22 CHRIS ROBERTS
E026 VICTORIA BOOTH
H005 EDUARDO RIBEIRO
H016 DEBORAH WADE
H017 JENNIFER KERN
J013 JIM REAGAN
L003 JOLINE FERNANDEZ
L012 STEVEN RISI
L014 CINDY THORNE

WARNING
NOTICE OF SPECIAL TOWN MEETING
OF THE TOWN OF BETHEL, CONNECTICUT

The Legal Voters of the Town of Bethel, Connecticut, and those persons entitled to vote therein, are notified to assemble at a Special Town Meeting to be held in the Clifford J. Hurgin Municipal Center - Meeting Room A, 1 School Street, Bethel, Connecticut 06801 on Wednesday, July 10, 2013 at 7:00 p.m. for the following purposes, to wit:

1.)To consider and take action upon a recommendation of the Bethel Board of Selectmen and approved by the Bethel Board of Finance to sell all of the assets of the Bethel Water System which includes certain real property to Aquarion Water Company of Connecticut pursuant to an Asset Purchase Agreement dated effective as of April 29, 2013 for the purchase price of Seven Million Two Hundred Thousand ($7,200,000.00) Dollars.

Pursuant to Connecticut General Statute § 7-7, the Bethel Board of Selectmen by resolution on July 2, 2013 have removed this Item No. 1, the sale of the assets of the Bethel Water System from vote by the body of this Special Town Meeting and adjourned this vote to a Town wide machine vote to be held on the date as established by this body of the Special Town Meeting between the hours of twelve o'clock noon (12:00) PM and eight o'clock (8:00) PM unless the body of this Special Town Meeting approves earlier hours for the opening of the Town wide machine vote pursuant to Connecticut General Statute § 7-7.

A copy of said Agreement for the sale of the Bethel Water System assets is available for review during normal business hours at the Office of the First Selectman of Bethel, Clifford J. Hurgin Municipal Center, 1 School Street, Bethel, CT.

2.)To consider and take action upon a recommendation of the Bethel Board of Selectmen and approved by the Bethel Board of Finance to accept the transfer of ownership of 119,890,1020 SQ.FT.-2.74 acres of real property as open space from T. B. And Sons which real property is located at Knollwood Drive and Rotella Drive adjacent to other land of the Town of Bethel. The transfer of said property fulfills the requirements of a resubdivision approval for Knollwood Drive and Granite Drive by the Bethel Planning & Zoning Commission.

A copy of said map depicting the real property to be transferred is available for review during normal business hours at the Office of the First Selectman of Bethel, Clifford J. Hurgin Municipal Center, 1 School Street, Bethel, CT.

3.) To take any and all action legally necessary or appropriate to accomplish the above intended results.

Dated at Bethel, CT this 2nd day of July, 2013.

BETHEL BOARD OF SELECTMEN
Matthew S. Knickerbocker, First Selectman
Richard C. Straiton, Selectman
Paul R. Szatkowski, Selectman

NOTICE OF PUBLIC HEARING ON
PROPOSED FARE AND SERVICE CHANGES

The Housatonic Area Regional Transit (HARTransit) invites public comment on proposed changes to fares and bus services. Proposals include:
•Raising the base fare for fixed route from $1.25 to $1.50 with other fixed route fare classes increasing proportionately.
•Elimination of the Danbury Trolley route.
•Increasing the minimum eligible age for senior half fare to 65, and
•Raising the minimum eligible age for senior SweetHART Dial-A-Ride to 65.
These changes, if approved by the HARTransit Board of Directors, are proposed to take effect on September 1, 2013. Hearings will take place at the following dates and locations:

Tuesday, August 6, 2:00pm
Bethel Senior Center, 1 School St., Bethel

Wednesday, August 7, 4:00pm
New Milford Town Hall, 10 Main St, New Milford

Thursday, August 8, 4:00pm
HARTransit, 62 Federal Rd., Danbury

Written comments may be submitted to HARTransit, 62 Federal Road, Danbury, CT 06810 until Friday, August 9, 2013. For information, contact HARTransit at (203)744-4070 or info@hartransit.com.

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and New Milford Hospital (NMH) will submit the following Certificate of Need application to the CT Office of Health Care Access:
Applicants: Western Connecticut Health Network, Inc. (WCHN) which includes The Danbury Hospital (DH) and New Milford Hospital, Inc. (NMH)
Addresses: WCHN and DH are located at 24 Hospital Avenue, Danbury, CT. NMH is located at 21 Elm Street, New Milford, CT.
Proposal: This proposal involves consolidating the operations of DH and NMH under a single license, as they are already governed by the same parent board of directions and have a unified mission to promote the health and well being of people in the communities it serves in a cost-effective manner.
Capital Expenditure: $ 0

GENERAL HELP WANTED

PROCESSING OPERATOR - FT
Chemical filling dept- 2nd Shift

GENERAL HELP WANTED

RECEIVING DEPARTMENT
If you are an organized, self-starter

PUBLIC NOTICES

LEGAL NOTICE

The Superior Court has found that the persons listed below own property seized in connection with a drug offense. Pursuant to General Statutes § 54-36h, the State of Connecticut has petitioned for forfeiture of the property. The State hereby gives notice that unless the owners appear to contest the forfeiture, the State will move the Court to enter a default and judgment, resulting in forfeiture of the property.

The Court has ordered a hearing on the State's Petition for July 26, 2013 at 11:15 a.m., at the Superior Court, G.A. 3 Danbury, 146 White Street, Danbury, CT 06810.

This case is pending:
CV13-4018376-S: State v. $10,625.00 in U.S. Currency [Kenneth Wright]
By: CHRISTOPHER MALANY
Supervisory Assistant
State's Attorney
Asset Forfeiture Bureau
Office of the
Chief State's Attorney
Tel.# (860) 258-5810

LEGAL NOTICE

NOTICE IS HEREBY GIVEN that on June 18, 2013 a demolition application was filed in the Brookfield Building Dept. by Bohan Contracting having an address at, 74 Mygatt Rd New Preston CT for the following address and action:

235 Federal Rd Permit # 2013000564, demolition of a commercial building

Said notice is on file in the Town of Brookfield Land Use Office.

Dated this 2nd day of July 2013
Brookfield Building Department

STATE OF CONNECTICUT
JUVENILE MATTERS
SUPERIOR COURT,
DANBURY, CT
NOTICE TO: DEREK WILSON of parts unknown.
A petition has been filed seeking: Commitment of minor child of the above named or vesting of custody and care of said child of the above named in a lawful, private or public agency or a suitable and worthy person.
The petition whereby the court's decision can impact your parental rights, if any, regarding the minor child will be heard on 7/10/13 at 10:15 am at SCJM 71 Main Street, Danbury, CT 06810.
It is therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the Danbury News-Times, 333 Main Street, Danbury, CT, a newspapar having a circulation in the town of Danbury.
Judge Donna Nelson Heller
Antoinette Beal, Clerk, 6/27/13.
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is to be held.

SCHOOLS & JOB TRAINING

AMERICAN RED CROSS

CNA/NURSE ASSISTANT TRAINING

Day & Evening Classes
Flexible Payment Plan

Offered at:

American Red Cross
7 Park Lawn Drive
Bethel, CT
(located near Target)
203-702-1280

American Red Cross
1057 Broad Street 3rd Flr.
Bpt., CT 203- 338-0951

Financial aid available for qualified applicants

Approved by the
CT Commissioner of Higher Education
and CT Department of Public Health

CAREER TRAINING

★ Certified Nurse's Aid
★ Patient Care Technician Level I-II
★ Phlebotomy

Day, Evenings and Weekends

BRANFORD HALL CAREER INSTITUTE
155 Main Street, Suite 302
Danbury, CT 06810
203-797-1461

SITUATIONS WANTED

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE
DANBURY PROBATE COURT

NOTICE TO CREDITORS

ESTATE OF
CLAIRE LORRAINE LUNDQUIST
AKA Claire L. Romig
(13-0367)

The Hon. Dianne E. Yanin, Judge of the Court of Probate, Danbury Probate District, by decree dated June 27, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Jessica E. Regan, Assistant Clerk

The fiduciary is:

Eric Lundquist, 20 Agnes Drive, Manchester, CT 06042
Paul Lundquist, 148 Currituck Road, Newtown, CT 06470.

MERCHANDISE FOR SALE

ANTIQUE TABLETOP wooden pinball game w/orig. 18 steel balls and stick. $100. 203-748-2774

AREA RUG Good cond. 5'6"L x 7'11"W. $29. 203-746-1711

BABY CAR SEAT
Britax Roundabout
Excellent Condition $50.00
203-775-6925

BABY HIGH CHAIR folds up. $19. call 203-743-3297

BASKETBALL CARD SET '90-91 NBA Hoops Series Complete Set 1-396 Mint , incl. Jordan $29. 203-291-4893

BED Queen Pillowtop Mattress & Boxspring. Brand New, Still in Plastic. Sacrifice $250. 203-557-0949

BEDROOM SET, Solid Wood, Queen Size, Boxspring, Mattress, Dresser, Chest, 2 Night Stands, Metal Frame Headboard, Custom Made By Stanley Woodworks, Excellent Condition, $450, 203-644-8750.

BEDROOM CHERRY solid sleighbed, dresser, mirror, chest, night stand. Cost $2500. Sacrifice $950. 203-557-0949

BED TABLE
asking $60. 203-731-0477

BEENIE BABY COLLECTION
TAGS IN PERFECT CONDITION
1997-2001 Vintage
Qty. over 400
Buy a few or the whole lot
Most $2.50 each
Many with matching McDonald's
$5.00
203-775-5925

BICYCLE: Woman's Schwinn World Sport. 12 speeds. 27 inch. Excellent condition. $75. 203-744-2955.

BIKE RACK for minivan - carries 2 bikes, $45 BO. call 203-743-3297

BROWN HUTCH $75.
203-300-4709 New Milford

BUNK BEDS by Stanley Furniture. Twin w/ storage unit. Wooden convertible to two twin beds. Excellent condition & quality. $449. Call 203-288-9531.

CABINETS Glazed Maple. New, Never Installed. All Wood, Dovetail. Can add or subtract to Fit Kitchen. Cost $9000, sell $2500. Can Deliver. 203-247-9459.

CALCULATORS - DESK TOP
WITH TAPE CASIO PR725G
12 DIGIT $20.00
203-775-6925

CALCULATORS - DESK TOP
WITH TAPE CASIO DL-25L
HEAVY DUTY 12 DIGIT $20.00
203-775-6925

CAMERA - CANNON 35MM
EOS REBEL G QD $50.00

ALSO

CANNON 35MM EOS
REBEL G11 $50.00

BOTH CAMERAS W/ MANUALS
IN WORKING ORDER
203-775-6925

CAMPING LANTERN AM/FM RADIO WEATHER LOTS MORE. $50. 203-746-5046

CAR RAMPS for repairing car, brakes, oil, etc. $29. 203-743-3297

CHAIR - IKEA PELLO HOLMBY
Natural light color fabric.
Great for dorm, kids room or den.
Very comfortable.
$25.00 203-775-6925

CHINA CABINET, Oak, Excellent Condition. Please call, 203-743-3196. Part of Set.

CHINA CLOSET Oak, Beveled glass. Exc. cond 47"Wx80" Hx20"D $190. 203-746-1711.

MERCHANDISE FOR SALE

DINING ROOM TABLE CHAIRS, 6. Oak. Excellent Cond. Please call. 203-743-3196. Part of Set.

DINING ROOM SERVER, Oak, quality Furniture. Please call 203-743-3196. Part of Set.

DINING ROOM TABLE Oak. Top Inlay, plus Extension Leaf for Table. Call 203-743-3196 Part of set.

DOLLY FLAT PLATFORM W/HANDLE, HEAVY DUTY, $99. 203-746-5046

DRESSER, 2 small dressers w/4 drawers, $20 each. Microwave $8. Call 203-512-3832

DRESSER with Mirror, great Condition. Please Call 203-743-3196.

DRUM SET 5 Piece inc. Zildjian & Paiste Cymbals & Sabian Hi-Hat $125 firm. 203-313-4535

END TABLES Pair of end tables, all wood brown fancy, very good cond. asking $50. 203-799-2310.

ENTERTAINMENT CENTER
48x38x19. $85. 203-746-5046

ATTENTION

EQUUS INDUCTIVE xenon timing light excellent condition $10 203-792-5557

FUR STOLES (2) mink - good condition, $25 each. call 203-743-3297

FUTON, $80 Call 203-512-3832

GAZEBO COVER
CANOPY TOP ONLY
TO FIT A
12' X 12' GAZEBO BEIGE
BRAND NEW $50.00
CALL 203-775-5925

GLASS PATIO TABLE, $10.
203-300-4709

Golf Clubs Ping iSI Stiff RW-3+Bag $75 203-313-4535

Golf Clubs Ram LH Junior SW-3 Hybrid+Bag $75 203-313-4535

GOLF PULL CART
PRO KENNEX
2 WHEEL
SUMMER IS HERE
AND SO IS GOLF SEASON
$35.00 203-775-6925

NEW AD!

Guardian adjustable Walker Model 30765P, with 6 in. wheels $40 203-792-5557

Guitar - Fender Telecaster and gig bag like new santiago 203-313-4535 $325.00

GUITAR AMP Peavey Classic 30 1X12 New tubes. $275 203-313-4535

HITCHCOCK: Wing chair and Ottoman ex. cond. $450. 860-355-0357

HOOSIER CABINET, Two piece w/ 3 cabinets on top & a flour bin and sifter. 4 drawers on bottom, metal pull-out counter & 1 cabinet. Original label. Some wood cracks on side. $275. 860-354-6720.

HOSPITAL BED
asking $350. 203-731-0477

SCHOOLS & JOB TRAINING

MERCHANDISE FOR SALE

HOT TUB: 2013 Model, 5/6 Pers, 40 Jets, all opt w/Cover. New in Pkg, never used. Full wrty. Orig. Cost $7000 sacrifice $2250. Can Deliver. 203-232-6778

ICE BOX, Old oak. $450. 203-746-1711

IKEA COAT, HAT & STORAGE RACK dark oak. Moving sale. $30. Call/text 860-488-0338

JOHN DEERE LEAF BAGGER
INCLUDES MANUAL

USE WITH RX, SX, SRX AND GX
RIDING MOWERS AND LX LAWN
TRACTOR.

NEEDS CLOTH BAGS
GOOD CONDITION
$50.00 203-775-6925

KENWOOD/BOSTON Acoustic Unity DVD Home theater Sys Awesome $125 Mike 203-994-0663

KITCHEN TABLE AND SEATING
Country corner Kitchen nook, oak, exc. cond. storage benches, seats 5-6 $200.00 203-746-4368

LAMPS (2), Dark Green. Great Cond. Please Call 203-743-3196.

Lands End NEVER WORN Womens Knit Shorts PINK&TAN 14/16 203 746-8488 Both for $25.00

LAPTOP TABLE LIGHTWEIGHT, FOLDS FLAT. LED LIGHT, $15. 203-746-5046

LARGE PAINTING OF CASTLE w/frame 3' x 4' . $23. 203-743-3297

LAWN MOWER: $25
Redding, CT. 203-938-3275

Lawn mower, self propelled, Sears, $100. 203-938-3275

LAWN SPREADER for seeding or fertilizing, $29 BO. call 203-743-3297

LEATHER RECLINER, $50.
Redding, CT 203-938-3275

LEATHER COAT WOMENS S/M
BEAUTIFUL COAT

BLACK, 3/4 LENGTH,
REMOVABLE LINER,
$50.00 203-775-6925

LIONEL TRAIN 3665 USAF BOX CAR MINUTEMAN

Unique car 1961-64 Roof opens & launching mech. elevates to firing position. Operates with O27 & O gauge Lionel for hers)
Very clean, no yellowing, free of cracks, chips or breaks $200.00 or best offer 203-775-6925

LUGGAGE -
AMERICAN TOURISTER
HARDSIDED LUGGAGE
SUMMER & TRAVEL IS HERE
SET OF 4 PIECES -
27" PULLMAN, 24", 21" AND
TOTE. BEIGE - EXCELLENT FOR
GOING TRAVEL OVER
SEAS OR ANYWHERE
OR USE AS STORAGE

$100.00 FOR SET OF 4
203-775-6925

MAN'S LEATHER JACKET like new warm liner, $49 BO. 203-743-3297

MATCHING FLOOR LAMPS (2)
$50. 203-300-4709

MATTRESS & Boxspring.
King size Pillowtop set, brand new, still in plastic. Sacrifice $399, 203-557-0949

SCHOOLS & JOB TRAINING

CLASSES AVAILABLE TO LEARN

- **PATIENT CARE TECHNICIAN IN 10 WEEKS**
- **CERTIFIED NURSING AIDE IN 4 WEEKS**
- **DENTAL ASSISTING IN 4 WEEKS**
- **PHLEBOTOMY**
- **EKG**

DAY, EVENING & SAT. CLASSES

NEW Bridgeport Location: 4637 Main Street
The Brookside Professional Bldg.
91 Shraffts Dr., Waterbury
203-378-2210 • 1-800-886-8773
valleymedicalinstitute.com

• JOB ASSISTANCE •
EASY PAYMENT PLANS • AS LITTLE AS $150 DOWN

Training Direct

Train in 3 – 4 Weeks to Become:

- Certified Nurse's Aide (Financial Classes Offered!)

THE NEWS-TIMES

Classified

SOUTHERNCTJOBS.com

monster

203-330-6556 | classified@newstimes.com | Hours: 8:30 a.m. – 5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

FORECLOSURE SALE-PUBLIC AUCTION
Docket No. DBD CV 12-6010575 S
Case Name: 1st Alliance Lending LLC v. Dean A. Grosso, et al
Property Address: 44 Putnam Park Road, Bethel, CT
Property Type: Residential
Date of Sale: July 13, 2013
Committee Name: Richard D. Arconti, Esq.,Committee Phone Number: (203) 790-7747
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE
The Zoning Board of Appeals of

PUBLIC NOTICES

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and New Milford Hospital (NMH) will submit the following Certificate of Need application to the CT Office of Health Care Access:
Applicants: Western Connecticut Health Network, Inc. (WCHN) which includes The Danbury Hospital (DH) and New Milford Hospital, Inc. (NMH)
Addresses: WCHN and DH are located at 24 Hospital Avenue, Danbury, CT. NMH is located at 21 Elm Street, New Milford, CT.
Proposal: This proposal involves consolidating the operations of DH and NMH under a single license, as they are already governed by the same parent board of directors and have a unified mission to promote the health and well being of people in the communities it serves in a cost-effective manner.
Capital Expenditure: $ 0

Town of Bethel, CT
LEGAL NOTICE
ZONING BOARD OF APPEALS
Notice is hereby given that the Zoning Board of Appeals of the

GENERAL HELP WANTED

SSS EARN CASH SSS
Be a Newspaper Carrier

GENERAL HELP WANTED

PUBLIC WORKS
Highway Superintendent
TOWN OF NEW MILFORD
The New Milford, CT Public Works Department is currently recruiting a Highway Superintendent to plan, coordinate, supervise and direct the work of subordinates in the maintenance construction and repair of streets, bridges, storm sewers, drainage systems and highway equipment.
Minimum qualifications include, High school diploma or equivalent required, Associate or Bachelor's degree in Civil Engineering or related field preferred. Min. of three years experience as a Public Works Supervisor with ten or more years of construction and construction management experience. Associate degrees will equate to 3 years of field

ABSOLUTELY FREE

TELEVISION, Sony 34" Hi Def TV, exc. 720p picture, matching stand, FREE for the taking. 203-947-1730

HEATING AND FIREWOOD

Firewood Seasoned $200/cord locally. 3 or more cords $180. Guaranteed full cord. Call Rod Fitch 860-355-9876

UNSEASONED FIREWOOD all hardwood $145.cord split 2 cord min. 203-312-2864/203-470-9438

MERCHANDISE FOR SALE

AERATOR: 36" with 18 plugging wheels. Tractor ready! $50. Call Bob @ 203-775-4567

ALUMINUM FOLDING LAWN

MERCHANDISE FOR SALE

must $99

COACH Men's Leather Bound Portfolio Dark Brown Leather. Excellent Condition! $60. 203-912-3683

must $99

COACH Men's Leather Messenger Bag Dark Brown Leather. Excellent Condition! $90. 203-912-3683

must $99

COACH IPAD COVERS One Brown and One Black with COACH Logo. Exc Condition. $30. 203-912-3683

must $149

THE NEWS-TIMES

Classified

SOUTHERNCTJOBS.com

monster

203-330-6556 | classified@newstimes.com | Hours: 8:30 a.m. – 5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and New Milford Hospital (NMH) will submit the following Certificate of Need application to the CT Office of Health Care Access:
Applicants: Western Connecticut Health Network, Inc. (WCHN) which includes The Danbury Hospital (DH) and New Milford Hospital, Inc. (NMH)
Addresses: WCHN and DH are located at 24 Hospital Avenue, Danbury, CT. NMH is located at 21 Elm Street, New Milford, CT.
Proposal: This proposal involves consolidating the operations of DH and NMH under a single license, as they are already governed by the same parent board of directors and have a unified mission to promote the health and well being of people in the communities it serves in a cost-effective manner.
Capital Expenditure: $ 0

GENERAL HELP WANTED

DISHWASHER
needed at BLUE COLONY DINER
Contact George 203-417-1268

DRIVER - Reliable person wanted for Recycle/Refuse collection route. 2 years Medium Truck driving experience required. Clean driving record & drug test. Email resume to **madhua@sboglobal.net** or fax to 203-227-1973.

SSS EARN CASH $SS

GENERAL HELP WANTED

PUBLIC WORKS
Highway Superintendent
TOWN OF NEW MILFORD
The New Milford, CT Public Works Department is currently recruiting a Highway Superintendent to plan, coordinate, supervise and direct the work of subordinates in the maintenance construction and repair of streets, bridges, storm sewers, drainage systems and highway equipment.
Minimum qualifications include, High school diploma or equivalent required, Associate or Bachelor's degree in Civil Engineering or related field preferred. Min. of three years

MERCHANDISE FOR SALE

ANTIQUE LINENS, box of 12 assorted small linens. $25. 203-748-2774.

ANTIQUE TABLETOP wooden pinball game w/orig. 18 steel balls and stick. $150. 203-748-2774

AREA RUG Good cond. 5'6"L x 7'11"W. $20. 203-748-1711

BABY CAR SEAT
Britax Roundabout
Excellent Condition $50.00
203-775-6825

BABY HIGH CHAIR folds up, $10, call 203-748-3287

MERCHANDISE FOR SALE

DRUM SET 5 Piece inc. Zildjian & Paiste Cymbals & Sabian Hi-Hat $125 firm. 203-313-4535

END TABLES Pair of end tables, all wood brown fancy, very good cond. asking $50. 203-798-2310.

ATTENTION

EQUUS INDUCTIVE xenon timing light excellent condition $10 203-792-5557

FUR STOLES (2) mink - good condi-

AFFIDAVIT

Applicant: Western Connecticut Health Network, Inc.: The Danbury Hospital and New Milford Hospital, Inc.

Project Title: WCHN Single License: The Danbury Hospital and New Milford Hospital, Inc.

I, Steven H. Rosenberg, Senior Vice President and CFO, of Western Connecticut Health Network, Inc., being duly sworn, depose and state that The Danbury Hospital and New Milford Hospital, Inc.'s information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Steven Rosenberg
Signature

8/12/13
Date

Subscribed and sworn to before me on August 12, 2013

Alberta B. Ricciardi

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2014

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:	TBD
Applicant:	Western Connecticut Health Network, Inc.
Contact Person:	Sally F. Herlihy, MBA, FACHE
Contact Person's Title:	Vice President, Planning
Contact Person's Address:	24 Hospital Avenue Danbury, CT 06810
Contact Person's Phone Number:	203-739-4903
Contact Person's Fax Number:	203-739-1974
Contact Person's Email Address:	sally.herlihy@wchn.org
Project Town:	Danbury, CT, New Milford, CT
Project Name:	WCHN Single License: The Danbury Hospital and New Milford Hospital, Inc.
Statute Reference:	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$0

Project Description: Service Termination

a. For each of the Applicant's programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.

In October 2010, with Docket No. 10-31560-CON, The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH") as well as their affiliated entities became wholly owned subsidiaries of a newly formed entity, Western Connecticut Health Network, Inc. ("WCHN"). As part of that transaction, the governing instruments of DH and NMH were revised so that both corporations have the same governance with the same sole member and the same directors. WCHN also has the same reserved powers / voting rights as to both NMH and DH.

DH is a 371-bed acute care hospital located at 24 Hospital Avenue, Danbury, CT. DH's total licensed bed capacity includes 345 general hospital beds and 26 bassinets. For DH, the following 6 towns account for 75% of its activity: Danbury, Bethel, Newtown, Ridgefield, Brookfield and Southbury, CT.

NMH is an 85-bed acute care hospital located at 21 Elm Street in New Milford, CT. NMH's total licensed bed capacity is 85 licensed beds with 0 bassinets. For NMH, the following 6 towns account for 75% of the inpatient activity currently at NMH: New Milford, Kent, Sherman, Brookfield, Danbury, and Washington, CT.

Individual hospital licenses for DH and NMH are enclosed as Exhibit A.

See Exhibit B for inpatient utilization of DH and NMH.

WCHN proposes to merge DH and NMH under a single general hospital license, with no associated capital expenditure in order to improve efficiency and allow for NMH to be compliant with ICD10 requirements by the October 1, 2014 deadline. WCHN understands that the Office of Health Care Access ("OHCA") considers a merger a termination of all services by one of the entities because only one license remains. There is no actual termination of any health care services as part of this Project. Similarly, no change in governance or control is contemplated as part of this Project. Upon accomplishment of the merger, the same services will be offered at the same locations.

This Project will involve the consolidation of DH and NMH into one licensed general hospital that is operationally and financially integrated with two campuses at the existing locations in Danbury, CT and New Milford, CT. No addition, replacement or termination of any health care functions or services at DH or NMH is contemplated as part of this Project. Immediately after the merger, the existing campuses will remain in operation, with inpatient services provided at both locations.

The primary service area ("PSA") for WCHN includes a population of 275,000 for residents in the following communities: Bethel, Bridgewater, Brookfield, Danbury, Kent, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman, Washington, CT (the "CT PSA"); and Brewster, Pawling, Patterson, and Wingdale, NY (the "NY PSA"). During FY 2012, 8 out of 10 residents in the CT PSA utilized either DH or NMH for their inpatient services and 1 out of 7 residents in the NY PSA utilized either facility for their inpatient care. Additionally, WCHN's secondary service area

("SSA") includes an estimated population of 165,000 residents in towns located adjacent to the PSA, including Southbury, CT. A map of WCHN's service area is enclosed as Exhibit C. The PSA and SSA of the proposed consolidated successor hospital will consist of the same towns currently served by both hospitals.

The purpose of the WCHN affiliation 2 ¾ years ago was to develop a regional health care delivery system (*OHCA Final Decision, 9/23/10, Docket No. 10-31560-CON, p.3*). In its decision, OHCA found that "the affiliation would improve the quality, accessibility and cost effectiveness of the health care delivery in the region" (*OHCA Final Decision, p.21*). This proposal involves further consolidation of the operations of DH and NMH, as the two organizations are already governed by the same parent and board of directors and have a unified mission to promote the health and well being of people in the communities it serves in a cost effective a manner. See the WCHN organizational chart in Exhibit D.

At the time of affiliation, the direction was to maintain two separate licenses for the individual hospitals. (*OHCA Final Decision, Finding of Fact #10, p 3).* However, since the affiliation in October 2010, the two hospitals have integrated operations to create consistent quality and a more cost effective delivery of care. A matrix organizational structure, which includes a service line executive and physician director, has been developed across service lines for WCHN (See Exhibit E). This structure ensures provision of a single standard of care for our patients, supported by ongoing alignment of policies and procedures and practices at both Hospitals.

This Project supports necessary further consolidation of DH and NMH in order for NMH to comply with ICD10 requirements, since NMH's existing Meditech system will not become compliant without a significant financial investment. Moreover, the maintenance of two different information technology (IT) platforms hinders operational, financial and clinical efficiencies within WCHN. Given the level of work that would be required to convert NMH's existing IT platform, the only viable solution to ensure NMH's compliance with ICD10 and enable billing to occur on October 1, 2014 is to integrate NMH's system with DH's and bill as one entity. By moving the 2 Hospitals to a single license with a single IT platform, WCHN would avoid incurring an estimated $3.2M in additional costs and would realize an operating savings of approximately $715K annually including savings associated with a reduction in redundant platforms, maintenance costs, licensing, and IT staff productivity. Without this Project NMH will be unable to bill under ICD 10 requirements, which will have a significant impact on the cash and financial position of NMH.

b. Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.

This Project involves a termination only in that the two separate general hospital licenses of DH and NMH will be merged into one general hospital license with operations at the same facilities existing prior to the merger on the two campuses at the existing locations in Danbury, CT and New Milford, CT. This Project does not involve the addition, replacement or termination of any health care functions or services at DH or NMH. The goal is to enhance the quality of care that is provided, while delivering it as efficiently and consistently as possible. NMH is a small, community hospital located in close proximity to DH, which currently faces a tremendous challenge to satisfy all requirements on a standalone basis. Operating with one license would reduce cost redundancies

and support consistency and quality in all the programs. A single license also enables savings to be achieved through economies of scale, thus reducing the cost of health care (such as a single approach to accreditation processes, Medical Staff credentialing and peer review, Medicare Cost Reporting, consolidating and standardizing IT system platforms and annual auditing). This merger of DH and NMH will strengthen both hospitals by working together to provide the right care, at the right place, at the right time, for the right price for the residents of the DH and NMH service areas.

c. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.

As noted, this request is not to terminate services at DH or NMH; rather it is a change to consolidate licenses to operate one acute care general hospital with two campuses. The ability to achieve synergies in activities, maintain and enhance quality, and realize cost-savings with streamlined operations has become a paramount concern for all hospitals. Government and commercial reimbursement rates have not kept pace with operating expenses and hospitals are constantly making adjustments to remain financially viable. Further compounding WCHN's ability to efficiently deliver quality care at the lowest cost are funding cuts from the recently approved State of Connecticut fiscal budget, which will reduce Medicaid reimbursements to the Network by $30M over the next two years. As a result, WCHN is carefully evaluating its ability to maintain access and offer community programs and to maintain staffs who have dedicated their lives to serving others, and continues to scrutinize its operations to find any opportunity to operate more efficiently to preserve our mission. The reductions in revenue are compounded by increases in costs associated with compliance with regulatory requirements such as ICD10 and the Accountable Care Act.

Pursuing a single license is one means of addressing the need for cost reduction while improving the quality of care provided to all of WCHN's patients through clinical, financial and operational integration. The immediate effect of a single license would be cost-avoidance related to a necessary one-time upgrade and testing of NMH's Meditech IT platform that is not compliant with ICD10 requirements. To avoid this unnecessary expense, the two Hospitals must move to a single license with a single IT platform.

A brief description of the billing process will highlight the complexity of the process and importance of operating under one billing entity.

- There are several key fields in billing systems that need to be separate when 2 hospitals are different entities. The first is the Medical Record Number of the patient. Each hospital bases the patient identification on a single master number which is the basis for the legal medical record and for billing purposes. One person would have one identifier for Danbury Hospital and another for New Milford Hospital. Each separate encounter within a hospital will also contain a unique account number for that patient, which is used for billing and identification of statistics for that visit. In addition, the tax identification number (TIN) is a separate number for each hospital. In billing and accounts receivable, electronic claims are submitted by each hospital using the Medical Record, Account and TIN. Payer systems process claims and return electronic remittances for payment using the same 3 numbers as keys. These payments are returned to a separate "lockbox" managed for each TIN for the individual hospital before applying the amount to specific medical record and account numbers.

Statistics required for Medicare cost reporting would also need to be separated under 2 licenses.

- Danbury Hospital currently uses Siemens' Invision Patient Management/Patient Accounting systems for managing patient financial information. This application can only function as a "single entity" system, and cannot accommodate multiple medical record numbers for one person and cannot process claims or accounts receivable for multiple TINs. To accommodate this for 2 separate hospitals operating on separate licenses, we will need to implement a separate version of the software on different hardware. All master tables, files, screens and coding logic would need to be rebuilt and tested. In addition, all clinical systems that are interfaced with the Patient Management and Accounting system would need to be built as a separate entity using the medical record and account numbers to process all clinical orders, results viewing, billing, and clinical documentation. The project would take approximately 1 year to build and test.

A Task Force comprised of WCHN leadership evaluated the impacts of upgrading the current Meditech platform at NMH to be compliant for ICD10 billing. This resulted in a recommendation to the Board of Directors in December 2012 and subsequent endorsement to pursue a single license. A Modification Request to Docket No. 10-31560-CON was submitted to OHCA in March 2013, which resulted in a May 31, 2013 decision that a CON would be required to pursue a single license (Docket No. 13-31560-MDF). WCHN has already invested $596K to support alignment of its IT systems to achieve efficiencies.

This Project is now submitted as a CON for OHCA review, and is time-sensitive to the ability to implement the new system by the October 1, 2014 deadline. As noted above, this consolidation to a single IT platform for the two hospitals will result in significant additional cost savings for the Network and is the only viable solution to ensure NMH's compliance with ICD10 and enable billing to occur on October 1, 2014.

d. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted.

The WCHN Board of Directors is comprised of the same individuals who serve on the DH NMH Boards. The Board Members understand the challenges facing NMH in complying with ICD10 and support this CON request as a solution to that problem as well as a natural evolution of the plan to provide the best services possible at the most reasonable cost for all of the patients in the WCHN service area. The Board adopted resolutions supporting this project and authorizing the operational activities necessary to develop a plan of merger and single licensure for DH and NMH at its meeting on December 6, 2012. A copy of such resolutions are attached as Exhibit F

There will be no impact or change in the governance or controlling body of NMH or DH as a result of this proposal to allow both hospitals to operate under a single license.

e. Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

It is in the public's interest to maintain the financial viability of NMH and to ensure that high quality health care is provided in the most efficient manner. By joining the two hospitals under one license, WCHN provides one high standard of care at both campuses and avoids a large out of pocket cost for a redundant IT infrastructure which would only foster silos and impede clinical and financial integration within the Network. It would allow WCHN to realize substantial cost savings at a time when hospital resources are already strained. The Table below demonstrates the financial impact of merging DH and NMH under one hospital license and IT infrastructure.

			Year 1	Year 2	Year 3
Dept	**Operating Expense**	**FTE**	**Annual Budget Impact**	**Annual Budget Impact**	**Annual Budget Impact**
Finance	Audit Fees		(175,000)	(175,000)	(175,000)
Finance	Consolidate Audit Preparations	(1.0)	(150,000)	(150,000)	(150,000)
Quality	CHA Fees		(18,000)	(18,000)	(18,000)
Quality	JCAHO Fees		(10,000)	(10,000)	(10,000)
Quality	Press Ganey Fees		(8,000)	(8,000)	(8,000)
Quality	Core Measures/VBP Fees		(27,000)	(27,000)	(27,000)
ITG	ITG Productivity Savings	(1.0)	(200,000)	(200,000)	(200,000)
ITG	Siemens System maintenance		173,028	181,679	190,763
ITG	Meditech System Maintenance		(300,446)	(313,021)	(326,151)
	Total	**(2.0)**	**(715,418)**	**(719,341)**	**(723,388)**
	Capital Impact				
ITG	Meditech Upgrade Capital Required		(3,160,902)		
ITG	Integration cost to single system		596,965		
	Total Capital Impact		**(2,563,937)**		

2. · Termination's Impact on Patients and Provider Community

a. List all existing providers (name, address, services provided, hours and days of operation, and current utilization) of the services proposed for termination in the towns served by the Applicant, and in nearby towns.

WCHN currently consists of two hospitals and its affiliated entities. WCHN is a comprehensive health system that includes 24/7 acute care and emergency services, home health, behavioral health, diagnostic services, and outpatient surgical services; DH is a 371-bed acute care hospital

located at 24 Hospital Avenue, Danbury, CT, and NMH is an 85-bed acute care hospital located at 21 Elm Street in New Milford; CT. The estimated driving distance between the Danbury and New Milford campuses of the proposed successor hospital is 15.4 miles, and the estimated driving time is 20-25 minutes.

This proposal does not involve the addition, replacement or termination of any health care functions or services at DH or NMH. It would have no impact on any of the existing providers in the towns served by DH or NMH other than the realized benefits to DH, NMH and WCHN described in this application if the project is completed.

b. Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.

Access to the services currently provided by DH and NMH will be unaffected by this Project. There will be no change to the services provided by DH or NMH as a result of this proposal. NMH and DH will improve the overall quality of the services provided and the financial viability of the two hospitals.

c. For each provider to whom the Applicant proposes to transfer or refer clients, provide the current available capacity, as well as the total capacity and actual utilization for the current year and last completed year.

No transfer or referral of patients is contemplated as a result of this Project. Immediately following the merger, both hospitals would continue to provide the same services and the same capacity and utilization is anticipated to continue.

d. Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.

There will be no closure of a service location as a result of this merger.

e. Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.

Not applicable.

f. Describe how clients will be notified about the termination and transferred to other providers.

This proposal does not involve the addition, replacement or termination of any health care functions or services at DH or NMH. This change will be seamless to patients and the community.

3. Actual and Projected Volume

a. Provide volumes for the most recently completed FY by town.

The NMH total volume for FY 2012 is provided in descending order in the chart below:

	FY2012 Volume
New Milford- CT	31,983
Danbury- CT	3,230
Washington Depot- CT	2,608
Sherman- CT	2,386
Kent- CT	2,377
Brookfield Center- CT	2,063
Marble Dale- CT	1,867
Roxbury- CT	1,573
Bridgewater- CT	1,494
Wingdale- NY	1,368
Gaylordsville- CT	1,307
Cornwall Bridge- CT	999
Pawling- NY	809
Dover Plains- NY	707
Southbury- CT	644
South Kent- CT	593
Woodbury- CT	585
Torrington- CT	478
Bantam- CT	473
Litchfield- CT	401
Bethel- CT	352
Newtown- CT	313
All Other Towns	4,925
Total	63,535

b. Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for both number of visits and number of admissions, by service.

Table 1: Historical and Current Visits & Admissions

	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	2010	2011	2012	2013 YTD June
Inpatient:				
Medicine	1,515	1,579	1,538	1,072
Surgical	456	403	264	220
Obsetrics	270	267	245	58
Pediatrics	10	2	1	-
Newborn	261	264	243	55
Inpatient Total	2,512	2,515	2,291	1,405
Outpatient:				
Ambulatory IV	291	250	195	186
Cardiac Rehab	149	168	158	321
Cardiovascular	2,604	2,216	2,193	1,378
Cat Scan	1,960	1,765	1,865	1,315
Diabetes	58	50	74	25
Dietary/Nutrition	90	40	46	35
Emergency Room	16,238	16,459	16,210	11,308
Endoscopy	1,972	1,805	1,827	1,318
Laboratory	42,927	43,614	12,159	453
Outpt Psych	4,159	4,314	4,119	3,670
Nuclear Medicine	274	203	185	133
Lactation / Breast Feeding	12	39	29	4
Lithotripsy	38	49	56	43
Outpt Obstetrics	280	381	319	134
Oncology	3,942	3,680	3,178	2,266
One Day Surgery/ASU	2,617	2,336	2,178	1,559
Observation	481	557	586	539
Radiation Therapy	734	679	730	627
Radiology	7,293	6,924	7,242	5,208
Invasive Radiology	379	400	414	312
MRI	1,631	2,313	2,391	1,787
Primary Care Office	3,700	3,552	1	-
PET	2	1	10	-
Respiratory Therapy	56	115	113	70
Sleep Center	522	377	316	158
Speech Therapy	247	236	148	78
Women's Imaging	4,359	4,284	4,466	3,111
Misc other	137	71	36	18
Outpatient Total	97,152	96,878	61,244	36,056
Grand Total	**99,664**	**99,393**	**63,535**	**37,461**

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

** Identify each service type and add lines as necessary. Provide both number of visits and number of admissions for each service listed.

*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the tables above.

Inpatient volume has declined in both OB/Newborn from FY2012 to FY2013 as a direct result of the closing of the OB services at NMH. In addition, inpatient surgical volume has decreased due to a very active general surgeon that moved out of the community at the end of the first quarter of the fiscal year, impacting inpatient and one day surgery volumes.

Outpatient volume has experienced a decline overall related to several key changes. Oncology volume has seen a year over year decline. This is due to the loss of several key physicians. To date, physicians have been recruited and we anticipate the volume to return to historic levels. In addition, outpatient volume relating to both Primary Care Practice as well as the Outpatient Laboratory shows declines. This decline is not a loss of volume but a transition of volume associated with the integration. The Primary Care practice transitioned all billing functions from NMH and has been consolidated into the WCMG entity structure under WCHN. The Outpatient Laboratory service has declined due to the transition of the drawing station from NMH to a consolidated laboratory function with a satellite office at 120 Park Lane in New Milford.

d. For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:
   i. Average daily census;
   ii. Number of clients on the last day of the month;
   iii. Number of clients admitted during the month; and
   iv. Number of clients discharged during the month.

Not Applicable.

4. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

WCHN has strong leadership at the management level based on a great deal of depth and experience in health care in general, and hospitals in particular. A copy of the CV's for each of the following leaders from WCHN are attached in Exhibit G.

President & CEO, John Murphy, MD
Senior VP, COO, Danbury Hospital, Michael Daglio
Executive Director, Senior VP, New Milford Hospital, Deborah Weymouth
Senior VP, CFO & Treasurer, Steven Rosenberg
Senior VP, Human Resources, Phyllis Zappala
Chief Medical Officer, Matt Miller, MD
Senior VP Patient Care Services, CNO, Moreen Donahue, RN
General Counsel, Carolyn McKenna
Chief Risk & Compliance Officer, Joe Campbell

Chief Information Officer, Kathy DeMatteo
VP, Facilities, Morris Gross
VP, Marketing & Communications, Mark Schumann
VP, Quality & Patient Safety, Dawn Myles
VP, Planning, Sally Herlihy
Executive Director & VP Foundation, Grace Linhard

WCHN already provides system-wide management of both DH and NMH. The close proximity of the two hospitals allows for effective involvement of centralize WCHN management. In addition, Deborah Weymouth provides on-site administration at NMH and will continue to do so immediately after the merger is accomplished.

b. Explain how the proposal contributes to the quality of health care delivery in the region.

Although the two hospitals are already formally affiliated, creating a single license has significant implications for the two separate Medical Staffs and how they, together, can further enhance the quality and efficiency of healthcare for the region.

With separate licenses, there is a requirement for each hospital entity to have its own medical staff, with its own set of Bylaws and Medical Staff leadership. The latter is structured as a Medical Executive Committee and currently both hospitals maintain this separate structure. While there have already been efficiencies and standardization of care achieved across the region due to the opportunities presented through the formal affiliation, more formal synergies can be achieved by combining the medical staff under a single license: a single set of bylaws that wholly govern the medical staff---from initial appointment to setting a single standard for expectations of providers, to setting a single standard of care for all clinical conditions, to a formal and consistent peer review process, to reappointment based on unified standards and to a centralized oversight of the quality and safety of care rendered across the region.

The proposed consolidation will create one unified medical staff with the same policies, procedures, clinical pathways/order sets that support the delivery of one standard of high quality, cost-effective care. Under this single license the medical staff will have greater opportunity to coordinate care across the network --consistently, efficiently and under one standard. The implementation of a single electronic health record spanning both campuses will further enhance the quality and safety of health care delivery by improving communications across sites of care, including physician offices, emergency services, ambulatory centers and the inpatient environment. Access will be improved through better coordination between providers, emergency rooms, and hospitals.

Supporting the single standard of care concept is a Policy & Procedure project undertaken by WCHN and its affiliated hospitals in the summer of 2012. This initiative will align and simplify their collective policies and procedures. Driven by an executive steering committee and including over 150 staff representing every functional area of the two organizations, well over 6,000 policies were reviewed. Using a standard template these polices has now been consolidated into approximately 3,700 in total. As a direct result of this project, care and service practices have been standardized, variation has been reduced and training is streamlined. The policies will eventually be accessible from a single electronic site for easy 24/7 access by all staff in all locations. Overall the project has

the potential to deliver improved quality and reduced cost. Single licensure will ensure that the benefits of this project can be fully adopted in all care and service functions at both campuses.

Additional quality benefits of single license include:

- Allows for us to be on a shared medical record. Information will seamlessly be shared across the two hospitals without the inefficiencies of duplicative efforts (CMS requires separate medical records for separate CCN numbers).
- Increased coordination of care with all clinicians working off of the same admit information, med/allergy lists, care plans, etc.
- More efficient QA and Peer Review through (again) seamless access to information from any campus.
- Increased ability to perform quality analytics since all data is in the same database. Can truly look at care across sites without having to make adjustments for different data capture or coding.
- Efficiencies in Value Based Purchasing (VBP) data abstraction, since it is all from the same formatted medical records, and not multiple versions in multiple sites.

The collective impact of these efforts will contribute to the quality of health care delivery in the region.

c. Identify when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.

Activities supporting achievement of a single license have been explored and a work plan is under development (i.e. single medical staff structure, Medicare Conditions of Participation, IT integration schedules, etc.). Outreach will be pursued with the licensing division of DPH and the federal government simultaneously with this CON application, for execution immediately upon approval from OHCA.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

Non-profit tax exempt corporations.

b. Does the Applicant have non-profit status?
☒ Yes (Provide documentation) ☐ No

c. Financial Statements

i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

Audited Financial Statements for the most recently completed fiscal year for both DH and NMH are on file with OHCA.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

d. Submit a final version of all capital expenditures/costs.

Not Applicable.

e. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Not Applicable.

f. Demonstrate how this proposal will affect the financial strength of the state's health care system.

Continued operational and clinical integration will positively benefit the cost of delivery of health care through savings realized from the integration of duplicative functions, and enhanced IT functionality, particularly NMH's ability to bill with the new ICD10 requirements. Financial health of two hospitals in the region will support the financial health of the State's health care system.

6. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

See Exhibit H for Financial Attachment I for both DH and NMH.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

Not Applicable, as this proposal is not adding or eliminating any new services. The financials provided reflect the shifting of all revenue and expenses existing at NMH into the DH financials (see Exhibit H).

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

See Exhibit I for the Financial Assumptions utilized in development of Financial Attachment I.

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

Not Applicable.

e. Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

Yes, NMH was being reimbursed by payers for all existing services. Reimbursement levels are not expected to change as we are not terminating any services with this Project.

f. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

Not Applicable.

g. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

We are not anticipating any projected incremental losses from this Project. This Project will demonstrate a savings as outlined.

h. Describe how this proposal is cost effective.

DH and NMH are operating as a unified entity, and additional efficiencies can be realized if there is a single license, including efficiencies achieved in financial operations (single audit and single charge master), IT conversion and preparation for ICD10 requirements. Savings can also be achieved through consolidation of accreditation surveys, organizational fees for participation in professional organizations and some service contracts that are billed to individual entities. These efforts will reduce further the duplication of work and positively benefit the cost of delivery of health care in the community.

Exhibit A

Hospital Licenses

STATE OF CONNECTICUT

Department of Public Health

License No. 0039

General Hospital

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

The Danbury Hospital of Danbury, CT, d/b/a The Danbury Hospital is hereby licensed to maintain and operate a General Hospital.

The Danbury Hospital is located at 24 Hospital Avenue, Danbury, CT 06810

The maximum number of beds shall not exceed at any time:
345 General Hospital beds
26 Bassinets

This license expires **September 30, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2011. RENEWAL.

Satellites
Center for Child and Adolescent Treatment Services, 152 West Street, Danbury, CT
Community Center for Behavorial Health (ADH-PHP), 152 West Street, Danbury, CT
The Pediatric Health Center, 70 Main Street, Danbury, CT
Seifert & Ford Community Health Center, 70 Main Street, Danbury, CT
Ridgefield Surgical Center, 901 Ethan Allen Highway, Ridgefield, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0032

General Hospital

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

New Milford Hospital, Inc. of New Milford, CT d/b/a New Milford Hospital is hereby licensed to maintain and operate a General Hospital.

New Milford Hospital is located at 21 Elm Street, New Milford, CT 06776.

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

0 Bassinets
85 General Hospital Beds

This license expires **June 30, 2015** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, July 1, 2013. RENEWAL.

Satellite:
New Milford Hospital Community Mental Health Services, 23 Poplar Street, New Milford, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

Exhibit B

FY 2012 Hospital Dependency by Town

DANBURY HOSPITAL

	2012	% Total	Cum %
DANBURY	7,638	40.0%	40.0%
BETHEL	1,628	8.5%	48.5%
NEWTOWN	1,580	8.3%	56.8%
RIDGEFIELD	1,332	7.0%	63.8%
BROOKFIELD	1,210	6.3%	70.1%
SOUTHBURY	1,098	5.8%	75.9%
NEW MILFORD	927	4.9%	80.7%
NEW FAIRFIELD	893	4.7%	85.4%
REDDING	439	2.3%	87.7%
BREWSTER	225	1.2%	88.9%
WATERBURY	153	0.8%	89.7%
WOODBURY	152	0.8%	90.5%
PAWLING	126	0.7%	91.2%
SHERMAN	112	0.6%	91.7%
CARMEL	107	0.6%	92.3%
OXFORD	101	0.5%	92.8%
PATTERSON	79	0.4%	93.3%
NAUGATUCK	67	0.4%	93.6%
BRIDGEWATER	61	0.3%	93.9%
MAHOPAC	60	0.3%	94.2%
ROXBURY	57	0.3%	94.5%
MIDDLEBURY	55	0.3%	94.8%
KENT	53	0.3%	95.1%
ALL OTHER ZIPS (90)	935	4.9%	100.0%
Grand Total	19,088		

NEW MILFORD HOSPITAL

	2012	% Total	Cum %
NEW MILFORD	1,219	55.7%	55.7%
KENT	128	5.8%	61.5%
SHERMAN	96	4.4%	65.9%
BROOKFIELD	77	3.5%	69.4%
DANBURY	65	3.0%	72.4%
WASHINGTON	65	3.0%	75.3%
NEW PRESTON	61	2.8%	78.1%
BRIDGEWATER	55	2.5%	80.6%
ROXBURY	50	2.3%	82.9%
WINGDALE	46	2.1%	85.0%
PAWLING	38	1.7%	86.8%
CORNWALL BRIDGE	37	1.7%	88.4%
SOUTHBURY	32	1.5%	89.9%
BANTAM	30	1.4%	91.3%
DOVER PLAINS	25	1.1%	92.4%
WOODBURY	25	1.1%	93.6%
NEWTOWN	18	0.8%	94.4%
BETHEL	16	0.7%	95.1%
ALL OTHER ZIPS (34)	107	4.9%	100.0%
Grand Total	2,190		

Source: CHIME and HANYS

Exhibit C

WCHN Primary Service Area & Hospital Utilization

WCHN Primary Service Area

Population: 275,000

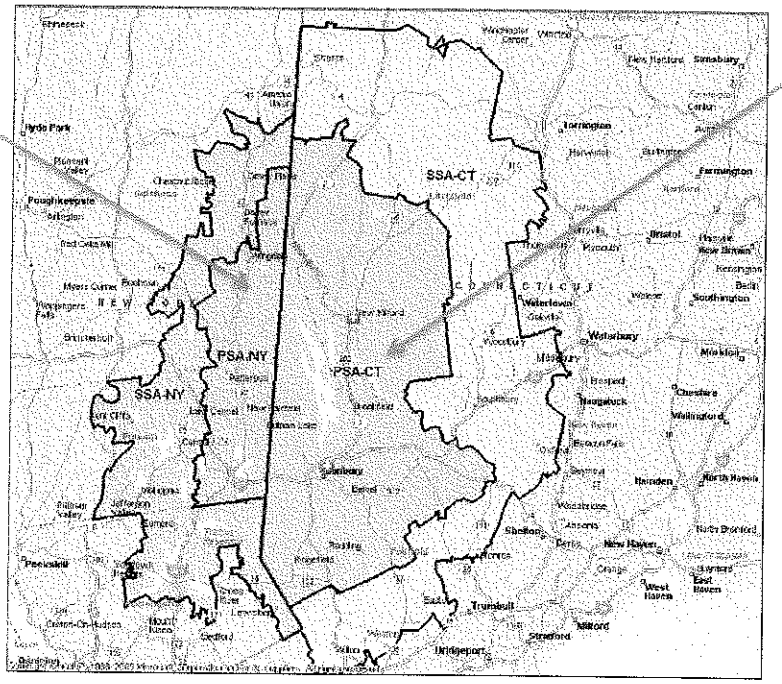
Primary - NY

RANK:

#3 Danbury Hospital
– 467 / 12.4%

#6 New Milford Hospital
– 86 / 2.3%

PSA-NY:
1 out of 7 individuals utilized DH or NMH



Primary – CT

RANK:

#1 Danbury Hospital
– 15,896 / 73.3%

#2 New Milford Hospital
– 1,871 / 8.6%

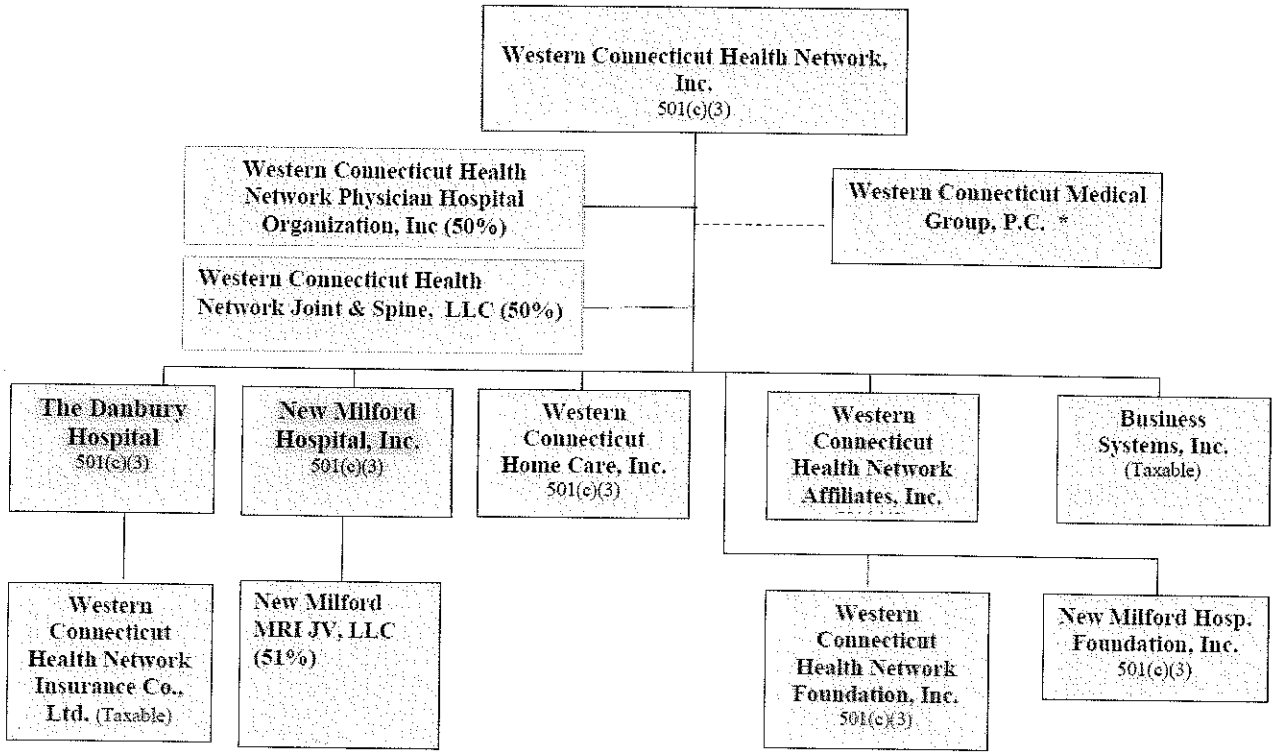
PSA-CT:
8 out of 10 individuals utilized DH or NMH

FY 2012

Source: CHIME and HANYS

Exhibit D

Current Organizational Chart for Western Connecticut Health Network, Inc – 2013



*Controlled entity via management agreement

WCHN Org Chart 8-2012

Exhibit E

WCHN Matrix Organizational Chart

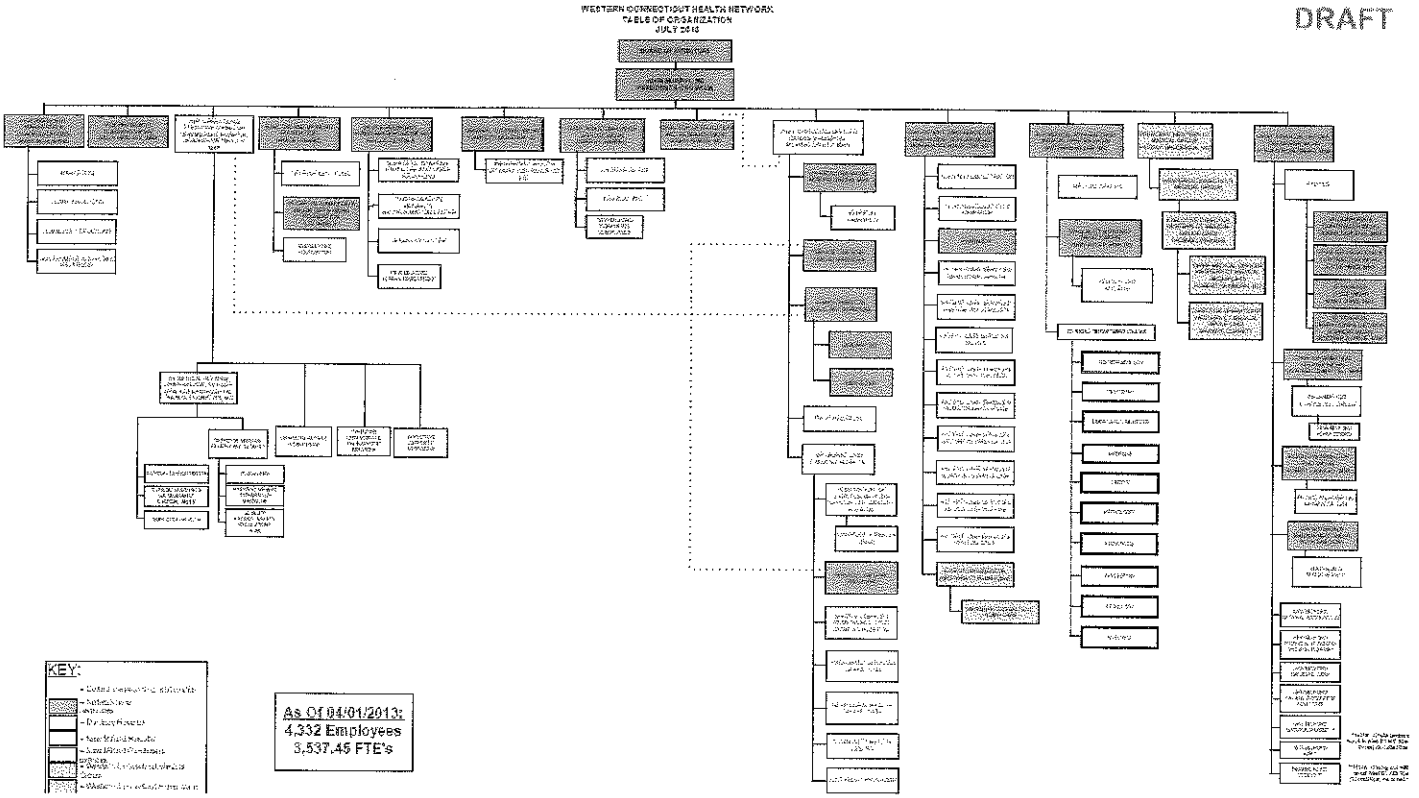


Exhibit F

WCHN Board of Directors Endorsement of Single License

WESTERN CONNECTICUT HEALTH NETWORK
BOARD OF DIRECTORS
December 6, 2012

Draft

A meeting of the Board of Directors of Western Connecticut Health Network, New Milford Hospital and Danbury Hospital was held on Thursday, December 6, 2012 at 8:00 a.m. in the Robison Conference Room at New Milford Hospital. Chairman of the Board Jim Kennedy presided.

PRESENT:	A. Altorelli, M.D, A. Disney, S. Houldin, J. Kennedy, J. Murphy, MD., J. Patrick, J. Skrzypczak, B. White
VIA TELECONFERENCE:	D. Cyganowski, N. Culligan, and M.D. D. Kramer, M.D.
ABSENT:	R. Jabara,
GUESTS:	Lisa Boyle, Esq. – Robinson & Cole Bruce Barth, Esq. – Robinson & Cole (via teleconference)
ALSO PRESENT:	M. Daglio, C. McKenna, S. Rosenberg, D. Weymouth

CHAIRMAN'S REMARKS

Chairman Kennedy welcomed the directors and guests and noting that we had a quorum, began with the opening of the meeting of the WCHN Board of Directors to review the status of due diligence work being done towards the possible affiliation with Norwalk Hospital.

NEW MILFORD HOSPITAL

GENERAL/CONSENT

Approvals/Resolutions (attachments):

a. Licensure – New Milford

RESOLUTIONS TO BE CONSIDERED FOR ADOPTION AT THE MEETING OF THE GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF WESTERN CONNECTICUT HEALTH NETWORK, INC.

December 6, 2012

Licensure

WHEREAS, Western Connecticut Health Network, Inc. ("WCHN") is the sole member of The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH");

WHEREAS, the DH and NMH each operate separately licensed hospitals (the "Hospitals"); and

WHEREAS, the DH and NMH desire to authorize the operational activities necessary to present the board of directors of each entity with a plan to merge the two entities and operate the Hospitals as one licensed facility with two campuses.

NOW, THEREFORE, BE IT:

RESOLVED, that, WCHN, as the sole member of each of DH and NMH, hereby authorizes and directs the proper officers of DH and NMH, on behalf of each entity, to take all necessary and appropriate actions to develop a plan of merger and single licensure for DH and NMH, including without limitation engaging consultants and authorizing communications with the Connecticut Department of Health, the Centers for Medicare and Medicaid Services, and the Joint Commission, the taking of such action to be conclusive evidence of the necessity, appropriateness or desirability thereof.

Exhibit G

Curriculum Vitaes

Western Connecticut Health Network, Inc.
President & CEO, John Murphy, MD
Senior VP, COO, Danbury Hospital, Michael Daglio
Executive Director, Senior VP, New Milford Hospital, Deborah Weymouth
Senior VP, CFO & Treasurer, Steven Rosenberg
Senior VP, Human Resources, Phyllis Zappala
Chief Medical Officer, Matt Miller, MD
VP Patient Care Services, CNO, Moreen Donahue, RN
General Counsel, Carolyn McKenna
Chief Risk & Compliance Officer, Joe Campbell
Chief Information Officer, Kathy DeMatteo
VP, Facilities, Morris Gross
VP, Marketing & Communications, Mark Schumann
VP, Quality & Patient Safety, Dawn Myles
VP, Planning, Sally Herlihy
Executive Director & VP Foundation, Grace Linhard

Curriculum Vitae
John M. Murphy, M.D.

Professional Experience

Western Connecticut Health Network (formerly DHS) **July 2010 - PRESENT**
President & Chief Executive Officer
Responsible for direction of core strategic programs, objectives and the enhancement of operational excellence, growth and financial performance of the $750M integrated delivery network. Work in collaboration with physician and nursing leadership to align operational areas to support quality care, patient safety and service excellence initiatives of Danbury Hospital, New Milford Hospital, Western Connecticut Medical Group, Western Connecticut Home Care and associated subsidiaries and the surrounding communities

Danbury Health Systems (DHS), Danbury, CT **July 2008 – June 2010**
Executive Vice President (President /CEO Designee)

Associated Neurologists, P.C., Danbury, CT **1989- 2008**
Clinical neurologist with a particular interest in stroke, multiple sclerosis, and neurodegenerative disorders. I was active both clinically as well as administratively serving as the president of the group for 18 years and actively expanded the group to include clinical research, neurophysiology, neuropsychology and infusion therapy. In addition I was active in clinical research and both undergraduate as well as graduate medical education

Education
Fordham University, Bronx, NY
Major: Biology
Summa cum Laude (G.P.A. 4.0)
B.S., May 1981

UMDNJ -Rutgers Medical School
Piscataway, NJ
M.D., May 1985

Medical Training
1985-1986: Internship, Internal Medicine
UMDNJ-Rutgers Medical School
Middlesex General University Hospital
New Brunswick, NJ

1986-1988: Resident in Neurology

UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

1988-1989: Chief Resident in Neurology
UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

Professional Certifications

Fellow – American College of Physicians – Appointed 2012
Attending Neurologist – Danbury Hospital – 1989 – Present
Clinical Assistant Professor of Neurology – University of Vermont – 2010-Present
Fellow – American Academy of Neurology

Professional Organizations

American College of Healthcare Executives
Board of Directors – Voluntary Hospital Association (VHA)
Board of Trustees – Connecticut Hospital Association (CHA)
Board of Trustees – Union Savings Bank
Connecticut State Medical Society
Fairfield County Medical Society
Fairfield County Neurology Society
American Academy of Neurology

Curriculum Vitae
Michael J. Daglio

Professional Experience

Danbury Hospital, Danbury, CT **June 2004 –Present**

Senior Vice President and Chief Operating Officer ***October 2010 – present***

- Responsible for the following operational areas: Cardiovascular Service Line, Surgical Services, Cancer Center, Women's and Children's, Emergency Department, Radiology, Laboratory, Pharmacy, Facilities, Medical Education and Research.
- Provide senior level oversight of 7 direct reports and 1,400 indirect reports.
- Oversee Operating Budgets of $400,000,000 and manage capital budget of $30,000,000.
- Responsible for the post-merger integration of Danbury Hospital and New Milford Hospital operational and clinical departments.
- Developed a "Portfolio Review" process to identify cost reduction opportunities throughout the network. Achieved $18,000,000 in cost reduction in first twelve months of the program.
- Responsible for physician relations and physician acquisition strategy for key clinical services.
- Developed a "Staffing Management Council" to review all position requests for the Network. Reduced 140 positions through tighter controls, sharing of resources and more stringent approval process.

Vice President, Operations ***October 2007 – October 2010***

- Responsible for Medical Education and Research , the Cardiovascular, Radiology, Laboratory and Women's and Children's Service Lines, and The Emergency and Behavioral Health Departments
- Manage operating budget of $100,000,000 with gross revenues exceeding $350,000,000
- Manage average annual capital budget of $10,000,000 for service lines
- Provide senior level oversight of 10 Directors and a staff of 725 FTEs
- Leading $150,000,000 Hospital facility expansion project, including securing CON approval from the State
- Collaborate in partnerships with Chairmen and Physician Executives for the Service Lines
- Lead physician recruitment efforts and negotiate and execute physician contracts for service lines

Other Positions

- Danbury Hospital - Service Line Executive, Cardiovascular Services and Radiology Services- June 2004-October 2007
- Continuum Health Partners, New York, NY Director, Ambulatory Care - June 2001-June 2004
- Continuum Health Partners, New York, NY Assistant Director, Physician Initiatives Group– May 2000 – June 2001
- The George Washington University Hospital, Washington, DC Administrative Resident – May 1999-April 2000
- The George Washington University Hospital, Washington, DC Interim Administrative Director, Department of Medical Imaging – July 1998- May 1999
- The George Washington University Hospital, Washington, DC Project Coordinator, Department of Quality Management – July 1996 – July 1998

Education

The George Washington University – School of Business and Public Management, Washington, DC Masters of Health Administration, May 2000

The University of Hartford – West Hartford, CT
Bachelor of Arts, Secondary Education and Allied Health, May 1991

Professional Organizations

Danbury Hospital, Regional YMCA of Western Connecticut and the Pound Ridge Partnership – Pound Ridge, NY

Awards

2005 Recipient of the Fairfield County Business Journal's "40 under 40" award for extraordinary leadership qualities and outstanding professional accomplishments that have made a significant impact on my organization and Fairfield County, CT

Curriculum Vitae
Deborah Kinney Weymouth

Professional Experience

Executive Director, Senior Vice President, New Milford Hospital ▪ New Milford, CT Western Connecticut Health Network, Danbury, CT	2011 – Present
Executive Vice President/Chief Operating Officer, Thompson Health ▪ Canandaigua, NY	2009 – 2011
Chief Financial Officer/Senior Vice President, Thompson Health ▪ Canandaigua, NY	2004 – 2009
Senior Vice President of Support Services, Thompson Health ▪ Canandaigua, NY	1999 – 2004
Vice President of Operations, FFThompson Continuing Care Center ▪ Canandaigua, NY	1995 – 1999
Vice President, Key Bank of New York ▪ Rochester, NY	1992 – 1994
Chief Operating Officer, Concierge Services of America ▪ Washington, D.C.	1990 – 1992
Vice President, Citicorp NA/Citibank ▪ Los Angeles, CA and Phoenix, AZ	1985 – 1990
Vice President of Operations, Great Western Bank ▪ Phoenix, AZ	1984 – 1985

Education

Fellow, American College of Healthcare Executives (FACHE)	2007
Master in Business Administration - Master of International Management / Finance Thunderbird Global Management School ▪ Phoenix, AZ	1984
Bachelor of Science - Education and Rehabilitation, Cum Laude Springfield College ▪ Springfield, MA	1979

Professional Certifications

Examiner, Malcolm Baldridge National Quality Award Program	2010-2011
Institute of Healthcare Improvement (IHI) Executive Hospital Operations	2009
Graduate of Citibank Global Credit Training Program ▪ New York, NY	1987

Professional Organizations

Member, New Milford Economic Development Corporation Board	2012 – Present
Member, DNS-Connecticut Hospital Association Fee-Based Services Board	2011 – Present
Member, United Way of Western Connecticut Board	2011 – Present
Chair, CFO Committee - Rochester Regional Healthcare Association	2009-11
Member, Finance Committee – Healthcare Association of NY	2008-11
Member, Information Technology Committee – Healthcare Association of NY	2009-11
Member, Board of Directors- Rochester Healthcare Financial Management Association	2010
Financial Executive of the Year - Rochester Business Journal	2008
Associate of the Year - Thompson Health Shining Star Award	2006
Athena Award, Outstanding Female Leadership - Canandaigua Chamber of Commerce	2002
Lifetime Achievement Award - Canandaigua Chamber of Commerce	1999
Employee of the Year - Great Western Bank	1984
8 Time NCAA All-American Swimmer	1975-79

Curriculum Vitae
Steven H. Rosenberg

Professional Experience

November 2010 – Present **Senior Vice President-Chief Financial Officer-Treasurer**
Western Connecticut Health Network

March 1987 – November 2010 **Senior Vice President and Chief Financial Officer**
Saint Francis Hospital and Medical Center - Hartford, CT

Steven H. Rosenberg is the Senior Vice President-Chief Financial Officer-Treasurer of Western Connecticut Health Network in Danbury, Connecticut. Mr. Rosenberg oversees all financial operations including patient accounting & billing, information technology, materials management, payor relations, contract management, general accounting and financial reporting, payroll, accounts payable, budget, reimbursement and decision support. Danbury Hospital is a 371-bed regional medical center and teaching hospital associated with Yale University, UConn and University of Vermont. The hospital's Centers of Excellence include: cardiovascular services, cancer, weight loss surgery, orthopedic and spine care, digestive disorders and radiology and employs approximately 2,400 FTEs.

Prior to his arrival at the Western Connecticut Health Network, Mr. Rosenberg was Senior Vice President and Chief Financial Officer for Saint Francis Hospital and Medical Center in Hartford, CT. Their health system included a hospital with 619 licensed beds; a 60-bed acute rehabilitation hospital; a faculty practice plan, (Woodland Physician Associates), which employed 110 physicians; a joint laboratory service with Bristol and St. Mary's Hospitals; and a very successful Physician Hospital Organization, which was jointly owned by physicians and the hospital.

Education

University of Connecticut
Storrs, CT
Accounting, BS 1975

University of New Haven
West Haven, CT
MBA 1980

Professional Organizations

Member, Connecticut Hospital Association Committee on Finance
Member, The Healthcare Financial Management Association

Curriculum Vitae
Phyllis F. Zappala

Professional Experience:
In her progressive career spanning over 25 years in general industry and healthcare, Phyllis has served in numerous HR leadership roles with increasing responsibility. Phyllis is known for her expertise in directing rapid growth and change in healthcare, services and manufacturing environments. She has successfully used HR strategies to help organizations achieve their business goals.

Western Connecticut Health Network, Danbury CT – 1998-Present
Senior Vice President Human Resources 2008 to date
Vice President Human Resources 1998 to 2007
Western Connecticut Health Network, consisting of Danbury and New Milford hospitals and numerous subsidiaries, is a leading regional health care provider located in western Connecticut with nearly 5000 employees including a 250 member physician practice subsidiary.

Staveley Industries plc, Norwalk, CT - 1988-1998
A UK based publically traded company with services and manufacturing holdings in 15 countries
Senior Vice President Human Resources, North America 1994-1998
Vice President Human Resources 1988-1994

The Penn Central Corporation – 1978-1988
Vice President of Human Resources and Corporate Communications
services and manufacturing businesses
HR Director 1981-1984
HR Manager 1978-1981

Education
Undergraduate: Bachelors Degree, St. John's University

Professional Certifications
Certificate from the New York School of Industrial Relations at Cornell University

Professional Organizations
American Society for Healthcare Human Resources Administrators (ASHHRA)
Connecticut Hospital Association (CHA)
The HR Investment Center, a program of the Health Care Advisory Board in Washington, D.C.

Curriculum Vitae
Matthew Alan Miller, MD

Professional Experience

1980-94	Director, Medical Intensive Care Unit, Danbury Hospital
1980-94	Chief, Pulmonary/Critical Care, Danbury Hospital
1991-Present	Vice President for Medical Affairs, Danbury Hospital
1994-Present	President, Healthcare Partners (Danbury Physician Hospital Organization)
1996-Present	President, Foundation for Community Health Care, Inc.
2004-Present	Chief Medical Officer, Danbury Hospital

Education

1968	BA	Amherst College, Amherst, Massachusetts
1972	M.D.	New York University School of Medicine, New York, NY

Postdoctoral Training

1972-73	Intern, Internal Medicine, Bellevue Hospital, New York, NY
1973-75	Resident, Internal Medicine, Bellevue Hospital, New York, NY
1975-76	Chief Medical Resident, Bellevue Hospital, New York, NY
1976-78	Clinical and Research Fellow, Pulmonary Unit, Massachusetts General Hospital; Research Fellow, Harvard Medical School, Boston, MA

Licenses and Board Certifications

1975	Diplomat, American Board of Internal Medicine
1975	American Thoracic Society
1978	Diplomat, American Board of Internal Medicine in Pulmonary Disease
1981	Fellowship American College of Chest Physicians

Curriculum Vitae
Moreen Donahue, DNP, RN, NEA-BC, FAAN

Professional Experience

Sr. Vice President, Patient Care Services & Chief Nursing Officer	Western Connecticut Health Network, Danbury, CT	2010 - Present
Sr. Vice President, Patient Care Services & Chief Nursing Officer	Danbury Hospital, Danbury, CT	2006 - 2010
Sr. Vice President, Patient Care Services & Chief Nursing Officer	Greenwich Hospital, Greenwich, CT	2000 – 2005
Director, Home Care & Hospice	Greenwich Hospital, Greenwich, CT	1997 - 2000
Vice President, Patient Care Services	United Home Care, Fairfield, CT	1990 - 1997

Professional History
Four decades of progressive administrative responsibilities in a variety of health care settings

Education

BS (Nursing)	Boston College, Boston, MA
MS (Education)	State University of New York, Cortland, NY
MSN	Case Western Reserve University, Cleveland, OH
DNP	Case Western Reserve University, Cleveland, OH

Professional Certifications

Nurse Executive Advanced – Board Certified	2008 – 2013
Certified Nurse Administrator	2003 – 2008
Certified Home/Hospice Care Executive (CHCE)	1998 – 2002
Professional Educator (State of Connecticut)	Permanent Certification

Professional Organizations

American Academy of Nursing Fellowship	2011 – Present
American Organization of Nurse Executives	2007 – Present
American Organization of Nurse Executives – Connecticut	2007 - Present
Sigma Theta Tau International Honor Society of Nursing	2004 – Present
American College of Healthcare Executives	2002 - Present
American Nurses Association	2000 – Present
Connecticut Hospital Association Patient Care Executive Committee	2000 – Present
VHA Northeast CNO Network	2000 - Present

Curriculum Vitae
Kathleen DeMatteo

Professional Experience

July 2011 – Present	Western Connecticut Health Network, Danbury, CT Chief Information Officer

Current responsibilities include oversight of all Information Technology for WCHN including clinical and financial systems, infrastructure, customer service, networking, telecommunications and health information management.

Recent accomplishments include the following:

- Developed an Information Technology Strategic Plan to align with the WCHN Strategic Plan.
- Implemented an IT governance structure to ensure alignment with business priorities.
- Established a strategy to centralize IT resources from Danbury Hospital and New Milford Hospital and standardize infrastructure and applications for the two hospitals.

2004 – 2007	Saint Francis Care, Hartford, CT Chief Information Officer
1999 - 2004	Saint Francis Care, Hartford, CT Director, Information Technology

Education

BS	Occupational Therapy University of New Hampshire, Durham NH
MPH	Healthcare Policy and Administration New York Medical College, Valhalla NY

Professional Organizations

College of Healthcare Information Management Executives (CHIME)
Health Information Management Systems Society (HIMSS)

Curriculum Vitae
Carolyn L. McKenna, Esq.

Professional Experience

Western Connecticut Health Network, Inc., Danbury, CT ***April, 2011 - Present***
General Counsel. Provide legal support for a two-hospital regional health system with home care services, a multi-specialty physician group, research and a multiple joint ventures. Support all corporate transactions, contracting, regulatory issues, litigation oversight, governance, risk and compliance. Provide management oversight responsibility for Western Connecticut Health Network Insurance Company, Ltd., an offshore captive insurance company. Participate in strategic development as a senior team member.

Eastern Connecticut Health Network, Inc., Manchester, CT	2003 - 2011
CIGNA Healthcare, Bloomfield, CT	2002 - 2003
YALE NEW HAVEN HEALTH SERVICES CORP., New Haven, CT	1998 - 2002
UNITED HEALTHCARE, INC., Hartford, CT Associate General Counsel	1995 - 1998
QUINNIPIAC UNIVERSITY SCHOOL OF LAW, Hamden, CT	1998 - 2001
U.S. DISTRICT COURT, District of Connecticut	1993 - 1995
U.S. COURT OF APPEALS FOR THE SECOND CIRCUIT	1992 - 1993

Education

UNIVERSITY OF BRIDGEPORT SCHOOL OF LAW, Bridgeport, CT
(Note: This is now Quinnipiac University School of Law, Hamden, CT)
J.D., May 1992 (Rank: Top 4%)
Honors: *magna cum laude*; Dean's Scholarship recipient
Activities: *University of Bridgeport Law Review*, Managing Editor; Phi Delta Phi Honors Fraternity

UNIVERSITY OF VERMONT, Burlington, VT
B.A. in English May 1985

Professional Certifications

Member of Connecticut and District of Connecticut Bars

Professional Organizations

American Health Lawyers In House Legal Counsel
Healthcare Roundtable
Association of Corporate Counsel
Connecticut Health Lawyers Association

Curriculum Vitae
Joseph A. Campbell

Professional Experience

2001 to Present	Chief Risk & Compliance Officer – Western Connecticut Health Network
1989 – 2001	Chief Compliance Officer & Quality Executive – Greater Waterbury Health Network
1987 – 1989	Visiting Nurse Association of South Central Connecticut – Chief Financial Officer

Professional experience includes more than thirty years in the non-profit, healthcare industry in Connecticut; approximately ten years in Finance, ten years in Quality Management and fourteen years in Compliance.

Currently responsible for WCHN's Compliance Program that includes Regulatory Compliance, Revenue Compliance, Physician Coding Compliance, Internal Audit, Enterprise Risk and HIPAA Privacy.

The Chief Risk & Compliance Officer serves as a consultant to senior management in a matrix organization; is the key contact with outside regulators, i.e., DHHS Office of the Inspector General; U.S. Department of Justice; DHHS Office of Civil Rights; State of Connecticut Department of Social Services; and State of Connecticut Office of the Attorney General.

Education

B.S. Degree in Accounting/Business Administration
M.S. Degree in Healthcare Management
Rensselaer Polytechnic Institute

Professional Organizations

American College of Healthcare Executives
Health Care Compliance Association
Healthcare Financial Management Association
Institute of Internal Auditors

Professional Presentations

"The Role of Compliance in the Revenue Cycle"
Connecticut Chapter – Healthcare Financial Management Association, Uncasville, CT

"Retrospective Review of an OIG Self-disclosure"
American Health Lawyers Association/Healthcare Compliance Association, (AHLA/HCCA)
Fraud and Abuse Forum, Baltimore, MD

"Improving Internal Response to Audit & Compliance Situations"
Connecticut Hospital Association Annual Compliance Conference, Wallingford, CT

"Physician Responsibilities Under EMTALA"
National Association of Medical Staff Services, Las Vegas, NV

Curriculum Vitae
Morris Gross

Professional Experience

Danbury Hospital since 1975 in administration (38 years). During this time period has been responsible for almost all hospital departments, both clinical and support departments. Has held role of Vice President Facilities since 1992, and since October 2010 has been responsible for Facilities for Western Connecticut Health Network which includes both Danbury and New Milford Hospitals.

Since 1975, I have provided administrative support for all major construction projects including the Tower Project completed in 1979, the construction of the Stroock building, Cancer Center, Medical Arts Center building and Garage, and currently am responsible for the New North Tower project totaling 316,000 sq ft plus Blue Garage expansion. I am also responsible for the siting, development and ongoing facilities support for all offsite locations for Danbury and New Milford Hospitals as well as the development and implementation of the Master Facility Plan of both hospitals. In addition to construction and offsite development, I am currently administratively responsible for the Facilities division at Danbury and New Milford Hospitals including all plant operations, safety, security, environmental services, dietary, gift shops, and spiritual care.

Education

Undergraduate- University of Connecticut, Bachelors in Physical Therapy (1971)
Graduate- New York University, Masters in Health Administration within Graduate School of Public Administration (1975)

Professional Certifications

Licensed in Physical Therapy in Connecticut and New York
Fellow in the American College of Health Executives

Professional Organizations

Fellow in the American College of Healthcare Executives
Education Chairman for Connecticut for the American College of Healthcare Executives (since 1992)
On Board of Habitat for Humanity for Fairfield County

Other Areas of Interest

Member of Danbury Connecticut Lions Club since 1978

Curriculum Vitae:
D. Mark Schumann

Professional Experience:
April 2013-Present: Vice President, Marketing and Communications, WCHN
January 2010-April 2013: Principal, re-communicate
January 1984-January 2010: Managing Principal, Towers Perrin
June 1978-January 1984: Director, Public Relations/Advertising, Frontier Airlines

Education:
1977: Bachelor of Arts, Austin College, Sherman, Texas
1978: Master of Arts, University of Denver, Denver, Colorado

Professional Certifications:
Accredited Business Communicator, International Association of Business Communicators

Professional Organizations:
1978-Present: International Association of Business Communicators
Chair, 2009-2010

Other Areas of Interest:
September 1999-Present: Film Critic, Hersam Acorn Press, Connecticut

Curriculum Vitae
Dawn N. Myles

Professional Experience

12/08-Present — *Vice President, Quality and Patient Safety, Western Connecticut Health Network, Danbury, CT*
Direct the strategic planning and program implementation for quality improvement, patient safety/risk management, patient relations, volunteers, and infection control. Responsible for regulatory compliance programming and communication. Oversee initiatives with high impact on quality, patient safety, and efficiency.

10/97-12/08 — *Director of Performance Improvement/Chief Quality Officer, Danbury Hospital, Danbury CT*
Directed performance improvement, patient safety/risk management, patient relations, infection control, project management, and medical informatics functions. Responsible for clinical regulatory compliance functions. Oversaw participation in national quality programs, such as those sponsored by Leapfrog and the Institute for Healthcare Improvement

02/96-6/00 — *Director of Nursing & Quality Management, Behavioral Health, Danbury Hospital, Danbury, CT*
Supervised nursing practice in all inpatient and outpatient psychiatric and chemical dependency programs. Was directly responsible for daily operations on the inpatient psychiatric unit. Organized a system of orientation and cross training of service line nursing staff. Redesigned the Behavioral Health Quality Management program.

Education

01/95-09/96 — *M.S., Nursing, Clinical Nurse Specialist - Psychiatric/Mental Health Nursing, Pace University, Pleasantville, NY*
09/89-05/92 — *B.S., Nursing, Western Connecticut State University, Danbury, CT*
09/88-05/90 — *M.S., Counseling, Southern Connecticut State University, New Haven, CT*
09/84-05/88 — *B.A., Psychology/Communications, Western Connecticut State University, Danbury, CT*

Professional Certifications

Certified Professional in Healthcare Quality (CPHQ)
Certified Professional in Healthcare Risk Management (CPHRM)

Professional Organizations

American Society for Healthcare Risk Management
Connecticut Society for Healthcare Risk Management

Other Areas of Interest

Mentoring and Training

Curriculum Vitae
Sally F. Herlihy, MBA, FACHE

Professional Experience

2010 – Present — Western Connecticut Health Network, Danbury, CT
2010 – Present, VP, Planning
2011– 2013 Interim VP, Marketing

Plans, organizes, directs and facilitates strategic planning processes, including creation of an overall WCHN Strategic Plan and monitoring implementation. Manages and coordinates planning across network entities, consults and informs leadership and service lines on business and strategic planning issues, including market share, market surveys, planning processes, future trends, and environmental assessments, and managing the regulatory/CON process. Directs community needs assessments, and collaborates in the strategic marketing planning for WCHN.

1985 – 2010 — New Milford Hospital, Inc. New Milford, CT
2007 – 2010 VP, Regulatory Compliance
1997 – 2007 VP, Planning and Marketing
1988 – 1997 VP, General Services
1985 – 1988 Corporate Project Planner

1980 – 1985 — The Seiler Corporation, Waltham, MA
1983-1985 Director, Food Services, New Milford Hospital, CT
1981-1983 Chief Dietitian, New Milford Hospital, CT
1980-1981 Clinical Dietitian, St. Elizabeth Hospital, Utica, NY

Education

1995 — University of New Haven, New Haven, CT
MBA (concentration in Health Care Management)

1980 — University of Connecticut, Storrs, CT
BS Degree, School of Allied Health (Clinical Dietetics)

Professional Certifications

1992 - Present — American College of Health Care Executives
Fellow Status – 2007, recertified - 2010
Diplomate – 1998, recertified - 2006
Member – 1992

American Dietetic Association
Registered Dietitian – 1980 - 2000

Curriculum Vitae
Grace Linhard

Professional Experience
Executive Director & Vice President, WCHN Foundation
2011-present

Vice President, Danbury Hospital Development Fund
2004-2011

Chief Development Officer, Waterbury Hospital
1998-2004

- Fundraising professional for 20 years
  Experience in United Way system (4 years) and healthcare philanthropy (16 years)
- Currently overseeing $50 million campaign for WCHN
- Manage $10+ million annual fundraising effort for WCHN's two hospitals
- Oversee fundraising department with 13 staff members
- Work closely with WCHN leadership team, physician leaders, Boards of Directors and other volunteer committees to maximize fundraising potential
- Develop and execute fundraising goals/plans

Education
Stonehill College
BA, Communication/Journalism

Professional Organizations
Association of Fundraising Professionals
New England Association of Healthcare Professionals
Planned Giving Society of Connecticut

Volunteer Affiliations

Board Chairman	- Jane Doe No More, Inc.
Alumni Class Agent	- Stonehill College
Volunteer	- Church of the Nativity, Bethlehem
Fundraising Consultant/Volunteer	- Clube Uniao Portuguesa

Awards / Recognitions

2010 Conference Speaker	- Int'l Assn of Fundraising Professionals
2009 Conference Speaker	- NE Assn of Healthcare Professionals
2008 Leadership Graduate	- Danbury Chamber of Commerce
2002 Leadership Graduate	- Greater Waterbury Chamber of Commerce
2002 Conference Chairman	- Assn of Fundraising Professionals

Exhibit H

Financial Attachment 1

Danbury Hospital

6.A. Financial Attachment I

(Dollars are in thousands)

Total Facility: / Description	FY2012 Actual Actuals	FY2013 Projected Actuals	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected Actuals	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected Actuals	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected Actuals	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$295,802	296,980	-	296,980	$306,428	47,042	353,470	$316,214	48,544	$364,759	$327,138	50,221	$377,357
Medicare	170,634	172,906	-	172,906	179,721	18,687	192,408	175,181	18,842	194,023	177,543	19,098	196,641
Medicaid and Other Medical Assistance	35,821	37,362	-	37,362	37,391	5,344	42,735	37,425	5,349	42,774	37,515	5,376	42,891
Other Government	366	325	-	325	325	85	410	325	85	410	325	85	410
Total Net Patient Patient Revenue	$502,429	506,973	$0	506,973	517,865	$71,157	589,022	529,125	$72,820	$601,945	542,519	$74,780	617,299
Other Operating Revenue	$22,127	$11,393	-	$11,393	$11,409	$980	$12,389	$10,649	$980	$11,628	$10,844	$950	$11,804
Revenue from Operations	$524,549	$518,366	$0	$518,366	$529,274	$72,137	$601,411	$539,774	$73,799	$613,573	$553,263	$75,730	$629,022
OPERATING EXPENSES													
Salaries and Fringe Benefits	$255,664	$254,095	-	$254,095	$260,093	40,979	$301,072	$266,239	41,909	$308,147	$273,083	42,859	$315,943
Professional / Contracted Services	55,287	55,938	-	55,938	57,057	8,712	65,769	58,198	8,890	67,088	59,362	9,071	68,434
Supplies and Drugs	77,391	80,299	-	80,299	82,708	9,876	92,585	85,150	10,173	95,362	87,745	10,478	98,223
Other Operating Expense	61,088	61,267	-	61,267	61,465	10,170	71,635	60,062	10,166	70,228	60,067	10,152	70,219
Subtotal	$452,369	$451,599	$0	$451,599	$461,324	69,737	$531,061	$469,688	71,137	$540,825	$480,248	72,570	$552,818
Depreciation/Amortization	31,663	31,876	-	31,876	35,128	5,649	40,776	40,976	6,642	47,625	45,392	7,649	52,981
Interest Expense	4,155	3,997	-	3,997	4,697	268	4,965	8,337	368	8,705	8,295	288	8,583
Lease Expense	7,206	7,472	-	7,472	7,621	832	8,453	7,775	841	8,614	7,929	846	8,775
Total Operating Expenses	$495,394	$494,933	$0	$494,933	$508,767	$76,487	$585,194	$526,774	79,988	$605,669	$541,864	$81,337	$623,140
Gain/(Loss) from Operations	$29,155	$23,433	$0	$23,433	$20,507	($4,349)	$16,218	$13,000	($5,098)	$7,904	$11,400	($6,677)	$5,882
Plus: Non-Operating Income	$24,211	$14,627		$14,627	$14,481	$0	$14,481	$14,396	$0	$14,396	$14,193	$0	$14,193
Income before provision for income taxes	$53,376	$38,060	$0	$38,060	$35,048	($4,349)	$30,699	$27,396	($5,098)	$22,240	$25,662	($6,677)	$20,075
Provision for Income taxes			-	$0		$0	$0		$0	$0		$0	$0
Revenue Over/(Under) Expense	$53,376	$38,060	$0	$38,060	$35,048	($4,349)	$30,699	$27,396	($5,098)	$22,240	$25,662	($6,677)	$20,075
FTEs	2,405.1	2,376.5	-	2,376.5	2,371.6	373.0	2,744.6	2,369.2	373.0	2,742.2	2,371.7	373.0	2,744.7
*Volume Statistics: Inpatient Discharges	19,578	19,681		19,681	18,464	1,903	20,367	18,309	1,884	20,193	18,129	1,865	19,991
Outpatient Visits	430,495	434,235	-	434,235	436,973	47,849	483,821	437,717	47,853	485,565	439,468	48,030	487,497
Key Ratios:													
Op Margin	5.6%	4.5%		4.5%	3.9%		2.7%	2.4%		1.8%	2.1%		0.9%
Operating EBIDA Margin	12.4%	11.4%		11.4%	11.4%		10.3%	11.5%		10.5%	11.8%		10.7%
Excess Margin	10.2%	7.3%		7.3%	6.6%		5.1%	5.1%		3.6%	4.6%		3.2%

New Milford Hospital

6.A. Financial Attachment I

(Dollars are in thousands)

Total Facility: / Description	FY 2012 Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$48,136	45,592	-	$45,592	47,042	(47,042)	-	48,544	(48,544)	-	50,221	(50,221)	-
Medicare	24,242	19,229	-	$19,229	18,687	(18,687)	$0	18,842	(18,842)	$0	19,098	(19,098)	$0
Medicaid and Other Medical Assistance	5,633	5,340	-	$5,340	5,344	(5,344)	$0	5,349	(5,349)	$0	5,376	(5,376)	$0
Other Government	101	85	-	85	85	(85)	$0	85	(85)	$0	85	(85)	$0
Total Net Patient Patient Revenue	$78,111	$70,245	$0	$70,245	$71,157	($71,157)	$0	$72,820	($72,820)	$0	74,780	($74,780)	$0
Other Operating Revenue	$1,101	$980	-	$980	$980	($980)	$0	$980	($980)	$0	$980	($980)	$0
Revenue from Operations	$79,212	$71,225	$0	$71,225	$72,137	($72,137)	$0	$73,799	($73,799)	$0	$75,759	($75,759)	$0
OPERATING EXPENSES													
Salaries and Fringe Benefits	$45,235	$40,419	-	$40,419	$41,329	(41,329)	$0	$42,259	(42,259)	$0	$43,209	(43,209)	$0
Professional / Contracted Services	12,196	8,713	-	8,713	8,887	(8,887)	-	9,065	(9,065)	-	9,246	(9,246)	-
Supplies and Drugs	10,418	9,589	-	9,589	9,876	(9,876)	-	10,173	(10,173)	-	10,478	(10,478)	-
Other Operating Expense	10,942	10,360	-	10,360	10,360	(10,360)	-	10,360	(10,360)	-	10,360	(10,360)	-
Subtotal	$78,792	$69,081	$0	$69,081	$70,452	($70,452)	$0	$71,856	($71,856)	$0	$73,294	($73,294)	$0
Depreciation/Amortization	5,527	5,862	-	5,862	6,162	(6,162)	-	7,162	(7,162)	-	8,162	(8,162)	-
Interest Expense	419	268	-	268	268	(268)	-	268	(268)	-	268	(268)	-
Lease Expense	447	824	-	824	832	(832)	-	841	(841)	-	849	(849)	-
Total Operating Expenses	$85,184	$76,035	$0	$76,035	$77,715	($77,715)	$0	$80,127	($80,127)	$0	$82,573	($82,573)	$0
Gain/(Loss) from Operations	($5,972)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
Plus: Non-Operating Income	$772	$0	-	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income before provision for income taxes	($5,200)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
Provision for income taxes			-	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense	($5,200)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
FTEs	420.0	375.0	-	375.0	375.0	(375.0)	-	375.0	(375.0)	-	375.0	(375.0)	-
*Volume Statistics: Inpatient Discharges	2,285	1,922		1,922	1,903	(1,903)	-	1,884	(1,884)	-	1,865	(1,865)	-
Outpatient Visits	61,244	47,456	-	47,456	47,648	(47,648)	-	47,838	(47,838)	-	48,030	(48,030)	-
			-	-	-	-	-	-	-	-	-	-	-
Key Ratios:													
Op Margin	-7.5%	-6.8%		-6.8%	-7.7%		0.0%	-8.6%		0.0%	-9.0%		0.0%
Operating EBIDA Margin	0.0%	1.9%		1.7%	1.2%		0.0%	1.5%		0.0%	2.1%		0.0%
Excess Margin	-6.6%	-6.8%		-6.8%	-7.7%		0.0%	-8.6%		0.0%	-9.0%		0.0%

Exhibit I

Financial Assumptions

Western CT Health Network - DH / NMH Single License

6.C. Financial Assumptions

Financial Assumptions With Project anticipate all revenue and expenses will shift from New Milford Hospitals financials to Danbury Hospitals financials statements (see incremental column). In addition, savings as a result of this project have been further incorporated as follows:

Current NMH Operating Expenses/FTEs by Projected By Year:

Dollars reflected in thousands	Year 1	Year 2	Year 3	
NMH Without Project Operating Income	($5,578)	($6,328)	($6,813)	
Savings Projected with Project:				
Salaries & Fringe Benefits	350	350	350	2.0 FTE Savings anticipated with system integration
Contracted Services	175	175	175	Audit Services
Other Operating Expense				
Software Expense	154	158	162	Savings with consolidation of software
Membership Dues	26	26	26	Savings with consolidation of membership dues
JCAHO	10	10	10	Reduction
Depreciation	513	513	513	Savings in capital costs from elim Meditech upgrade (see below)
Total Savings	1,228	1,232	1,236	
Operating Income WITH PROJECT	(4,349)	(5,096)	(5,577)	

Depreciation Savings identified above is comprised of the following capital costs depreciated over 5yrs.

Cost to Upgrade Meditech Systems (reflected as savings)	3,161
Incremental implementation costs to move to single platform	(597)
Net Savings	2,564
Depreciation Exp over 5yrs	513

* Moving to a single platform avoids extensive capital investment as well as ongoing annual maintenance savings.

Overall Hospital Projections WITHOUT PROJECT were based on the assumptions outlined below:

Net Patient Revenue/Volume:	Determined using historical payment experience and anticipated overall volume increases
Other Operating Revenue:	Assumes 0% increase annually
Salaries and Fringe Benefits:	Based on historic and planned expense combined with inflationary increases.
Professional / Contracted Srvs:	Assumes 2% annual increase, based on projected trend
Supplies and Drugs:	Assumes 3% annual increase, based on historical data combined with inflationary increases
Other Op Expense:	Based on historic trend
Depreciation:	Assumption is based on historic and planned annual capital spending
Interest:	Based on current interest of existing debt rolled forward annually.
Lease Expense:	Includes a 1% annual increase on expenses annually.
FTEs:	Includes increase in variable staffing required to support growth combined with continued productivity initiatives currently underway.

Danbury Hospital

6.A. Financial Attachment I

(Dollars are in thousands)

Total Facility: / Description	FY2012 Actual Actuals	FY2013 Projected Actuals	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected Actuals	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected Actuals	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected Actuals	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$295,602	296,980	-	296,980	$306,428	47,042	353,470	$316,214	48,544	364,759	$327,136	50,221	377,357
Medicare	170,634	172,306	-	172,306	173,721	18,687	192,408	175,161	18,842	194,003	177,543	19,098	196,641
Medicaid and Other Medical Assistance	35,821	37,362	-	37,362	37,391	5,344	42,735	37,425	5,349	42,774	37,615	5,376	42,991
Other Government	366	325	-	325	325	85	410	325	85	410	325	85	410
Total Net Patient Patient Revenue	$502,423	506,973	$0	506,973	517,865	$71,157	589,022	529,125	$72,820	$601,945	542,619	$74,780	617,399
Other Operating Revenue	$22,127	$11,393	-	$11,393	$11,409	$980	$12,389	$10,649	$980	$11,628	$10,644	$980	$11,624
Revenue from Operations	$524,549	$518,366	$0	$518,366	$529,274	$72,137	$601,411	$539,774	$73,799	$613,573	$553,263	$75,759	$629,022
OPERATING EXPENSES													
Salaries and Fringe Benefits	$258,694	$254,095	-	$254,095	$260,093	40,979	$301,072	$266,239	41,909	$308,147	$273,083	42,859	$315,943
Professional / Contracted Services	55,287	55,938	-	55,938	57,057	8,712	65,769	58,198	8,890	67,088	59,362	9,071	68,434
Supplies and Drugs	77,291	80,299	-	80,299	82,708	9,876	92,585	85,189	10,173	95,362	87,745	10,478	98,223
Other Operating Expense	61,088	61,267	-	61,267	61,465	10,170	71,635	60,062	10,166	70,228	60,057	10,162	70,219
Subtotal	$452,359	$451,599	$0	$451,599	$461,324	69,737	$531,061	$469,688	71,137	$540,825	$480,248	72,570	$552,818
Depreciation/Amortization	31,663	31,876	-	31,876	35,126	5,649	40,775	40,976	6,649	47,625	45,332	7,649	52,981
Interest Expense	4,156	3,987	-	3,987	4,637	268	4,905	8,337	268	8,605	8,295	268	8,563
Lease Expense	7,206	7,472	-	7,472	7,621	832	8,453	7,773	841	8,614	7,929	849	8,778
Total Operating Expenses	$495,384	$494,933	$0	$494,933	$508,707	$76,487	$585,194	$526,774	78,895	$605,669	$541,804	$81,337	$623,140
Gain/(Loss) from Operations	$29,165	$23,433	$0	$23,433	$20,567	($4,349)	$16,218	$13,000	($5,096)	$7,904	$11,460	($5,577)	$5,882
Plus: Non-Operating Income	$24,211	$14,627		$14,627	$14,481	$0	$14,481	$14,336	$0	$14,336	$14,193	$0	$14,193
Income before provision for income taxes	$53,376	$38,060	$0	$38,060	$35,048	($4,349)	$30,699	$27,336	($5,096)	$22,240	$25,652	($5,577)	$20,075
Provision for income taxes			-	$0		$0	$0		$0	$0		$0	$0
Revenue Over/(Under) Expense	$53,376	$38,060	$0	$38,060	$35,048	($4,349)	$30,699	$27,336	($5,096)	$22,240	$25,652	($5,577)	$20,075
FTEs	2,405.1	2,376.5	-	2,376.5	2,371.6	373.0	2,744.6	2,369.2	373.0	2,742.2	2,371.7	373.0	2,744.7
*Volume Statistics: Inpatient Discharges	19,676	18,681		18,681	18,494	1,903	20,397	18,309	1,884	20,193	18,126	1,865	19,991
Outpatient Visits	430,495	434,236	-	434,236	435,973	47,648	483,621	437,717	47,838	485,555	439,468	48,030	487,497
Key Ratios:													
Op Margin	5.6%	4.5%		4.5%	3.9%		2.7%	2.4%		1.3%	2.1%		0.9%
Operating EBIDA Margin	12.4%	11.4%		11.4%	11.4%		10.3%	11.5%		10.5%	11.8%		10.7%
Excess Margin	10.2%	7.3%		7.3%	6.6%		5.1%	5.1%		3.6%	4.6%		3.2%

New Milford Hospital

6.A. Financial Attachment I

(Dollars are in thousands)

Total Facility: / Description	FY 2012 Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$48,136	45,592	-	$45,592	47,042	(47,042)	-	48,544	(48,544)	-	50,221	(50,221)	-
Medicare	24,242	19,229	-	$19,229	18,687	(18,687)	$0	18,842	(18,842)	$0	19,098	(19,098)	$0
Medicaid and Other Medical Assistance	5,632	5,340	-	$5,340	5,344	(5,344)	$0	5,349	(5,349)	$0	5,376	(5,376)	$0
Other Government	101	85	-	85	85	(85)	$0	85	(85)	$0	85	(85)	$0
Total Net Patient Patient Revenue	$78,111	$70,245	$0	$70,245	$71,157	($71,157)	$0	$72,820	($72,820)	$0	74,780	($74,780)	$0
Other Operating Revenue	$1,101	$980	-	$980	$980	($980)	$0	$980	($980)	$0	$980	($980)	$0
Revenue from Operations	$79,212	$71,225	$0	$71,225	$72,137	($72,137)	$0	$73,799	($73,799)	$0	$75,759	($75,759)	$0
OPERATING EXPENSES													
Salaries and Fringe Benefits	$45,235	$40,419	-	$40,419	$41,329	(41,329)	$0	$42,259	(42,259)	$0	$43,209	(43,209)	$0
Professional / Contracted Services	12,196	8,713	-	8,713	8,887	(8,887)	-	9,065	(9,065)	-	9,246	(9,246)	-
Supplies and Drugs	10,418	9,589	-	9,589	9,876	(9,876)	-	10,173	(10,173)	-	10,478	(10,478)	-
Other Operating Expense	10,942	10,360	-	10,360	10,360	(10,360)	-	10,360	(10,360)	-	10,360	(10,360)	-
Subtotal	$78,792	$69,081	$0	$69,081	$70,452	($70,452)	$0	$71,856	($71,856)	$0	$73,294	($73,294)	$0
Depreciation/Amortization	5,527	5,862	-	5,862	6,162	(6,162)	-	7,162	(7,162)	-	8,162	(8,162)	-
Interest Expense	419	268	-	268	268	(268)	-	268	(268)	-	268	(268)	-
Lease Expense	447	824	-	824	832	(832)	-	841	(841)	-	849	(849)	-
Total Operating Expenses	$85,184	$76,035	$0	$76,035	$77,715	($77,715)	$0	$80,127	($80,127)	$0	$82,573	($82,573)	$0
Gain/(Loss) from Operations	($5,972)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
Plus: Non-Operating Income	$772	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income before provision for income taxes	($5,200)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
Provision for income taxes			-	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense	($5,200)	($4,810)	$0	($4,810)	($5,578)	$5,578	$0	($6,328)	$6,328	$0	($6,813)	$6,813	$0
FTEs	420.0	375.0	-	375.0	375.0	(375.0)	-	375.0	(375.0)	-	375.0	(375.0)	-
*Volume Statistics: Inpatient Discharges	2,288	1,922		1,922	1,903	(1,903)	-	1,884	(1,884)	-	1,865	(1,865)	-
Outpatient Visits	61,244	47,458	-	47,458	47,648	(47,648)	-	47,838	(47,838)	-	48,030	(48,030)	-
			-	-	-	-	-	-	-	-	-	-	-
Key Ratios:													
Op Margin	-7.5%	-6.8%		-6.9%	-7.7%		0.0%	-8.6%		0.0%	-9.0%		0.0%
Operating EBIDA Margin	0.0%	1.9%		1.7%	1.2%		0.0%	1.5%		0.0%	2.1%		0.0%
Excess Margin	-6.6%	-6.8%		-6.9%	-7.7%		0.0%	-8.6%		0.0%	-9.0%		0.0%

Western CT Health Network - DH / NMH Single License

6.C. Financial Assumptions

Financial Assumptions With Project anticipate all revenue and expenses will shift from New Milford Hospitals financials to Danbury Hospitals financials statements (see incremental column). In addition, savings as a result of this project have been further incorporated as follows:

Current NMH Operating Expenses/FTEs by Projected By Year:

Dollars reflected in thousands	Year 1	Year 2	Year 3	
NMH Without Project Operating Income	**($5,578)**	**($6,328)**	**($6,813)**	
Savngs Projected with Project:				
Salaries & Fringe Benefits	**350**	**350**	**350**	2.0 FTE Savings anticipated with system integration
Contracted Services	**175**	**175**	**175**	Audit Services
Other Operating Expense				
Software Expense	**154**	**158**	**162**	Savings with consolidation of software
Membership Dues	**26**	**26**	**26**	Savings with consolidation of membership dues
JCAHO	**10**	**10**	**10**	Reduction
Depreciation	**513**	**513**	**513**	Savings in capital costs from elim Meditech upgrade (see below)
Total Savings	**1,228**	**1,232**	**1,236**	
Operating Income WITH PROJECT	**(4,349)**	**(5,096)**	**(5,577)**	

Depreciation Savings identified above is comprised of the following capital costs depreciated over 5yrs.

Cost to Upgrade Meditech Systems (reflected as savings)	**3,161**
Incremental implementation costs to move to single platform	**(597)**
Net Savings	**2,564**
Depreciation Exp over 5yrs	**513**

*** Moving to a single platform avoids extensive capital investment as well as ongoing annual maintenance savings.**

Overall Hospital Projections WITHOUT PROJECT were based on the assumptions outlined below:

Net Patient Revenue/Volume:	Determined using historical payment experience and anticipated overall volume increases
Other Operating Revenue:	Assumes 0% increase annually
Salaries and Fringe Benefits:	Based on historic and planned expense combined with inflationary increases.
Professional / Contracted Srvs:	Assumes 2% annual increase, based on projected trend
Supplies and Drugs:	Assumes 3% annual increase, based on historical data combined with inflationary increases
Other Op Expense:	Based on historic trend
Depreciation:	Assumption is based on historic and planned annual capital spending
Interest:	Based on current interest of existing debt rolled forward annually.
Lease Expense:	Includes a 1% annual increase on expenses annually.
FTEs:	Includes increase in variable staffing required to support growth combined with continued productivity initatives currently underway.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

September 13, 2013 VIA FAX ONLY

Sally Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31859-CON
Western Connecticut Health Network, Danbury Hospital and New Milford Hospital

Dear Ms. Herlihy:

On August 15, 2013, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") application filing on behalf of Western Connecticut Health Network, Inc. ("WCHN"). Based upon its review of the application, OHCA has determined that Danbury Hospital ("DH") and New Milford Hospital ("NMH") must be made Applicants to the CON application. WCHN, DH and NMH are hereinafter referred to as "the Applicants." The Applicants are proposing the termination of NMH's acute care general hospital license with the Connecticut Department of Public Health and to operate it under DH's current acute care general hospital license.

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c). The page numbers given in each question refer to the submitted initial CON application.

1. Considering NMH and DH are both affiliates (as referenced on pages 7-8) of WCHN, why is it necessary to terminate NMH's license and operate NMH under DH's license in order able to provide the IT upgrades mentioned?

2. Regarding services currently offered at DH and NMH (as discussed on pages 7-9), please address the following:

    a) Have the Applicants undertaken efforts to evaluate the need for services at each of these locations after the proposed merger under one license?
    b) Have there been any studies conducted by the Applicants regarding whether or not the current services offered at both hospitals are duplicative?

3. For FYs 2010-2012, please reconcile and explain any differences between Table 1 on page 14 for NMH and (1) data submitted through CHIME to OHCA's Inpatient Discharge Database and (2) data reported for HRS Schedule 450. Please update and annualize 2013 YTD.

4. Please complete and submit Table 1 on page 14 for Danbury Hospital, reconcile and explain any differences from (1) OHCA's Inpatient Discharge Data submitted through CHIME and (2) HRS Schedule 450, for FYs 2010-2013, annualizing 2013 YTD.

5. Explain in detail the reason(s) NMH has experienced a historical decline in total hospital utilization (as presented on page 14) over the past three years and specifically, the approximately 36% decline between FY2011 and 2012. In addition, provide explanations for declines reported by specific services. If declines are reported for DH in responding to question 4 above, please also explain in detail reasons for those declines.

6. As part of this proposed merger under one license, have the Applicants developed any plans to address the declining overall and service-specific utilization at NMH?

7. Please confirm that as part of this proposal the Applicants are proposing that DH acquire the 85 licensed beds at NMH and add them to DH's total licensed beds. If so, please provide a rationale for and explain in detail the need for DH to add 85 additional beds to its current complement of licensed beds. Provide any studies conducted as evidence.

8. Discuss how this proposal is consistent with the goals and objectives of the Connecticut's Statewide Heath Care Facilities and Services Plan ("Plan").

9. Regarding the financials, as presented on pages 47-51, identify and provide specific examples of financial savings and benefits for NMH, DH and WCHN as a result of this proposal. Is the table on page 11 showing capital avoidance and operational savings estimates entirely related to the entity, NMH? Please reconcile to the Financial Attachment(s) and provide supporting documentation for the capital avoidance figure and each of the operating expense reduction estimates.

10. Will the proposed single general hospital license be able to use greater purchasing power as a cost savings (or reduction to operating expenses) mechanism? If so, please quantify and provide specific details, and reconcile or revise Financial Attachment I (provided on pages 47-51) for both hospitals.

11. Discuss and provide a specific timeline for WCHN to implement any of the savings listed above.

12. NMH has experienced significant losses, Excess/(Deficiency) of Revenues over Expenses of $(5,165,070), $190,247, ($93,942) and ($6,456,113) for FYs 2009 through projected

2013 (pp. 47-51). Please provide a detailed explanation for these losses and specifically for projected FY 2013.

13. Please provide a discussion which shows in greater detail how this proposal will benefit NMH given the fact that NMH has shown a loss from operations from FY 2011 to FY 2012, has had a decrease in days cash on hand and an increase in the average payment period. NMH's total net assets, equity financing ratio and long term debt to capitalization ratio were also negative over the period of FY 2011 to FY 2012. Please explain.

14. What specific plans have the Applicants developed to address the operating losses at NMH? Provide evidence.

15. Considering the operating losses at NMH, is merging/consolidating NMH's financials under DH a reasonable course of action as the proposal will reduce DH's Revenue Over/(Under) Expenses at an increasing rate starting in FY 2014? Please explain the impact of this proposal on DH's financial status and provide specific details.

16. Provide a discussion of how the system, WCHN, and its two hospitals are prepared to meet the provisions of federal Health Care Reform (the Affordable Care Act). Include in your discussion Value-Based Purchasing, Accountable Care Organizations and the Medicare Shared Savings Program. Has any financial impact been reflected in the projected financial statements provided in the application?

17. Did either hospital apply for incentive payments related to the CMS Electronic Health Record Incentive Program? If not, would the $3.1 million projected upgrade to New Milford's IT system (the capital avoidance figure) (pages 7-8) have qualified for the Incentive Program? Please indicate whether this program was pursued by either or both hospitals.

18. Do the Applicants assume that gifts and bequests (non-operating revenue) will continue at the same rate with a single license under Danbury Hospital as it would if New Milford Hospital continued as a separately licensed entity? Could this project negatively impact future gifts/bequests (pages 47-51)?

19. Provide support or documentation related to the statement that Medicaid reimbursements to WCHN will be reduced by $30 million over the next two years.

20. The Applicants identify an "Integration cost to single system" of $596,965 on page 11 and make the statement on page 10 that "WCNH has already invested $596K to support alignment of its IT systems to achieve efficiencies." Please clarify that the Applicants have already expended the capital dollars to achieve the estimated cost savings related to the proposal before OHCA.

21. Regarding the operating expense reductions estimated on page 11, verify that each of these cannot be achieved without a single license.

22. Please further explain the statement on page 16, "With separate licenses, there is a requirement for each hospital entity to have its own medical staff with its own set of Bylaws and Medical Staff leadership."

23. Please complete and submit the Patient Payer Mix table for both NMH and DH and explain any changes that may occur as a result of this proposal.

24. Discuss any effect this proposal may have on payer contract negotiations. How has any projected impact been reflected in the financial statements provided?

25. To illustrate the impact of this proposal on charges for patients utilizing the New Milford campus, please provide a comparison of NMH and DH's current pricemaster charges for twenty procedures which represent large volume service lines. Be sure to list the item code, item description and item price as used in the hospitals' pricemaster filings and indicate whether there is any bundling involved in the service charges listed.

26. Provide a copy of any and all agreements related to the consolidation into one license and provide documents evidencing current- and post-merger board composition.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 51 and reference "Docket Number: 13-31859-CON." Submit one (1) original and two (2) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information not later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than November 12, 2013, otherwise your application will be automatically considered withdrawn.

If you have any questions concerning this letter, please feel free to contact Paolo Fiducia at (860) 418-7035 or me at (860) 418-7012.

Sincerely,

S. Lazarus (AV)

Steven W. Lazarus
Associate Health Care Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3696
RECIPIENT ADDRESS	912037391974
DESTINATION ID	
ST. TIME	09/13 15:56
TIME USE	02'15
PAGES SENT	5
RESULT	OK

ST. TE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HERLI HY

FAX: 203.739.1974

AGENCY: NATCHAUG H OSPITAL

FROM: OHCA

DATE: 09/13/13 **Time:**

NUMBER OF PAGES: 5
(inci ding transmittal sheet

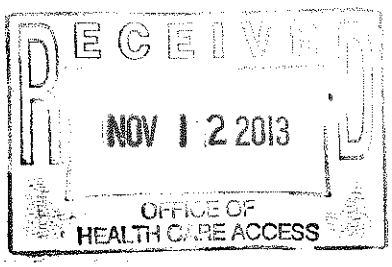
Comments:
Docket Number 13-31859

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROB EMS

Phone: (8(0) 418-7001 Fax: (860) 418-7053

WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL



24 Hospital Ave
Danbury, CT 06810
203.739.4903
DanburyHosptial.org

From: Sally Herlihy
Vice President, Planning

To: Steven Lazarus

Fax: 860-418-7053 No. of Pages: 37 (including fax cover sheet)

Phone: 860-418-7012 Date: November 12, 2013

RE: Docket No. 13-31859-CON CC:

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Fax

The original document along with two hard copies and a CD will be mailed to your office via FedEx.

Thank you

CONFIDENTIALITY

The document accompanying this transmission contains information from Danbury Hospital, which is confidential and/or legally privileged. The information is intended only for use by the individual or entity named on the transmission sheet.

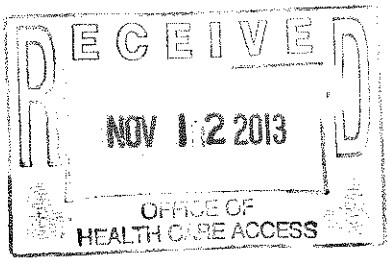
If you are not the intended recipient, you are hereby notified that using, disclosing, copying, distributing or taking any action in reliance on the contents of the transmitted information is strictly prohibited and that the document should be immediately returned to Danbury Hospital.

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

November 12, 2013



Mr. Steven W. Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Certificate of Need Application, Docket No. 13-31859-CON
Responses to OHCA CON Completeness Questions

Dear Mr. Lazarus,

Enclosed please find Responses on behalf of New Milford Hospital, Inc. and Western Connecticut Health Network, Inc. to the Completeness Questions asked by OHCA in a letter dated September 13, 2013 in the above-captioned docket. We have included the original and two hard copies of the Responses, as well as a CD with an Adobe format of the Responses.

Please contact me if you have any questions regarding this submission.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosure

Western Connecticut Health Network
Docket No.: 13-31859-CON

COMPLETENESS QUESTIONS AND RESPONSES

1. **Considering NMH and DH are both affiliates (as referenced on pages 7-8) of WCHN, why is it necessary to terminate NMH's license and operate NMH under DH's license in order to be able to provide the IT upgrades mentioned?**

Response:

Although it is possible to utilize existing systems operated at DH for NMH without changing to a single license, it requires a different strategy for implementation. It was more cost effective to develop the IT platform necessary for clinical care and operations under a single license due to the limitations of our existing patient accounting system (Siemens Invision). This system can only handle a single entity on each platform. Accordingly, if WCHN moved forward with consolidation of IT systems under two licenses, a complete duplication of the Invision system would be required to accommodate the different tax identification numbers required for billing and managing accounts. The existing system required only minor modifications to accommodate NMH as part of DH's license and tax ID number. We have already arranged for these modifications to bill both hospitals under a single license.

Additionally, the determination to operate on one platform supports our delivery of one standard of high-quality cost-effective care across the network. As stated in response to Q.4.b. on page 16 of the original CON submission, the proposed consolidation will create one unified medical staff with the same policies, procedures and clinical pathways/order sets. Under this single license, the medical staff will have greater opportunity to coordinate care across the network --consistently, efficiently and under one standard. The implementation of a single electronic health record spanning both campuses further enhances the quality and safety of health care delivery by improving communications across sites of care, including physician offices, emergency services, ambulatory centers and the inpatient environment. Access will be improved through better coordination between providers, emergency rooms, and hospitals. The single license allows for better clinical and operational integration resulting in improved efficiency and quality of care.

2. **Regarding services currently offered at DH and NMH (as discussed on pages 7-9), please address the following:**

    a) **Have the Applicants undertaken efforts to evaluate the need for services at each of these locations after the proposed merger under one license?**
    b) **Have there been any studies conducted by the Applicants regarding whether or not the current services offered at both hospitals are duplicative?**

Response:

a) As demonstrated by the Family Birthing CON and the PET CT CON requests for NMH that have been submitted since the affiliation of DH and NMH, WCHN (as a health system that includes DH and NMH) has been focusing on determining the appropriate mix of services for each location and each patient population. Over the past year, the process for evaluating

our services has been a continuing effort driven by community needs, demographics, patient convenience, technology, and physician preference. This process continues to evolve. Discussions have been ongoing in a variety of forums, including with members of the WCHN, DH and NMH Boards, NMH and DH Medical Staffs, WCHN Leadership, WCHN Planning Committee and NMH Community Board. This process has resulted in the submission of CONs for the closure of the Family Birthing Center, the termination of PET CT services and the replacement of the simulator technology. An overall specific long term action or implementation plan has not been identified at this time. WCHN will continue to evaluate the needs of the community served by NMH and DH and to provide those services at NMH which are identified as responsive to the needs of its community.

b) Patient access to needed care is our objective. Any two acute care hospitals with an overlap in historical service areas could be considered to have some duplication. There has not been a direct study to identify duplication. Our objective is to deliver what is needed as efficiently and as effectively as possible. WCHN is considering which services are best provided at the local level, the travel patterns of patients for various health services and the needs and preferences of the populations served. This is an ongoing process and specific conclusions (other than those resulting in the CON requests described above) have not yet been reached. This will continue to be a priority focus over the next year. One example of this process that underscores this point is our network-wide improved treatment of STEMI patients. This project included our regional EMS system, network-wide cardiac catheter conferences and overall reduced door to balloon time for patients by over 30 minutes. This effort was recognized statewide by CHA last year as a winning example of using data to make regional quality care a reality.

3. **For FYs 2010-2012 please reconcile and explain any differences between Table 1 on page 14 for NMH and (1) data submitted through CHIME to OHCA's Inpatient Discharge Database and (2) data reported for HRS Schedule 450. Please update and annualize 2013 YTD.**

Response:

See Exhibit A which has been revised consistent with OHCA Annual Reporting Schedule #450 format for NMH, inclusive of FYE 2013 data. The original submission of Table 1 on page 14 of the CON differs from OHCA Schedule #450 as it defined volume by number of patients or unique account numbers by registered service line. OHCA Schedule #450 defines volume as procedures or visits by department.

The differences between the two definitions are highlighted utilizing a CT scan as an example:

- Patients registered to CT scan service line in FY12 = 1,865. Total CT scans performed in FY12 (OHCA 450) = 5,319.
- We performed CT Scans on patients registered under another service line i.e. ED, Inpatients
- Another factor for the difference is that multiple CT Scans could be performed on the same patient. Table 1 provided in original CON would have counted this with a value of "1" whereas OHCA 450 would count multiples.

As the "definitions" differed, we have revised the volume table to reflect OHCA's format for ease in comparison. Reconciliation of Inpatient discharges vs. CHIME is outlined below. Differences are immaterial and a result only of timing.

NEW MILFORD HOSPITAL	Actual Volume		
	2010	**2011**	**2012**
Inpatient Discharges	2,512	2,515	2,291
CHIME Inpatient Discharges	2,494	2,510	2,291

4. **Please complete and submit Table 1 on page 14 for Danbury Hospital, reconcile and explain any differences from (1) OHCA's Inpatient Discharge Data submitted through CHIME and (2) HRS Schedule 450, for FYs 2010-2013, annualizing 2013 YTD.**

Response:

See Exhibit B which has been revised consistent with OHCA Annual Reporting format for DH, inclusive of FYE 2013 data. Reconciliation of Inpatient discharges vs. CHIME is outlined below. Differences are immaterial and a result only of timing.

DANBURY HOSPITAL	Actual Volume		
	2010	**2011**	**2012**
Inpatient Discharges	20,712	20,728	19,676
CHIME Inpatient Discharges	20,668	20,725	19,606

5. **Explain in detail the reason(s) NMH has experienced a historical decline in total hospital utilization (as presented on page 14) over the past three years and specifically, the approximately 36% decline between FY2011 and 2012. In addition, provide explanations for declines reported by specific services. If declines are reported for DH in responding to question 4 above, please also explain in detail reasons for those declines.**

Response:

Advancements in technology and payer shifts to observation status have reduced both the length and the need for inpatient admissions. This shift to outpatient care is accelerating with lower admission and readmissions as we get better at managing the health of the population, including care managers and patient centered medical homes. Specific to NMH, discharges have also declined as a result of physician turnover, specifically in surgery, and as observation program utilization has increased:

- Inpatient Patient Days and Discharges deceased by 9% due to lower inpatient surgeries, and a decrease in Maternity and Newborn due to closure of the unit
- Outpatient Surgery cases decreased by 8% and overall Operating Room volume softened by 11%, in part due to some physicians shifting their activity to freestanding surgical centers
- Other Outpatient services volume also declined overall; for example, Sleep Clinic cases decreased by 16% as well as CT Scans decreased by 6%

- Ancillary testing, specifically diagnostic services such as CT Scans were reduced due to volume decline as well as improved utilization management

The shift of inpatient volume to Observation (OBV) setting has been occurring for several years at both DH and NMH and the experience is similar to the statewide activity where OBV volumes have increased. It is anticipated this general trend to more outpatient services will continue.

Hospital	OBV FY 2011	OBV FY 2012	OBV FY 2013	FY11-FY13 % Change
New Milford Hospital	548	570	666	21.5%
Danbury Hospital	1,831	2,095	2,607	42.4%
All CT Hospitals*	46,836	58,501	64,740	38.2%

*Connecticut Hospital Association PCR Report at the end of FY2011 and the end of FY 2012.

Also, a nationally recognized goal to reduce unscheduled readmission rates is driven by the Medicare Value-Based Purchasing Program, and NMH and DH have both been focused on reducing the rates of readmission for specific diagnoses, including congestive heart failure (CHF), Pneumonia, Chronic obstructive pulmonary disease (COPD), Stroke and Acute myocardial infarction (MI). The effort on the part of hospitals across the country to reduce readmissions has been successful, as Medicare saw a decline of 70,000 admissions in 2012 as a result of similar efforts.

6. **As part of this proposed merger under one license, have the Applicants developed any plans to address the declining overall and service-specific utilization at NMH?**

Response:

As healthcare reform is actively unfolding, one of the aspects that will make WCHN successful is its response to anticipated declines for inpatient service utilization, at both NMH and DH. We anticipate this will result in a shift in focus and resources to population health status, outpatient services, and wellness efforts. When we look to the range of services we intend to offer, we see patients who are living longer and with a broader range of chronic illnesses. How, when, and where to treat these patients is an evolving challenge. To ensure better outcomes, we reserve inpatient care for patients who actually need to be treated in an acute care setting while simultaneously enhancing our outpatient capabilities where we can better coordinate and expedite care.

This commitment to ambulatory care is demonstrated by the building of a new Emergency Department at NMH, along with ongoing enhancements to NMH's Diebold Family Cancer Center. Additionally, as confirmed by the recent Family Birthing CON and the PET CT CON requests to close services at NMH due to declining volumes and effective use of resources, the hospitals are working to provide key services that the community requires.

7. **Please confirm that as part of this proposal the Applicants are proposing that DH acquire the 85 licensed beds at NMH and add them to DH's total licensed beds. If so, please provide a rationale for and explain in detail the need for DH to add 85 additional**

beds to its current complement of licensed beds. Provide any studies conducted as evidence.

Response:

There is no intent or request to move beds as part of this CON request for a single license between NMH and DH. The beds are currently in service at NMH and there is no proposed physical move or relocation of any beds. The addition of NMH's 85 beds to DH's license is a technicality associated with the merger of DH and NMH under a single license. The intention is to retain the status quo with respect to the beds at DH and NMH but just under one license with one tax identification number. Accordingly, WCHN is NOT requesting a reduction in the overall system beds. We have not identified a need for a reduction at this time but will look at it as part of our overall strategic planning, which will include an assessment of the distribution of inpatient services for the defined service area that both DH and NMH serve. The variables we face at this time, including the distribution of inpatient services across a larger geographic area, the unknown impact of healthcare reform, and bringing online the new bed tower at DH (Docket No. 09-31490-CON) (anticipated in the late spring of 2014), will ultimately determine the number of required licensed beds for WCHN overall and the allocation of these licensed beds at each facility.

Given the uncertainty at this time resulting from changes in health care and within WCHN, there is no anticipated change in the total number of required beds. At such time when a more accurate number can be determined, if a reduction in beds is warranted, WCHN will apply for a CON, using the Connecticut Bed Need Calculation[1] methodology. It is anticipated that this can be accomplished within the next twelve months.

8. **Discuss how this proposal is consistent with the goals and objectives of the Connecticut's Statewide Heath Care Facilities and Services Plan ("Plan").**

Response:

In this era of health care reform and the associated transformation that is underway, the proposed single license between NMH and DH furthers the objectives outlined in the *Statewide Health Care Facilities and Services Plan (The Plan")*, specifically to "improve the health of Connecticut residents, increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services." (*See* Exhibit C, The Plan, p. 2, Sec. 1.4). This proposal to operate under a single license will enable WCHN to achieve greater efficiencies in the delivery of health care, avoid increased costs associated with building a second Siemens billing platform and maintaining two clinical platforms for NMH and improve quality of care by unifying the medical staff and operations so there is one standard of care across the network.

[1] Connecticut Department of Public Health - Office of Health Care Access, *Statewide Healthcare Facilities and Service Plan*, October 2012, Pg. 26

Western Connecticut Health Network
Docket No.: 13-31859-CON

9. **Regarding the financials, as presented on pages 47-51, identify and provide specific examples of financial savings and benefits for NMH, DH and WCHN as a result of this proposal. Is the table on page 11 showing capital avoidance and operational savings estimates entirely related to the entity, NMH? Please reconcile to the Financial Attachment(s) and provide supporting documentation for the capital avoidance figure and each of the operating expense reduction estimates.**

Response:

All savings outlined on Page 11 of the initial filing (outlined below) relate specifically to NMH. As NMH and DH are already consolidated into the financials of the parent company of WCHN, these savings are also reflected in the overall network financials. The upgrade to the Meditech System is highlighted below as capital avoidance. This investment would not be necessary if DH and NMH have a single license. All other expenses outlined are projected savings based upon current annual expenses incurred by NMH.

NMH Projected Operational Expense Savings:

NMH Projected Operational Expense Savings:

	Year 1 Savings	Year 2 Savings	Year 3 Savings
Audit Fees	$ (175,000)	$ (175,000)	$ (175,000)
CHA Fees	(18,000)	(18,000)	(18,000)
TJC Fees	(10,000)	(10,000)	(10,000)
Press Ganey Fees	(8,000)	(8,000)	(8,000)
Core Measures/VBP	(27,000)	(27,000)	(27,000)
Staffing Efficiencies	(350,000)	(350,000)	(350,000)
Siemens System Maintanence	173,028	181,679	190,763
Meditech System Maintenance	(300,446)	(313,021)	(326,151)
* Depreciation - Siemens	119,393	119,393	119,393
Subtotal Operating Savings	(596,025)	(599,949)	(603,995)
Capital Avoidance:			
** Depreciation - Meditech	(632,180)	(632,180)	(632,180)
Total Impact	$ (1,228,205)	$ (1,232,129)	$ (1,236,175)

** Depreciation - Siemens System based upon $596,965 current cost incurred for system integration amortized over 5 years.*
***Depreciation - Meditech is based on $3,160,902 vendor estimate of cost to upgrade current system reflected as capital avoidance amortized over 5 years. This cost would not be incurred based on the single license.*

Financial Attachment reconciliation below outlines the impact of the savings on NMH as well as the consolidation of the financials into a single license.

Western Connecticut Health Network
Docket No.: 13-31859-CON

Reconciliaton of Financial Attachments 1: (Dollars in thousands)

	FY2014	FY2015	FY2016
NMH Projected Op Margin Without CON	(5,578)	(6,328)	(6,813)
Projected Savings from Single License	(1,228)	(1,232)	(1,236)
NMH Op Margin before consolidation	(4,349)	(5,096)	(5,577)
DH Projected Op Margin Without CON	35,048	27,336	25,652
Consolidated Impact - Single License:			
DH Projected Op Margin WITH CON	$ 30,699	$ 22,240	$ 20,075
NMH Projected Op Margin WITH CON	$ -	$ -	$ -

10. Will the proposed single general hospital license be able to use greater purchasing power as a cost savings (or reduction to operating expenses) mechanism? If so, please quantify and provide specific details, and reconcile or revise Financial Attachment I (provided on pages 47-51) for both hospitals.

Response:

No, as subsidiaries of WCHN, NMH and DH have already consolidated their purchasing functions thus providing enhanced purchasing power for the network. Purchasing is centralized and negotiated across the network with all vendors. Moving to a single general hospital license will not provide further purchasing enhancements from what NMH is already experiencing today.

11. Discuss and provide a specific timeline for WCHN to implement any of the savings listed above.

Response:

The anticipated savings identified on the chart above in response to Q.9 are expected to be realized if successful approval of the CON is granted in time for ICD10 readiness. All systems are required to be ICD10 ready by October 1, 2014, with system upgrades occurring currently and system testing to begin by March 2014. All savings inclusive of FTE and nonsalary savings would be achieved in the first twelve month period. If CON approval is not obtained, ICD10 compliance will be at risk as will the NMH's cash flow position.

12. NMH has experienced significant losses, Excess/(Deficiency) of Revenues over Expenses of $(5,165,070), $190,247, ($93,942) and ($6,456,113) for FYs 2009 through projected 2013 (pp. 47-51). Please provide a detailed explanation for these losses and specifically for projected FY 2013.

Response:

Significant declines in revenue outpaced expense reductions during the time period largely in chemotherapy, outpatient surgery, and ancillary testing. Volume at NMH has declined significantly in major service lines as a result of physician turnover specifically in surgery and

oncology. The most significant drop in revenue of $9M was experienced from FY2011 to FY2012 and was the result of the following:

- Inpatient Patient Days and Discharges deceased by 9% due to lower inpatient surgeries, decrease in Maternity and Newborn due to anticipated closure of the unit, and the transfer of the Hospitalist physicians and the corresponding professional billing from NMH to Western Connecticut Medical Group, the WCHN subsidiary that employs physicians.
- Outpatient Surgery cases decreased by 8%
- Other Outpatient services volume also declined overall; for example, Sleep Clinic cases decreased by 16% as well as CT Scans decreased by 6%

In addition, as capital improvements were held to a minimum in FY2009 and FY2010, necessary investments were made beginning in FY2011 to infrastructure, systems, and clinical equipment which is reflected in depreciation expense growing from $4.9M in 2009 to $5.8M by 2013. Finally, variability in financial market performance has impacted non-operating income as represented in the audited financial statements.

Revenue trend continued to decline in FY2013 and can be attributed to the following:

- Closing of the Family Birthing Center and PET Scan Services
- Shifting of Inpatient volume to Observation setting
- Operating room volume continued to soften by 11.4%
- Ancillary testing, specifically diagnostic services such as CT Scans were reduced due to volume decline as well as improved utilization management.
- Reduction in DSH funding amounting to $730,000 combined with an approx $1M decline in Medicare TOPS payments.

13. Please provide a discussion which shows in greater detail how this proposal will benefit NMH given the fact that NMH has shown a loss from operations from FY 2011 to FY 2012, has had a decrease in days cash on hand and an increase in the average payment period. NMH's total net assets, equity financing ratio and long term debt to capitalization ratio were also negative over the period of FY 2011 to FY 2012. Please explain.

Response:

NMH's current IT systems cannot be ICD-10 compliant which means that unless NMH is moved to DH's Siemens platform, NMH will no longer be able to bill and will have no cash flow after October 1, 2014. The most cost-effective option to provide an ICD-10 compliant billing system is to consolidate their billing into DH's existing system which would require one license. There is not enough time left to create and build another separate entity within DH's current billing system, test it, etc. Not only would the timing be an issue, it would be much more costly ($3.1 million). The benefit to NMH is the cost savings/cost avoidance and not exacerbating further its current financial position.

14. What specific plans have the Applicants developed to address the operating losses at NMH? Provide evidence.

Western Connecticut Health Network
Docket No.: 13-31859-CON

Response:

NMH's decline in financial performance has primarily been attributed to a significant reduction in volume, as described in the response to Q. 12 above. NMH's approach to offsetting these resulting operating losses has included program changes, staff efficiencies and supply chain improvements. From 2012 to 2013, total non-salary expense was reduced by $7.3 million coupled with a total FTE reduction of 55.4 FTEs. Specific projects that supported these efforts included: Bio-Medical Engineering transition to an in-house team; change in Dining Services Contract; PET CT program consolidation with DH; MRI joint venture organizational structure change, and the Family Birthing Center transition. Numerous shared staffing positions were created enabling staff to shift locations between DH and NMH as volumes and need mandate, while building network flexibility and cross training depth. Additionally, equipment was standardized for cost savings as well as improved clinical outcomes. This included pulse oximetry, bed exit alarms, wound care products, and patient information boards.

15. **Considering the operating losses at NMH, is merging/consolidating NMH's financials under DH a reasonable course of action as the proposal will reduce DH's Revenue Over/(Under) Expenses at an increasing rate starting in FY 2014? Please explain the impact of this proposal on DH's financial status and provide specific details.**

Response:

NMH and DH are already consolidated at the parent company level as subsidiaries of WCHN and as such, report to the WCHN Finance Committee and WCHN Board. Both hospitals' operating results (gains or losses) are included in the WCHN consolidated financial statements. As an integrated health care delivery system, WCHN and all of its subsidiaries have consolidated financial performance. Accordingly, merging NMH and DH into a single hospital license has no impact on overall financial position and will avoid the incurrence of costs to build a redundant IT platform to bring NMH into ICD10 compliance. Allowing a single license will provide additional benefits to the WCHN health system by reducing other costs associated with two medical staffs, two Joint Commission surveys, etc.

16. **Provide a discussion of how the system, WCHN, and its two hospitals are prepared to meet the provisions of federal Health Care Reform (the Affordable Care Act). Include in your discussion Value-Based Purchasing, Accountable Care Organizations and the Medicare Shared Savings Program. Has any financial impact been reflected in the projected financial statements provided in the application?**

Response:

In anticipation of the Affordable Care Act (ACA), WCHN and its two hospitals have been engaged in a variety of activities and strategies to manage patients more effectively and efficiently across the continuum of care. The core goals are to improve outcomes that are meaningful for patients, to improve patient satisfaction wherever they encounter our system, and to reduce the total cost of care through elimination of duplicative or unnecessary services that are not evidence based. Specifically, we focus on CMS core measures as part of value-based

purchasing, reducing unnecessary hospital readmissions, judicious and appropriate use of observation beds, and targeted reductions in unnecessary variations in care. We have developed a Physician Hospital Organization that is preparing us for future full clinical integration and risk-based contracting in order to be more responsible for the outcomes and quality of care for our patients.

Health Care Reform (the ACA), value-based purchasing, ACO's, etc. all necessitate a continued focus on cost-effectiveness as well as quality. With approval of this CON request for a single license, we will continue to address unnecessary, redundant costs (billing, IT, audits, cost reports, etc.) in order to reduce our overall cost structure.

17. Did either hospital apply for incentive payments related to the CMS Electronic Health Record Incentive Program? If not, would the $3.1 million projected upgrade to New Milford's IT system (the capital avoidance figure) (pages 7-8) have qualified for the Incentive Program? Please indicate whether this program was pursued by either or both hospitals.

Response:

DH applied for and received meaningful incentive payments in fiscal year 2011 and 2012, and will also apply in 2013. WCHN plans to incorporate NMH into the attestation for meaningful use as soon as we move the hospital to the certified Siemens EHR system.

NMH has not applied for meaningful use incentive payments because NMH's incentive payment eligibility was dependent upon the upgrade of the Meditech system. However, WCHN's long term IT strategy is to focus on efficiency of our IT systems while maximizing the technology available in a cost effective manner. Moving to a single system will allow us to streamline our processes, improve productivity, eliminate waste and excess interfaces, and eliminate multiple system maintenance costs. The incremental cost of upgrading Meditech for NMH less the potential meaningful use incentive payments would have still left WCHN with multiple systems and added overall cost to the network. Our plan was to be up on Siemens as a single entity, obtain all the meaningful use dollars available and be ICD10 compliant, while avoiding the expensive Meditech upgrade for NMH. Implementation of our plan has been postponed due to the CON process. Of note, if NMH is not "live" on the new platform by July 2014, NMH will incur penalties in 2015 from Medicare for failure to achieve meaningful use.

18. Do the Applicants assume that gifts and bequests (non-operating revenue) will continue at the same rate with a single license under Danbury Hospital as it would if New Milford Hospital continued as a separately licensed entity? Could this project negatively impact future gifts/bequests (pages 47-51)?

Response:

Philanthropy at both hospitals has already increased since WCHN became the sole member of, and financially responsible for, NMH. During the last three years (2011-2013), funds raised for WCHN totaled $57 million. In contrast, the total raised during the previous three years (2008-

2010) for WCHN was $26 million. In addition, the cost per dollar raised at NMH moved from a three-year average of 58.16% during 2008-2010 to 15.09% during 2011-2013.

It is important to note that the New Milford Hospital Foundation was merged into the Western Connecticut Health Network Foundation in 2011. During this time, philanthropic support continued to increase. In FY2012, New Milford Hospital experienced one of its most successful years to date for fundraising, with $4,886,000 realized from donations and a 13.4% cost per dollar raised.

As we look ahead, we remain optimistic this trend will continue. The WCHN Foundation is currently engaged in a $50 million capital campaign, which includes an $8 million goal for a new Emergency Department at New Milford Hospital. The lead campaign gift for this project ($2 million) was secured and the expectation is that we will hit or exceed this goal by the end of FY14.

19. Provide support or documentation related to the statement that Medicaid reimbursements to WCHN will be reduced by $30 million over the next two years.

Response:

Outlined below is the impact of the State of Connecticut Tax Impact showing the Hospital tax as well as the State DSH and Supplemental Payments.

State Budget Reduction to DSH Program to WCHN

Danbury	Tax Liability	DSH/Supplemental Payments	Total	Impact
SFY12	20,585,238	21,134,039	548,801	
SFY13	20,585,238	16,833,405	(3,751,833)	(4,300,634)
SFY14	20,585,238	10,540,433	(10,044,805)	(10,593,606)
SFY15	20,585,238	4,314,705	(16,270,533)	(16,819,334)
				(31,713,574)

New Milford	Tax Liability	DSH/Supplemental Payments	Total	Impact
SFY12	1,446,301	2,059,503	613,202	
SFY13	1,446,301	1,574,891	128,590	(484,612)
SFY14	1,446,301	905,189	(541,112)	(1,154,314)
SFY15	1,446,301	370,537	(1,075,764)	(1,688,966)
				(3,327,892)

	Total Impact	(35,041,466)

20. The Applicants identify an "Integration cost to single system" of $596,965 on page 11 and make the statement on page 10 that "WCNH has already invested $596K to support alignment of its IT systems to achieve efficiencies." Please clarify that the Applicants have already expended the capital dollars to achieve the estimated cost savings related to the proposal before OHCA.

Response:

WCHN has already incurred the $596,965 to support alignment of the IT systems. This amount represents the incremental licensing costs for all of the WCHN systems required to replace the current Meditech platform used at New Milford Hospital.

21. Regarding the operating expense reductions estimated on page 11, verify that each of these cannot be achieved without a single license.

Response:

The annual operating savings outlined in Question 9 cannot be achieved without the single license approval. This operating savings is created by the elimination of multiple system maintenance contracts, audit and professional fees per entity as well as the productivity efficiencies by consolidating systems and processes.

22. Please further explain the statement on page 16, "With separate licenses, there is a requirement for each hospital entity to have its own medical staff with its own set of Bylaws and Medical Staff leadership."

Response:

Each individually licensed acute care facility must comply with The Public Health Code of the State of Connecticut[2]. In section C, it indicates each licensed hospital, in this case DH and NMH, must have the following:
(1) There shall be an organized medical staff of not fewer than five physicians, one of whom shall serve as a chief or president of the medical staff.
(2) The medical staff shall adopt written rules and regulations governing its own activities, subject to approval by the governing board of the hospital. As a minimum, these shall include:
(A) Method of control of privileges granted to members of the medical staff;
(B) Method of control of clinical work;
(C) Provision for regular staff conferences;
(D) Appointment of a medical executive committee, or its equivalent, and other committees as appropriate;
(E) Procedure for recommending appointments to the medical staff and for hearing complaints regarding the conduct of members and referring the same, with recommendations, to the governing board.

[2] General Statutes §19-13-D3, Chapter IV "Hospitals, Child Day Care Centers, Other Institutions and Children's General Hospitals

In addition, the Centers for Medicare and Medicaid Services ("CMS") concluded in the preamble to the May 16, 2012 final rule which changed the Hospital Medicare & Medicaid Conditions of Participation (CoP), that the CMS medical staff CoP Section 482.22 "will continue to [be interpreted] to require that each hospital, regardless of whether it is a part of a multi-hospital system, have a single and separate medical staff, as a matter of CMS policy."

As a combined entity operating under one single license, the medical staff structure would be combined.

23. Please complete and submit the Patient Payer Mix table for both NMH and DH and explain any changes that may occur as a result of this proposal.

Response:

Danbury Hospital : Patient Population Mix based on Inpatient Discharges				
Total Facility Description	Current FY2013	FY2014	FY2015	FY2016
1. Medicare	45.5%	45.5%	45.5%	45.5%
2. Medicaid	17.7%	17.7%	17.7%	17.7%
3. Champus / TriCare	0.2%	0.2%	0.2%	0.2%
Total Government	63.4%	63.4%	63.4%	63.4%
1. Commercial Insurers	35.5%	35.5%	35.5%	35.5%
2. Self Pay	0.7%	0.7%	0.7%	0.7%
3. Workers Compensation	0.4%	0.4%	0.4%	0.4%
Total Non-Government Payers	36.6%	36.6%	36.6%	36.6%
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

New Milford Hospital : Patient Population Mix based on Inpatient Discharges				
Total Facility Description	Current FY2013	FY2014	FY2015	FY2016
1. Medicare	57.9%	57.9%	57.9%	57.9%
2. Medicaid	10.3%	10.3%	10.3%	10.3%
3. Champus / TriCare	0.1%	0.1%	0.1%	0.1%
Total Government	68.3%	68.3%	68.3%	68.3%
1. Commercial Insurers	27.8%	27.8%	27.8%	27.8%
2. Self Pay	3.1%	3.1%	3.1%	3.1%
3. Workers Compensation	0.9%	0.9%	0.9%	0.9%
Total Non-Government Payers	31.7%	31.7%	31.7%	31.7%
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

Combined				
Total Facility Description	Current FY2013	FY2014	FY2015	FY2016
1. Medicare	46.7%	46.7%	46.7%	46.7%
2. Medicaid	17.0%	17.0%	17.0%	17.0%
3. Champus / TriCare	0.2%	0.2%	0.2%	0.2%
Total Government	63.8%	63.8%	63.8%	63.8%
1. Commercial Insurers	34.8%	34.8%	34.8%	34.8%
2. Self Pay	0.9%	0.9%	0.9%	0.9%
3. Workers Compensation	0.4%	0.4%	0.4%	0.4%
Total Non-Government Payers	36.2%	36.2%	36.2%	36.2%
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

Neither the patient population nor the payor mix is projected to change as a result of this proposal.

24. Discuss any effect this proposal may have on payer contract negotiations. How has any projected impact been reflected in the financial statements provided?

Response:

We believe that this proposal will be revenue neutral to us and the payors. No impact is expected.

25. To illustrate the impact of this proposal on charges for patients utilizing the New Milford campus, please provide a comparison of NMH and DH's current pricemaster charges for twenty procedures which represent large volume service lines. Be sure to list the item code, item description and item price as used in the hospitals' pricemaster filings and indicate whether there is any bundling involved in the service charges listed.

Response:

NMH's and DH's pricemasters differ based on historic policy. However shifting to a single license will accelerate the pricing alignment which will provide consistency across WCHN. A charge will be the same regardless of location. This alignment, which has been communicated to our payors, will be revenue neutral.

Exhibit D contains a table comparing the current NMH and DH price master charges for twenty procedures which represent large volume service lines.

26. Provide a copy of any and all agreements related to the consolidation into one license and provide documents evidencing current- and post-merger board composition.

Response:

Attached as Exhibit E is a *DRAFT* Merger Agreement which would accomplish the merger of NMH into DH with the resulting one license and taxpayer identification number. The composition of the Board of Directors of DH after the merger will be the same as the current Board of DH and NMH and there are no proposed changes as a result of this merger.

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit A

New Milford Hospital Table 1 with Annualized 2013 Volume

Western Connecticut Health Network
Docket No.: 13-31859-CON

New Milford Hospital - Revised Volume Table with FYE 2013

	Actual Volume			
Inpatient	FY 2010	FY 2011	FY 2012	FY 2013
Adult Med/Surg	1,971	1,982	1,802	1,711
Maternity	270	267	245	58
Newborn	261	264	243	55
Peds	10	2	1	0
Inpatient Discharges	2,512	2,515	2,291	1,824
CHIME (Inpt Discharges)	2,494	2,510	2,291	n/a
CT Scans				
Inpatient Scans	1,267	889	766	710
Outpt Scans (Includes ED)	6,858	5,251	4,553	4,114
Total CT Scans	8,125	6,140	5,319	4,824
MRI Scans				
Inpatient Scans	124	144	114	117
Outpt Scans (Includes ED)	2,036	2,767	2,802	2,735
Total MRI Scans	2,160	2,911	2,916	2,852
PET/CT Scans				
Inpatient Scans	1	0	0	0
Outpt Scans (Includes ED)	202	165	122	7
Total PET/CT Scans	203	165	122	7
Surgical Procedures				
Inpatient Surgical Procedures	847	785	621	519
Outpatient Surgical Procedures	2,380	2,268	2,116	1,905
Total Surgical Procedures	3,227	3,053	2,737	2,424
Endoscopy Procedures				
Inpatient Endoscopy Procedures	103	74	89	83
Outpatient Endoscopy Procedures	2,226	2,064	2,110	1,963
Total Endoscopy Procedures	2,329	2,138	2,199	2,046
Hospital Emergency Room Visits				
Emergency Room Visits: Treated and	1,901	2,042	2,050	2,135
Emergency Room Visits: Treated and	16,972	16,738	16,366	15,715
Total Emergency Room Visits	18,873	18,780	18,416	17,850
Hospital Clinic Visits				
Psychiatric Clinic Visits	7,038	6,845	6,875	10,563
Total Hospital Clinic Visits	7,038	6,845	6,875	10,563
Other Hospital Outpatient Visits				
Rehabilitation (PT/OT/ST)	598	652	465	164
Cardiology	1,007	882	914	1,199
Chemotherapy	1,635	1,612	1,048	1,052
Other Outpatient Visits	82,600	77,740	45,169	29,420
Total Other Hospital Outpatient Visits	85,840	80,886	47,596	31,835

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit B

Danbury Hospital Table 1 with Annualized 2013 Volume

Western Connecticut Health Network
Docket No.: 13-31859-CON

Danbury Hospital - Volume Table with FYE2013				
	Actual Volume			
Inpatient	FY 2010	FY 2011	FY 2012	FY 2013
Adult Med/Surg/NICU	15,166	15,452	14,476	13,516
Psych	710	746	707	686
Rehab	304	295	291	292
Maternity	2,251	2,110	2,083	2,058
Newborn	1,958	1,851	1,814	1,783
Peds	323	284	305	256
Inpatient Discharges	20,712	20,738	19,676	18,591
CHIME (Inpatient Discharges)	20,668	20,725	19,606	n/a
CT Scans				
Inpatient Scans	11,998	12,277	10,946	10,214
Outpt Scans (Including ED, exc NonHosp)	24,665	23,700	23,533	24,165
Total CT Scans	36,663	35,977	34,479	34,379
MRI Scans				
Inpatient Scans	1,413	1,309	1,188	1,193
Outpt Scans (Including ED, exc NonHosp)	7,060	7,120	7,130	7,109
Total MRI Scans	8,473	8,429	8,318	8,302
PET Scans				
PET Scans	167	188	6	260
PET/CT Scans	574	671	636	774
Linear Accelerator Procedures				
Inpatient Procedures	479	322	377	465
Outpatient Procedures	10,168	11,654	9,763	10,260
Total Linear Accelerator Procedures	10,647	11,976	10,140	10,725
Cardiac Catheterization Procedures				
Inpatient Procedures	871	856	864	814
Outpatient Procedures	800	856	864	876
Total Cardiac Catheterization Procedures	1,671	1,712	1,728	1,690
Cardiac Angioplasty Procedures				
Primary Procedures	100	107	132	98
Elective Procedures	305	318	299	304
Total Cardiac Angioplasty Procedures	405	425	431	402
Electrophysiology Studies				
Inpatient Studies	19	24	24	31
Outpatient Studies	100	115	95	128
Total Electrophysiology Studies	119	139	119	159
Surgical Procedures				
Inpatient Surgical Procedures	4,825	4,442	4,322	3,875
Outpatient Surgical Procedures	7,615	7,776	10,811	10,586
Total Surgical Procedures	12,240	12,218	15,133	14,461
Endoscopy Procedures				
Inpatient Endoscopy Procedures	834	909	795	797
Outpatient Endoscopy Procedures	9,891	9,777	10,519	10,753
Total Endoscopy Procedures	10,725	10,686	11,314	11,550
Hospital Emergency Room Visits				
ER Visits: Treated and Admitted	14,124	14,603	14,260	11,548
ER Visits: Treated and Discharged	56,136	54,992	56,362	58,017
Total Emergency Room Visits	70,260	69,595	70,622	69,565
Hospital Clinic Visits				
Dental Clinic Visits	12,450	12,421	12,816	12,722
Psychiatric Clinic Visits	21,693	20,411	22,067	20,574
Medical Clinic Visits	39,561	45,970	61,238	63,931
Specialty Clinic Visits	3,067	2,569	2,319	2,307
Total Hospital Clinic Visits	76,871	81,371	98,440	99,534
Other Hospital Outpatient Visits				
Rehabilitation (PT/OT/ST)	41,425	42,519	46,077	42,782
Cardiology	6,715	6,501	6,260	6,301
Chemotherapy	2,931	2,931	6,199	7,322
Total Other Hospital Outpatient Visits	51,071	51,951	58,536	56,405

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit C

Statewide Health Care Facilities and Services Plan Excerpt

Western Connecticut Health Network
Docket No.: 13-31859-CON

Statewide Health Care Facilities and Services Plan

October 2012

Connecticut Department Of Public Health
Office Of Health Care Access
410 Capitol Avenue - Hartford, CT 06134

Connecticut Department of Public Health

1.3 ADVISORY BODY

In October 2010, the Office of Health Care Access invited representatives from a cross section of the health care industry and State government to participate in an advisory body that would be charged with providing guidance on the development of the Plan. Advisory Body members are listed in Appendix B. The advisory body met monthly beginning in November 2010. In May 2011, advisory body subcommittees were formed to conduct more in-depth work in the areas of Acute Care/Ambulatory Surgery, Behavioral Health and Primary Care. Subcommittee members are listed in Appendix C.

Both advisory body and subcommittee members provided OHCA with guidance and expertise in the development of CON guidelines, standards, methodologies and analyses used in the Plan, including:

- Reviewing research conducted by OHCA on other states' facilities plans' standards, guidelines and methodologies and providing feedback and discussion regarding adaptation and applicability for Connecticut's Plan;
- Recommending authoritative professional organizations, published studies, industry-recognized standards/ guidelines/methodologies, etc., to be considered by OHCA in the development of its plan;
- Providing insight on industry best practices and evidenced based research;
- Recommending data sources; and
- Offering feedback on OHCA's use and interpretation of available data.

1.4 GUIDING PRINCIPLES

The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage and support health education, promotion and prevention initiatives;
- Encourage collaboration among health care providers to develop health care delivery networks;
- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;
- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state.

In November, 2010, the Department of Public Health, in accordance with Public Act 10-179, adopted interim Certificate of Need Policies and Procedures for Implementation of Public Act 10-179, §87, 89-93, which will be utilized by OHCA until official regulations are adopted by the General Assembly.

1.8.4 CERTIFICATE OF NEED AND HEALTH CARE REFORM

The 2010 Patient Protection and Affordable Care Act (PPACA) includes two provisions that may affect Connecticut's CON program: an increase in the insured population that will demand more services, which, in turn, may call for increased provider capacity; and provider payment reforms, which may restore some of the market constraints on prior health care system expansion. While it is unclear what the exact effect of these provisions will be, certain communities or regions may have adequate capacity to absorb increased demand, whereas those with a higher proportion of currently uninsured and less capacity may increase health care providers' reliance upon the CON program for health planning.[12]

1.8.5 MERGERS, ACQUISITIONS AND AFFILIATIONS

Even before health care reform has been fully implemented, the state's health care system has begun a transformation in response to and in anticipation of major changes in the way health care is financed and delivered. Many provisions of the PPACA favor integrated systems to create efficiencies and address quality. Hospital mergers and the acquisitions of imaging centers and physician practices are key issues surrounding Connecticut's CON process today.

Hospitals are pursuing affiliation arrangements and mergers in an effort to contend with growing financial pressures driven by such factors as providing uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients whose cost of care often exceeds federal and State reimbursement rates, the threat of reduced reimbursement by government payers and tough negotiations with health insurers over contract terms related to the cost of medical services. Financially struggling hospitals see mergers with stronger hospitals as a way to survive in the face of thin profits, gain access to capital to make needed facilities improvements or acquire technological equipment and contend with debt and liability issues. Affiliations help smaller hospitals share the cost of new technology, provide the opportunity to access specialists at larger hospitals and also offer patients a wider range of treatment and services.[13]

A growing number of Connecticut hospitals have become members of larger corporate health care systems. This trend may be the result of a variety of factors including: a weak economy, increased competition in the health care market, anticipation of changes due to federal health care reform, an attempt to gain leverage in payer contract negotiations, to develop economies of scale when purchasing supplies and services, and to improve access to capital. Additional hospitals are currently in discussion with other health care systems or have officially submitted applications for regulatory approval that would alter the current structure of Connecticut's existing hospitals. It should be noted that while every hospital is analyzing the advantages and disadvantages of pursuing affiliations and possible mergers, some hospitals are deciding that affiliating or merging is not the best route for their institutions or their communities. Table 1.1 represents general hospitals that are part of a larger health care system at the time this document was published.

[12] Yee, T., Stark, L.B., Bond, A. M. & Carries, E. (2011). Health Care Certificate of Need Laws: Policy or Politics? National Institute for Health Care Reform. (Research Brief Number 4). 7. Retrieved from http://www.nihcr.org/CON_Laws.html

[13] Sturdevant, M. (2012, February 3). Hartford Hospital, Backus in Norwich Consider Joining Forces. *The Hartford Courant*. Retrieved from http://articles.courant.com/2012-02-03/business/hc-hartford-hospital-backus-20120203_1_hartford-healthcare-hartford-hospital-windham-hospital

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit D

Comparison Price Master
New Milford Hospital and Danbury Hospital

Western Connecticut Health Network
Docket No.: 13-31859-CON

New Milford Hospital

CDM	Description	Charge	Comments
3200060	Polysomnography	5,940.70	
1300029	Ambulatory Surgery	20.60	Man min charge then multiplied by person in OR (avg 3 to 4)
2800019	Recovery Room	11.85	Charge per Minute
3400163	ER Level 3 Tech	451.00	
3600271	Chemo IV Infusion Initial	1,087.05	
3610125	Complex Trmt 6-10	1,046.70	
3610126	Complex Tremt 11-19	1,141.90	
3610159	IMRT Delivery per session	3,079.95	
3610198	CT Guidance	479.50	
2110002	Colonoscopy	1,566.50	
550145	CBC W/AUTO DIFF & PLT COU	48.80	
3100013	EKG	393.75	
3100080	ECHO W/ DOP & CLR FLW MAP	2,482.10	
810200	Chest - Xray	401.10	
860900	Mammo Bilateral	498.85	
860957	Breast Ultrasound	657.30	
900035	CT Scan w/o contrasts	1,540.40	
900901	CT Scan Abd & Pel w/ contr	4,823.80	
891003	MRI - Head w & w/o contr	4,261.85	
891026	MRI-Lumbar spine w/o contr	2,463.05	

Danbury Hospital

CDM	Description	Charge	Comments
7450006	Polysomnography 4 + Para	4,710.00	
4700205	Surgery Minutes Normal OP	84.00	Per Man Min (already adjusted for persons in OR)
4800012	Recovery Room per Hour	593.00	Charge per Hour
6101003	ED Visit Lvl 3 Tech	464.00	
2610011	Chemo IV Infusion, Initial Hr	732.00	
3977413	Daily Treat Com 6-10	1,162.00	
3977414	Daily Treat Com 11-19	1,316.00	
3977418	IMRT Treatment	2,387.00	
3976370	CT Guided Plcmnt RDT Flds	413.00	
4000105	Lower GI Minor	2,199.00	Bundle incl supplies
5555009	CBC - 5 PART DIFF	49.00	
7690001	EKG 12 LEAD TRACE	190.00	
2515015	ECHO Complt w/spectl&color flw	1,873.00	
2530012	Chest 2 View	308.00	
2517001	Mammo Screening Digital	458.00	
2550023	US Breast Bilateral	551.00	
2540027	CT Head or Brain w/o cont	1,350.00	
2540052	CT Abd/pel w/ contrast	3,364.00	
2560006	MRI Brain wow contrast	3,487.00	
2560052	MRI Spine Lumbar wo contrast	3,405.00	

Exhibit E

DRAFT

Agreement and Plan of Merger

AGREEMENT AND PLAN OF MERGER

This **AGREEMENT AND PLAN OF MERGER** (this "Agreement"), dated as of _____ __, 201_, is by and between THE DANBURY HOSPITAL, a Connecticut nonstock corporation ("DH") and NEW MILFORD HOSPITAL, INC., a Connecticut nonstock corporation ("NMH").

WITNESSETH:

WHEREAS, the board of directors of DH and NMH each deem it desirable and in the best interest of each of DH and NMH, respectively, to merge on the terms and subject to the conditions herein provided;

NOW, THEREFORE, in consideration of the premises and the mutual covenants and agreements herein contained, the parties hereto, intending to be legally bound hereby, agree as follows:

1. **The Merger.** Upon the terms and subject to the conditions of this Agreement, at the Effective Time (as defined in Section 2 hereof), NMH shall merge with and into DH (the "Merger") under the laws of the State of Connecticut. The separate corporate existence of NMH shall cease and DH shall survive the Merger and continue to exist and operate as a corporation incorporated under the laws of the State of Connecticut under the name "[_____]"[3] (DH, as the surviving corporation in the Merger, sometimes being referred to herein as the "Surviving Entity"). After the Merger, Western Connecticut Health Network, Inc. shall remain the sole member of the Surviving Entity.

2. **Effective Time.** The Merger shall become effective as of 12:01 a.m. on _____ __, 201_; provided that if the Certificate of Merger (as defined below) has not then been filed with the Secretary of State of the State of Connecticut, the effective time of the Merger shall be the time and the date of such filing. The time that the Merger shall become effective is hereinafter referred to as the "Effective Time."

[3] The Name of the Surviving Entity shall be determined prior to execution of the Agreement and Plan of Merger.

3. **Certificate of Incorporation; Bylaws.** The Certificate of Incorporation of the Surviving Entity shall be the Certificate of Incorporation of DH, as amended and restated, as provided for in the certificate of merger, in the form attached as Exhibit A (the "Certificate of Merger"), until altered, amended or repealed in accordance with its terms and applicable law. The Bylaws of the Surviving Entity shall be the Bylaws of DH, as amended and restated in the form attached as Exhibit B, until further altered, amended or repealed in accordance with its terms and applicable law.

4. **Name; Offices.** The name of the Surviving Entity shall be "[_____]".[4] The main office of the Surviving Entity shall be the main office of the DH immediately prior to the Effective Time.

5. **Directors and Officers.** Upon consummation of the Merger, the directors and corporate officers of the Surviving Entity shall be the persons set forth on Exhibit C, each holding the positions set forth opposite their names. Directors and corporate officers of the Surviving Entity shall serve for such terms as are specified in the Certificate of Incorporation and Bylaws of the Surviving Entity.

6. **Representations and Warranties; Due Diligence.**

(a) Each of the parties represents and warrants that: (i) this Agreement has been duly authorized, executed and delivered by such party and constitutes a legal, valid and binding obligation of such party, enforceable against it in accordance with the terms hereof; (ii) neither the execution and delivery, nor the performance of, this Agreement by any of the parties does or will constitute a violation of, or result in a default under, its certificates of incorporation or bylaws or any statute, law, regulation, rule, court order, decree or award applicable to it, or any contract, agreement, indenture, lease, mortgage or other instrument to which it is a party or to which any of its assets is subject; and (iii) no consent, authorization, permit or approval (whether from a governmental authority or a private entity) not already obtained or expressly contemplated by this Agreement is required on such party's part to enter into this Agreement or to carry out the transactions contemplated hereby, except for those consents, authorizations or permits with respect to which the failure to obtain would not have a material adverse effect on the business of the Surviving Entity .

[4] The Name of the Surviving Entity shall be determined prior to execution of the Agreement and Plan of Merger.

(b) Each of the parties has had the opportunity to review such agreements, documents and information of the other party as they have requested in the conduct of their mutual due diligence investigations, and each of the parties represents and warrants that there is not presently any material breach or default, nor any basis for claiming such breach or default, by it or to its knowledge any other party under the aforementioned agreements to which it is a party.

(c) Each of the parties has investigated the grants, gifts and bequests controlled by the parties to develop and implement policies and procedures to ensure that the terms of such grants, gifts and bequests are honored by the Surviving Corporation, and each of the parties represents and warrants that there is not presently any material breach or default, nor any basis for claiming such breach or default, by it or to its knowledge any other party under the aforementioned grants to which it is a party.

(d) Each of the parties represents and warrants that, to the best of its knowledge, all facts, statements and information, including but not limited to the financial information, disclosed by it during the due diligence process are true and accurate and contain no material inaccuracies or omissions.

7. **Effects of the Merger.** Upon consummation of the Merger, the Merger shall have the effect provided for in Section 33-1158 of the Connecticut Revised Nonstock Corporation Act.

8. **Additional Actions.** If, at any time after the Effective Time, the Surviving Entity shall consider that any further assignments or assurances in law or any other acts are necessary or desirable to (i) vest, perfect or confirm, of record or otherwise, in the Surviving Entity its rights, title or interest in, to or under any of the rights, properties or assets of NMH acquired or to be acquired by the Surviving Entity as a result of, or in connection with, the Merger, or (ii) otherwise carry out the purposes of this Agreement, NMH and its proper officers and directors shall be deemed to have granted to the Surviving Entity an irrevocable power of attorney to execute and deliver all such proper deeds, assignments and assurances in law and to do all acts necessary or proper to vest, perfect or confirm title to and possession of such rights, properties or assets in the Surviving Entity and otherwise to carry out the purposes of this Agreement; and the proper officers and directors of the Surviving Entity are fully authorized in the name of NMH or otherwise to take any and all such action.

9. **Counterparts.** This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original but all of which together shall constitute one agreement.

10. **Governing Law.** This Agreement shall be governed in all respects, including, but not limited to, validity, interpretation, effect and performance, by the laws of the State of Connecticut.

11. **Amendment.** This Agreement may be amended, modified or supplemented only by written agreement of DH and NMH at any time prior to the Effective Time.

12. **Waiver.** Subject to applicable law, any of the terms or conditions of this Agreement may be waived at any time by whichever of the parties hereto is entitled to the benefit thereof by action taken by the Board of Directors of such party.

13. **Successors and Assigns.** This Agreement may not be assigned by any party hereto without the prior written consent of the other party. Subject to the foregoing, this Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and permitted assigns.

14. **Termination.**

(a) This Agreement may be terminated at any time prior to the Effective Time by mutual consent of DH and NMH in a written instrument, if and to the extent authorized by the respective Boards of Directors of the DH and NMH.

(b) This Agreement may be terminated at any time prior to the Effective Time by DH, if a Material Adverse Event (as defined below) has occurred with respect to NMH. This Agreement may be terminated at any time prior to the Effective Time by NMH if a Material Adverse Event has occurred with respect to DH. "Material Adverse Event" shall herein mean any event, circumstance or change that has or might have such effect on the business, operations, prospects, financial condition or capital of a party, which would materially impair the ability of such party to perform its obligations hereunder or prevent the consummation of any of the transactions contemplated hereby.

In the event of the termination of this Agreement, this Agreement shall forthwith become null and void and of no further force or effect and there shall be no liability or obligation under this Agreement on the part of any of the parties hereto or any of their respective directors, officers or affiliates.

IN WITNESS WHEREOF, each of the parties hereto has caused this Agreement and Plan of Merger to be executed on its behalf by its duly authorized officers, all as of the date first above written.

THE DANBURY HOSPITAL

By:_____
Name:
Its:

NEW MILFORD HOSPITAL, INC.

By:_____
Name:
Its:

EXHIBIT A

CERTIFICATE OF MERGER

OF

NEW MILFORD HOSPITAL, INC.
(a Connecticut nonstock corporation)

WITH AND INTO

THE DANBURY HOSPITAL
(a Connecticut nonstock corporation)

(Under Connecticut General Statutes Section 33-1157 of the Connecticut Revised Nonstock Corporation Act)

Each of the parties to the merger hereby certifies that:

1. The names of the parties to the merger are as follows:

   (a) The Danbury Hospital, a Connecticut nonstock corporation ("DH"); and

   (b) New Milford Hospital, Inc. ("NMH"), a Connecticut nonstock corporation.

2. The name of the corporation that will survive the merger is The Danbury Hospital (the "Surviving Corporation").

3. The date on which the merger is to be effective is as of 12:01 a.m. on _____ __, 201_.

4. The Certificate of Incorporation of the Surviving Corporation is being amended as provided in Exhibit A attached hereto [to, among other things, change the name of the Surviving Corporation to "_____"].[5]

5. The Board of Directors of DH approved the plan of merger at a meeting held on _____ __, 201_, in the manner required by Sections 33-1000 to 33-1290, inclusive, of the Connecticut Revised Nonstock Corporation Act (the "Act") and the certificate of incorporation of DH, and the Board of Directors of NMH approved the plan of merger at a meeting held on _____ __, 201_, in the manner required by Sections 33-1000 to 33-1290, inclusive, of the Act, and the certificate of incorporation of NMH.

[5] The Name of the Surviving Entity shall be determined prior to execution of the Agreement and Plan of Merger.

6. The plan of merger was duly approved by Western Connecticut Health Network, Inc., as the sole member of DH and NMH, at a meeting held on _____ __, 201_, in the manner required by Sections 33-100 to 33-1290, inclusive, of the Act.

IN WITNESS WHEREOF, the parties hereto have caused this Certificate of Merger to be executed by their respective duly authorized officers as of this ___ day of _____, 201_.

THE DANBURY HOSPITAL

By:_____
Name:
Title:

NEW MILFORD HOSPITAL, INC.

By:_____
Name:
Title:

EXHIBIT A

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

[The Certificate of Incorporation of the Surviving Entity shall be that of DH existing immediately prior to the Merger]

Western Connecticut Health Network
Docket No.: 13-31859-CON

EXHIBIT B

AMENDED AND RESTATED BYLAWS

[The Bylaws of the Surviving Entity shall be that of DH existing immediately prior to the Merger]

Western Connecticut Health Network
Docket No.: 13-31859-CON

EXHIBIT C

DIRECTORS AND CORPORATE OFFICERS

[The directors and corporate officers of the Surviving Entity shall be that of DH existing immediately prior to the Merger]

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

RECEIVED
NOV 13 2013
OFFICE OF
HEALTH CARE ACCESS

November 12, 2013

Mr. Steven W. Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Certificate of Need Application, Docket No. 13-31859-CON
Responses to OHCA CON Completeness Questions

Dear Mr. Lazarus,

Enclosed please find Responses on behalf of New Milford Hospital, Inc. and Western Connecticut Health Network, Inc. to the Completeness Questions asked by OHCA in a letter dated September 13, 2013 in the above-captioned docket. We have included the original and two hard copies of the Responses, as well as a CD with an Adobe format of the Responses.

Please contact me if you have any questions regarding this submission.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosure

Western Connecticut Health Network
Docket No.: 13-31859-CON

COMPLETENESS QUESTIONS AND RESPONSES

1. **Considering NMH and DH are both affiliates (as referenced on pages 7-8) of WCHN, why is it necessary to terminate NMH's license and operate NMH under DH's license in order to be able to provide the IT upgrades mentioned?**

Response:

Although it is possible to utilize existing systems operated at DH for NMH without changing to a single license, it requires a different strategy for implementation. It was more cost effective to develop the IT platform necessary for clinical care and operations under a single license due to the limitations of our existing patient accounting system (Siemens Invision). This system can only handle a single entity on each platform. Accordingly, if WCHN moved forward with consolidation of IT systems under two licenses, a complete duplication of the Invision system would be required to accommodate the different tax identification numbers required for billing and managing accounts. The existing system required only minor modifications to accommodate NMH as part of DH's license and tax ID number. We have already arranged for these modifications to bill both hospitals under a single license.

Additionally, the determination to operate on one platform supports our delivery of one standard of high-quality cost-effective care across the network. As stated in response to Q.4.b. on page 16 of the original CON submission, the proposed consolidation will create one unified medical staff with the same policies, procedures and clinical pathways/order sets. Under this single license, the medical staff will have greater opportunity to coordinate care across the network --consistently, efficiently and under one standard. The implementation of a single electronic health record spanning both campuses further enhances the quality and safety of health care delivery by improving communications across sites of care, including physician offices, emergency services, ambulatory centers and the inpatient environment. Access will be improved through better coordination between providers, emergency rooms, and hospitals. The single license allows for better clinical and operational integration resulting in improved efficiency and quality of care.

2. **Regarding services currently offered at DH and NMH (as discussed on pages 7-9), please address the following:**

    a) **Have the Applicants undertaken efforts to evaluate the need for services at each of these locations after the proposed merger under one license?**
    b) **Have there been any studies conducted by the Applicants regarding whether or not the current services offered at both hospitals are duplicative?**

Response:

a) As demonstrated by the Family Birthing CON and the PET CT CON requests for NMH that have been submitted since the affiliation of DH and NMH, WCHN (as a health system that includes DH and NMH) has been focusing on determining the appropriate mix of services for each location and each patient population. Over the past year, the process for evaluating

our services has been a continuing effort driven by community needs, demographics, patient convenience, technology, and physician preference. This process continues to evolve. Discussions have been ongoing in a variety of forums, including with members of the WCHN, DH and NMH Boards, NMH and DH Medical Staffs, WCHN Leadership, WCHN Planning Committee and NMH Community Board. This process has resulted in the submission of CONs for the closure of the Family Birthing Center, the termination of PET CT services and the replacement of the simulator technology. An overall specific long term action or implementation plan has not been identified at this time. WCHN will continue to evaluate the needs of the community served by NMH and DH and to provide those services at NMH which are identified as responsive to the needs of its community.

b) Patient access to needed care is our objective. Any two acute care hospitals with an overlap in historical service areas could be considered to have some duplication. There has not been a direct study to identify duplication. Our objective is to deliver what is needed as efficiently and as effectively as possible. WCHN is considering which services are best provided at the local level, the travel patterns of patients for various health services and the needs and preferences of the populations served. This is an ongoing process and specific conclusions (other than those resulting in the CON requests described above) have not yet been reached. This will continue to be a priority focus over the next year. One example of this process that underscores this point is our network-wide improved treatment of STEMI patients. This project included our regional EMS system, network-wide cardiac catheter conferences and overall reduced door to balloon time for patients by over 30 minutes. This effort was recognized statewide by CHA last year as a winning example of using data to make regional quality care a reality.

3. **For FYs 2010-2012 please reconcile and explain any differences between Table 1 on page 14 for NMH and (1) data submitted through CHIME to OHCA's Inpatient Discharge Database and (2) data reported for HRS Schedule 450. Please update and annualize 2013 YTD.**

Response:

See Exhibit A which has been revised consistent with OHCA Annual Reporting Schedule #450 format for NMH, inclusive of FYE 2013 data. The original submission of Table 1 on page 14 of the CON differs from OHCA Schedule #450 as it defined volume by number of patients or unique account numbers by registered service line. OHCA Schedule #450 defines volume as procedures or visits by department.

The differences between the two definitions are highlighted utilizing a CT scan as an example:

- Patients registered to CT scan service line in FY12 = 1,865. Total CT scans performed in FY12 (OHCA 450) = 5,319.
- We performed CT Scans on patients registered under another service line i.e. ED, Inpatients
- Another factor for the difference is that multiple CT Scans could be performed on the same patient. Table 1 provided in original CON would have counted this with a value of "1" whereas OHCA 450 would count multiples.

As the "definitions" differed, we have revised the volume table to reflect OHCA's format for ease in comparison. Reconciliation of Inpatient discharges vs. CHIME is outlined below. Differences are immaterial and a result only of timing.

NEW MILFORD HOSPITAL	Actual Volume		
	2010	**2011**	**2012**
Inpatient Discharges	2,512	2,515	2,291
CHIME Inpatient Discharges	2,494	2,510	2,291

4. **Please complete and submit Table 1 on page 14 for Danbury Hospital, reconcile and explain any differences from (1) OHCA's Inpatient Discharge Data submitted through CHIME and (2) HRS Schedule 450, for FYs 2010-2013, annualizing 2013 YTD.**

Response:

See Exhibit B which has been revised consistent with OHCA Annual Reporting format for DH, inclusive of FYE 2013 data. Reconciliation of Inpatient discharges vs. CHIME is outlined below. Differences are immaterial and a result only of timing.

DANBURY HOSPITAL	Actual Volume		
	2010	**2011**	**2012**
Inpatient Discharges	20,712	20,728	19,676
CHIME Inpatient Discharges	20,668	20,725	19,606

5. **Explain in detail the reason(s) NMH has experienced a historical decline in total hospital utilization (as presented on page 14) over the past three years and specifically, the approximately 36% decline between FY2011 and 2012. In addition, provide explanations for declines reported by specific services. If declines are reported for DH in responding to question 4 above, please also explain in detail reasons for those declines.**

Response:

Advancements in technology and payer shifts to observation status have reduced both the length and the need for inpatient admissions. This shift to outpatient care is accelerating with lower admission and readmissions as we get better at managing the health of the population, including care managers and patient centered medical homes. Specific to NMH, discharges have also declined as a result of physician turnover, specifically in surgery, and as observation program utilization has increased:

- Inpatient Patient Days and Discharges deceased by 9% due to lower inpatient surgeries, and a decrease in Maternity and Newborn due to closure of the unit
- Outpatient Surgery cases decreased by 8% and overall Operating Room volume softened by 11%, in part due to some physicians shifting their activity to freestanding surgical centers
- Other Outpatient services volume also declined overall; for example, Sleep Clinic cases decreased by 16% as well as CT Scans decreased by 6%

- Ancillary testing, specifically diagnostic services such as CT Scans were reduced due to volume decline as well as improved utilization management

The shift of inpatient volume to Observation (OBV) setting has been occurring for several years at both DH and NMH and the experience is similar to the statewide activity where OBV volumes have increased. It is anticipated this general trend to more outpatient services will continue.

Hospital	**OBV FY 2011**	**OBV FY 2012**	**OBV FY 2013**	**FY11-FY13 % Change**
New Milford Hospital	548	570	666	21.5%
Danbury Hospital	1,831	2,095	2,607	42.4%
All CT Hospitals*	46,836	58,501	64,740	38.2%

*Connecticut Hospital Association PCR Report at the end of FY2011 and the end of FY 2012.

Also, a nationally recognized goal to reduce unscheduled readmission rates is driven by the Medicare Value-Based Purchasing Program, and NMH and DH have both been focused on reducing the rates of readmission for specific diagnoses, including congestive heart failure (CHF), Pneumonia, Chronic obstructive pulmonary disease (COPD), Stroke and Acute myocardial infarction (MI). The effort on the part of hospitals across the country to reduce readmissions has been successful, as Medicare saw a decline of 70,000 admissions in 2012 as a result of similar efforts.

6. As part of this proposed merger under one license, have the Applicants developed any plans to address the declining overall and service-specific utilization at NMH?

Response:

As healthcare reform is actively unfolding, one of the aspects that will make WCHN successful is its response to anticipated declines for inpatient service utilization, at both NMH and DH. We anticipate this will result in a shift in focus and resources to population health status, outpatient services, and wellness efforts. When we look to the range of services we intend to offer, we see patients who are living longer and with a broader range of chronic illnesses. How, when, and where to treat these patients is an evolving challenge. To ensure better outcomes, we reserve inpatient care for patients who actually need to be treated in an acute care setting while simultaneously enhancing our outpatient capabilities where we can better coordinate and expedite care.

This commitment to ambulatory care is demonstrated by the building of a new Emergency Department at NMH, along with ongoing enhancements to NMH's Diebold Family Cancer Center. Additionally, as confirmed by the recent Family Birthing CON and the PET CT CON requests to close services at NMH due to declining volumes and effective use of resources, the hospitals are working to provide key services that the community requires.

7. Please confirm that as part of this proposal the Applicants are proposing that DH acquire the 85 licensed beds at NMH and add them to DH's total licensed beds. If so, please provide a rationale for and explain in detail the need for DH to add 85 additional

beds to its current complement of licensed beds. Provide any studies conducted as evidence.

Response:

There is no intent or request to move beds as part of this CON request for a single license between NMH and DH. The beds are currently in service at NMH and there is no proposed physical move or relocation of any beds. The addition of NMH's 85 beds to DH's license is a technicality associated with the merger of DH and NMH under a single license. The intention is to retain the status quo with respect to the beds at DH and NMH but just under one license with one tax identification number. Accordingly, WCHN is NOT requesting a reduction in the overall system beds. We have not identified a need for a reduction at this time but will look at it as part of our overall strategic planning, which will include an assessment of the distribution of inpatient services for the defined service area that both DH and NMH serve. The variables we face at this time, including the distribution of inpatient services across a larger geographic area, the unknown impact of healthcare reform, and bringing online the new bed tower at DH (Docket No. 09-31490-CON) (anticipated in the late spring of 2014), will ultimately determine the number of required licensed beds for WCHN overall and the allocation of these licensed beds at each facility.

Given the uncertainty at this time resulting from changes in health care and within WCHN, there is no anticipated change in the total number of required beds. At such time when a more accurate number can be determined, if a reduction in beds is warranted, WCHN will apply for a CON, using the Connecticut Bed Need Calculation[1] methodology. It is anticipated that this can be accomplished within the next twelve months.

8. Discuss how this proposal is consistent with the goals and objectives of the Connecticut's Statewide Heath Care Facilities and Services Plan ("Plan").

Response:

In this era of health care reform and the associated transformation that is underway, the proposed single license between NMH and DH furthers the objectives outlined in the *Statewide Health Care Facilities and Services Plan (The Plan")*, specifically to "improve the health of Connecticut residents, increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services." (*See* Exhibit C, The Plan, p. 2, Sec. 1.4). This proposal to operate under a single license will enable WCHN to achieve greater efficiencies in the delivery of health care, avoid increased costs associated with building a second Siemens billing platform and maintaining two clinical platforms for NMH and improve quality of care by unifying the medical staff and operations so there is one standard of care across the network.

---

[1] Connecticut Department of Public Health - Office of Health Care Access, *Statewide Healthcare Facilities and Service Plan*, October 2012, Pg. 26

Western Connecticut Health Network
Docket No.: 13-31859-CON

9. Regarding the financials, as presented on pages 47-51, identify and provide specific examples of financial savings and benefits for NMH, DH and WCHN as a result of this proposal. Is the table on page 11 showing capital avoidance and operational savings estimates entirely related to the entity, NMH? Please reconcile to the Financial Attachment(s) and provide supporting documentation for the capital avoidance figure and each of the operating expense reduction estimates.

Response:

All savings outlined on Page 11 of the initial filing (outlined below) relate specifically to NMH. As NMH and DH are already consolidated into the financials of the parent company of WCHN, these savings are also reflected in the overall network financials. The upgrade to the Meditech System is highlighted below as capital avoidance. This investment would not be necessary if DH and NMH have a single license. All other expenses outlined are projected savings based upon current annual expenses incurred by NMH.

NMH Projected Operational Expense Savings:

	NMH Projected Operational Expense Savings:	Year 1 Savings	Year 2 Savings	Year 3 Savings
	Audit Fees	$ (175,000)	$ (175,000)	$ (175,000)
	CHA Fees	(18,000)	(18,000)	(18,000)
	TJC Fees	(10,000)	(10,000)	(10,000)
	Press Ganey Fees	(8,000)	(8,000)	(8,000)
	Core Measures/VBP	(27,000)	(27,000)	(27,000)
	Staffing Efficiencies	(350,000)	(350,000)	(350,000)
	Siemens System Maintanence	173,028	181,679	190,763
	Meditech System Maintenance	(300,446)	(313,021)	(326,151)
*	Depreciation - Siemens	119,393	119,393	119,393
	Subtotal Operating Savings	**(596,025)**	**(599,949)**	**(603,995)**
	Capital Avoidance:			
**	Depreciation - Meditech	(632,180)	(632,180)	(632,180)
	Total Impact	**$ (1,228,205)**	**$ (1,232,129)**	**$ (1,236,175)**

** Depreciation - Siemens System based upon $596,965 current cost incurred for system integration amortized over 5 years.*
***Depreciation - Meditech is based on $3,160,902 vendor estimate of cost to upgrade current system reflected as capital avoidance amortized over 5 years. This cost would not be incurred based on the single license.*

Financial Attachment reconciliation below outlines the impact of the savings on NMH as well as the consolidation of the financials into a single license.

Western Connecticut Health Network
Docket No.: 13-31859-CON

Reconciliaton of Financial Attachments 1: (Dollars in thousands)

	FY2014	FY2015	FY2016
NMH Projected Op Margin Without CON	(5,578)	(6,328)	(6,813)
Projected Savings from Single License	(1,228)	(1,232)	(1,236)
NMH Op Margin before consolidation	**(4,349)**	**(5,096)**	**(5,577)**
DH Projected Op Margin Without CON	**35,048**	**27,336**	**25,652**
Consolidated Impact - Single License:			
DH Projected Op Margin WITH CON	**$ 30,699**	**$ 22,240**	**$ 20,075**
NMH Projected Op Margin WITH CON	**$ -**	**$ -**	**$ -**

10. Will the proposed single general hospital license be able to use greater purchasing power as a cost savings (or reduction to operating expenses) mechanism? If so, please quantify and provide specific details, and reconcile or revise Financial Attachment I (provided on pages 47-51) for both hospitals.

Response:

No, as subsidiaries of WCHN, NMH and DH have already consolidated their purchasing functions thus providing enhanced purchasing power for the network. Purchasing is centralized and negotiated across the network with all vendors. Moving to a single general hospital license will not provide further purchasing enhancements from what NMH is already experiencing today.

11. Discuss and provide a specific timeline for WCHN to implement any of the savings listed above.

Response:

The anticipated savings identified on the chart above in response to Q.9 are expected to be realized if successful approval of the CON is granted in time for ICD10 readiness. All systems are required to be ICD10 ready by October 1, 2014, with system upgrades occurring currently and system testing to begin by March 2014. All savings inclusive of FTE and nonsalary savings would be achieved in the first twelve month period. If CON approval is not obtained, ICD10 compliance will be at risk as will the NMH's cash flow position.

12. NMH has experienced significant losses, Excess/(Deficiency) of Revenues over Expenses of $(5,165,070), $190,247, ($93,942) and ($6,456,113) for FYs 2009 through projected 2013 (pp. 47-51). Please provide a detailed explanation for these losses and specifically for projected FY 2013.

Response:

Significant declines in revenue outpaced expense reductions during the time period largely in chemotherapy, outpatient surgery, and ancillary testing. Volume at NMH has declined significantly in major service lines as a result of physician turnover specifically in surgery and

oncology. The most significant drop in revenue of $9M was experienced from FY2011 to FY2012 and was the result of the following:

- Inpatient Patient Days and Discharges deceased by 9% due to lower inpatient surgeries, decrease in Maternity and Newborn due to anticipated closure of the unit, and the transfer of the Hospitalist physicians and the corresponding professional billing from NMH to Western Connecticut Medical Group, the WCHN subsidiary that employs physicians.
- Outpatient Surgery cases decreased by 8%
- Other Outpatient services volume also declined overall; for example, Sleep Clinic cases decreased by 16% as well as CT Scans decreased by 6%

In addition, as capital improvements were held to a minimum in FY2009 and FY2010, necessary investments were made beginning in FY2011 to infrastructure, systems, and clinical equipment which is reflected in depreciation expense growing from $4.9M in 2009 to $5.8M by 2013. Finally, variability in financial market performance has impacted non-operating income as represented in the audited financial statements.

Revenue trend continued to decline in FY2013 and can be attributed to the following:

- Closing of the Family Birthing Center and PET Scan Services
- Shifting of Inpatient volume to Observation setting
- Operating room volume continued to soften by 11.4%
- Ancillary testing, specifically diagnostic services such as CT Scans were reduced due to volume decline as well as improved utilization management.
- Reduction in DSH funding amounting to $730,000 combined with an approx $1M decline in Medicare TOPS payments.

13. Please provide a discussion which shows in greater detail how this proposal will benefit NMH given the fact that NMH has shown a loss from operations from FY 2011 to FY 2012, has had a decrease in days cash on hand and an increase in the average payment period. NMH's total net assets, equity financing ratio and long term debt to capitalization ratio were also negative over the period of FY 2011 to FY 2012. Please explain.

Response:

NMH's current IT systems cannot be ICD-10 compliant which means that unless NMH is moved to DH's Siemens platform, NMH will no longer be able to bill and will have no cash flow after October 1, 2014. The most cost-effective option to provide an ICD-10 compliant billing system is to consolidate their billing into DH's existing system which would require one license. There is not enough time left to create and build another separate entity within DH's current billing system, test it, etc. Not only would the timing be an issue, it would be much more costly ($3.1 million). The benefit to NMH is the cost savings/cost avoidance and not exacerbating further its current financial position.

14. What specific plans have the Applicants developed to address the operating losses at NMH? Provide evidence.

Western Connecticut Health Network
Docket No.: 13-31859-CON

Response:

NMH's decline in financial performance has primarily been attributed to a significant reduction in volume, as described in the response to Q. 12 above. NMH's approach to offsetting these resulting operating losses has included program changes, staff efficiencies and supply chain improvements. From 2012 to 2013, total non-salary expense was reduced by $7.3 million coupled with a total FTE reduction of 55.4 FTEs. Specific projects that supported these efforts included: Bio-Medical Engineering transition to an in-house team; change in Dining Services Contract; PET CT program consolidation with DH; MRI joint venture organizational structure change, and the Family Birthing Center transition. Numerous shared staffing positions were created enabling staff to shift locations between DH and NMH as volumes and need mandate, while building network flexibility and cross training depth. Additionally, equipment was standardized for cost savings as well as improved clinical outcomes. This included pulse oximetry, bed exit alarms, wound care products, and patient information boards.

15. Considering the operating losses at NMH, is merging/consolidating NMH's financials under DH a reasonable course of action as the proposal will reduce DH's Revenue Over/(Under) Expenses at an increasing rate starting in FY 2014? Please explain the impact of this proposal on DH's financial status and provide specific details.

Response:

NMH and DH are already consolidated at the parent company level as subsidiaries of WCHN and as such, report to the WCHN Finance Committee and WCHN Board. Both hospitals' operating results (gains or losses) are included in the WCHN consolidated financial statements. As an integrated health care delivery system, WCHN and all of its subsidiaries have consolidated financial performance. Accordingly, merging NMH and DH into a single hospital license has no impact on overall financial position and will avoid the incurrence of costs to build a redundant IT platform to bring NMH into ICD10 compliance. Allowing a single license will provide additional benefits to the WCHN health system by reducing other costs associated with two medical staffs, two Joint Commission surveys, etc.

16. Provide a discussion of how the system, WCHN, and its two hospitals are prepared to meet the provisions of federal Health Care Reform (the Affordable Care Act). Include in your discussion Value-Based Purchasing, Accountable Care Organizations and the Medicare Shared Savings Program. Has any financial impact been reflected in the projected financial statements provided in the application?

Response:

In anticipation of the Affordable Care Act (ACA), WCHN and its two hospitals have been engaged in a variety of activities and strategies to manage patients more effectively and efficiently across the continuum of care. The core goals are to improve outcomes that are meaningful for patients, to improve patient satisfaction wherever they encounter our system, and to reduce the total cost of care through elimination of duplicative or unnecessary services that are not evidence based. Specifically, we focus on CMS core measures as part of value-based

purchasing, reducing unnecessary hospital readmissions, judicious and appropriate use of observation beds, and targeted reductions in unnecessary variations in care. We have developed a Physician Hospital Organization that is preparing us for future full clinical integration and risk-based contracting in order to be more responsible for the outcomes and quality of care for our patients.

Health Care Reform (the ACA), value-based purchasing, ACO's, etc. all necessitate a continued focus on cost-effectiveness as well as quality. With approval of this CON request for a single license, we will continue to address unnecessary, redundant costs (billing, IT, audits, cost reports, etc.) in order to reduce our overall cost structure.

17. Did either hospital apply for incentive payments related to the CMS Electronic Health Record Incentive Program? If not, would the $3.1 million projected upgrade to New Milford's IT system (the capital avoidance figure) (pages 7-8) have qualified for the Incentive Program? Please indicate whether this program was pursued by either or both hospitals.

Response:

DH applied for and received meaningful incentive payments in fiscal year 2011 and 2012, and will also apply in 2013. WCHN plans to incorporate NMH into the attestation for meaningful use as soon as we move the hospital to the certified Siemens EHR system.

NMH has not applied for meaningful use incentive payments because NMH's incentive payment eligibility was dependent upon the upgrade of the Meditech system. However, WCHN's long term IT strategy is to focus on efficiency of our IT systems while maximizing the technology available in a cost effective manner. Moving to a single system will allow us to streamline our processes, improve productivity, eliminate waste and excess interfaces, and eliminate multiple system maintenance costs. The incremental cost of upgrading Meditech for NMH less the potential meaningful use incentive payments would have still left WCHN with multiple systems and added overall cost to the network. Our plan was to be up on Siemens as a single entity, obtain all the meaningful use dollars available and be ICD10 compliant, while avoiding the expensive Meditech upgrade for NMH. Implementation of our plan has been postponed due to the CON process. Of note, if NMH is not "live" on the new platform by July 2014, NMH will incur penalties in 2015 from Medicare for failure to achieve meaningful use.

18. Do the Applicants assume that gifts and bequests (non-operating revenue) will continue at the same rate with a single license under Danbury Hospital as it would if New Milford Hospital continued as a separately licensed entity? Could this project negatively impact future gifts/bequests (pages 47-51)?

Response:

Philanthropy at both hospitals has already increased since WCHN became the sole member of, and financially responsible for, NMH. During the last three years (2011-2013), funds raised for WCHN totaled $57 million. In contrast, the total raised during the previous three years (2008-

Western Connecticut Health Network
Docket No.: 13-31859-CON

2010) for WCHN was $26 million. In addition, the cost per dollar raised at NMH moved from a three-year average of 58.16% during 2008-2010 to 15.09% during 2011-2013.

It is important to note that the New Milford Hospital Foundation was merged into the Western Connecticut Health Network Foundation in 2011. During this time, philanthropic support continued to increase. In FY2012, New Milford Hospital experienced one of its most successful years to date for fundraising, with $4,886,000 realized from donations and a 13.4% cost per dollar raised.

As we look ahead, we remain optimistic this trend will continue. The WCHN Foundation is currently engaged in a $50 million capital campaign, which includes an $8 million goal for a new Emergency Department at New Milford Hospital. The lead campaign gift for this project ($2 million) was secured and the expectation is that we will hit or exceed this goal by the end of FY14.

19. Provide support or documentation related to the statement that Medicaid reimbursements to WCHN will be reduced by $30 million over the next two years.

Response:

Outlined below is the impact of the State of Connecticut Tax Impact showing the Hospital tax as well as the State DSH and Supplemental Payments.

State Budget Reduction to DSH Program to WCHN

Danbury	**Tax Liability**	**DSH/Supplemental Payments**	**Total**	**Impact**
SFY12	20,585,238	21,134,039	548,801	
SFY13	20,585,238	16,833,405	(3,751,833)	(4,300,634)
SFY14	20,585,238	10,540,433	(10,044,805)	(10,593,606)
SFY15	20,585,238	4,314,705	(16,270,533)	(16,819,334)
				(31,713,574)

New Milford	**Tax Liability**	**DSH/Supplemental Payments**	**Total**	**Impact**
SFY12	1,446,301	2,059,503	613,202	
SFY13	1,446,301	1,574,891	128,590	(484,612)
SFY14	1,446,301	905,189	(541,112)	(1,154,314)
SFY15	1,446,301	370,537	(1,075,764)	(1,688,966)
				(3,327,892)
			Total Impact	**(35,041,466)**

Western Connecticut Health Network
Docket No.: 13-31859-CON

20. The Applicants identify an "Integration cost to single system" of $596,965 on page 11 and make the statement on page 10 that "WCNH has already invested $596K to support alignment of its IT systems to achieve efficiencies." Please clarify that the Applicants have already expended the capital dollars to achieve the estimated cost savings related to the proposal before OHCA.

Response:

WCHN has already incurred the $596,965 to support alignment of the IT systems. This amount represents the incremental licensing costs for all of the WCHN systems required to replace the current Meditech platform used at New Milford Hospital.

21. Regarding the operating expense reductions estimated on page 11, verify that each of these cannot be achieved without a single license.

Response:

The annual operating savings outlined in Question 9 cannot be achieved without the single license approval. This operating savings is created by the elimination of multiple system maintenance contracts, audit and professional fees per entity as well as the productivity efficiencies by consolidating systems and processes.

22. Please further explain the statement on page 16, "With separate licenses, there is a requirement for each hospital entity to have its own medical staff with its own set of Bylaws and Medical Staff leadership."

Response:

Each individually licensed acute care facility must comply with The Public Health Code of the State of Connecticut[2]. In section C, it indicates each licensed hospital, in this case DH and NMH, must have the following:
(1) There shall be an organized medical staff of not fewer than five physicians, one of whom shall serve as a chief or president of the medical staff.
(2) The medical staff shall adopt written rules and regulations governing its own activities, subject to approval by the governing board of the hospital. As a minimum, these shall include:
(A) Method of control of privileges granted to members of the medical staff;
(B) Method of control of clinical work;
(C) Provision for regular staff conferences;
(D) Appointment of a medical executive committee, or its equivalent, and other committees as appropriate;
(E) Procedure for recommending appointments to the medical staff and for hearing complaints regarding the conduct of members and referring the same, with recommendations, to the governing board.

---

[2] General Statutes §19-13-D3, Chapter IV "Hospitals, Child Day Care Centers, Other Institutions and Children's General Hospitals

Western Connecticut Health Network
Docket No.: 13-31859-CON

In addition, the Centers for Medicare and Medicaid Services ("CMS") concluded in the preamble to the May 16, 2012 final rule which changed the Hospital Medicare & Medicaid Conditions of Participation (CoP), that the CMS medical staff CoP Section 482.22 "will continue to [be interpreted] to require that each hospital, regardless of whether it is a part of a multi-hospital system, have a single and separate medical staff, as a matter of CMS policy."

As a combined entity operating under one single license, the medical staff structure would be combined.

23. Please complete and submit the Patient Payer Mix table for both NMH and DH and explain any changes that may occur as a result of this proposal.

Response:

Danbury Hospital : Patient Population Mix based on Inpatient Discharges				
Total Facility Description	Current FY2013	FY2014	FY2015	FY2016
1. Medicare	45.5%	45.5%	45.5%	45.5%
2. Medicaid	17.7%	17.7%	17.7%	17.7%
3. Champus / TriCare	0.2%	0.2%	0.2%	0.2%
Total Government	**63.4%**	**63.4%**	**63.4%**	**63.4%**
1. Commercial Insurers	35.5%	35.5%	35.5%	35.5%
2. Self Pay	0.7%	0.7%	0.7%	0.7%
3. Workers Compensation	0.4%	0.4%	0.4%	0.4%
Total Non-Government Payers	**36.6%**	**36.6%**	**36.6%**	**36.6%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

New Milford Hospital : Patient Population Mix based on Inpatient Discharges				
Total Facility Description	Current FY2013	FY2014	FY2015	FY2016
1. Medicare	57.9%	57.9%	57.9%	57.9%
2. Medicaid	10.3%	10.3%	10.3%	10.3%
3. Champus / TriCare	0.1%	0.1%	0.1%	0.1%
Total Government	**68.3%**	**68.3%**	**68.3%**	**68.3%**
1. Commercial Insurers	27.8%	27.8%	27.8%	27.8%
2. Self Pay	3.1%	3.1%	3.1%	3.1%
3. Workers Compensation	0.9%	0.9%	0.9%	0.9%
Total Non-Government Payers	**31.7%**	**31.7%**	**31.7%**	**31.7%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Combined				
Total Facility Description	Current FY2013	FY2014	FY2015	FY2016
1. Medicare	46.7%	46.7%	46.7%	46.7%
2. Medicaid	17.0%	17.0%	17.0%	17.0%
3. Champus / TriCare	0.2%	0.2%	0.2%	0.2%
Total Government	**63.8%**	**63.8%**	**63.8%**	**63.8%**
1. Commercial Insurers	34.8%	34.8%	34.8%	34.8%
2. Self Pay	0.9%	0.9%	0.9%	0.9%
3. Workers Compensation	0.4%	0.4%	0.4%	0.4%
Total Non-Government Payers	**36.2%**	**36.2%**	**36.2%**	**36.2%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Neither the patient population nor the payor mix is projected to change as a result of this proposal.

24. Discuss any effect this proposal may have on payer contract negotiations. How has any projected impact been reflected in the financial statements provided?

Response:

We believe that this proposal will be revenue neutral to us and the payors. No impact is expected.

25. To illustrate the impact of this proposal on charges for patients utilizing the New Milford campus, please provide a comparison of NMH and DH's current pricemaster charges for twenty procedures which represent large volume service lines. Be sure to list the item code, item description and item price as used in the hospitals' pricemaster filings and indicate whether there is any bundling involved in the service charges listed.

Response:

NMH's and DH's pricemasters differ based on historic policy. However shifting to a single license will accelerate the pricing alignment which will provide consistency across WCHN. A charge will be the same regardless of location. This alignment, which has been communicated to our payors, will be revenue neutral.

Exhibit D contains a table comparing the current NMH and DH price master charges for twenty procedures which represent large volume service lines.

26. Provide a copy of any and all agreements related to the consolidation into one license and provide documents evidencing current- and post-merger board composition.

Response:

Attached as Exhibit E is a *DRAFT* Merger Agreement which would accomplish the merger of NMH into DH with the resulting one license and taxpayer identification number. The composition of the Board of Directors of DH after the merger will be the same as the current Board of DH and NMH and there are no proposed changes as a result of this merger.

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit A

New Milford Hospital Table 1 with Annualized 2013 Volume

Western Connecticut Health Network
Docket No.: 13-31859-CON

New Milford Hospital - Revised Volume Table with FYE 2013

	Actual Volume			
Inpatient	FY 2010	FY 2011	FY 2012	FY 2013
Adult Med/Surg	1,971	1,982	1,802	1,711
Maternity	270	267	245	58
Newborn	261	264	243	55
Peds	10	2	1	0
Inpatient Discharges	**2,512**	**2,515**	**2,291**	**1,824**
CHIME (Inpt Discharges)	**2,494**	**2,510**	**2,291**	**n/a**
CT Scans				
Inpatient Scans	1,267	889	766	710
Outpt Scans (Includes ED)	6,858	5,251	4,553	4,114
Total CT Scans	**8,125**	**6,140**	**5,319**	**4,824**
MRI Scans				
Inpatient Scans	124	144	114	117
Outpt Scans (Includes ED)	2,036	2,767	2,802	2,735
Total MRI Scans	**2,160**	**2,911**	**2,916**	**2,852**
PET/CT Scans				
Inpatient Scans	1	0	0	0
Outpt Scans (Includes ED)	202	165	122	7
Total PET/CT Scans	**203**	**165**	**122**	**7**
Surgical Procedures				
Inpatient Surgical Procedures	847	785	621	519
Outpatient Surgical Procedures	2,380	2,268	2,116	1,905
Total Surgical Procedures	**3,227**	**3,053**	**2,737**	**2,424**
Endoscopy Procedures				
Inpatient Endoscopy Procedures	103	74	89	83
Outpatient Endoscopy Procedures	2,226	2,064	2,110	1,963
Total Endoscopy Procedures	**2,329**	**2,138**	**2,199**	**2,046**
Hospital Emergency Room Visits				
Emergency Room Visits: Treated and	1,901	2,042	2,050	2,135
Emergency Room Visits: Treated and	16,972	16,738	16,366	15,715
Total Emergency Room Visits	**18,873**	**18,780**	**18,416**	**17,850**
Hospital Clinic Visits				
Psychiatric Clinic Visits	7,038	6,845	6,875	10,563
Total Hospital Clinic Visits	**7,038**	**6,845**	**6,875**	**10,563**
Other Hospital Outpatient Visits				
Rehabilitation (PT/OT/ST)	598	652	465	164
Cardiology	1,007	882	914	1,199
Chemotherapy	1,635	1,612	1,048	1,052
Other Outpatient Visits	82,600	77,740	45,169	29,420
Total Other Hospital Outpatient Visits	**85,840**	**80,886**	**47,596**	**31,835**

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit B

Danbury Hospital Table 1 with Annualized 2013 Volume

Western Connecticut Health Network
Docket No.: 13-31859-CON

Danbury Hospital - Volume Table with FYE2013

	Actual Volume			
Inpatient	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**
Adult Med/Surg/NICU	15,166	15,452	14,476	13,516
Psych	710	746	707	686
Rehab	304	295	291	292
Maternity	2,251	2,110	2,083	2,058
Newborn	1,958	1,851	1,814	1,783
Peds	323	284	305	256
Inpatient Discharges	**20,712**	**20,738**	**19,676**	**18,591**
CHIME (Inpatient Discharges)	**20,668**	**20,725**	**19,606**	**n/a**
CT Scans				
Inpatient Scans	11,998	12,277	10,946	10,214
Outpt Scans (Including ED, exc NonHosp)	24,665	23,700	23,533	24,165
Total CT Scans	**36,663**	**35,977**	**34,479**	**34,379**
MRI Scans				
Inpatient Scans	1,413	1,309	1,188	1,193
Outpt Scans (Including ED, exc NonHosp)	7,060	7,120	7,130	7,109
Total MRI Scans	**8,473**	**8,429**	**8,318**	**8,302**
PET Scans				
PET Scans	**167**	**188**	**6**	**260**
PET/CT Scans	**574**	**671**	**636**	**774**
Linear Accelerator Procedures				
Inpatient Procedures	479	322	377	465
Outpatient Procedures	10,168	11,654	9,763	10,260
Total Linear Accelerator Procedures	**10,647**	**11,976**	**10,140**	**10,725**
Cardiac Catheterization Procedures				
Inpatient Procedures	871	856	864	814
Outpatient Procedures	800	856	864	876
Total Cardiac Catheterization Procedures	**1,671**	**1,712**	**1,728**	**1,690**
Cardiac Angioplasty Procedures				
Primary Procedures	100	107	132	98
Elective Procedures	305	318	299	304
Total Cardiac Angioplasty Procedures	**405**	**425**	**431**	**402**
Electrophysiology Studies				
Inpatient Studies	19	24	24	31
Outpatient Studies	100	115	95	128
Total Electrophysiology Studies	**119**	**139**	**119**	**159**
Surgical Procedures				
Inpatient Surgical Procedures	4,625	4,442	4,322	3,875
Outpatient Surgical Procedures	7,615	7,776	10,811	10,586
Total Surgical Procedures	**12,240**	**12,218**	**15,133**	**14,461**
Endoscopy Procedures				
Inpatient Endoscopy Procedures	834	909	795	797
Outpatient Endoscopy Procedures	9,891	9,777	10,519	10,753
Total Endoscopy Procedures	**10,725**	**10,686**	**11,314**	**11,550**
Hospital Emergency Room Visits				
ER Visits: Treated and Admitted	14,124	14,603	14,260	11,548
ER Visits: Treated and Discharged	56,136	54,992	56,362	58,017
Total Emergency Room Visits	**70,260**	**69,595**	**70,622**	**69,565**
Hospital Clinic Visits				
Dental Clinic Visits	12,450	12,421	12,816	12,722
Psychiatric Clinic Visits	21,803	20,411	22,067	20,574
Medical Clinic Visits	39,551	45,970	61,238	63,931
Specialty Clinic Visits	3,067	2,569	2,319	2,307
Total Hospital Clinic Visits	**76,871**	**81,371**	**98,440**	**99,534**
Other Hospital Outpatient Visits				
Rehabilitation (PT/OT/ST)	41,425	42,519	46,077	42,782
Cardiology	6,715	6,501	6,260	6,301
Chemotherapy	2,931	2,931	6,199	7,322
Total Other Hospital Outpatient Visits	**51,071**	**51,951**	**58,536**	**56,405**

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit C

Statewide Health Care Facilities and Services Plan Excerpt

Western Connecticut Health Network
Docket No.: 13-31859-CON

Statewide Health Care Facilities and Services Plan

October 2012

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Connecticut Department Of Public Health
Office Of Health Care Access
410 Capitol Avenue • Hartford, CT 06134

1.3 ADVISORY BODY

In October 2010, the Office of Health Care Access invited representatives from a cross section of the health care industry and State government to participate in an advisory body that would be charged with providing guidance on the development of the Plan. Advisory Body members are listed in Appendix B. The advisory body met monthly beginning in November 2010. In May 2011, advisory body subcommittees were formed to conduct more in-depth work in the areas of Acute Care/Ambulatory Surgery, Behavioral Health and Primary Care. Subcommittee members are listed in Appendix C.

Both advisory body and subcommittee members provided OHCA with guidance and expertise in the development of CON guidelines, standards, methodologies and analyses used in the Plan, including:

- Reviewing research conducted by OHCA on other states' facilities plans' standards, guidelines and methodologies and providing feedback and discussion regarding adaptation and applicability for Connecticut's Plan;
- Recommending authoritative professional organizations, published studies, industry-recognized standards/ guidelines/methodologies, etc., to be considered by OHCA in the development of its plan;
- Providing insight on industry best practices and evidenced based research;
- Recommending data sources; and
- Offering feedback on OHCA's use and interpretation of available data.

1.4 GUIDING PRINCIPLES

The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage and support health education, promotion and prevention initiatives;
- Encourage collaboration among health care providers to develop health care delivery networks;
- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;
- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state.

In November, 2010, the Department of Public Health, in accordance with Public Act 10-179, adopted interim Certificate of Need Policies and Procedures for Implementation of Public Act 10-179, §87, 89-93, which will be utilized by OHCA until official regulations are adopted by the General Assembly.

1.8.4 CERTIFICATE OF NEED AND HEALTH CARE REFORM

The 2010 Patient Protection and Affordable Care Act (PPACA) includes two provisions that may affect Connecticut's CON program: an increase in the insured population that will demand more services, which, in turn, may call for increased provider capacity; and provider payment reforms, which may restore some of the market constraints on prior health care system expansion. While it is unclear what the exact effect of these provisions will be, certain communities or regions may have adequate capacity to absorb increased demand, whereas those with a higher proportion of currently uninsured and less capacity may increase health care providers' reliance upon the CON program for health planning.[12]

1.8.5 MERGERS, ACQUISITIONS AND AFFILIATIONS

Even before health care reform has been fully implemented, the state's health care system has begun a transformation in response to and in anticipation of major changes in the way health care is financed and delivered. Many provisions of the PPACA favor integrated systems to create efficiencies and address quality. Hospital mergers and the acquisitions of imaging centers and physician practices are key issues surrounding Connecticut's CON process today.

Hospitals are pursuing affiliation arrangements and mergers in an effort to contend with growing financial pressures driven by such factors as providing uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients whose cost of care often exceeds federal and State reimbursement rates, the threat of reduced reimbursement by government payers and tough negotiations with health insurers over contract terms related to the cost of medical services. Financially struggling hospitals see mergers with stronger hospitals as a way to survive in the face of thin profits, gain access to capital to make needed facilities improvements or acquire technological equipment and contend with debt and liability issues. Affiliations help smaller hospitals share the cost of new technology, provide the opportunity to access specialists at larger hospitals and also offer patients a wider range of treatment and services.[13]

A growing number of Connecticut hospitals have become members of larger corporate health care systems. This trend may be the result of a variety of factors including: a weak economy, increased competition in the health care market, anticipation of changes due to federal health care reform, an attempt to gain leverage in payer contract negotiations, to develop economies of scale when purchasing supplies and services, and to improve access to capital. Additional hospitals are currently in discussion with other health care systems or have officially submitted applications for regulatory approval that would alter the current structure of Connecticut's existing hospitals. It should be noted that while every hospital is analyzing the advantages and disadvantages of pursuing affiliations and possible mergers, some hospitals are deciding that affiliating or merging is not the best route for their institutions or their communities. Table 1.1 represents general hospitals that are part of a larger health care system at the time this document was published.

[12] Yee, T., Stark, L.B., Bond, A. M. & Carrier, E. (2011). Health Care Certificate of Need Laws: Policy or Politics? National Institute for Health Care Reform. (Research Brief Number 4). 7. Retrieved from http://www.nihcr.org/CON_Laws.html

[13] Sturdevant, M. (2012, February 3). Hartford Hospital, Backus in Norwich Consider Joining Forces. *The Hartford Courant*. Retrieved from http://articles.courant.com/2012-02-03/business/hc-hartford-hospital-backus-20120203_1_hartford-healthcare-hartford-hospital-windham-hospital

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit D

Comparison Price Master
New Milford Hospital and Danbury Hospital

Western Connecticut Health Network
Docket No.: 13-31859-CON

New Milford Hospital			
CDM	Description	Charge	Comments
3200060	Polysomnography	5,940.70	
1300029	Ambulatory Surgery	20.60	Man min charge then multiplied by person in OR (avg 3 to 4)
2800019	Recovery Room	11.85	Charge per Minute
3400163	ER Level 3 Tech	451.00	
3600271	Chemo IV Infusion Initial	1,087.05	
3610125	Complex Trmt 6-10	1,046.70	
3610126	Complex Tremt 11-19	1,141.90	
3610159	IMRT Delivery per session	3,079.95	
3610198	CT Guidance	479.50	
2110002	Colonoscopy	1,566.50	
550145	CBC W/AUTO DIFF & PLT COU	48.80	
3100013	EKG	393.75	
3100080	ECHO W/ DOP & CLR FLW MAP	2,482.10	
810200	Chest - Xray	401.10	
860900	Mammo Bilateral	498.85	
860957	Breast Ultrasound	657.30	
900035	CT Scan w/o contrasts	1,540.40	
900901	CT Scan Abd & Pel w/ contr	4,823.80	
891003	MRI - Head w & w/o contr	4,261.85	
891026	MRI-Lumbar spine w/o contr	2,463.05	

Danbury Hospital			
CDM	Description	Charge	Comments
7450006	Polysomnography 4 + Para	4,710.00	
4700205	Surgery Minutes Normal OP	84.00	Per Man Min (already adjusted for persons in OR)
4800012	Recovery Room per Hour	593.00	Charge per Hour
6101003	ED Visit Lvl 3 Tech	464.00	
2610011	Chemo IV Infusion, Initial Hr	732.00	
3977413	Daily Treat Com 6-10	1,162.00	
3977414	Daily Treat Com 11-19	1,316.00	
3977418	IMRT Treatment	2,387.00	
3976370	CT Guided Plcmnt RDT Flds	413.00	
4000105	Lower GI Minor	2,199.00	Bundle incl supplies
5555009	CBC - 5 PART DIFF	49.00	
7690001	EKG 12 LEAD TRACE	190.00	
2515015	ECHO Complt w/spectl&color flw	1,873.00	
2530012	Chest 2 View	308.00	
2517001	Mammo Screening Digital	458.00	
2550023	US Breast Bilateral	551.00	
2540027	CT Head or Brain w/o cont	1,350.00	
2540052	CT Abd/pel w/ contrast	3,364.00	
2560006	MRI Brain wow contrast	3,487.00	
2560052	MRI Spine Lumbar wo contrast	3,405.00	

Western Connecticut Health Network
Docket No.: 13-31859-CON

Exhibit E

DRAFT

Agreement and Plan of Merger

AGREEMENT AND PLAN OF MERGER

This **AGREEMENT AND PLAN OF MERGER** (this "Agreement"), dated as of _____ __, 201_, is by and between THE DANBURY HOSPITAL, a Connecticut nonstock corporation ("DH") and NEW MILFORD HOSPITAL, INC., a Connecticut nonstock corporation ("NMH").

WITNESSETH:

WHEREAS, the board of directors of DH and NMH each deem it desirable and in the best interest of each of DH and NMH, respectively, to merge on the terms and subject to the conditions herein provided;

NOW, THEREFORE, in consideration of the premises and the mutual covenants and agreements herein contained, the parties hereto, intending to be legally bound hereby, agree as follows:

1. **The Merger.** Upon the terms and subject to the conditions of this Agreement, at the Effective Time (as defined in Section 2 hereof), NMH shall merge with and into DH (the "Merger") under the laws of the State of Connecticut. The separate corporate existence of NMH shall cease and DH shall survive the Merger and continue to exist and operate as a corporation incorporated under the laws of the State of Connecticut under the name "[_____]"[3] (DH, as the surviving corporation in the Merger, sometimes being referred to herein as the "Surviving Entity"). After the Merger, Western Connecticut Health Network, Inc. shall remain the sole member of the Surviving Entity.

2. **Effective Time.** The Merger shall become effective as of 12:01 a.m. on _____ __, 201_; provided that if the Certificate of Merger (as defined below) has not then been filed with the Secretary of State of the State of Connecticut, the effective time of the Merger shall be the time and the date of such filing. The time that the Merger shall become effective is hereinafter referred to as the "Effective Time."

[3] The Name of the Surviving Entity shall be determined prior to execution of the Agreement and Plan of Merger.

3. **Certificate of Incorporation; Bylaws.** The Certificate of Incorporation of the Surviving Entity shall be the Certificate of Incorporation of DH, as amended and restated, as provided for in the certificate of merger, in the form attached as Exhibit A (the "Certificate of Merger"), until altered, amended or repealed in accordance with its terms and applicable law. The Bylaws of the Surviving Entity shall be the Bylaws of DH, as amended and restated in the form attached as Exhibit B, until further altered, amended or repealed in accordance with its terms and applicable law.

4. **Name; Offices.** The name of the Surviving Entity shall be "[_____]".[4] The main office of the Surviving Entity shall be the main office of the DH immediately prior to the Effective Time.

5. **Directors and Officers.** Upon consummation of the Merger, the directors and corporate officers of the Surviving Entity shall be the persons set forth on Exhibit C, each holding the positions set forth opposite their names. Directors and corporate officers of the Surviving Entity shall serve for such terms as are specified in the Certificate of Incorporation and Bylaws of the Surviving Entity.

6. **Representations and Warranties; Due Diligence.**

(a) Each of the parties represents and warrants that: (i) this Agreement has been duly authorized, executed and delivered by such party and constitutes a legal, valid and binding obligation of such party, enforceable against it in accordance with the terms hereof; (ii) neither the execution and delivery, nor the performance of, this Agreement by any of the parties does or will constitute a violation of, or result in a default under, its certificates of incorporation or bylaws or any statute, law, regulation, rule, court order, decree or award applicable to it, or any contract, agreement, indenture, lease, mortgage or other instrument to which it is a party or to which any of its assets is subject; and (iii) no consent, authorization, permit or approval (whether from a governmental authority or a private entity) not already obtained or expressly contemplated by this Agreement is required on such party's part to enter into this Agreement or to carry out the transactions contemplated hereby, except for those consents, authorizations or permits with respect to which the failure to obtain would not have a material adverse effect on the business of the Surviving Entity .

[4] The Name of the Surviving Entity shall be determined prior to execution of the Agreement and Plan of Merger.

(b) Each of the parties has had the opportunity to review such agreements, documents and information of the other party as they have requested in the conduct of their mutual due diligence investigations, and each of the parties represents and warrants that there is not presently any material breach or default, nor any basis for claiming such breach or default, by it or to its knowledge any other party under the aforementioned agreements to which it is a party.

(c) Each of the parties has investigated the grants, gifts and bequests controlled by the parties to develop and implement policies and procedures to ensure that the terms of such grants, gifts and bequests are honored by the Surviving Corporation, and each of the parties represents and warrants that there is not presently any material breach or default, nor any basis for claiming such breach or default, by it or to its knowledge any other party under the aforementioned grants to which it is a party.

(d) Each of the parties represents and warrants that, to the best of its knowledge, all facts, statements and information, including but not limited to the financial information, disclosed by it during the due diligence process are true and accurate and contain no material inaccuracies or omissions.

7. **Effects of the Merger.** Upon consummation of the Merger, the Merger shall have the effect provided for in Section 33-1158 of the Connecticut Revised Nonstock Corporation Act.

8. **Additional Actions.** If, at any time after the Effective Time, the Surviving Entity shall consider that any further assignments or assurances in law or any other acts are necessary or desirable to (i) vest, perfect or confirm, of record or otherwise, in the Surviving Entity its rights, title or interest in, to or under any of the rights, properties or assets of NMH acquired or to be acquired by the Surviving Entity as a result of, or in connection with, the Merger, or (ii) otherwise carry out the purposes of this Agreement, NMH and its proper officers and directors shall be deemed to have granted to the Surviving Entity an irrevocable power of attorney to execute and deliver all such proper deeds, assignments and assurances in law and to do all acts necessary or proper to vest, perfect or confirm title to and possession of such rights, properties or assets in the Surviving Entity and otherwise to carry out the purposes of this Agreement; and the proper officers and directors of the Surviving Entity are fully authorized in the name of NMH or otherwise to take any and all such action.

9. **Counterparts.** This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original but all of which together shall constitute one agreement.

10. **Governing Law.** This Agreement shall be governed in all respects, including, but not limited to, validity, interpretation, effect and performance, by the laws of the State of Connecticut.

11. **Amendment.** This Agreement may be amended, modified or supplemented only by written agreement of DH and NMH at any time prior to the Effective Time.

12. **Waiver.** Subject to applicable law, any of the terms or conditions of this Agreement may be waived at any time by whichever of the parties hereto is entitled to the benefit thereof by action taken by the Board of Directors of such party.

13. **Successors and Assigns.** This Agreement may not be assigned by any party hereto without the prior written consent of the other party. Subject to the foregoing, this Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and permitted assigns.

14. **Termination.**

(a) This Agreement may be terminated at any time prior to the Effective Time by mutual consent of DH and NMH in a written instrument, if and to the extent authorized by the respective Boards of Directors of the DH and NMH.

(b) This Agreement may be terminated at any time prior to the Effective Time by DH, if a Material Adverse Event (as defined below) has occurred with respect to NMH. This Agreement may be terminated at any time prior to the Effective Time by NMH if a Material Adverse Event has occurred with respect to DH. "Material Adverse Event" shall herein mean any event, circumstance or change that has or might have such effect on the business, operations, prospects, financial condition or capital of a party, which would materially impair the ability of such party to perform its obligations hereunder or prevent the consummation of any of the transactions contemplated hereby.

In the event of the termination of this Agreement, this Agreement shall forthwith become null and void and of no further force or effect and there shall be no liability or obligation under this Agreement on the part of any of the parties hereto or any of their respective directors, officers or affiliates.

IN WITNESS WHEREOF, each of the parties hereto has caused this Agreement and Plan of Merger to be executed on its behalf by its duly authorized officers, all as of the date first above written.

THE DANBURY HOSPITAL

By:_____
Name:
Its:

NEW MILFORD HOSPITAL, INC.

By:_____
Name:
Its:

EXHIBIT A

CERTIFICATE OF MERGER

OF

NEW MILFORD HOSPITAL, INC.
(a Connecticut nonstock corporation)

WITH AND INTO

THE DANBURY HOSPITAL
(a Connecticut nonstock corporation)

(Under Connecticut General Statutes Section 33-1157 of the Connecticut Revised Nonstock Corporation Act)

Each of the parties to the merger hereby certifies that:

1. The names of the parties to the merger are as follows:

   (a) The Danbury Hospital, a Connecticut nonstock corporation ("DH"); and

   (b) New Milford Hospital, Inc. ("NMH"), a Connecticut nonstock corporation.

2. The name of the corporation that will survive the merger is The Danbury Hospital (the "Surviving Corporation").

3. The date on which the merger is to be effective is as of 12:01 a.m. on _____ __, 201_.

4. The Certificate of Incorporation of the Surviving Corporation is being amended as provided in Exhibit A attached hereto [to, among other things, change the name of the Surviving Corporation to "_____"].[5]

5. The Board of Directors of DH approved the plan of merger at a meeting held on _____ __, 201_, in the manner required by Sections 33-1000 to 33-1290, inclusive, of the Connecticut Revised Nonstock Corporation Act (the "Act") and the certificate of incorporation of DH, and the Board of Directors of NMH approved the plan of merger at a meeting held on _____ __, 201_, in the manner required by Sections 33-1000 to 33-1290, inclusive, of the Act, and the certificate of incorporation of NMH.

[5] The Name of the Surviving Entity shall be determined prior to execution of the Agreement and Plan of Merger.

6. The plan of merger was duly approved by Western Connecticut Health Network, Inc., as the sole member of DH and NMH, at a meeting held on _____ __, 201_, in the manner required by Sections 33-100 to 33-1290, inclusive, of the Act.

IN WITNESS WHEREOF, the parties hereto have caused this Certificate of Merger to be executed by their respective duly authorized officers as of this ___ day of _____, 201_.

THE DANBURY HOSPITAL

By:_____
Name:
Title:

NEW MILFORD HOSPITAL, INC.

By:_____
Name:
Title:

Western Connecticut Health Network
Docket No.: 13-31859-CON

EXHIBIT A

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

[The Certificate of Incorporation of the Surviving Entity shall be that of DH existing immediately prior to the Merger]

Western Connecticut Health Network
Docket No.: 13-31859-CON

EXHIBIT B

AMENDED AND RESTATED BYLAWS

[The Bylaws of the Surviving Entity shall be that of DH existing immediately prior to the Merger]

Western Connecticut Health Network
Docket No.: 13-31859-CON

EXHIBIT C

DIRECTORS AND CORPORATE OFFICERS

[The directors and corporate officers of the Surviving Entity shall be that of DH existing immediately prior to the Merger]

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 20, 2013 VIA FACISIMILE ONLY

Sally Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31859-CON
Western Connecticut Health Network, Danbury Hospital and New Milford Hospital
Certificate of Need Application Deemed Complete

Dear Ms. Herlihy,

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of December 20, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7012.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3900
RECIPIENT ADDRESS	912037391974
DESTINATION ID	
ST. TIME	12/20 12:17
TIME USE	00'39
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HERLIHY

FAX: 203.739.1974

AGENCY: NEW MILFORD HOSPITAL

FROM: OHCA

DATE: 09/20/13 Time:

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
Docket Number 13-31859

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: January 14, 2014

RE: Certificate of Need Application; Docket Number: 13-31859-CON
Western Connecticut Health Network, Danbury Hospital and New Milford Hospital
Proposing the termination of New Milford Hospital's acute care general hospital license with the Connecticut Department of Public Health and to operate it under Danbury Hospital's current acute care general hospital license.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

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

January 16, 2014

Sally Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31859-CON
Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital
The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it Under The Danbury Hospital's Current General Acute Care Hospital License

Dear Ms. Herlihy:

With the receipt of the completed Certificate of Need ("CON") application information submitted by Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital ("Applicants") on December 20, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant(s):	Western Connecticut Health Network The Danbury Hospital New Milford Hospital
Docket Number:	13-31859-CON
Proposal:	The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it under The Danbury Hospital's Current General Acute Care Hospital License with no associated capital expenditure.

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: February 5, 2014

Time: 4:00 p.m.

Place: New Milford High School
388 Danbury Road, 2nd Floor Lecture Hall
New Milford, CT 06776

The Applicant is designated as a party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in *The News Times* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Steven Lazarus, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: SWL:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

January 16, 2014 Requisition # 44288

The News Times
333 Main Street
Danbury, CT 06810

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, January 17, 2014**. Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:lmg

News Times **January 16, 2014**
Notice of Public Hearing, Docket Number 13-31859-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant(s):	Western Connecticut Health Network The Danbury Hospital New Milford Hospital
Town:	Waterbury
Docket Number:	13-31859-CON
Proposal:	The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it under The Danbury Hospital's Current General Acute Care Hospital License
Date:	February 5, 2014
Time:	4:00 p.m.
Place:	New Milford High School 388 Danbury Road, 2nd Floor Lecture Hall New Milford, CT 06776

Any person who wishes to request status in the above listed public hearing may file a written petition no later than February 1, 2014 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3932
RECIPIENT ADDRESS	912037391974
DESTINATION ID	
ST. TIME	01/17 12:37
TIME USE	01'20
PAGES SENT	5
RESULT	OK

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

FAX SHEET

TO: SALLY HERLIHY

FAX: (203) 739-1974

AGENCY: WESTERN CONNECTICUT HEALTH NETWORK, INC.

FROM: OHCA

DATE: 1/17/14

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 13-31859 CON Public Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Thursday, January 16, 2014 12:28 PM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 13-31859-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

*Consider adding **color** to your Chronicle of Higher Education print ads or upgrading to a Featured Job Banner online.*

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Thursday, January 16, 2014 12:14 PM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31859-CON

Please run the attached hearing notice in The News Times by 1/17/14. For billing purposes, refer to requisition 44288. In addition, please forward me a copy of the "proof of publication" for my records when available.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Thursday, January 16, 2014 4:42 PM
To: Greer, Leslie
Subject: FW: Hearing Notice DN: 13-31859-CON
Attachments: 13-31859p News Times.doc

Your legal notice is all set to run as follows:

Danbury News, 1/17 issue - $431.20

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Thursday, January 16, 2014 12:14 PM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31859-CON

Please run the attached hearing notice in The News Times by 1/17/14. For billing purposes, refer to requisition 44288. In addition, please forward me a copy of the "proof of publication" for my records when available.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

JAN 2 3 2014
OFFICE OF
HEALTH CARE ACCESS

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

IN RE: PROPOSAL BY WESTERN CONNECTICUT HEALTH NETWORK TO ESTABLISH A SINGLE LICENSE FOR DANBURY HOSPITAL AND NEW MILFORD HOSPITAL	:	**DOCKET NO.: 13-31859-CON**
	:	**JANUARY 23, 2014**

APPEARANCE

Please enter the appearance of the undersigned on behalf of Western Connecticut Health Network, Inc.

Respectfully submitted,

WESTERN CONNECTICUT HEALTH NETWORK, INC.

By _____

Theodore J. Tucci
Email: ttucci@rc.com
Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103-3597
Tel. No.: (860) 275-8200
Fax No.: (860) 275-8299

By _____

Brian D. Nichols
Email: bnichols@rc.com
Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103-3597
Tel. No.: (860) 275-8200
Fax No.: (860) 275-8299

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

January 24, 2014

VIA FAX ONLY

Sally Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application; Docket Number: 13-31859-CON
Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital
The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut of Department of Public Health and Operation of it Under The Danbury Hospital's Current General Acute Care Hospital License

Dear Ms. Herlihy:

The Office of Health Care Access ("OHCA") will hold a public hearing on Wednesday, February 5, 2014, at 4:00 p.m. at New Milford High School, 388 Danbury Road, 2nd Floor Lecture Hall, New Milford, regarding the Certificate of Need ("CON") application identified above. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. The Applicants' prefilled testimony must be submitted to OHCA on or before the close of business **on Friday, January 31, 2014.**

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find OHCA's attachment outlining the suggested discussion points to prepare for the hearing.

Please contact Steven W. Lazarus at (860) 418-7012, if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

ISSUES

for Public Hearing:

Certificate of Need Application, Docket Number: 13-31859-CON

Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital

The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut of Department of Public Health and Operation of it Under The Danbury Hospital's Current General Acute Care Hospital License

Please be fully prepared to discuss the following:

1. The need for The Danbury Hospital to increase its total licensed beds from 371 to 466.

2. Historical and projected licensed bed occupancy rates at both The Danbury Hospital and New Milford Hospital.

3. Provide a discussion on the efforts/plan of evaluating/determining services by location for New Milford Hospital and The Danbury Hospital.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3952
RECIPIENT ADDRESS	912037391974
DESTINATION ID	
ST. TIME	01/24 14:23
TIME USE	00'55
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HERLIHY

FAX: 203.739.1974

AGENCY: NEW MILFORD HOSPITAL

FROM: OHCA

DATE: 1/24/14 Time:

NUMBER OF PAGES: 3
(including transmittal sheet)

Comments:

Docket Number 13-31859, Request for Prefile Testimony and Issues Paper enclosed.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

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

THE NEWS-TIMES

Classified

SOUTHERNCTJOBS.COM

monster®

203-330-6556 | classified@newstimes.com | Hours: 8:30 a.m. – 5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

LEGAL NOTICE

Pursuant to Chap. 14, Secs. 1 228 & 1-229 of the CT General Statutes, as amended, the public hearings regarding the following petitions were adjourned and continued by order of the Zoning Commission of the City of Danbury to the 25th day of February 2014, to be held in the City Council Chambers at City Hall, Danbury, CT at 7:30 PM:

Petition of Caraluzzi's Danbury Market, LLC for a Special Permit for the Sale of Grocery Beer at 102 Mill Plain Rd. (#C14014).

Petition of Caraluzzi's Wine & Spirits, LLC for a Special Permit for a Package Store License at 102 Mill Plain Rd. (#C14014).

Robert C. Melillo, Chairman

LEGAL NOTICE

Notice is hereby given that the Zoning Commission of the City of Danbury will hold public hearings on January 28, 2014 commencing at 7:30 PM in the City Council Chambers, 155 Deer Hill Ave. to consider the following matters:

Petition of the City of Danbury by Dennis I. Elpern, Planning Director to Amend Sections 2.B. & 10.J. of the Zoning Regulations. (Temporary Moratorium on Applications for Medical Marijuana Dispensaries & Facilities)

Petition of Dora Minchala d/b/a La Kubanita Restaurant, 35 White St. (#I13059) For Restaurant Beer & Wine.
Petition of Plumtrees Green Wine & Liquors LLC d/b/a Warehouse Wine & Liquors, 61 (a.k.a. 63) Newtown Rd./Plumtrees Plaza (#L12018) for a Special Permit for a Package Store Permit.
Parties in interest and citizens shall have an opportunity to be heard at this time.

Robert C. Melillo, Chairman

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No.: DBD-CV-12-6010807-S -- Case Name: Wells Fargo Bank, N.A. v. Mark Azzarito, et al
Property Address: 246 Berkshire Road, Newtown, CT 06482
Property Type: Residential
Date of Sale: Saturday, January 18, 2014
Committee Name: Richard A. Smith, Esq., Committee Phone Number: 203-746-6656
See Foreclosure sales at www.jud.ct.gov for more detailed information.

REQUESTS FOR PROPOSALS
FOOD SERVICES
The Easton, Redding and Region 9 Boards of Education are hereby soliciting bids for a food service management company for the Easton, Redding & Region 9 schools. The RFP can be picked up at the board of education offices located at 654 Morehouse Rd, Easton, CT, or viewed online at www.er9.org. Bids are due back by 2 p.m. on March 3, 2014.
A voluntary pre-bid conference/walkthrough starting at Joel Barlow High School is scheduled for Feb. 5, 2014 at 2:30 p.m.

FORECLOSURE NOTICE

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No.DBD CV 12 6010382 S
Case Name: The Bank of New York Mellon fka The Bank of New York, as Trustee for the Certificateholders of CWABS, Inc., Asset-backed Certificates, Series 2007-2 vs. Harry Gorman, et al.
Property Address: 2 Parkwood Terrace Drive., Danbury, CT 06810
Property Type: Residential
Date of Sale: January 25, 2014
Committee Name: Joseph P. Secola, Secola Law Offices LLC
Committee Phone Number: 203-740-2350
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE
FORECLOSURE AUCTION SALE
DOCKET NO.: DBD CV 136012850-S
Case Caption: JPMorgan Chase Bank v Peter J. Heinsohn, et al
Property Address: 39 Berkshire Road, Sandy Hook, CT 06482
Property Type: Residential
Date of Sale: January 25, 2014
Committee Name: Christopher G. Winans, Esq.
Committee Phone: 203-748-4888 x 14
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No. DBD CV 13 6012087 S
Case Name: JPMorgan Chase Bank v. Higginson, et al
Property Address: 5 Florida Hill Road, Ridgefield, CT
Property Type: Residential
Date of Sale: January 18, 2014 at 12:00pm, Committee Name: Neil R. Marcus, Esq.
Committee Phone Number: 203-792-2771
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

PUBLIC NOTICES

LEGAL NOTICE

Pursuant to Conn. Gen. Stat. §16-19b, the Public Utilities Regulatory Authority (PURA) will conduct a reopened public hearing at Ten Franklin Square, New Britain, Connecticut, on January 24, 2014, at 1:00 p.m., concerning Docket No 13-01-30, PURA Annual Review of the Conservation Adjustment Mechanism Reconciliation Including Sales and Costs Forecasts Filed by Connecticut Natural Gas Corporation, The Southern Connecticut Gas Company and Yankee Gas Servcies Company Credits - Annual CAM Rate Effective March 1, 2013. The Authority may continue the hearing. For information and the Notice of Hearing filed with the Secretary of State's Office, contact: PUBLIC UTILITIES REGULATORY AUTHORITY, NICHOLAS E. NEELEY, ACTING EXECUTIVE SECRETARY. The Connecticut Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation contact us at (860) 418-5910 or deep.accommodations@ct.gov.

PUBLIC NOTICE
Office of Health Care Access Public Hearing

Statute Reference:
19a-638
Applicant(s): Western Connecticut Health Network
The Danbury Hospital
New Milford Hospital
Town: Waterbury
Docket Number: 13-31859-CON
Proposal: The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it under The Danbury Hospital's Current General Acute Care Hospital License
Date: February 5, 2014
Time: 4:00 p.m.
Place: New Milford High School
388 Danbury Road, 2nd Floor Lecture Hall
New Milford, CT 06776
Any person who wishes to request status in the above listed public hearing may file a written petition no later than February 1, 2014 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

FORECLOSURE NOTICE

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No. DBD CV13 6012513-S
Case Name: American Tax Funding, LLC vs. Robert L. Davis, et al.
Property Address: 77 Alpine Drive, Newtown, CT
Property Type: Residential
Date of Sale: January 18, 2014
Committee Name: Christopher PP. Norris, Esq.
Committee Phone Number: (203)748-2671
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket Number: DBD-CV13-6012725 S
Case Name: American Tax Funding, LLC vs. Catherine Elaine Yamin, et al
Property Address: 38 Black Bridge Road, Newtown, CT 06482
Property Type: Residential
Date of Sale: Saturday, January 18, 2014 @ 12:00 Noon
Committee Name: Steven M. Olivo, Esquire
Committee Phone No.: (203)792-8333
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE
FORECLOSURE AUCTION SALE
Docket No. DBD-CV11-6006898-S
PNMAC Mortgage Co LLC v. Alexander Cortez aka et. al.
Property Address: 22 Skyline Dr. Ext. aka Skyline Dr., Danbury, CT
Property Type: Residential
Date of Sale: January 25, 2014
Committee Name: Eric S. DaSilva, Esq., Committee Phone Number: (203) 270-9996
See Foreclosure Sales at www.jud.ct.gov for more information.

GENERAL HELP WANTED

ASSEMBLER
for Brookfield Mfg. Co.
Temp/FT Hours: 7:00-3:30 pm.
High School/GED,
Must speak, read & write English.
Previous exp. In Mfg. Environment required. Computer exp. required.
Contact H.R. Dept. via e-mail at:
mhendrix@trident-itw.com
or via fax at: 203-775-9660,
P: 203-740-9333, ext. 3025
We support diversity in the workplace. We are an E.O.E.

COLOR ASSISTANT So. Norwalk textile co. seeking Color Assistant to work in a production setting. Must be organized & able to work independently. Methodical work skills a must. F/T with benefits. Please Call Eileen at 203-831-9435.

CUSTOMER SERVICE Entry Level Full time Customer Service Trainee for busy Danbury office. Must be able to communicate clearly, multi-task, computer skills, and have a desire to learn. This position will require flexibility and willingness to wear many hats. E-mail resume to: customerservice@eschenbach.com or fax to (203) 744-8332.

DELIVERY DRIVER/ WAREHOUSE
Apply in person at
D&S Pump & Supply, Mon- Fri, 8-4
3784 Danbury Road. Brewster, NY.
No Calls Please!

DENTAL OFFICE
Danbury area seeks mature professionals for FT & PT
CHAIRSIDE DENTAL ASSISTANT .
Experience pref'd. Flexibility a must.
Email dental987np@yahoo.com

THE NEWS-TIMES CLASSIFIED
IS NOW OPEN FOR
PHONE CALLS...
MONDAY-FRIDAY
'TIL 5PM
FOR MORE INFO CALL
797-1414 OR
1-800-268-1441

GENERAL HELP WANTED

DRIVERS
NEWSPAPER HOME DELIVERY
PCF, Inc. is seeking Delivery Service Providers (DSPs) for newspaper home delivery routes. DSPs are independently contracted. Most routes are 7 days, 2-3 hours daily, starting around 3AM. $350-$500/bi-weekly. Routes in: Upper and Lower Fairfield County including Danbury and surrounding areas.
No $$ collections. Must be 18+.
Be sure to ask about our 2014 Winter DSP Recognition Program offering cash and other prizes.
Call 1-800-515-8000

EDUCATION- TEACHER , FT, Infant/Toddler
Must be flexible with scheduling. Must hold a current associates or bachelors degree in Early Childhood or related field 2+ yrs exp. preferred but not req'd. Center seeking NAEYC accreditation so NAEYC knowledge is a plus. CPR/FA cert. a plus but not requiered. Salary competitive and negotiable.
Please email resumes to
educationcenter@newmilfordumc.org

ELECTRICIAN- E2,
401k, retirement/health/vacation. P/T, prevailing rate, available van, Class B license. 203-748-5690 or email shockelectric81@hotmail.com

HHA/CNA'S LIVE IN/OUT
Creole & Portugese speaking helpful. Car needed. Stamford, Norwalk, Waterbury areas.
Lifeline Nursing 203-891-8243

HOTEL MAINTENACE
Danbury Area • Full Time
Knowledge of Carpentry, Plumbing, Electric, Painting, Tiling & HVAC. Good organizational & compliance skills. email **rosaria@sproviero.net**

HOUSEKEEPERS & NANNIES LIVE-IN OR OUT Throughout CT: Must be professional, 2+ yrs exp, driver's license, 2 references. $700-1000/week.
Apply at www.lifeworx.com

HVAC TECHNICIAN
S2 or D2 license required.
Neves Plumbing Service, Danbury
Call 203-790-8018

LANDSCAPE HORTICULTURIST wanted for large landscape contractor firm in Greenwich. Must have 3 yrs minimum exp. with knowledge of pruning, planting of annual flowers & property maintenance skills. Must have valid driver's lic. Email: ceci@cecibros.com

MAINTENANCE PERSON - Per diem for property management company. Knowledge of carpentry electrical plumbing & painting. Must have own tools & transportation.
Email resumes to
anthony@sproviero.net

SCHOOLS & JOB TRAINING

GENERAL HELP WANTED

MAINTENANCE
Property Management Company seeking a per–diem maintenance person for interior and exterior building repairs. Must have experience, hold a valid drivers license and own vehicle.
email resume to
sproviero@aspoviero.net
Se Habla Espanol

MANUFACTURING
Applied Laser Solutions, of Danbury CT, is a Fast paced Metal Fabrication Shop seeking additional staff. Job duties inc sanding & grinding of processed parts & weldments, sandblasting, assisting in outbound merchandise, and incoming raw materials. Must keep accurate parts count. Have ability to work independently and efficiently. Maintain cleanliness & organization of work areas. Knowledge of metal work a plus. Forklift exp mandatory. Must have High School Diploma (or equiv), reliable transportation & clean driving record. Ideal candidates will offer a strong work ethic, steady work history, ability to work overtime & be self-motivated. We offer a competitive wage & benefits program. Call 203-739-0179 for appointment M-F 8 AM-4:30 PM.

MECHANIC Oxford company seeking Class B mechanic for heavy equipment. Must have own tools, CDL helpful. Seasonal/Full-Time position. Call 203-267-6780

★★★
PATIENT COORDINATOR PART TIME
Needed in a fast-paced medical practice. Front desk responsibilities & heavy phone volume requiring the ability to multi-task. Computerized appointment scheduling experience in a medical practice required. Willingness to work in both Danbury and Southbury offices. Fax resume with salary requirements to 203-731-5499.

PERSONAL ASSISTANT
needed to organize and help. Basic computer skills needed & good with organization. Willing to pay $300 per week interested person should contact: lucypaul1111@live.com

PLUMBING MECHANIC
P2 license required.
Neves Plumbing Service, Danbury
Call 203-790-8018

RESTAURANT - NEW in Danbury has multiple positions available
MANAGER- strong people skills- Manages daily operations
WAITSTAFF - Exp a must!
Call 860-250-7407, or email saddmun1994@gmail.com

SALES REPS
High Volume Dealer
Some exp. preferred - Will train the right canidate. Leaders now earning over $100k a year.
Call Jack 203-720-5600 or walk-in 423 Rubber Ave. Naugatuck CT

TREE SERVICE/CREW FOREMAN F/T min 2 yrs experience leading general tree crew, operate chain saws, chippers, hand tools, proficient at removals, pruning, rigging, cabling/bracing. Valid drivers license. Bilingual English/Spanish a plus. Call Bob 203-869-2583.

HEALTHCARE & EMPLOYMENT OPS

BILLING STAFFER - FT, for Danbury Ophthalmology practice. Exp'd CPC only. Attractive comp pkg., 4-day wk + flex hrs.
Fax resumes to: 203-798-7048.

PSYCHIATRIC NURSE PRACTITIONER WANTED
Private Treatment Program seeks CT licensed, part time Psychiatric Nurse Practitioner. Applicant will receive strong clinical support and collaboration from the psychiatrist and clinical team and be part of a multi-disciplinary practice that is currently expanding to offer outpatient, day treatment, and residential services. Position starts at 6 hours per week and will increase to 12 hours. Please fax resume to 203-942-2693 Attn: Danielle Quinn or email dquinn@blueskybh.com

SCHOOLS & JOB TRAINING

CLASSES AVAILABLE TO LEARN
Valley Medical Institute
FREE CPR CLASS WITH ALL OUR CLASSES
NEW • PATIENT CARE TECHNICIAN IN 10 WEEKS
• CERTIFIED NURSING AIDE IN 4 WEEKS
• DENTAL ASSISTING IN 4 WEEKS
NEW • PHLEBOTOMY
NEW • EKG
DAY, EVENING & SAT. CLASSES
NEW Bridgeport Location: 4637 Main Street
The Brookside Professional Bldg.
91 Shraffts Dr., Waterbury
203-378-2210 • 1-800-886-8773
valleymedicalinstitute.com Like us on Facebook
• JOB ASSISTANCE •
EASY PAYMENT PLANS • AS LITTLE AS $150 DOWN

HEALTHCARE & EMPLOYMENT OPS

TRAINER
Female Personal Trainer Needed Part Time Position Sunday's, Tuesday and Wednesday evenings with the possibility of more hours.

Phys-Ed Health and Performance in New Milford, CT is seeking Nationally Certified Personal Trainers to join our team! Who are we looking for? A self-starter, positive, enthusiastic individual who wants to help others. We are a one of a kind, state of the art facility looking to add to our dynamic team.
Qualified individuals please email your resume to:
Valerie Walsh (Assistant GM and Personal Training Manager)
valeriew@phys-ednm.com

SCHOOLS & JOB TRAINING

TRAINING DIRECT
(203) 295-4606
3885 MAIN STREET • BPT.
Enroll Now!
Graduate in 3-4 Weeks!
Train To Become A
Certified Nurses Aide
Work in hospitals, private patient care & healthcare facilities
DAY • EVE• SAT CLASSES
TRAININGDIRECTUSA.COM

SITUATIONS WANTED

ATTENTION
The advertisers in this classification are providing a service.

CLEANING/HOUSEKEEPER & Eldery Care, Exp. hardworking Polish Lady w/ great refs. Call Maria 203-751-2772 mamuniana5@poczta.fm

CNA LOOKING to take care of your love one. At home and/or assistant living. 20 yrs exp. and references. Contact Rose 203-297-7325

HONEST CNA w/ over 10 yrs exp, avail to work weekdays, flexible overnights & weekends. Exc refs. 203-257-3105 or 203-923-8667

I AM A NURSE'S AIDE /Companion looking to care for elderly. Day or night. Friendly, licensed & exp'd w/ drivers license. Call 203-371-7611

ROSARIO BURGA House Cleaning & apartments. Dynamic, honest lady will clean your house, do your laundry & care for you pets. Lots of exp, Exc. references. Call 914-258-5371

SENIOR LADIES looking for work. Very caring. References and car. Call Mary 203-450-9503.

LOST AND FOUND

LOST PAIR of prescription eye glasses, with light pink plastic frames in Family Dollar, Main St. Danbury,CT. 203-748-2503

ABSOLUTELY FREE

FULTON, fold down to double bed. 203-744-4136

SNOW BLOWER - Craftsman 22" dual stage, 5HP, runs well but needs gear box. FREE. You pick up in Bethel. Call 203-797-8207

TREADMILL - looking for treadmill that is in great working cond. but taking up space in your house. If it is not too heavy and you live in or near Newtown please call me. I need a treadmill to keep my arthritis at bay. 203-270-9251

HEATING AND FIREWOOD

SEASONED FIREWOOD
for sale $180/cord, split and delivered. Please call Northern Tree & Construction Company
203-770-4267

SEASONED FIREWOOD
$200/per cord. 860-868-7529

GENERAL HELP WANTED

MERCHANDISE FOR SALE

2 Snowboards 4sale Liquid 149CM 5150 w/Burton FS $99 Call Mike 203-994-0683 $140

★★★
3D PUZZLE, GAMES: Scene It, Guess Hue, Harry Potter. New or like new. Prices vary. 203-270-5560.

AB LOUNGE SPORT new in box, $25 firm. 203-573-0820

ANTIQUE LINENS, box of 12 assorted small linens. $25. 203-748-2774

NEW AD!
A+ QUEEN PILLOWTOP MATTRESS,new, still in plastic. $150.00 Mike 860 601 3101

ARM CHAIR & OTTOMAN w/ adj headrest & sliding seat mech. Exc cond. $400. Call 203-258-9531.

ATTENTION
Bar Chair w/Pad; New. Originally $70; sell for $15. 203-746-0346

BED Queen Pillowtop Mattress & Boxspring. Brand New. Still in Plastic. Sacrifice $250. 203-557-0949

BEDROOM CHERRY solid sleighbed, dresser, mirror, chest, night stand. Cost $2500. Sacrifice $850. 203-557-0949

BUDWEISER MIRROR SIGN older, 14 by 27. exc. cond. $150. call 860-354-9691

BUDWEISER MIRROR sign, older, excl.cond. $150. call 860-354-9691

BUNK BED set, solid wood, never used, 65x42x81, can deliver, $195/obo . 203-510-8559.

CABINETS Glazed Maple. New, Never Installed. All Wood. Dovetail. Can add or subtract to Fit Kitchen, Cost $9000, sell $2500. Can Deliver. 203-247-9459.

CAMERA ZOOM, DAY, DATE w/x-tra battery & instruction book, $25. 203-261-5925

Cassettes Rock 70s-80s 600 total Milford 203-306-6766 $120.00

CHEST - 4 draw Chest Darker Brown. $50. 203-270-3566

CHILD'S LITTLE TYKES stand up workshop w/tools, $40. 860-354-4283

CHINA BROYHILL CABINET Oak. Great Cond. Call 203-743-3196. Part of Set.

CRYSTAL CHANDELIER from 1950's, $195. 860-354-4283

DARK PINE, PENNSYLVANIA HOUSE dining set, large china cabinet, table with 2 leafs, 2 captains chairs, 4 regular chairs, excellent condition,$700. 203-798-9393

DINING ROOM TABLE 36x48 plus two leaves dark pine, $50. call 860-354-9231

DINING TABLE Oak. Top Inlay, Great Cond. Call 203-743-3196 Part of set.

DOG CRATE, Petco, 2 door, $95. 203-743-3494

DRESSERS, set of 3, shaker solid cherry dovetail, 2 upright chests, one long chest with framed mirror, $475. 860-350-2433

DRILL BITS (FORSTNER)1"-3" and PLUMBERS EXTRACTOR KIT 1/8"-3/4", $105. 203-746-5046

DRUM SET with hardware and cymbals excellent condition, $250. 203-866-4879

ELECTRIC/ACOUSTIC GUITAR w/10 W Amp. Esteban Celestial Nights 203-746-1544 $180.00

ENTERTAINMENT CENTER Lt. oak, glass doors, dvd storage, 63"w X 57"h, well made. $75 203-417-9119

NEW AD!
GENERATOR 4400 watt 110/220 runs great, $200. call 860-354-9231

GENERAL HELP WANTED

Retail & Event Promotions
Fun work and flexible scheduling!
- Your personality and people skills = $20 + /hour
- Full training provided
- Work at a variety of retail and event locations
- Part-time – earn $350 to $600+ weekly
- Full time – earn $700+ weekly
- Vehicle and valid drivers license required
- Additional information provided @ WWW.HEADLINE-PROMO.COM

Contact Mr. Mack @ 215-904-8851

ROBINSON & COLE LLP

BRIAN D. NICHOLS

280 Trumbull Street
Hartford, CT 06103-3597
Main (860) 275-8200
Fax (860) 275-8299
bnichols@rc.com
Direct (860) 275-8354

Also admitted in Massachusetts
and District of Columbia

Via Hand Delivery

January 31, 2014

Deputy Commissioner Lisa Davis
Department of Public Health – Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Docket No.: **13-31859-CON**
Applicant: **Western Connecticut Health Network, Inc.**
Proposal: **Establish a Single License for Danbury Hospital and New Milford Hospital**

Dear Deputy Commissioner Davis:

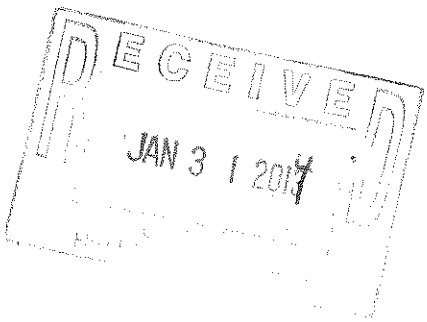
Pursuant to Section 19a-9-29(e) of the Regulations of Connecticut State Agencies, enclosed for filing in the above-captioned Docket are originals and two (2) copies of the prefiled testimony of John M. Murphy, M.D., President and CEO of Western Connecticut Health Network, Inc., and Steven H. Rosenberg, Senior Vice President and Chief Financial Officer of Western Connecticut Health Network, Inc.

Thank you for your consideration of this matter.

Respectfully,

Brian D. Nichols

Enclosures



Law Offices
BOSTON
PROVIDENCE
HARTFORD
NEW LONDON
STAMFORD
WHITE PLAINS
NEW YORK CITY
ALBANY
SARASOTA
www.rc.com

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

IN RE: PROPOSAL BY WESTERN CONNECTICUT HEALTH NETWORK TO ESTABLISH A SINGLE LICENSE FOR DANBURY HOSPITAL AND NEW MILFORD HOSPITAL	:	**DOCKET NO.: 13-31859-CON**
	:	**JANUARY 31, 2014**

PREFILED TESTIMONY
OF STEVEN H. ROSENBERG

Good afternoon Hearing Officer Hansted and Office of Health Care Access ("OHCA") staff. My name is Steven H. Rosenberg and I am the Senior Vice President and Chief Financial Officer of Western Connecticut Health Network ("WCHN"). A copy of my curriculum vitae is attached as an exhibit to this prefiled testimony.

This request to merge New Milford Hospital ("NMH") and Danbury Hospital ("DH") with one resulting general hospital license is the most fiscally responsible way for NMH to comply with ICD-10 and meaningful use requirements, since NMH's existing Meditech system would require a significant financial investment from WCHN. Moreover, the maintenance of two different information technology (IT) platforms hinders operational, financial and clinical efficiencies within WCHN.

Fiscal Responsibility

Given the time, money and effort that would be required to convert NMH's existing IT platform, the best solution to ensure NMH's compliance with ICD-10 and enable billing to occur on October 1, 2014 is to integrate NMH's system with DH's system and bill for medical services as a single licensed entity.

I want to share with you a brief description of the billing process in order to highlight the complexity of the process and the importance of operating under one license and billing number.

- There are several key fields in billing systems that are required to be separate when two hospitals have individual separate licenses. The first is the medical record number of the patient. Each hospital uses a single master medical record number for patient identification which is the basis for the legal medical records and for billing purposes. A patient would have one medical record number for DH and another for NMH. Each separate encounter within a hospital will also contain a unique account number for that patient, which is used for billing and identification of statistics for that visit. In addition, each hospital has a separate tax identification number (TIN). In billing and accounts receivable, electronic claims are submitted by each hospital using the medical record number, account number and TIN. Payer systems process claims and return electronic remittances for payment using the same three numbers as identifiers. These payments are returned to a separate "lockbox" managed for each TIN for the individual hospital before

applying the amount to specific medical record and account numbers. All statistics required for Medicare cost reporting would also be separated by hospital under two licenses.

- DH currently uses Siemens' Invision Patient Management/Patient Accounting systems for managing patient financial information. This application can only function as a "single entity" system, and cannot accommodate multiple medical record numbers for one person and cannot process claims or accounts receivable for multiple TINs. To accommodate this for two separate hospitals operating on separate licenses with separate TINs, we would need to implement as a separate organization on duplicate software and hardware.. All master tables, files, screens and coding logic would need to be rebuilt and tested. In addition, all clinical systems that are interfaced with the Patient Management and Accounting system would need to be built as a separate entity using the medical record and account numbers to process all clinical orders, results viewing, billing, and clinical documentation. This approach to achieving ICD-10 and meaningful use compliance would take approximately 1 year to build and test and would cost approximately $3.2 million of additional costs. In addition to the time delay in achieving ICD-10 compliance and the financial impact thereof, by NMH remaining separately licensed, the benefits of integrated clinical care and operations within WCHN would be hindered by continued investment in NMH's standalone system.

As referenced above, DH's existing Siemens Invision patient accounting system has limitations and can only handle a single entity on each platform. Accordingly, if WCHN moved forward with consolidation of IT systems under two licenses, a complete duplication of the Invision system would be required to accommodate the different tax identification numbers required for billing and managing accounts. The existing system required only minor modifications to accommodate NMH as part of DH's license and tax ID number. In anticipation that OHCA will consider this application favorably and to avoid delay that would make NMH achieving ICD-10 compliance on Siemens Invision impossible, preparatory work has been started to allow the IT integration process to be accomplished.

By moving the two Hospitals to a single license with a single IT platform, WCHN will avoid incurring an estimated $3.2M in additional costs and would realize an operating savings of approximately $715,000 annually, including savings associated with a reduction in redundant platforms, maintenance costs, licensing, and IT staff productivity. These savings can be realized if CON approval is granted in time for ICD-10 readiness. All systems are required to be ICD-10 ready by October 1, 2014. This will require system testing to begin in March 2014. All savings, inclusive of FTE and nonsalary savings would be achieved in the first twelve month period. If CON approval is not obtained, not only will ICD-10 compliance be at risk but meaningful use criteria will also not be met, and NMH will penalized which will further deteriorate NMH's financial position.

Licensed Beds

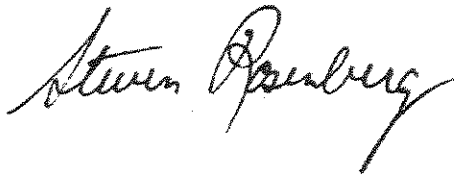
There is no intent or request to move beds as part of this CON request for a single license between NMH and DH. WCHN is not seeking to expand overall bed capacity at this time. As Dr. Murphy indicated, this will be part of WCHN's overall strategic planning, which will include

an assessment of the distribution of inpatient services for the defined service area that both DH and NMH serve.

The variables WCHN faces as an integrated healthcare delivery system, including the distribution of inpatient services across a larger geographic area, the developing impact of healthcare reform, and completion of construction of the new bed tower at DH (Docket No. 09-31490-CON, anticipated opening in midyear 2014), will ultimately factor into the analysis of the appropriate level and types of licensed beds for WCHN overall and the allocation of these licensed beds at each of our campuses. To confirm our statement in the CON application, WCHN will utilize the Connecticut Bed Need Calculation[1] methodology as part of its system-wide evaluation. We anticipate that further clarity around bed need can be achieved within the next twelve months.

As CFO of WCHN, I ask that you approve our CON request to merge NMH with DH resulting in the termination of the NMH Hospital license and the operation of the NMH facilities under the DH acute care license.

Respectfully Submitted,



Steven H. Rosenberg

[1] Connecticut Department of Public Health - Office of Health Care Access, *Statewide Healthcare Facilities and Service Plan*, October 2012, Pg. 26

CURRICULUM VITAE

Steven H. Rosenberg

Professional Experience

November 2010 – Present **Senior Vice President-Chief Financial Officer-Treasurer**
Western Connecticut Health Network

March 1987 – November 2010 **Senior Vice President and Chief Financial Officer**
Saint Francis Hospital and Medical Center - Hartford, CT

Steven H. Rosenberg is the Senior Vice President-Chief Financial Officer-Treasurer of Western Connecticut Health Network in Danbury, Connecticut. Mr. Rosenberg oversees all financial operations including patient accounting & billing, information technology, materials management, payor relations, contract management, general accounting and financial reporting, payroll, accounts payable, budget, reimbursement and decision support. Danbury Hospital is a 371-bed regional medical center and teaching hospital associated with Yale University, UConn and University of Vermont. The hospital's Centers of Excellence include: cardiovascular services, cancer, weight loss surgery, orthopedic and spine care, digestive disorders and radiology and employs approximately 2,400 FTEs.

Prior to his arrival at the Western Connecticut Health Network, Mr. Rosenberg was Senior Vice President and Chief Financial Officer for Saint Francis Hospital and Medical Center in Hartford, CT. Their health system included a hospital with 619 licensed beds; a 60-bed acute rehabilitation hospital; a faculty practice plan, (Woodland Physician Associates), which employed 110 physicians; a joint laboratory service with Bristol and St. Mary's Hospitals; and a very successful Physician Hospital Organization, which was jointly owned by physicians and the hospital.

Education

University of Connecticut
Storrs, CT
Accounting
BS 1975

University of New Haven
West Haven, CT
MBA 1980

Professional Organizations

Member, Connecticut Hospital Association Committee on Finance
Member, The Healthcare Financial Management Association

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

IN RE: PROPOSAL BY WESTERN CONNECTICUT HEALTH NETWORK TO ESTABLISH A SINGLE LICENSE FOR DANBURY HOSPITAL AND NEW MILFORD HOSPITAL	:	**DOCKET NO.: 13-31859-CON**
	:	**JANUARY 31, 2014**

PREFILED TESTIMONY
OF JOHN M. MURPHY, M.D.

Good afternoon Hearing Officer Hansted and Office of Health Care Access ("OHCA") staff. My name is John M. Murphy, M.D. and I am the President & CEO of Western Connecticut Health Network ("WCHN"). A copy of my curriculum vitae is attached as an exhibit to this prefiled testimony.

In October 2010, with Docket No. 10-31560-CON, The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH") as well as their affiliated entities became wholly owned subsidiaries of a newly formed sole member, "WCHN." The existing governing instruments of DH and NMH now provide for the same governance and the same directors for both NMH and DH. WCHN also has the same reserved powers / voting rights as to both NMH and DH. WCHN was created for the purpose of creating an integrated care delivery system for patients residing in the adjoining service areas of both NMH and DH.

WCHN is seeking your approval of our application to merge NMH into DH to allow for NMH and DH to operate under a single license with a resulting termination of NMH's acute care license and no associated capital expenditure. This consolidation is motivated by the need to bring NMH into compliance with ICD-10 and meaningful use requirements but is also a meaningful step toward improved efficiency and quality of services through integration. Implementing an appropriate infrastructure in order for NMH and DH to bill under the new, complex ICD-10 system on October 1, 2014 is of critical importance to the financial stability of NMH, and to WCHN as a system.

Our Hospitals

While WCHN understands that the merger of NMH under the DH license is technically considered a termination of NMH's licensed services, the practical reality is there will be no actual termination of any health care services at NMH as part of this CON application. Similarly, this application does not request to move beds between NMH and DH. Inclusion of NMH's 85 beds under DH's license is simply the result of joining the operations of DH and NMH under a single license. The existing bed distribution at NMH and DH is unaffected by this CON

application, except that the two campuses will now function under one license, with one tax identification number.

Our Mission

The merger of NMH and DH under a single license is consistent with WCHN's mission to operate its healthcare system in a manner that is both cost efficient and promotes delivery of high quality healthcare. This mission requires WCHN to constantly evaluate the appropriate distribution of services across our system, continually mindful of community needs, demographics, patient convenience, technology, and physician preference.

The consolidation of licensure for NMH and DH and the resulting transfer of NMH approved beds under DH's license is a logical step in the ongoing planning process for the integration of care within the WCHN system. WCHN is committed to a careful analysis and planning process that must necessarily take into account our patient population, physician mix, travel times and other access issues in formulating a proposed strategy for the long-term viability of NMH. This process is among the highest priorities for WCHN in the coming year, and we are committed to working with OHCA to obtain approval for any future changes in bed capacity and clinical services that may be warranted after careful study. We are committed to providing the most appropriate health care at the NMH campus, as evidenced by our submission of CONs over the past three years for the closure of the NMH Family Birthing Center, the termination of NMH PET CT services and the replacement of the simulator technology in the NMH Diebold Family Cancer Center. Our comprehensive analysis of the needs of the communities served by NMH and DH will arrive at specific conclusions regarding the most appropriate services to be provided at NMH (other than those resulting in the CON requests described above), however that has not yet been reached. It would be premature to make changes affecting the future of NMH in a vacuum, without assessing the role of NMH and the needs of the community served by NMH within the framework of the entire WCHN health system. Such changes would diminish WCHN's flexibility to manage and deploy services in the locations that make the most sense.

Efficiencies and Economies of Scale

The ability to achieve synergies in activities, maintain and enhance quality, and realize cost-savings by streamlining operations has become a paramount concern for all hospitals. Government and commercial reimbursement rates have not kept pace with operating expenses and hospitals are constantly seeking efficiencies to remain financially viable. This pressure has been compounded by the reduction in reimbursement payments to hospitals this past fall as part of its fiscal 2014 budget; which will result in WCHN experiencing a $30M cut over the next two years. The reductions in revenue are compounded by increases in costs associated with compliance with regulatory requirements such as ICD-10 and the Accountable Care Act.

In order to advance its mission to offer accessible and affordable care delivered by dedicated, quality medical professional, WCHN must carefully scrutinize its operations to find any opportunity to operate more efficiently to preserve this mission. Pursuing a single license is one means of addressing the need for cost reduction while, at the time, improving the quality of care provided to all of WCHN's patients through clinical, financial and operational integration. The

immediate effect of a single license would be cost-avoidance related to a necessary one-time upgrade and testing of NMH's Meditech IT platform that is not compliant with ICD-10 requirements. To avoid paying more than is necessary for this upgrade, the two Hospitals must move to a single license with a single IT platform.

In this era of health care reform and the associated transformation that is underway, we believe the proposed single license between NMH and DH furthers the objectives outlined in the Statewide Health Care Facilities and Services Plan, specifically to "improve the health of Connecticut residents, increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services." The determination to operate the NMH and DH campuses under a single license supports our delivery of one standard of high-quality cost-effective care across the network; benefits of single license include:

- Creation of a shared medical record. Information will seamlessly be shared across the two hospitals without the inefficiencies of duplicative efforts (CMS requires separate medical records for separate CMS Certification Numbers (CCN).
- One standard of care across the two hospitals through combined Joint Commission accreditation and compliance with CMS Conditions of Participation and Connecticut Department of Public Health licensure requirements.
- Increased coordination of care with all clinicians working off of the same admit information, med/allergy lists, care plans.
- One medical staff to more effectively coordinate care and more efficient performance of Quality Assurance and Peer Review through seamless access to information from both campuses.
- Increased ability to perform quality analytics through patient data housed in the same database.
- Efficiencies in Value Based Purchasing (VBP) data abstraction, by avoiding cumbersome searches of records both in different formats and across fragmented sites.

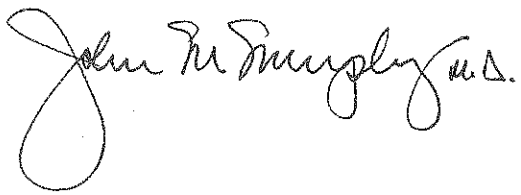
Summary

To conclude, I want to reiterate the importance of this application to WCHN's mission. We are committed to serving our communities with high quality, accessible care. Our commitment to the New Milford community reaches beyond just bricks and mortar. We look at how to serve our patients' healthcare needs effectively no matter where they may have or what service they may need. And we listen to every voice, opinion, comment and concern. We are committed to improving the health of our area one person at a time.

Our application materials submitted previously and the testimony offered today outline a careful planning process, which has led WCHN to request OHCA's approval to strengthen our infrastructure and operate our two hospitals under one license.

I am happy to answer any questions that you may have now or at the end of the remaining presentations.

Respectfully Submitted,



John M. Murphy, M.D.

CURRICULUM VITAE

JOHN M. MURPHY, M.D.

Professional Experience

Western Connecticut Health Network **July 2010 - PRESENT**
President & Chief Executive Officer

Responsible for direction of core strategic programs, objectives and the enhancement of operational excellence, growth and financial performance of the $750M integrated delivery network. Work in collaboration with physician and nursing leadership to align operational areas to support quality care, patient safety and service excellence initiatives of Danbury Hospital, New Milford Hospital, Western Connecticut Medical Group, Western Connecticut Home Care and associated subsidiaries and the surrounding communities

Danbury Health Systems, Danbury, CT **July 2008 – June 2010**
Executive Vice President (President /CEO Designee)

As a senior member of the management team, was responsible for the direction of core strategic programs and objectives. Worked closely with the retiring President/CEO during this transition period on all aspects of the hospital's core strategic goals to ensure a smooth transition.

Associated Neurologists, P.C., Danbury, CT **1989- 2008**
Clinical neurologist with a particular interest in stroke, MS, and neurodegenerative disorders. I was active both clinically as well as administratively serving as the president of the group for 18 years and actively expanded the group to include clinical research, neurophysiology, neuropsychology and infusion therapy. In addition I was active in clinical research and both undergraduate as well as graduate medical education.

EDUCATION:

Fordham University, Bronx, NY
Major: Biology
Summa cum Laude (G.P.A. 4.0)
B.S., May 1981

UMDNJ -Rutgers Medical School
Piscataway, NJ
M.D., May 1985

MEDICAL TRAINING:

1985-1986: Internship, Internal Medicine
UMDNJ-Rutgers Medical School
Middlesex General University Hospital
New Brunswick, NJ

1986-1988: Resident in Neurology
UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

1988-1989: Chief Resident in Neurology
UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

MEDICAL LICENSURE: Connecticut
New Jersey

DIPLOMATE: National Board of Medical Examiners
American Board of Psychiatry and Neurology

HONORS & AWARDS:

1980	Rhodes Scholarship Candidate
1981	Graduated Summa Cum Laude, Fordham University
1985	Alpha Omega Alpha National Medical Honor Society
1986	Intern of the Year Award, Middlesex General University Hospital
1995	Recipient of the Melville G. Magida Award for "Demonstrated Notable Capability in Patient Treatment and Care". Presented jointly by the Fairfield County Medical Association and the Richard and Hinda Rosenthal Foundation.
	Listed in Connecticut Magazine's "Best Doctors in Connecticut"
	Listed in "Best Doctors in New York Metropolitan Area"
	Listed in New York Magazine's "Best Doctors in New York"
	Listed in "Best Doctors in America"
2011	Entrepreneur of the Year Award – Western Connecticut State University

MEMBERSHIPS: American Heart Association, Council on Stroke
American Academy of Neurology
Connecticut State Medical Society

Connecticut State Neurological Society
The Movement Disorder Society
Fairfield County Medical Society
Fairfield County Neurology Society
Parkinson's Study Group (PSG)

APPOINTMENTS:

Attending Neurologist, Danbury Hospital
Danbury, CT.
1989-Present

American Heart Association, Connecticut Affiliate
Statewide Stroke Task Force
1993-1995

Consultant in Neurology
Southbury Training School, Southbury, CT.
1990-2008

Treasurer, Connecticut State Neurological Society
1993-2010

Fellow, American Academy of Neurology

Clinical Assistant Professor of Neurology
New York Medical College
1994-Present

Executive Committee, Danbury Hospital
1992-2001

Board of Directors, Danbury Hospital and Danbury Health Systems
1995-2008

Medical Affairs Committee
Danbury Hospital Board of Directors
1997-2000

Governance Committee
Danbury Health Systems Board of Directors
2003-2008

President of the Medical Staff, Danbury Hospital
1998- 2000

Board of Trustees, Connecticut Hospital Association
2000

Danbury Health Systems & Danbury Hospital,
Vice Chairman, Board of Directors, 2003-2005

Danbury Hospital & Danbury Health Systems, Inc
Chairman, Board of Directors,
2005-2008

Union Savings Bank
Board of Trustees
2006-Present

RESEARCH:

Investigator, "A Treatment IND (Investigational New Drug) Protocol for the Use of Cognex® (Tacrine Hydrochloride) for the Management of Patients with Mild to Moderate Alzheimer's Dementia" 1993

Investigator, "A Double Blind, Randomized, Placebo-Controlled Study to Determine the Effectiveness and Safety of Migramist™ (Dihydroergotamine Mesylate Nasal Spray) for the Acute Treatment of Migraine Headache With or Without Aura in Migraineur Families." 1994-1995

Co-Investigator, "A Placebo-Controlled Study to Determine the Effects of 500 mg., 1000 mg., and 2000 mg., Citicoline in Ischemic Stroke Patients" (Protocol #IP302-001A) 1995

Co-Investigator, "The Clomethiazole Acute Stroke Study in t-PA Treated Ischemic Stroke (CLASS-T): A double blind, parallel group, multinational, multicenter study of safety of i.v. clomethiazole compared to placebo in patients treated with t-PA (tissue plasminogen activator) for acute ischemic stroke. 1997

Principal Investigator, "A prospective, randomized, parallel-group, double-blind, placebo-controlled, multi-center study to evaluate the short-term efficacy and safety of entacapone administered together with levodopa in subjects with Parkinson's Disease without motor fluctuations." 1998-2000

Co-Investigator, "Pregabalin BID Add-On Trial: A Randomized, Double-Blind, Placebo-Controlled, Parallel Group, Multicenter Study in Patients With Partial Seizures (Protocol 1008-034)." 1998

Co-Investigator, "Topamax Monotherapy Comparison Trial to Standard Monotherapy in the Treatment of Newly Diagnosed Epilepsy. Protocol TOPMAT-EPMN-105. Phase IIIb." 1998

Principal Investigator, "An open label study to evaluate the long-term safety and effectiveness of subcutaneous apomorphine in the treatment of "off" episodes in patients with "on-off" or "wearing-off" effects associated with late-stage Parkinson's Disease." 2000

Principal Investigator, " A multicenter, double-blind, placebo-controlled study to assess the tolerability and effect of entacapone on the quality of life in Parkinson's Disease patients treated with levodopa/carbidopa experiencing end-of-dose wearing off." 2000

Principal Investigator, "A multicenter, randomized, double-blind, placebo-controlled study of three fixed doses of aripiprazole in the treatment of psychosis in patients with Parkinson's Disease." 2001

Principal Investigator, "A prospective, randomized, placebo-controlled, parallel groups study of the continued efficacy and safety of subcutaneous injections of apomorphine in the treatment of "off" episodes in patients with "on/off" or "wearing-off" effects associated with late-stage Parkinson's Disease after apomorphine use for at least a three month duration." 2001

Principal Investigator, "A multicenter, multinational, phase III randomized, double blind, placebo-controlled trial of the efficacy and safety of the rotigotine CDS patch in subjects with early stage, idiopathic Parkinson's disease (Part I) and open-label extension to assess the safety of long-term treatment of rotigotine CDS (Part II)." 2001

Principal Investigator, "A multicenter, multinational, phase III randomized, double blind, placebo-controlled trial of the efficacy and safety of the rotigotine CDS patch in subjects with advanced stage idiopathic Parkinson's disease who are not well controlled on levodopa (Part I) and open-label extension to assess the safety of long-term treatment of rotigotine CDS (Part II)." 2002

Principal Investigator, "A Phase II, multi-center, randomized, double-blind, placebo-controlled, parallel-group, 2-year study to evaluate the effects of GPI 1485 on SPECT scanning and clinical efficacy in symptomatic Parkinson's disease receiving dopamine agonist therapy". 2002

Principal Investigator, "A Phase II fourteen-week placebo-controlled dose-response efficacy and safety study of NS 2330 in early Parkinson's disease patients (Study for Proof of Concept in Early

Parkinson's Disease of a Triple Reuptake Inhibitor, NS 2330/SCEPTRE)" 2003

Principal Investigator, "A 12 week, double-blind, placebo controlled, parallel group study to assess the efficacy and safety of ropinorole in patients suffering from Restless Legs Syndrome (RLS) 101468/249." 2003

Principal Investigator, "A Phase II double-blind, randomized dose-ranging, placebo-controlled, multicenter safety and efficacy evaluation of three doses of NS 2330 in patients with mild to moderate Dementia of the Alzheimer's Type." 2003

Principal Investigator, "A double-blind, placebo-controlled, multicenter, multinational Phase II study to evaluate the safety and efficacy of Sarizotan HCL 1 mg. b.i.d. in patients with Parkinson's disease suffering from treatment-associated dyskinesia (PADDY1)." 2004

Sub-Investigator, "A Phase 2, Multi-Center, Single-Arm, Open-Label Study to Evaluate the Safety and Efficacy of GPI 1485 (1000 mg QID) in Symptomatic Parkinson's Disease Patients." 2004

Principal Investigator, "A Phase 2, multicenter, placebo-controlled, double blind trial of ACP-103 in the treatment of Psychosis in Parkinson's Disease." 2004

Principal Investigator; "An open-label safety study of ACP-103 in Parkinson's Disease patients." 2005

Principal Investigator, "An open-label, multicenter, multinational Phase III follow-up study to investigate the long-term safety and efficacy of Sarizotan HCl 1 mg b.i.d. in patients with Parkinson's disease suffering from treatment-associated dyskinesia (PADDY 0)." 2005

Principal Investigator, "A multi-center, double-blind, randomized start, placebo-controlled, parallel-group study to assess the effect of rasagaline mesylate on disease progression in early Parkinson's Disease patients." 2005

"A two year phase IIIb randomized, multicenter, double-blind, Sinemet-controlled, parallel group, flexible dose study, to assess the effectiveness of controlled release ropinorole add-on therapy to L-dopa at increasing the time to onset of dyskinesias in Parkinson's disease subjects." 2005

Principal Investigator, "Compass1: A study to assess the sensitivity and specificity of the wearing- off questionnaire-9." 2005

Principal Investigator, "A multi-center, double-blind, placebo-controlled, parallel-group study to assess rasagaline as a disease modifying therapy in early parkinson's disease subjects." 2005

Prinicipal Investigator, "A multi-center, double-blind, placebo-controlled, parallel-group study of the efficacy, safety, and tolerability of E2007 in levodopa treated Parkinson's Disease patients with motor fluctuations." 2006

Principal Investigator, "A cross- sectional, retrospective screening and case-control study examining the frequency of, and risk factors associated with, impulse control disorders in Parkinson's disease patients treated with MIRAPEX® (pramipexole) and other anti-parkinson agents (DOMINION Study)." 2006

Principal Investigator, "A randomized, double-blind, active (pramipexole 0.5 mg tid) and placebo controlled efficacy study of pramipexole given 0.5 mg and 0.75 mg bid over a 12-week treatment phase in early Parkinson's disease patients (PramiBID)." 2006

Prinicipal Investigator, "A multi-center,open label extension study to evaluate the long-term safety, tolerability and efficacy of E2007 as an adjunctive therapy in levodopa treated Parkinson's Disease patients with motor fluctuations." 2007

Principal Investigator, "A multi-center, placebo-controlled, double-blind trial to examine the safety and eEfficacy of ACP-103 in the Treatment of Psychosis in Parkinson's Disease." 2007

Principal Investigator, "A multi-center,open-label extension study to examine the safety and tolerability of ACP-103 in the treatment of psychosis in Parkinson's Disease." 2007

Principal Investigator, "A double-blind, double-dummy, placebo-controlled, randomized, three parallel groups study comparing the Efficacy, Safety and Tolerability of Pramipexole ER versus placebo and vesus Pramipexole IR administered orally over a 26-week maintenance phase in patients with early Parkinson's disease (PD)." 2007

Principal Investigator, "Long-term safety study of open-label pramipexole extended release (ER) in patients with early Parkinson's disease (PD)." 2007

PUBLICATIONS:

Murphy JM., Sage JI. Trimethaphan or Nitroprusside in the Setting of Intracranial Hypertension.
Clinical Neuropharmacology 1988; 11(5): 436-442.

Murphy JM., Mashman J., Miller J., Bell J.
Suppression of Carbamazepine-Induced Rash with Prednisone.
Neurology 1991; 41:436-442.

Murphy JM., Motiwala R., Devinsky O. Phenytoin Intoxication.
Southern Medical Journal 1991; 84(10): 1199-1204.

Murphy JM., Meyer S., Hurley E., Preston L., Culligan N.
Transcranial Doppler and Stroke Outcome
Connecticut Medicine 1995; 59 (10): 610-611.

Syed N, Murphy J, Zimmerman T, Mark M, Sage J.
Ten Years' Experience with Enteral Levodopa Infusions for Motor Fluctuations in Parkinson's Disease.
Movement Disorders 1998; 13(2): 336-338.

Garzon R, Murphy JM. Acute Bulbar Dysfunction in Hyperthyroidism. **Connecticut Medicine** 2002; 66(1) 3-6.

Jennings DL, Seibyl JP, Murphy JM, Marek K. β-CIT/SPECT vs. Clinical Examination in Parkinsonian syndrome: Unmasking an Early Diagnosis. **Movement Disorders** 2002; Vol. 17, Suppl 5, P521.

Jennings DL, Seibyl JP, Oakes D, Eberly S, Murphy J, Marek K, ^{123}β-CIT and Single-Photon Emission Computed Tomographic Imaging vs Clinical Evaluation in Parkinsonian Syndrome. **Arch Neurology** 2004; 61:1224-1229.

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

February 4, 2014

Sally Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31859-CON
Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital
The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it Under The Danbury Hospital's Current General Acute Care Hospital License

Dear Ms. Herlihy:

Due to inclement weather expected on February 5, 2014, the Office of Health Care Access ("OHCA") is rescheduling the hearing, which was originally scheduled for February 5, 2014, to February 19, 2014. Please see details below.

With the receipt of the completed Certificate of Need ("CON") application information submitted by Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital ("Applicants") on December 20, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant(s): Western Connecticut Health Network
The Danbury Hospital
New Milford Hospital

Docket Number: 13-31859-CON

Proposal: The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it under The Danbury Hospital's Current General Acute Care Hospital License with no associated capital expenditure.

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: February 19, 2014 (Rescheduled from February 5, 2014)

Time: 4:00 p.m.

Place: New Milford High School
388 Danbury Road, 2nd Floor Lecture Hall
New Milford, CT 06776

The Applicant is designated as a party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The News Times* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Steven Lazarus, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: SWL:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

February 4, 2014 Requisition # 44464

The News Times
333 Main Street
Danbury, CT 06810

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, February 5, 2014**. Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:lmg

News Times **February 4, 2014**
Notice of Public Hearing, Docket Number 13-31859-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant(s):	Western Connecticut Health Network The Danbury Hospital New Milford Hospital
Town:	New Milford
Docket Number:	13-31859-CON
Proposal:	The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it under The Danbury Hospital's Current General Acute Care Hospital License
Date:	February 19, 2014 (Rescheduled from February 5, 2014)
Time:	4:00 p.m.
Place:	New Milford High School 388 Danbury Road, 2nd Floor Lecture Hall New Milford, CT 06776

Any person who wishes to request status in the above listed public hearing may file a written petition no later than February 14, 2014 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Tuesday, February 04, 2014 10:58 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 13-31859-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

*Consider adding **color** to your Chronicle of Higher Education print ads or upgrading to a Featured Job Banner online.*

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Tuesday, February 4, 2014 10:13 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31859-CON

Please run the attached hearing notice in the News Times by 2/5/14. For billing purposes, please reference requisition 44464. In addition, please forward me a copy of the "proof of publications" for my records.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

* * * COMMUNICATION RESULT REPORT (FEB. 4. 2014 2:35PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FEB. 4. 2014 2:34PM

FILE MODE	OPTION	ADDRESS	RESULT	PAGE
052 MEMORY TX		912037391974	OK	5/5

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

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

FAX SHEET

TO: SALLY HERILHY

FAX: (203) 739-1974

AGENCY: WESTERN CT HEALTH NETWORK, INC.

FROM: STEVEN LAZARUS

DATE: 2/4/14

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 13-31859-CON Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

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

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Tuesday, February 04, 2014 4:06 PM
To: Greer, Leslie
Subject: FW: Hearing Notice DN: 13-31859-CON
Attachments: 13-31859p News Times rescheduled.doc

Your legal notice is all set to run as follows:

Danbury News, 2/5 issue - $535.92

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Tuesday, February 4, 2014 10:13 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31859-CON

Please run the attached hearing notice in the News Times by 2/5/14. For billing purposes, please reference requisition 44464. In addition, please forward me a copy of the "proof of publications" for my records.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

* * * COMMUNICATION RESULT REPORT (FEB. 18. 2014 12:05PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FEB. 18. 2014 12:01PM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
080 MEMORY TX		98602758299	OK	10/10

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

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

FAX SHEET

TO: BRIAN D. NICHOLS

FAX: (860) 275-8299

AGENCY:

FROM: OHCA

DATE: 2/18/14 **Time:**

NUMBER OF PAGES: 9 *(including transmittal sheet*

Comments: Docket Number 13-31859, information for tomorrow's hearing to be held in New Milford

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT(S): **Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital**

DOCKET NUMBER: **13-31859-CON**

PUBLIC HEARING: **February 19, 2014 at4:00 pm (rescheduled from February 5, 2014)**

PLACE: **New Milford High School, 388 Danbury Road, 2nd Floor Lecture Hall, New Milford, CT**

EXHIBIT	DESCRIPTION
A	Letter from the **Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital ("Applicant")** dated August 12, 2013, enclosing the CON application under Docket Number 13-31859, received by OHCA on August 12, 2013.(48 pages)
B	OHCA's letter to the Applicant dated September 13, 2013, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31859. (4 pages)
C	Applicant's responses to OHCA's letter of September 13, 2013, dated November 12, 2013, in the matter of the CON application under Docket Number 13-31859, received by OHCA on November 12, 2013. (35 pages)
D	OHCA's letter to the Applicant dated December 20, 2013 deeming the application complete in the matter of the CON application under Docket Number 13-31859. (1 page)
E	Designation letter dated January 14, 2014 designating Keven Hansted as hearing officer in the matter of the CON application under Docket Number 13-31859. (1 page)
F	OHCA's request for legal notification in *The News Times* and OHCA's Notice to the Applicant of the public hearing scheduled for February 5, 2014, in the matter of the CON application under Docket Number 13-31859, dated January 16, 2014. (4 pages)
G	Applicants letter to OHCA dated January 23, 2014 noticing the appearance of attorneys Thodore J. Tucci and Brian D. Nichols of Robinson & cole LLP in the matter of the CON application under Docket Number 13-31859, received by OHCA on January 23, 2014. (1 page)

H	OHCA's letter to the Applicant dated January 24, 2014, requesting prefile testimony in the matter of the CON application under Docket Number 13-31859.
I	Letter from the Applicant enclosing Prefile Testimony dated January 31, 2014 in the matter of the CON application under Docket Number 13-31859, received by OHCA on January 31, 2014. (17 pages)
J	OHCA's request for legal notification in *The News Times* and OHCA's Notice to the Applicant of the public hearing scheduled for February 19, 2014, in the matter of the CON application under Docket Number 13-31859, dated February 4, 2014. (4 pages)

Administrative Notice is taken of the following:

Exhibit 1: Appendices 1 through V from 2013 Health Care Utilization Report by OHCA/DPH.

Exhibit 2: Norwalk Community Health Assessment.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31859-CON

Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital

The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and Operation of it Under The Danbury Hospital's Current General Acute Care Hospital License

February 19, 2014, at 4:00 p.m.
(rescheduled from February 5, 2014)

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (15 minutes)

III. OHCA's Questions

IV. Public Comment

V. Closing Remarks

VI. Public Hearing Adjourned

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

For this hearing, there will be two (2) OHCA exhibits:

OHCA Exhibit 1: Appendices I through V from 2013 Health Care Utilization Report by OHCA/DPH (Enclosed)

OHCA Exhibit 2: Norwalk Community Health Assessment, see the link below, and OHCA will provide a paper copy to the Applicants at the public hearing.

http://www.northwestunitedway.org/sites/northwestunitedway.org/files/CTG%20LC%20CHNA%20SECTIONS%201-6%20FINAL%2011%2021%2012.pdf

OHCA Exhibit 1

Appendix I: Connecticut Acute Care Hospitals, FY 2012

Hospital Name	Affiliation/Parent Corporation	Town	County	Teaching[1]	Licensed Beds[2]	Available Beds[3]	Staffed Beds[4]
Backus (William W.)	Backus Corporation	Norwich	New London		233	233	201
Bridgeport	Yale-New Haven Health Services Corporation	Bridgeport	Fairfield	√	383	371	281
Bristol	Bristol Hospital & Health Care Group	Bristol	Hartford		154	154	132
Charlotte Hungerford	Charlotte Hungerford Hospital	Torrington	Litchfield		122	122	75
CT Children's Medical	CCMC Corporation, Inc.	Hartford	Hartford	√	187	187	182
Danbury	Danbury Health Systems, Inc.	Danbury	Fairfield	√	371	371	265
Day Kimball	Day Kimball Healthcare Inc., d/b/a Day Kimball Hospital	Putnam	Windham		122	122	65
Essent - Sharon	Essent Healthcare Inc.	Sharon	Litchfield		94	94	49
Greenwich	Yale-New Haven Health Services Corporation	Greenwich	Fairfield	√	206	206	206
Griffin	Griffin Health Services Corporation	Derby	New Haven	√	180	180	82
Hartford	Hartford Health Care Corporation	Hartford	Hartford	√	867	802	667
Hospital of Central CT	Central Connecticut Health Alliance	New Britain	Hartford	√	446	383	356
John Dempsey	University of Connecticut Health Center	Farmington	Hartford	√	234	234	184
Johnson Memorial	Johnson Memorial Corporation	Stafford	Tolland		101	95	72
Lawrence & Memorial	Lawrence & Memorial Corporation	New London	New London	√	308	256	256
Manchester Memorial	Eastern Connecticut Health Network, Inc.	Manchester	Hartford		283	283	171
Middlesex Memorial	Middlesex Health System, Inc.	Middletown	Middlesex	√	297	260	183
MidState Medical	Hartford Health Care Corporation	Meriden	New Haven		156	156	144
Milford	Milford Health and Medical Incorporated	Milford	New Haven		118	118	47
New Milford	New Milford Hospital, Inc.	New Milford	Litchfield		95	95	27
Norwalk	Norwalk Health Services Corporation	Norwalk	Fairfield	√	366	320	193
Rockville General	Eastern Connecticut Health Network, Inc.	Vernon	Tolland		118	118	47
St. Francis	Saint Francis Care, Inc.	Hartford	Hartford	√	682	595	595
St. Mary's	Saint Mary's Health System, Inc.	Waterbury	New Haven	√	379	182	182
St. Vincent's	St. Vincent's Health Services Corporation	Bridgeport	Fairfield	√	520	456	456
Stamford	Stamford Health System	Stamford	Fairfield	√	330	325	267
Waterbury	Greater Waterbury Health Network	Waterbury	New Haven	√	393	280	190
Windham Community	Windham Community Memorial Hospital	Willimantic	Windham		144	144	87
Yale-New Haven[5]	Yale-New Haven Health Services Corporation	New Haven	New Haven	√	1,541	1,468	1,213
Statewide				**17**	**9,430**	**8,610**	**6,875**

Source: CT Department of Public Health Division of Office of Health Care Access Hospital Reporting System Report 400

[1]Teaching hospitals are hospitals that received payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year that information is available.

[2]The number of licensed beds and newborn bassinets listed on the hospital's Connecticut Department of Public Health (DPH) license on the last day of the fiscal year.

[3]The number of beds in service in nursing units that could be occupied by patients during the fiscal year.

[4]The average number of beds with sufficient staff occupied by patients during the fiscal year.

[5]Yale-New Haven Hospital acquired the Hospital of Saint Raphael on September 12, 2012 - totals include Saint Raphael's 533 licensed, 467 available and 354 staffed beds

Appendix II: Acute Care Hospital Bed Occupancy Rates-FYs 2010-2012

Hospital	2010					2011					2012				
	Patient Days	Beds		Occupancy Rate		Patient Days	Beds		Occupancy Rate		Patient Days	Beds		Occupancy Rate	
		Available	Staffed	Available	Staffed		Available	Staffed	Available	Staffed		Available	Staffed	Available	Staffed
Backus (William W.)	49,262	233	202	58%	67%	49,655	233	202	58%	67%	49,102	233	201	58%	67%
Bridgeport	104,936	397	290	72%	99%	105,010	406	289	71%	100%	101,436	371	281	75%	99%
Bristol	30,753	154	132	55%	64%	28,388	154	132	51%	59%	29,230	154	132	52%	61%
Charlotte Hungerford	28,103	122	81	63%	95%	27,465	122	81	62%	93%	25,210	122	75	57%	92%
CT Children's Medical Center	36,312	147	142	68%	70%	36,823	187	182	54%	55%	45,043	187	182	66%	68%
Danbury	95,142	365	278	71%	94%	96,560	371	286	71%	92%	91,875	371	265	68%	95%
Day Kimball	18,901	122	72	42%	72%	18,536	122	72	42%	71%	18,509	122	65	42%	78%
Essent - Sharon	11,624	94	47	34%	68%	12,353	94	49	36%	69%	11,818	94	49	34%	66%
Greenwich	52,678	206	206	70%	70%	52,774	206	206	70%	70%	46,444	206	206	62%	62%
Griffin	32,791	180	94	50%	96%	30,867	180	89	47%	95%	28,713	180	82	44%	96%
Hartford	219,730	760	630	79%	96%	222,710	796	640	77%	95%	232,399	802	667	79%	95%
Hospital of Central CT	81,939	356	341	63%	66%	83,163	383	356	59%	64%	76,333	383	356	55%	59%
John Dempsey	51,251	224	145	63%	97%	51,623	224	150	63%	94%	40,291	234	184	47%	60%
Johnson Memorial	17,698	95	72	51%	67%	15,609	95	72	45%	59%	16,228	95	72	47%	62%
Lawrence & Memorial	71,297	256	256	76%	76%	73,942	256	256	79%	79%	71,050	256	256	76%	76%
Manchester Memorial	44,029	283	140	43%	86%	43,501	283	171	42%	70%	45,098	283	171	44%	72%
Middlesex Memorial	55,808	214	178	71%	86%	57,496	248	183	64%	86%	57,063	260	183	60%	85%
MidState Medical	42,216	156	142	74%	81%	44,688	156	144	78%	85%	42,711	156	144	75%	81%
Milford	17,708	118	51	41%	95%	17,086	118	49	40%	96%	14,426	118	47	33%	84%
New Milford	9,346	95	30	27%	85%	9,378	95	29	27%	89%	8,566	95	27	25%	87%
Norwalk	70,058	312	194	62%	99%	70,411	312	196	62%	98%	67,464	320	193	58%	96%
Rockville General	14,136	118	66	33%	59%	12,278	118	66	29%	51%	13,128	118	47	30%	77%
St. Francis	154,831	593	593	72%	72%	158,020	595	595	73%	73%	157,137	595	595	72%	72%
St. Mary's	52,663	181	181	80%	80%	56,034	181	179	85%	86%	51,511	182	182	78%	78%
St. Raphael[1]	125,113	489	364	70%	94%	122,630	489	369	69%	91%	NA	NA	NA	NA	NA
St Vincent's	123,691	423	423	80%	80%	123,317	423	423	80%	80%	122,834	456	456	74%	74%
Stamford	76,488	322	269	65%	78%	75,041	322	271	64%	76%	70,198	325	267	59%	72%
Waterbury	59,698	292	192	56%	85%	58,933	284	190	57%	85%	57,490	280	190	56%	83%
Windham Community	20,865	144	87	40%	66%	20,001	144	87	38%	63%	18,674	144	87	36%	59%
Yale-New Haven[2]	284,667	919	871	85%	90%	299,973	918	827	90%	99%	415,905	1,468	1,213	78%	94%
Total	**2,053,724**	**8,370**	**6,769**	**67%**	**83%**	**2,074,265**	**8,515**	**6,841**	**67%**	**83%**	**2,025,886**	**8,610**	**6,875**	**64%**	**81%**

Source: CT Department of Public Health Office of Health Care Access Acute Care Discharge Database and Hospital Reporting System Report 400

[1]Saint Raphael acquired by Yale-New Haven Hospital on September 12, 2012

[2]Totals include 104,600 patient days, 467 available and 354 staffed beds reported by the Hospital of Saint Raphael

Appendix III: Connecticut Acute Care Hospital Staffed Beds by Service, FY 2012

Hospital Name	Adult Medical or Surgical	ICU/CCU	Psychiatric	Maternity	Newborn	Neonatal ICU	Rehabilitation	Pediatric	Other	Total
Backus (William W.)	138	12	18	15	18					**201**
Bridgeport	186	19	17	23	14	4	15	3		**281**
Bristol	78	14	14	15	8			3		**132**
Charlotte Hungerford	50	6	12	3	3			1		**75**
CT Children's Medical		18				72		92		**182**
Danbury	175	12	20	18	13	12	12	3		**265**
Day Kimball	36	6	13	5	5					**65**
Essent - Sharon	22	7	12	4	4					**49**
Greenwich	129	10		25	22	10		10		**206**
Griffin	55	7	10	5	5					**82**
Hartford	436	69	106	31	25					**667**
Hospital of Central CT	231	32	22	25	20	12		14		**356**
John Dempsey	100	15	25	20	10				14	**184**
Johnson Memorial	42	5	17	4	4					**72**
Lawrence & Memorial	148	20	18	24	14	10	16	6		**256**
Manchester Memorial	82	22	31	15	21					**171**
Middlesex Memorial	119	26	18	10	10					**183**
MidState Medical	111	7	6	10	10					**144**
Milford	33	6		4	4					**47**
New Milford	18	4		3	2					**27**
Norwalk	92	37	10	14	10	5	21	4		**193**
Rockville General	38	9								**47**
St. Francis	394	42	75	30	26	28				**595**
St. Mary's	123	16	12	16	7				8	**182**
St. Vincent's	275	30	92	22	27		10			**456**
Stamford	182	5	14	25	18	8	12	3		**267**
Waterbury	118	16	30	9	9				8	**190**
Windham Community	53	12		14	8					**87**
Yale-New Haven[1]	706	152	127	57	40	56	12	63		**1,213**
Total	**4,170**	**636**	**719**	**446**	**357**	**217**	**98**	**202**	**30**	**6,875**

Source: CT Department of Public Health Office of Health Care Access Hospital Reporting System Report 400

[1]Yale-New Haven Hospital acquired the Hospital of Saint Raphael on September 12, 2012 - totals include Saint Raphael's 214 Adult Medical/Surgical, 62 ICU/CCU, 37 Psychiatric, 12 Maternity, 11 Newborn, 6 Neonatal ICU, 11 Rehabilitation, and 1 Pediatric staffed bed

Appendix IV: Connecticut Acute Care Discharges: FYs 2008-2012

						Year-to-Year Change (%)				
Hospital Name	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	08/09	09/10	10/11	11/12	09/12
Backus (William W.)	11,918	11,849	12,132	11,958	11,836	-1%	2%	-1%	-1%	0%
Bridgeport	20,034	19,828	19,084	19,239	19,139	-1%	-4%	1%	-1%	-3%
Bristol	7,931	7,723	7,484	7,077	7,541	-3%	-3%	-5%	7%	-2%
Charlotte Hungerford	6,077	6,318	6,426	6,497	6,331	4%	2%	1%	-3%	0%
CT Children's Medical	5,793	6,349	6,797	6,132	6,602	10%	7%	-10%	8%	4%
Danbury	20,432	20,445	20,668	20,725	19,607	0%	1%	0%	-5%	-4%
Day Kimball	5,396	5,546	5,193	5,177	5,100	3%	-6%	0%	-1%	-8%
Essent - Sharon	2,834	2,658	2,682	2,701	2,666	-6%	1%	1%	-1%	0%
Greenwich	12,701	12,904	13,637	13,525	11,846	2%	6%	-1%	-12%	-8%
Griffin	7,467	7,395	7,563	7,330	6,892	-1%	2%	-3%	-6%	-7%
Hartford	40,105	41,434	41,532	40,775	41,405	3%	0%	-2%	2%	0%
Hospital of Central CT	20,989	20,056	19,509	20,547	18,239	-4%	-3%	5%	-11%	-9%
John Dempsey	9,858	9,586	9,566	9,086	8,373	-3%	0%	-5%	-8%	-13%
Johnson Memorial	4,080	3,609	3,424	3,251	3,250	-12%	-5%	-5%	0%	-10%
Lawrence & Memorial	14,568	14,819	15,426	15,338	14,956	2%	4%	-1%	-2%	1%
Manchester Memorial	8,994	8,817	8,933	9,203	8,759	-2%	1%	3%	-5%	-1%
Middlesex Memorial	13,719	13,474	13,450	13,295	13,667	-2%	0%	-1%	3%	1%
MidState Medical	9,723	9,957	9,800	10,166	10,293	2%	-2%	4%	1%	3%
Milford	4,935	4,740	4,458	4,278	3,506	-4%	-6%	-4%	-18%	-26%
New Milford	3,010	2,768	2,494	2,512	2,291	-8%	-10%	1%	-9%	-17%
Norwalk	15,560	15,638	14,810	15,188	15,048	1%	-5%	3%	-1%	-4%
Rockville General	3,538	3,499	3,361	2,498	2,518	-1%	-4%	-26%	1%	-28%
St. Francis	32,766	33,062	31,418	31,893	32,193	1%	-5%	2%	1%	-3%
St. Mary's	13,135	12,459	12,210	12,495	12,052	-5%	-2%	2%	-4%	-3%
St. Raphael Hospital[1]	24,969	24,968	24,510	23,140	NA	0%	-2%	-6%	NA	NA
St. Vincent's	20,199	21,718	21,884	22,099	22,028	8%	1%	1%	0%	1%
Stamford	15,300	14,855	15,061	14,899	14,255	-3%	1%	-1%	-4%	-4%
Waterbury	14,722	13,914	13,045	12,758	12,367	-5%	-6%	-2%	-3%	-11%
Windham Community	5,676	5,349	5,109	4,702	4,506	-6%	-4%	-8%	-4%	-16%
Yale-New Haven[2]	52,135	54,422	56,762	57,751	59,796	4%	4%	2%	4%	10%
Statewide	**428,564**	**430,159**	**428,428**	**426,235**	**397,062**	**0%**	**0%**	**-1%**	**-7%**	**-8%**

Source: CT Department of Public Health Office of Health Care Access Acute Care Hospitals Inpatient Discharge Database

[1]Saint Raphael acquired by Yale-New Haven Hospital on September 12, 2012

[2]Total for 2012 includes 19,947 discharges reported by the Hospital of Saint Raphael

Appendix V: Connecticut Acute Care Patient Days: FYs 2008-2012

Hospital Name	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Year-to-Year Change (%) 08/09	09/10	10/11	11/12	08/12
Backus (William W.)	50,572	49,521	49,262	49,655	49,102	-2%	-1%	1%	-1%	-3%
Bridgeport	108,274	104,355	104,936	105,010	101,436	-4%	1%	0%	-3%	-6%
Bristol	33,293	33,319	30,753	28,388	29,230	0%	-8%	-8%	3%	-12%
Charlotte Hungerford	27,254	28,325	28,103	27,465	25,210	4%	-1%	-2%	-8%	-7%
CT Children's Medical	37,110	36,200	36,312	36,823	45,043	-2%	0%	1%	22%	21%
Danbury	87,317	92,474	95,142	96,560	91,875	6%	3%	1%	-5%	5%
Day Kimball	20,491	20,251	18,901	18,536	18,509	-1%	-7%	-2%	0%	-10%
Essent - Sharon	11,809	11,466	11,624	12,353	11,818	-3%	1%	6%	-4%	0%
Greenwich	51,606	50,243	52,678	52,774	46,444	-3%	5%	0%	-12%	-10%
Griffin	34,295	33,040	32,791	30,867	28,713	-4%	-1%	-6%	-7%	-16%
Hartford	212,318	216,274	219,730	222,710	232,399	2%	2%	1%	4%	9%
Hospital of Central CT	88,517	86,383	81,939	83,163	76,333	-2%	-5%	1%	-8%	-14%
John Dempsey	60,351	56,200	51,251	51,623	40,291	-7%	-9%	1%	-22%	-33%
Johnson Memorial	21,730	18,031	17,698	15,609	16,228	-17%	-2%	-12%	4%	-25%
Lawrence & Memorial	69,988	68,917	71,297	73,942	71,050	-2%	3%	4%	-4%	2%
Manchester Memorial	43,893	43,426	44,029	43,501	45,098	-1%	1%	-1%	4%	3%
Middlesex Memorial	56,882	55,485	55,808	57,496	57,063	-2%	1%	3%	-1%	0%
MidState Medical	45,254	43,145	42,216	44,688	42,711	-5%	-2%	6%	-4%	-6%
Milford	21,719	19,657	17,708	17,086	14,426	-9%	-10%	-4%	-16%	-34%
New Milford	11,757	9,858	9,346	9,378	8,566	-16%	-5%	0%	-9%	-27%
Norwalk	77,978	71,088	70,058	70,411	67,464	-9%	-1%	1%	-4%	-13%
Rockville General	15,087	15,335	14,136	12,278	13,128	2%	-8%	-13%	7%	-13%
St. Francis	165,453	162,468	154,831	158,020	157,137	-2%	-5%	2%	-1%	-5%
St. Mary's	58,529	53,532	52,653	56,034	51,511	-9%	-2%	6%	-8%	-12%
St. Raphael[1]	134,996	131,885	125,113	122,630	NA	-2%	-5%	-2%	NA	NA
St. Vincent's	105,110	124,028	123,691	123,317	122,834	18%	0%	0%	0%	17%
Stamford	75,315	73,767	76,488	75,041	70,198	-2%	4%	-2%	-6%	-7%
Waterbury	70,697	68,137	59,698	58,933	57,490	-4%	-12%	-1%	-2%	-19%
Windham Community	20,882	20,761	20,865	20,001	18,674	-1%	1%	-4%	-7%	-11%
Yale-New Haven[2]	272,728	279,366	284,667	299,973	415,905	2%	2%	5%	39%	52%
Statewide	**2,091,205**	**2,076,937**	**2,053,724**	**2,074,265**	**2,025,886**	**-1%**	**-1%**	**1%**	**-2%**	**-3%**

Source: CT Department of Public Health Office of Health Care Access Acute Care Hospitals Inpatient Discharge Database

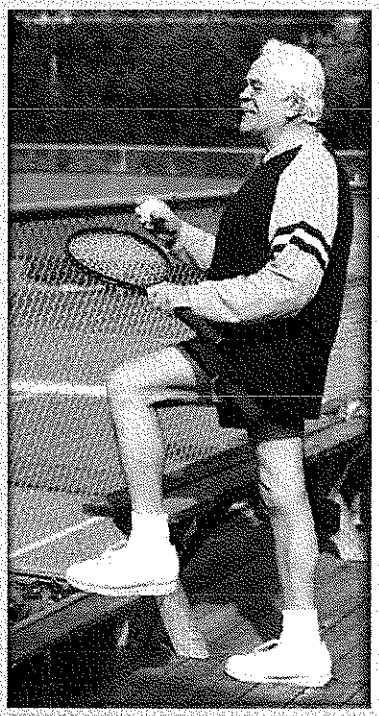
[1]Saint Raphael acquired by Yale-New Haven Hospital on September 12, 2012

[2]Total for 2012 includes 104,600 patient days reported by the Hospital of Saint Raphael

2012 Community Health Needs Assessment

Litchfield County

Community Transformation Grant Coalition



Making the Healthy Choice the Easy Choice through:

- Tobacco Free Living
- Active Living & Healthy Eating
- Quality Clinical and Other Preventive Services
- Social & Emotional Wellness
- Healthy & Safe Physical Environments

Funded by:
Connecticut Department of Public Health – CDC Community Transformation Grant
Torrington Area Health District
Charlotte Hungerford Hospital
United Way of Northwest Connecticut
Northwest Connecticut YMCA

Prepared by: The Center for Healthy Schools & Communities at EDUCATION CONNECTION

EDUCATION CONNECTION

Table of Contents

Introduction **2**
Litchfield County Population and Demographic Overview **4**
County and Town Designations and Governance **5**
Litchfield County Municipality Population and Demographic Highlights **5**
2000-2010 Census Comparisons, Growth Projections, and Ethnic/Racial Composition 5
Age Distribution 9
Educational Attainment 11
Economic Stability – Income, Poverty and Unemployment 14
Health Insurance Coverage 17
Housing and Homelessness 18
Community Safety 19
Community Health-Related and Environmental Assets **20**
Community-Health Related Assets 20
Environmental Assets 21
Special Populations **21**
Health Status of County Residents **22**
State and County Health Rankings 22
Lifestyle Behaviors and Risk Factors 23
Behavioral Risk Factor Surveillance 24
The Burden of Chronic Disease 28
Mortality and Leading Causes of Death 31
Healthy People 2020 Leading Health Indicators 36
Overview of Health Disparities & Inequities in Litchfield County **37**
Accidents and Violence 38
Cancer 38
Cardiovascular Disease 39
Diabetes 39
Health Care Access 40
Life Expectancy 40
Liver Disease 41
Mental Health 41
Renal Disease 42
Respiratory Illness 42
Description of Local Health-Related Programs and Services **43**
Tobacco Free Living 44
Active Living and Healthy Eating 44
High Impact Quality Clinical and Other Preventive Services 45
Social & Emotional Wellness 45
Healthy & Safe Physical Environment 46
Infoline 2-1-1 Top Requests and Unmet Needs for Services 47
CTG Coalition Overview and Collaborative Activities **49**
Key Findings & Recommendations **51**
Demographics 51
Health Status: Behavioral and Lifestyle Factors 51
Health Status: Burden of Chronic Disease 52
Health Status: ED Visits & Hospitalizations 52
Health Status: Mortality Data 52
Health Disparities & Inequities 52
Health Related Programs & Services 53
Appendix A –Asset Maps of Programs & Services by Strategic Direction **55**
Appendix B – Glossary of Abbreviations **94**

Introduction

The 2012 Litchfield County Community Health Needs Assessment (CHNA) represents the collaborative efforts of the Litchfield County Community Transformation Grant (CTG) Coalition to begin to assess and prioritize health needs in our community and to collectively develop strategies and mobilize resources to improve the health of county residents.

The CTG Program is funded by the Centers for Disease Control and Prevention (CDC). The CTG Program's overarching goal is to create healthier communities by making healthy living easier and more affordable. The CTG program aims to improve the the health of all Americans by improving weight, nutrition, physical activity, tobacco use, emotional well-being, and overall mental health. By promoting healthy lifestyles and communities, especially among population groups experiencing the greatest burden of chronic disease, CTGs help improve health, reduce health disparities, and lower health care costs. *www.cdc.gov/communitytransformation/Cached*

Litchfield County is one of five counties in the state awarded CTG funding in partnership with the Connecticut Department of Public Health (CTDPH) to build capacity to support healthy lifestyles in a combined county population of over 889,000 including a rural population of 306,000. Connecticut's CTG Program targets evidence-based strategies to promote tobacco-free living, active living and healthy eating, quality clinical and other preventive services, healthy and safe physical environments, and social and emotional wellness.

The CTG Program is closely aligned with two other nationwide health promotion initiatives, the National Prevention Strategy and the Million Hearts Campaign™. The National Prevention Strategy is a comprehensive plan to increase the number of Americans who are healthy at every stage of life. The Prevention Strategy recognizes that good health comes not just from receiving quality medical care, but also from clean air and water, safe outdoor spaces for physical activity, safe worksites, healthy foods, violence-free environments and healthy homes. Prevention should be woven into all aspects of our lives, including where and how we live, learn, work and play. *http://www.healthcare.gov/prevention/nphpphc/strategy/index.html.* The Million Hearts™ Campaign aims to prevent one million heart attacks and strokes over the next five years. Million Hearts™ brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke. *http://millionhearts.hhs.gov/index.html*

Conducting a community health needs assessment is the first step to developing a community health improvement plan. The CHNA describes the health of the community, by presenting relevant information on socioeconomic and demographic factors affecting health, personal health-related lifestyle practices, health status indicators, community health resources, and studies of current local health issues. The CHNA identifies population groups that may be at increased risk for poor health outcomes, assesses the larger community environment and how it impacts health, and identifies areas where additional or better information is needed. The assessment process is highly collaborative, involving a broad spectrum of community stakeholders.

The leading health issues in Litchfield County, as in the state and the nation, result from many underlying factors which can be controlled or modified. Harmful lifestyle behaviors such as smoking, overeating, poor nutrition, lack of physical activity, and substance abuse have major impacts on individual health. Economic and language/cultural factors present barriers to access and utilization of medical care and preventive health services. Income, employment status, educational attainment, housing, and other social factors impact health or limit access to care. Uncontrollable factors, including inherited health conditions or

increased susceptibility to disease, also significantly influence health.

Poverty underlies many of the social factors that contribute to poor health. Differences for many health indicators are also apparent by gender, race/ethnicity, age, and geographic area of residence. This information will be used to guide the development of programs and services to meet identified health needs.

Recent trends in health indicators for county residents show improvement in overall mortality rates for many leading causes of death. There are indications of improvement in personal health habits such as smoking and activity rates and accessing screening services for early detection of certain diseases. However, disparities in health care access and health status in certain populations persist. Expanded joint planning and coordination of programs and services among community partners can reduce health disparities and improve the health of all county residents.

The intent is for the Community Health Needs Assessment to have significant value for the community, and to be widely used to advance community health improvement planning by a diverse constituency of private and public agencies. We welcome your comments and reactions to this report, and invite you to join in the assessment process going forward.

The Litchfield County CTG Coalition Steering Committee

Jim Rokos, Director of Health
Torrington Area Health District

Leslie Polito, Assistant Director of Health
Torrington Area Health District

Sharon McCoy, Project Director
Torrington Area Health District

Stephanie Barksdale, Executive Director
United Way of Northwest Connecticut

Greg Brisco, Chief Executive Officer
Northwest Connecticut YMCA

Brian Mattiello, V.P. for Organizational Development, *Charlotte Hungerford Hospital*

Daniel Baroody, Director of Health
Town of Sharon

Mike Crespan, Director of Health
New Milford Health Department

Donna Culbert, Director of Health
Newtown Health District

Jennifer Kertanis, Director of Health
Farmington Valley Health District

Neal Lustig, Director of Health
Pomperaug Health District

Mary Bevan, Director, Center for Healthy Schools and Communities
EDUCATION CONNECTION

Jim Hutchison, Community Health Coordinator
Sharon Hospital

Andrea Rynn, Director of Public and Government Relations
Western CT Health Network

Mary Winar, Projects Coordinator
Connecticut Office of Rural Health

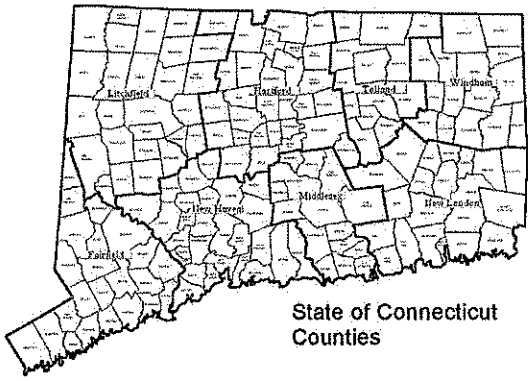
Litchfield County Population and Demographic Overview

Situated in the northwestern corner of Connecticut, Litchfield County occupies the largest land area of any county in the state (920 square miles). Consistent with the rural nature of many of its 26 municipalities, the county has the lowest population density of any county in CT. According to the 2010 Census, the total population of the county was 189,927 ranking 4th in population size among the eight CT counties. This represents a 4.3% increase in population since 2000, which is slightly less than the average state population growth rate of 4.9% over the past decade.

In 2010, as reported by the Census, there were 76,640 households in the county, and an average household size of 2.4 persons. Nearly 30% (29.9%) of households include persons under the age of 18 and 28.2% include persons ages 65 and over. Litchfield County has the distinction of having the highest proportion of residents ages 50 and over in the state (39%), compared with the CT average of 34%.

Overall, Litchfield County's population is relatively non-diverse; the Census 2010 racial/ethnic composition is 93.9% White and 1.3 % Black or African American, 1.5 % Asian, 0.2% American Indian, and 4.5% Hispanic or Latino (6.1% minority). However, as noted in Table 2, the county's two primary urban centers of Torrington and New Milford are considerably more diverse; the total minority population in Torrington is 11.3% and in New Milford is 8.3%.

According to the U.S. Census American Community Survey (ACS) 5-Year estimates for 2006-2010, the predominant ancestries in the county were: 23.0% Italian, 21.3% Irish, 14.8% English, 14.2% German and 9.5% French. Slightly over 6% (6.3%) of the county's population is foreign-born, and of those 42.5% are not U.S. citizens. The vast majority of county residents speak English (91.2%); 8.8% of residents have a primary language other than English, however only 2.7% speak English less than "very well". The predominant non-English



State of Connecticut Counties

languages spoken include "other Indo-European languages" and Spanish. It is important to note that Census ACS data are estimates based on a sample and therefore subject to sampling variability. In contrast, the decennial Census data are official population and housing counts. Additional information on the sampling methodology used in the ACS is available at www.census.gov.

Overall levels of educational attainment by Litchfield County residents surpass the state average - 96% of county residents are high school graduates, 29% completed some college, and 34% attained a bachelor's degree or higher.

The median income per household in the county as estimated by the 2006-2010 ACS was $69,639, and the median family income was $84,890. In 2009, 5.3% of the county's population was living in poverty, well below the state average of 8.7%. High poverty areas exist in certain communities, and poverty is most common in female-headed households with children under 18 years of age.

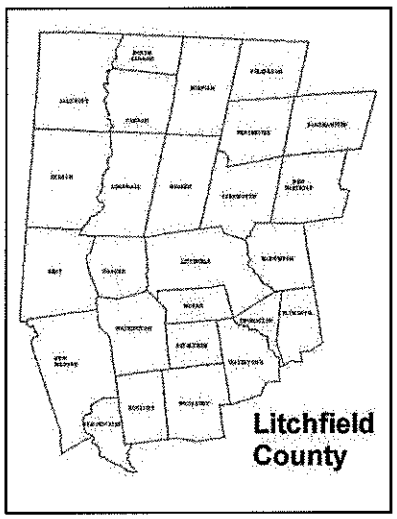
Related to housing characteristics, the majority of Litchfield County residents own their own homes (76.3%), with the remainder renting (23.7%). Homeownership in the county is well above the state average. According to CERC Town Profiles, one-third of the housing stock in the county was built prior to 1950 and there are over 3,400 subsidized housing units in the county.

County and Town Designations and Governance

There are 26 distinct municipalities in the county, including: Barkhamsted, Bethlehem, Bridgewater, Canaan, Colebrook, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, New Hartford, New Milford, Norfolk, North Canaan, Plymouth, Roxbury, Salisbury, Sharon, Thomaston, Torrington, Warren, Washington, Watertown, Winchester, and Woodbury.

Although Connecticut is divided geographically into eight counties, these counties do not have any associated government structure. The Connecticut General Assembly abolished all county governments in the state on October 1, 1960. The 169 towns of Connecticut are the principal units of local government in the state and have full municipal powers including: corporate powers, eminent domain, ability to levy taxes, public services (low cost housing, waste disposal, fire, police, ambulance, street lighting), public works (highways, sewers, cemeteries, parking lots, etc.), regulatory powers (building codes, traffic, animals, crime, public health), environmental protection, and economic development.

Under Connecticut's Home Rule Act, any municipality in CT is permitted to adopt its own local charter and choose its own structure of government. The three principal municipal government structures used in the state are: 1) selectman–town meeting, 2) mayor–council, and 3) manager–council.



Five Regional Planning Organizations (RPOs) serve Litchfield County municipalities including Central Connecticut Regional Planning Agency, Council of Governments of the Central Naugatuck Valley, Housatonic Valley Council of Elected Officials, Litchfield Hills Council of Elected Officials, and Northwestern CT Council of Governments. Through local ordinance, the municipalities within each of these planning regions have voluntarily created one of the three types of RPOs permitted under CT statute to carry out a variety of regional planning and other activities on their behalf.

Litchfield County Municipality Population and Demographic Highlights

2000-2010 Census Comparisons, Growth Projections, and Ethnic/Racial Composition

As noted in Table 1, the county's two most populated urban centers are Torrington (2010 population – 36,383), and New Milford (2010 population – 28,142). Five of the county's 26 municipalities have populations of 10,000 or greater; the least populated town in the county is Canaan, with 1,234 residents. Population projections from the CT State Data Center show an overall net growth rate in the county of 6.5%, for the 15 year period 2015-2030, with the highest growth rate in Woodbury, closely followed by New Hartford, New Milford, Bethlehem, and Goshen. Negative growth rates are projected in eight municipalities, with the greatest percentage loss in population projected for Canaan and Roxbury.

Table 1: 2010 Census Population and Projections for Litchfield County Municipalities, 2015-2030

Municipality	Census 2010 Population	2015	2020	2025	2030	% Change 2015-2030
Barkhamsted	3,799	3,837	3,967	4,083	4,165	**8.5%**
Bethlehem	3,607	3,874	4,010	4,169	4,308	**11.2%**
Bridgewater	1,727	2,090	2,167	2,249	2,304	**10.2%**
Canaan	1,234	1,122	1,105	1,069	1,024	**-8.7%**
Colebrook	1,485	1,512	1,515	1,522	1,517	**0.3%**
Cornwall	1,420	1,540	1,586	1,620	1,655	**7.5%**
Goshen	2,976	3,198	3,351	3,478	3,569	**11.6%**
Harwinton	**5,642**	**5,293**	**5,248**	**5,204**	**5,148**	**-2.7%**
Kent	2,979	3,294	3,455	3,561	3,608	**9.5%**
Litchfield	**8,466**	**10,218**	**10,796**	**11,064**	**11,009**	**7.7%**
Morris	2,388	2,325	2,324	2,334	2,321	**-0.2%**
New Hartford	**6,970**	**6,980**	**7,303**	**7,635**	**7,881**	**12.9%**
New Milford	**28,142**	**31,429**	**32,835**	**34,226**	**35,446**	**12.8%**
Norfolk	1,709	1,916	1,987	2,042	2,006	**4.7%**
North Canaan	3,315	3,465	3,510	3,547	3,568	**3.0%**
Plymouth	**12,243**	**12,307**	**12,426**	**12,528**	**12,552**	**2.0%**
Roxbury	2,262	2,069	2,026	1,982	1,941	**-6.2%**
Salisbury	3,741	4,790	4,907	4,794	4,594	**-4.1%**
Sharon	2,782	3,351	3,411	3,340	3,231	**-3.6%**
Thomaston	**7,887**	**7,512**	**7,495**	**7,462**	**7,411**	**-1.3%**
Torrington	**36,383**	**41,378**	**43,546**	**44,942**	**45,213**	**9.3%**
Warren	1,461	1,305	1,327	1,346	1,367	**4.8%**
Washington	3,578	3,566	3,513	3,460	3,421	**-4.1%**
Watertown	**22,514**	**23,407**	**23,974**	**24,601**	**25,213**	**7.7%**
Winchester	**11,242**	**11,025**	**11,091**	**11,128**	**11,142**	**1.1%**
Woodbury	**9,975**	**10,661**	**11,133**	**11,624**	**12,047**	**13.0%**
Litchfield County	**189,927**	**193,489**	**197,751**	**202,218**	**206,087**	**6.5%**
Connecticut	**3,574,097**	**3,573,885**	**3,622,774**	**3,669,990**	**3,702,400**	**3.6%**

** Notes: Ten most populated municipalities are listed in **bold type**.*

Sources: CERC Town Profiles, accessed at http://www.cerc.com and Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html

Changes in the ethnic and racial composition of the county by municipality over the past decade compiled by the CT State Data Center are shown in Tables 2 and 3. Overall, the county has become more diverse from 2000 - 2010, with the highest increase in the Hispanic or Latino population (4,641 persons or an increase of 119.2%), which is more than double the state average increase of 49.6%. Based on the increase in absolute numbers of persons, the next highest increase was in White residents (3,784 persons), followed by "other" (1,473 persons), Asian residents (771 persons), Black or African American residents (560 persons), followed by American Indian (85 persons) and lastly Pacific Islander. By far, the greatest gains in the number of minority residents were experienced in three communities - Torrington, New Milford, and Watertown.

Table 2: Litchfield County Municipality Census 2000 and 2010 Population Counts by Race/Ethnicity*

Municipality	Total population		White		Black		American Indian		Asian		Pacific Islander		Other		Hispanic or Latino	
	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010
Barkhamsted	3,494	3,799	3,443	3,703	2	11	6	0	14	23	0	0	10	21	31	57
Bethlehem	3,422	3,607	3,336	3,532	9	16	2	4	27	18	1	0	13	6	22	61
Bridgewater	1,824	1,727	1,779	1,681	17	14	1	0	13	16	0	0	2	8	9	26
Canaan	1,081	1,234	1,049	1,204	16	8	0	1	2	3	1	1	4	1	4	19
Colebrook	1,471	1,485	1,427	1,448	10	4	0	2	9	9	0	3	13	3	36	17
Cornwall	1,434	1,420	1,398	1,386	3	3	0	1	10	9	0	0	3	3	21	34
Goshen	2,697	2,976	2,650	2,898	13	10	4	4	20	36	0	0	0	9	33	67
Harwinton	5,283	5,642	5,214	5,515	4	13	3	8	27	49	3	4	7	10	47	80
Kent	2,858	2,979	2,737	2,813	16	35	22	22	28	49	1	1	20	21	72	94
Litchfield	8,316	8,466	8,066	8,149	62	52	19	13	39	77	1	12	38	43	130	173
Morris	2,301	2,388	2,243	2,325	16	12	3	2	19	18	0	0	4	3	20	50
New Hartford	6,088	6,970	5,946	6,776	39	23	3	4	45	79	4	0	12	21	82	124
New Milford	27,121	28,142	25,583	25,809	383	484	40	68	518	779	7	11	184	464	751	1,693
Norfolk	1,660	1,709	1,612	1,659	8	12	4	2	9	11	0	0	10	7	16	30
North Canaan	3,350	3,315	3,247	3,194	40	40	6	3	6	8	0	0	13	41	79	195
Plymouth	11,634	12,243	11,325	11,748	91	102	18	22	49	100	1	2	37	78	147	370
Roxbury	2,136	2,262	2,077	2,179	5	13	4	3	20	18	0	0	14	18	28	48
Salisbury	3,977	3,741	3,808	3,559	66	52	13	6	38	41	0	0	18	18	61	107
Sharon	2,968	2,782	2,875	2,670	28	44	13	2	17	20	0	0	10	18	58	56
Thomaston	7,503	7,887	7,342	7,631	45	34	8	26	37	60	0	0	31	53	109	202
Torrington	35,202	36,383	32,749	32,278	757	974	70	90	643	785	7	9	460	1,330	1,162	3,193
Warren	1,254	1,461	1,228	1,418	2	8	4	1	10	20	0	0	1	8	3	31
Washington	3,596	3,578	3,440	3,429	23	21	4	3	56	27	0	0	28	48	77	142
Watertown	21,661	22,514	20,894	21,249	162	315	27	58	276	376	10	1	103	213	406	838
Winchester	10,664	11,242	10,071	10,468	132	201	25	26	99	109	1	1	180	225	338	583
Woodbury	9,198	9,975	8,945	9,547	49	57	20	33	106	168	6	0	20	38	152	245
Litchfield County	182,193	189,927	174,484	178,268	1,998	2,558	319	404	2,137	2,908	43	45	1,235	2,708	3,894	8,535
Connecticut	3,405,565	3,574,097	2,780,355	2,772,410	309,843	362,296	9,639	11,256	82,313	135,565	1,366	1,428	147,201	198,466	320,323	479,087

** Note: Hispanic or Latino population counts include persons of any race.*

Source: CT State Data Center, University of Connecticut,http://ctsdc.uconn.edu/data/2010_2000_PL_Census_data_comparison_towns.xls

Table 3: Litchfield County Municipality Census 2000 and 2010 Numeric and Percent Population Change

Municipality	Total Population		White		Black or African American		Asian		Hispanic or Latino	
	# Change	% Change	# Change	% Change	# Change	% Change	# Change	% Change	# Change	% Change
Barkhamsted	305	8.7	260	7.6	9	450.0	9	64.3	26	83.9
Bethlehem	185	5.4	196	5.9	7	77.8	(9)	-33.3	39	177.3
Bridgewater	(97)	-5.3	(98)	-5.5	(3)	-17.6	3	23.1	17	188.9
Canaan	153	14.2	155	14.8	(8)	-50.0	1	50.0	15	375.0
Colebrook	14	1.0	21	1.5	(6)	-60.0	0	0.0	(19)	-52.8
Cornwall	(14)	-1.0	(12)	-0.9	0	0.0	(1)	-10.0	13	61.9
Goshen	279	10.3	248	9.4	(3)	-23.1	16	80.0	34	103.0
Harwinton	359	6.8	301	5.8	9	225.0	22	81.5	33	70.2
Kent	121	4.2	76	2.8	19	118.8	21	75.0	22	30.6
Litchfield	150	1.8	83	1.0	(10)	-16.1	38	97.4	43	33.1
Morris	87	3.8	82	3.7	(4)	-25.0	(1)	-5.3	30	150.0
New Hartford	882	14.5	830	14.0	(16)	-41.0	34	75.6	42	51.2
New Milford	1,021	3.8	226	0.9	101	26.4	261	50.4	942	125.4
Norfolk	49	3.0	47	2.9	4	50.0	2	22.2	14	87.5
North Canaan	(35)	-1.0	(53)	-1.6	0	0.0	2	33.3	116	146.8
Plymouth	609	5.2	423	3.7	11	12.1	51	104.1	223	151.7
Roxbury	126	5.9	102	4.9	8	160.0	(2)	-10.0	20	71.4
Salisbury	(236)	-5.9	(249)	-6.5	(14)	-21.2	3	7.9	46	75.4
Sharon	(186)	-6.3	(205)	-7.1	16	57.1	3	17.6	(2)	-3.4
Thomaston	384	5.1	289	3.9	(11)	-24.4	23	62.2	93	85.3
Torrington	1,181	3.4	(471)	-1.4	217	28.7	142	22.1	2,031	174.8
Warren	207	16.5	190	15.5	6	300.0	10	100.0	28	933.3
Washington	(18)	-0.5	(11)	-0.3	(2)	-8.7	(29)	-51.8	65	84.4
Watertown	853	3.9	355	1.7	153	94.4	100	36.2	432	106.4
Winchester	578	5.4	397	3.9	69	52.3	10	10.1	245	72.5
Woodbury	777	8.4	602	6.7	8	16.3	62	58.5	93	61.2
Litchfield County	7,734	4.3	3,784	2.2	560	28.0	771	36.1	4,641	119.2
Connecticut	168,532	4.9	(7,945)	-2.9	52,453	16.9	53,252	64.7	158,764	49.6

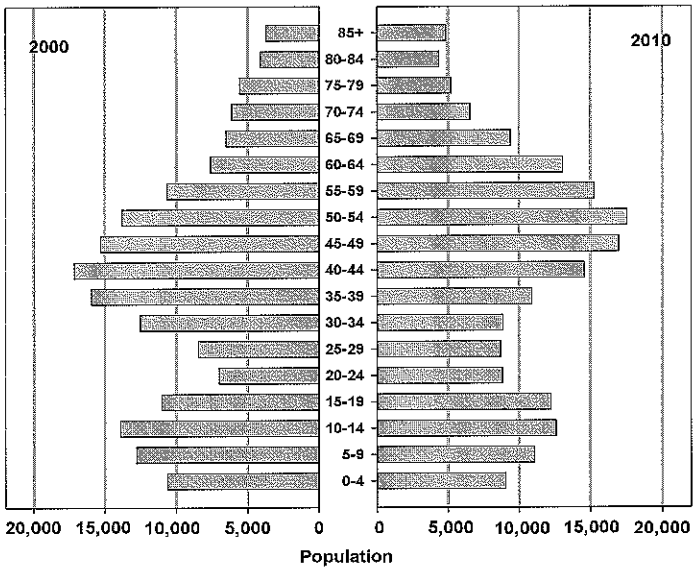
** Note: Hispanic or Latino population counts include persons of any race. Population change numbers in parentheses ( ) are negative and represent a loss in population for that subgroup.*

Source: CT State Data Center, University of Connecticut,http://ctsdc.uconn.edu/data/2010_2000_PL_Census_data_comparison_towns.xls

Age Distribution

As previously noted, the proportion of Litchfield County residents ages 50 and over exceeds the state average. Figure 1 graphically shows the increase in the county population ages 50 and over, and the decline in the population under the age of 14 from 2000-2010.

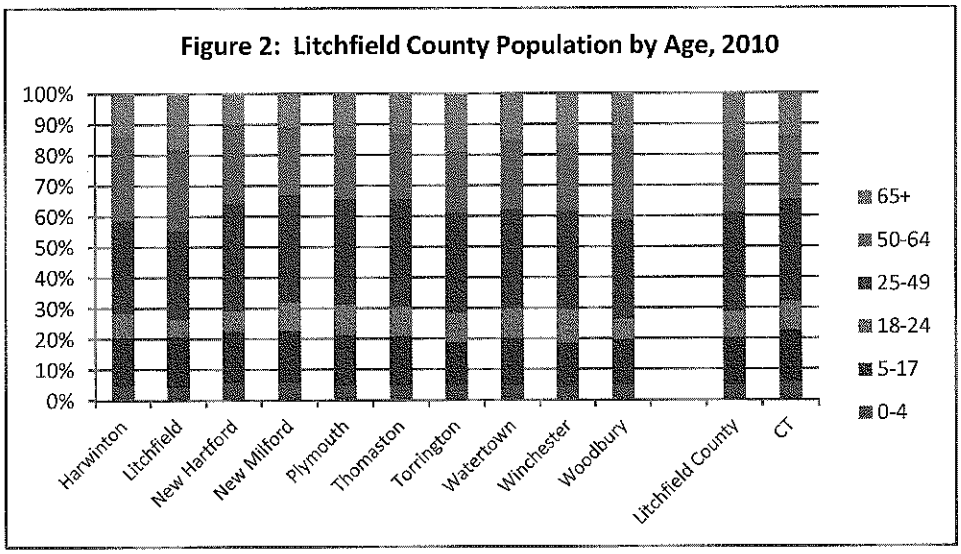
Figure 1
Population of Litchfield County
2000-2010, by Age Group



Source: U.S. Census, Decennial Census by Age, Race, Sex, Ethnicity, provided courtesy of HISR, Connecticut Department of Public Health *http://www.ct.gov/dph/cwp/view.asp?a=3132&q=488832*), accessed May 2, 2012.

Based on Census 2010 data, the age distribution of the county's ten most populated municipalities, compared with the county and the state is shown in Figure 2.

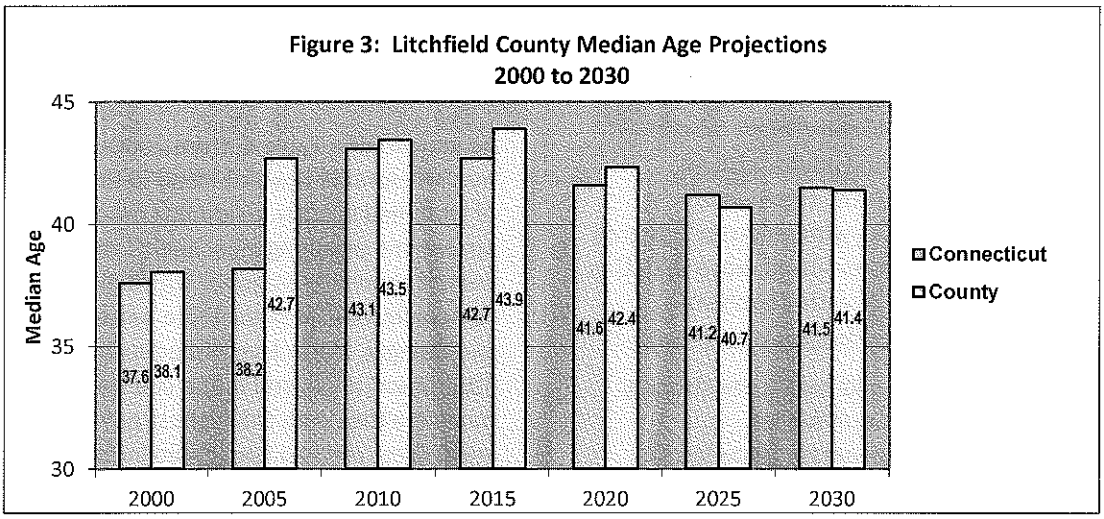
Figure 2: Litchfield County Population by Age, 2010



Source: CERC Town Profiles, http://www.cerc.com

The upward trend in the age distribution of Litchfield County's population is explained in large part by two factors - the advancing age of the "baby boomer" generation and declining birth rates, both of which are consistent with state and national trends. This shift in population demographics is noteworthy as the need for health care and support services by residents generally increases with advancing age. The CT State Data Center projects the median age in the county will to continue to rise through 2015, as shown in Figure 3.

Figure 3: Litchfield County Median Age Projections 2000 to 2030



Source: Connecticut State Data Center, University of Connecticut, http://ctsdc.edu/projections/ct_towns.html

In addition to having a higher percentage of residents ages 65 and over, overall the county has a lower percentage of residents under the age of 18 when compared with the state average. At the municipal level, the top 10 communities with the highest percentage of residents under the age of 18 and residents ages 65 and over are shown graphically in Figures 4 and 5. This information is important as it has broad implications for health, education, housing, and human services planning.

Figure 4: Top 10 Litchfield County Municipalities With Highest Percentage of Population Under Age 18, 2010

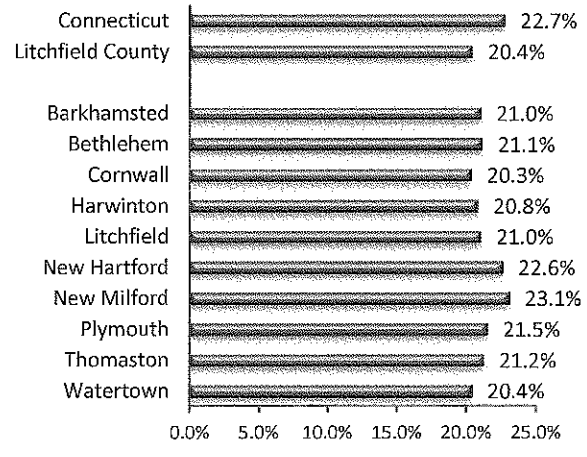
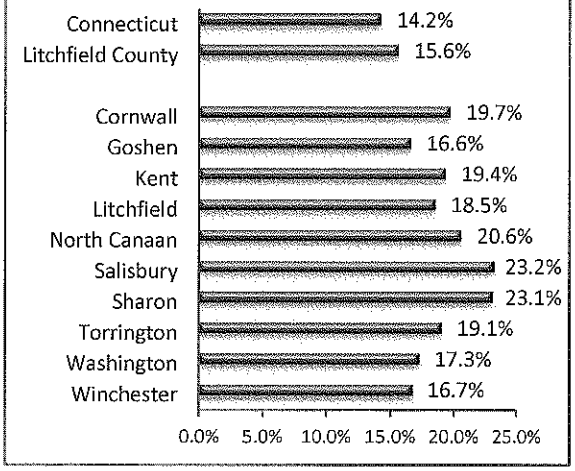


Figure 5: Top 10 Litchfield County Municipalities With Highest Percentage of Population Age 65 and Over, 2010



Source: CERC Town Profiles www.cerc.com

Educational Attainment

Advancing levels of education are strongly associated with increased income and the related benefits of improved socioeconomic status. According to the National Center for Educational Statistics, young adults with a bachelor's degree earned more than twice as much as those without a high school diploma or its equivalent in 2009, 50 percent more than young adult high school completers, and 25 percent more than young adults with an associate's degree. In 2009, the median earnings of young adults with a master's degree or higher was $60,000, one-third more than the median for young adults with a bachelor's degree. *http://nces.ed.gov/fastfacts/display.asp?id=77*

Socioeconomic status and health are strongly correlated, with persons of higher socioeconomic status generally experiencing better health status and access to health care. Persons with higher socioeconomic status are also more likely to live in safe neighborhoods, be steadily employed at higher paying jobs with health benefits, and practice healthy lifestyle behaviors. There is a growing body of research suggesting that socioeconomic factors underlie many of the observed racial, ethnic, and gender inequalities in health status, and that socioeconomic factors are powerful predictors of health status and health outcomes.

As indicated in Table 4, from 2000-2010 there was a favorable upward trend in the percentage of Litchfield County residents completing high school and attaining a bachelor's degree. The overall county average for high school completion exceeds the state average. Not surprisingly, lower levels of educational attainment are found in the county municipalities with the highest poverty rates and lowest median household incomes – Torrington, Winchester, Thomaston, North Canaan, and Plymouth.

Table 4: Educational Attainment in Litchfield County Residents Ages 25 and Over, Census 2000 and 2010

Municipality	High School Graduate or Higher		Bachelor's Degree or Higher	
	Census 2000 (%)	Census 2010 (%)	Census 2000 (%)	Census 2010 (%)
Barkhamsted	92.7	96.0	36.4	40.0
Bethlehem	90.6	94.0	35.3	39.0
Bridgewater	93.3	96.0	48.2	52.0
Canaan	91.5	96.0	33.0	37.0
Colebrook	90.2	94.0	33.5	37.0
Cornwall	94.8	97.0	47.4	51.0
Goshen	90.0	94.0	32.4	37.0
Harwinton	92.3	96.0	33.0	38.0
Kent	93.0	96.0	42.0	46.0
Litchfield	89.8	94.0	35.9	40.0
Morris	84.6	91.0	25.3	30.0
New Hartford	88.1	93.0	42.8	47.0
New Milford	90.5	95.0	30.5	35.0
Norfolk	91.3	95.0	37.1	41.0

North Canaan	84.2	91.0	20.8	26.0
Plymouth	81.4	89.0	13.9	19.0
Roxbury	96.2	97.0	46.6	50.0
Salisbury	89.4	94.0	45.3	49.0
Sharon	90.2	95.0	36.3	41.0
Thomaston	87.1	92.0	18.5	22.0
Torrington	78.4	87.0	15.7	21.0
Warren	91.9	94.0	34.5	38.0
Washington	90.9	95.0	41.5	46.0
Watertown	83.8	90.0	25.0	30.0
Winchester	78.7	87.0	17.4	22.0
Woodbury	90.2	95.0	41.8	46.0
County	85.9	96.0	27.5	34.0
Connecticut	84.0	89.0	31.4	35.0

Sources: U.S. Census Bureau, 2000 Census of Population and Housing. Summary Social, Economic and Housing Characteristics. Connecticut and CERC 2011 Town Profiles.

The Connecticut State Department of Education's (CSDE) Comprehensive Plan for Education includes high school reform to assure all students graduate and are prepared for lifelong learning and careers in the global competitive economy. As noted in Table 5, Regional School District 12 and the Explorations Charter School in Winchester achieved the goal of 100% high school completion and 0% high school dropouts for the class of 2008 (the most recent published data). Three school districts (Plymouth, The Gilbert School, and Torrington) had dropout rates considerably higher than the state average. With one exception, districts in the county achieved the *Healthy People 2020* target of 82.4% of students graduating from high school.

Table 5: High School Graduation Rates and Dropout Rates, School Districts in Litchfield County, 2008

District Name	Graduation Rate, Class of 2008	Cumulative Dropout Rate (%)
Explorations District (Charter School)	100.0	0.0
Litchfield School District	91.4	7.8
New Milford School District	96.2	3.6
Plymouth School District	86.7	11.4
Regional School District 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon)	92.0	7.1
Regional School District 6 (Goshen, Morris, Warren)	97.8	1.8
Regional School District 7 (Barkhamsted, Colebrook, New Hartford, Norfolk)	99.4	0.5
Regional School District 12 (Bridgewater, Roxbury, Washington)	100.0	0.0

Regional School District 14 (Bethlehem, Woodbury)	94.8	5.2
The Gilbert School (Winchester)	81.3	11.8
Thomaston School District	92.3	7.3
Torrington School District	83.4	13.7
Watertown School District	95.2	4.5
Connecticut	92.1	6.8

Source: CSDE CT Data Education and Research http://sdeportal.ct.gov/Cedar/WEB/ct_report/DTHome.aspx
Note: Harwinton is served by Regional School District 10, located in Hartford County.

Consistent with local demographic trends, there was an increase in the minority population in most school districts in the county over the past two academic years - this increase was most dramatic in Winchester. In 2009-2010, the Torrington School District reported the highest percentage of minority students (24.3%) and also the highest percentage of students who were English Language Learners (7.0%). In addition, over 13% of Torrington students were reported to live in households where English is not the primary language. There is considerable variation in the minority population by school in some school districts, for example, several schools in Torrington have student populations that exceed 30% minority.

Table 6: Percent of Minority and ELL Students Enrolled by School District, Litchfield County 2008-2010

	Minority (%)		Not Fluent in English (%)	
District Name	**2008-2009**	**2009-2010**	**2008-2009**	**2009-2010**
Explorations District	7.1	6.3	0.0	0.0
Litchfield School District	6.7	6.6	0.0	0.5
New Milford School District	13.2	13.5	2.7	2.6
Plymouth School District	5.7	6.0	0.8	0.6
Regional School District 1	4.0	6.1	0.0	0.0
Regional School District 6	3.6	4.0	1.5	1.5
Regional School District 7	2.0	2.6	0.0	0.0
Regional School District 12	6.1	5.6	0.7	0.9
Regional School District 14	4.8	4.5	0.9	0.6
The Gilbert School	11.7	14.4	3.3	4.2
Thomaston School District	2.6	2.7	0.4	0.7
Torrington School District	23.6	24.3	6.1	7.0
Watertown School District	8.6	9.1	1.9	1.8
Winchester School District	15.4	19.4	3.5	2.4
Connecticut			5.2	5.4

Source: CSDE http://sdeportal.ct.gov/Cedar/WEB/ResearchandReports/SSPReports.aspx

Economic Stability – Income, Poverty, and Unemployment

Healthy People 2020 emphasizes the inseparable connections between health and the environments in which we are born, live, learn, work, play, and age. The relationship between poverty and health is particularly strong. It is well documented that low income persons are more likely to be uninsured, have fragmented health care, and have higher rates of tobacco use, substance abuse, mental illness and certain chronic diseases such as obesity and diabetes. In addition, poor persons are more likely to have low levels of education, live in substandard housing and unsafe neighborhoods, be unemployed, and be victims of crime.

As shown in Table 7, Litchfield County residents generally have median incomes above the state and well above the national average, and poverty rates lower than the state and national averages. Income by municipality varies considerably , and in 2010 ranged from a low of $44,817 in North Canaan to a high of $120,008 in Roxbury. Five municipalities have median household incomes below the state average - North Canaan, Plymouth, Thomaston, Torrington, and Winchester. North Canaan's household median income is below the national average. Two municipalities - North Canaan and Torrington - have poverty rates that exceed the state average. A concerning finding is that over two-thirds of the county's muncipalities experienced a decline in the household median income from 2009-2010, likely related to the economic recession and rise in unemployment.

Table 7: Economic Characteristics of Litchfield County Municipalities, 2009-2010

	Median Household Income ($) in 2009	Median Household Income ($) in 2010	Poverty Rate (%) in 2009
Barkhamsted	84,923	80,359	1.5
Bethlehem	88,771	85,096	1.8
Bridgewater	104,559	107,934	2.9
Canaan	69,246	68,150	5.7
Colebrook	72,845	71,608	3.0
Cornwall	68,904	77,243	3.6
Goshen	81,797	78,571	2.3
Harwinton	86,149	80,943	4.9
Kent	70,496	71,008	5.5
Litchfield	73,500	73,510	5.1
Morris	72,451	69,436	6.2
New Hartford	89,151	89,456	3.6
New Milford	85,105	80,887	2.1
Norfolk	74,234	73,426	4.2
North Canaan	47,769	44,817	12.7
Plymouth	68,402	63,940	5.6
Roxbury	116,057	120,008	1.3
Salisbury	66,780	64,758	5.2
Sharon	68,857	69,258	7.4
Thomaston	67,211	62,898	2.9

Torrington	52,746	49,614	11.0
Warren	79,586	76,122	3.8
Washington	86,712	86,439	1.9
Watertown	75,357	72,257	3.2
Winchester	57,799	53,233	8.3
Woodbury	85,843	83,649	3.2
Litchfield County	71,095	70,291	**5.3**
CT	67,034	64,321	**8.7**
US	50,221	50,046	**14.3**

*Note: Ten most populated towns are listed in **bold type.***
Sources: CERC town profiles www.cerc.com and U.S. Census http://www.census.gov/prod/2010pubs/p60-238.pdf
Municipal 2009 & 2010 Median Income: http://pschousing.org/files/HC_2010_CTAffordability_Study.pdf
2009 U.S. Median Income: http://www.census.gov/newsroom/releases/archives/income_wealth/cb10-144.html
CT Median Income 2010: http://www.ers.usda.gov/data/unemployment/RDList2.asp?ST=CT
CT Median Income 2009:
http://www.census.gov/compendia/statab/cats/income_expenditures_poverty_wealth/income_and_poverty--state_and_local_data.html

In examining median income and poverty rates, it is important to note significant inequalities in income and poverty rates exist statewide and within Litchfield County by ethnicity, race, gender, and household composition. The Partnership for Strong Communities report, *2010 Housing in Connecticut: The Latest Measures of Affordabilit*y, indicates that the income disparity in Connecticut ranks second in the nation and has grown faster than any state in the nation, according to the CT Department of Economic and Community Development (DECD). *http://pschousing.org/files/hsginct2010.pdf.*

As noted in CT Department of Public Health's *2009 Connecticut Health Disparities Report*, Hispanic or Latino and Black or African American CT residents were 2 to 3 times more likely to live in poverty than White residents. In terms of household composition, according to U.S. Census ACS estimates, nearly one in four female-headed households (no husband present) in the county with children under the age of 18 live in poverty (23%); for female-headed households with children under the age of 5, this figure jumps to one in two (51%).

An additional consideration is that in areas with a high cost of living such as Litchfield County, families living well above the poverty level often struggle financially. The fair living wage in the county is double the current minimum wage. *http://www.universallivingwage.org/fmrtables_2011/CT_FMR2011.htm*

A timely indicator of financial hardship in the community is the percentage of school-age children who are eligible for free or reduced school meals. The income eligibility for free meals is 130% or below the federal poverty level; for reduced meals it is more than 130% and up to 185% of the federal poverty level. Data indicate that most school districts in the county fall below the statewide average for free or reduced price meal eligibility, with the exception of schools serving Torrington and Winchester. It is notable that over the past two years, there has been an increase in the proportion of eligible children in the majority of districts, with the highest percentage increases in Explorations (Winchester) , North Canaan, Cornwall, and Barkhamsted.

Table 8: Students Eligible for Free/Reduced Price School Meals, Rank Order by School District, 2009-2011

District Name	2009-2010 Eligible for Free/ Reduced Lunch (%)	2010-2011 Eligible for Free/ Reduced Lunch (%)
Explorations District	25.0	45.0
Torrington School District	38.2	42.6
Winchester School District	45.2	41.9
The Gilbert School	32.0	36.6
Plymouth School District	21.8	26.2
North Canaan School District	15.2	24.2
Regional School District 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon)	14.5	19.9
Sharon School District	16.6	18.8
Watertown School District	15.4	16.1
Thomaston School District	18.2	15.3
Colebrook School District	14.3	14.3
New Milford School District	13.9	15.7
Kent School District	11.3	12.9
Regional School District 6 (Goshen, Morris, Warren)	9.0	12.1
Cornwall School District	5.7	11.3
Salisbury School District	9.0	10.3
Litchfield School District	10.4	9.4
Canaan School District	11.6	9.3
Regional School District 14 (Bethlehem, Woodbury)	7.5	8.3
Norfolk School District	8.0	7.5
Barkhamsted School District	4.9	7.0
Regional School District 12 (Bridgewater, Roxbury, Washington)	5.0	6.9
New Hartford School District	8.2	5.8
Regional School District 07 (Barkhamsted, Colebrook, New Hartford, Norfolk)	6.4	5.5
State	32.9	34.4

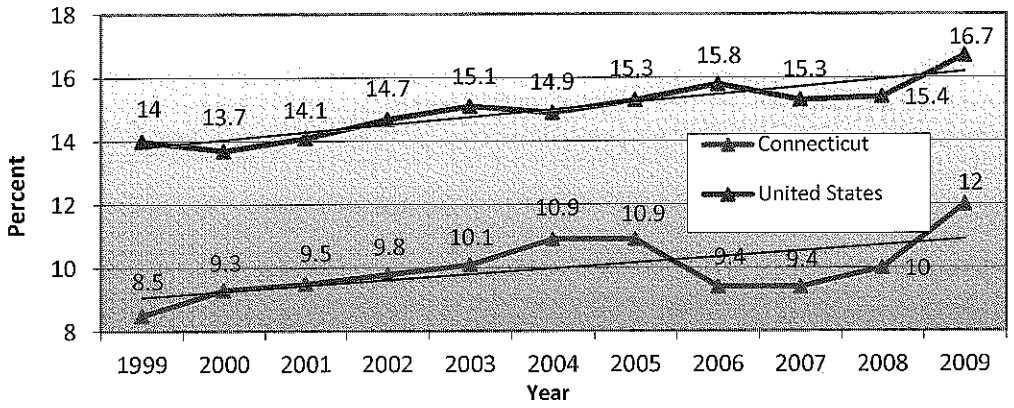
Source: Connecticut State Department of Education, Student Need Data, http://sdeportal.ct.gov/Cedar/WEB/ct_report/StudentNeedDT.aspx

Fortunately Connecticut counties and municipalities have experienced a decline in the unemployment rate over the past year. According to the CT Department of Labor, the state's unemployment rate in March 2011 was 9.2%, and as of March 2012 this had declined to 8.1%, slightly below the national rate of 8.4%. In March 2012, unemployment rates in Litchfield County ranked 4th among the 8 CT counties at 7.7%. Unemployment rates ranged from a low of 4.6% in Bridgewater to a high of 9.3% in North Canaan. http://www1.ctdol.state.ct.us/lmi/laus/laustown.asp. Unskilled workers, persons with low educational attainment, and minorities are historically at higher risk for unemployment.

Health Insurance Coverage

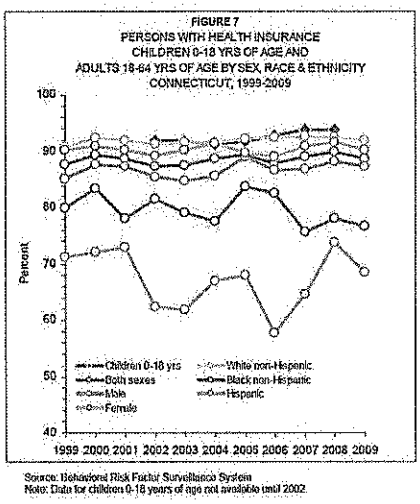
Having public or private health insurance coverage is a strong predictor of both access to and regular use of all types of health care services. Studies demonstrate that individuals lacking health insurance are far more likely to receive fragmented health care and experience delayed access to health screenings and diagnosis and treatment for disease. As shown in Figure 6, the percentage of CT residents who are uninsured is well below the national average. From 2007-2009, however, this percentage increased at a faster rate in CT than in the U.S. as a whole.

Figure 6: CT and U.S. Percent Uninsured Population, 1999-2009



Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/data/historical/index.html. Population as of March of the following year. Reprinted with permission from The 2011 Community Report Card For Western CT http://www.uwwesternct.org

The CT Department of Public Health's (DPH) report, *Healthy Connecticut 2010*, indicates that the likelihood of being insured in our state varies considerably by population subgroup. As shown in Figure 7, children in Connecticut are more likely than adults to have health insurance, females are more likely than males, and white non-Hispanic residents are significantly more likely than non-Hispanic Black and Hispanic residents to have coverage. HUSKY Health is Connecticut's comprehensive public health insurance program, designed to reduce the number of uninsured individuals and families and increase access to preventive care and diagnostic and treatment services.



Source: Healthy Connecticut 2010

As reported by the CT Voices for Children in *Uninsured Children in Connecticut, 2010*, the estimated percentage of uninsured persons in Litchfield County in 2010 based on U.S. Census ACS data, was 6.9% for persons of all ages and 2.4% for children under age 18. These percentages compare favorably with the 2010 CT rate of 9.1% overall and 3.0 % for children. The report also cites the impact of HUSKY in containing the numbers of uninsured children in spite of the recent economic downturn.

Housing and Homelessness

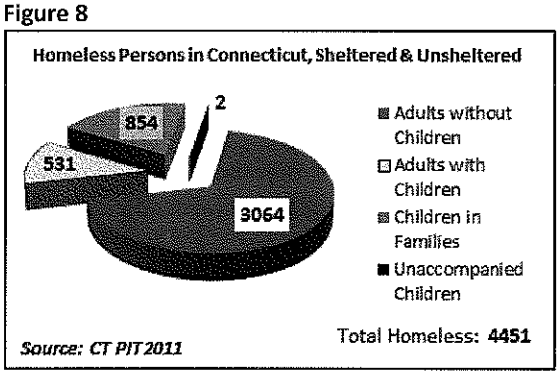
The U. S. Department of Housing and Urban Development defines cost-burdened renters or homeowners as those who pay more than 30% of their income for rent or mortgage payments. In many instances, this leaves little money for other necessities such as food, clothing, transportation, utilities, and healthcare. For renters, the situation is typically worse, as the median household income for renters is substantially less on average than for homeowners. According to U.S. Census 2006-2010 American Community Survey data, 48% of renter households in the county are cost-burdened and 41% of households who are paying a home mortgage are cost-burdened.

The National Low Income Housing Coalition's *2012 Out of Reach Study* indicates that Connecticut is the 7th most expensive state in the nation for housing. In Litchfield County, the hourly wage needed to afford a two-bedroom fair market rate apartment is $20.44 per hour, 2.5 times the minimum wage. *http://nlihc.org/sites/default/files/oor/2012-OOR.pdf*

According to the 2010 U.S. Census, 76.3% of Litchfield County residents own their homes and 23.7% rent. There is considerable variation by muncipality, with the proportion of residents who rent exceeding one in three in Torrington (33.6%) and Winchester (37.4%). The number of subsidized housing units and the proportion of pre-1950 housing stock are also highest in these two communities. Torrington has 1,777 subsidized units and Winchester has 593 units. In Winchester 50% of the housing stock is pre-1950; in Torrington this is 39%. *www.cerc.com*

Since 2007, Connecticut has conducted a statewide standardized and coordinated "census" of homelessness, to enumerate homelessness both in shelters and on the street. Each January, the Connecticut Coalition to End Homelessness coordinates a Point-In-Time Count, to collect data on the exact number of persons experiencing homelessness on a single night in defined geographic areas in the state. The most recent data specific to Litchfield County are from 2007, when a total of 136 single adults and 11 families were counted. According to Point-In-Time Count data for 2011, the number of homeless individuals in Connecticut was 4,451, an 8% increase since 2009. The breakdown by type is shown below.

Figure 8



The NW CT Collaborative for the Education of Homeless Children and Youth is a partnership between the Torrington Public Schools and EDUCATION CONNECTION, the Regional Educational Service Center in the county. This CSDE-funded initiative provides wraparound academic, social, and emotional support services to children living in homeless families, using the McKinney-Vento definition. In 2010-2011, 129 children in Torrington (pre-K through grade 12) were identified as homeless.

The CT Coalition to End Homelessness reports that emergency shelters have been at capacity for over two years, and as a result, there has been a 37% increase in the number of unsheltered homeless statewide. *http://www.cceh.org/files/publications/Connecticut_Point_in_Time_Count_2011_Brief_FINAL_2012.01.09.pdf*.

According to United Way's 2-1-1 community services database, homeless shelters in the county are operated by the New Milford Shelter Coalition (winter emergency shelters at local churches), FISH of Torrington (25 beds), and the Northwest CT YMCA (17 beds).

Community Safety

The Uniform Crime Reporting Program (URC) measures the extent, fluctuation, and distribution of crime in communities across the United States. Eight offenses were chosen to form the Crime Index, including the violent crimes of murder, rape, robbery, and aggravated assault and the property crimes of arson, burglary, larceny-theft, and motor vehicle theft. The Connecticut Department of Emergency Services and Public Protection has all 102 CT police departments participating in the UCR Program.

As shown in Table 9, Litchfield County's overall 2010 crime index compares favorably with the state total average and the state average for non-urban (population < 100,000) areas. The county's index offense rates for all offenses other than rape are consistently below the state total and non-urban area rates.

Table 9 –Litchfield County and CT Crime Rates, 2010

Index Offense	Litchfield County		Connecticut Non-Urban		Connecticut Total	
	#	Rate	#	Rate	#	Rate
Murder	0	0	54	1.8	132	3.7
Rape	39	20.4	401	13.7	599	16.8
Robbery	30	15.7	1,308	44.6	3,554	99.4
Aggravated Assault	91	47.6	2,564	87.4	5,792	162.1
Burglary	579	302.8	10,161	346.2	15,158	424.1
Larceny	2,198	1,149.6	40,903	1,393.7	56,705	1,586.6
Motor Vehicle Theft	97	50.7	3,371	114.9	6,656	186.2
Arson	13	6.8	281	9.6	424	11.9
Crime Index Total	3,034	1,586.8	58,762	2,002.2	88,596	2,478.8

Notes: 2010 rates only include half-year data for Hamden.
Rates are per 100,000 residents.
Source: http://www.dpsdata.ct.gov/dps/ucr/data/2010

In examining crime index rates by municipality in 2010, those with rates above the county average included Torrington, Plymouth, Winchester, and Thomaston. The lowest total crime rate was found in Warren, followed by Roxbury. It should be noted that due to the small population size of many Litchfield County municipalities, rates may vary considerably from one year to the next.

Indicators of community safety from the CT Health Equity Index (a composite score based on crimes against persons and crimes against property) show considerable variation by community, ranging from a low score of 2 in Torrington to a high score of 10 in Bridgewater. Low levels of community safety are also correlated with certain undesirable health outcomes such as lower life expectancy, higher rates of accidents, and mental illness. Socioeconomic factors such as unemployment rates, educational attainment, and income levels are strongly associated with both the prevalence and types of crime in communities.

Domestic abuse crosses all socioeconomic levels and is chronically underreported in crime statistics. The Centers for Disease Control and Prevention estimates that one in four women will be a victim of domestic abuse in their lifetime. The Connecticut Coalition Against Domestic Violence reports that from 7/1/10 – 6/30/11 their 18 domestic violence agencies, including 2 located in Litchfield County, provided services to 54,178 victims of domestic violence. Litchfield County agencies include Women's Support Services in Sharon and the Susan B. Anthony Center located in Torrington. *http://www.ctcadv.org/Portals/0/Uploads/Documents/FACT-SHT%202010%20-2011%20for%20email%20%20.pdf*

As reported in the July 2011 edition of the *Litchfield County Times,* the Susan B. Anthony Project reported nearly a doubling in the need for services from the previous year, and the Torrington Police reported that between 2008 and 2010 they responded to about 2,400 reports of domestic violence, resulting in 960 arrests.
http://www.countytimes.com/articles/2011/07/06/news/doc4e14713e68326011064513.txt?viewmode=fullstory

Community Health-Related and Environmental Assets

Community Health –Related Assets

Litchfield County is home to three acute care hospitals: Charlotte Hungerford Hospital in Torrington, Western CT Health Systems-New Milford Hospital in New Milford, and Sharon Hospital in Sharon. Some key statistics related to each hospital are provided below:

Hospital	Licensed Beds	ED Beds	ICU Beds	2011 Patient Days	2011 ED Visits
Charlotte Hungerford	109	14	10	27,425	39,535
New Milford	85	12	6	9,347	18,780
Sharon	78	11	n/a	11,883	15,265

Sources: http://www.charlottehungerford.org/wp-content/uploads/2012/03/CHH-Community-Report-11.pdf; http://countytimes.com/articles/2012/01/30/business/doc4f26abc9d88e2184167697.txt?viewmode=fullstory; email communication

In addition, there is one federally qualified health center located within the county, the Community Health and Wellness Center of Greater Torrington. Federally qualified health centers (FQHC) receive federal funding support to provide preventive, primary, and specialty care services in medically underserved areas. Within the county, Torrington is a federally designated primary care health professional shortage area. FQHC patients without insurance pay for care based on their income, using a sliding fee scale, however no one is refused care based on inability to pay.

According to data compiled by the Pomperaug Health District, there are 16 Long Term Care Facilities in the county, located in Canaan (1), Kent (1), Litchfield (1), Plymouth (1), New Milford (2), Salisbury (1), Sharon (1), Torrington (5), Watertown (2), and Winchester (1). The combined bed capacity of these facilities is 1,562.

Muncipalities within the county are served by 4 full-time health districts, 1 full-time health department, and 1 part-time health department. The majority (17 out of 26) of the county's muncipalities are served by the Torrington Area Health District, including Bethlehem, Canaan, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, Norfolk, North Canaan, Plymouth, Salisbury, Thomaston, Torrington, Warren, Watertown, and Winchester.

Within the county, the Pomperaug Health District serves Woodbury, the Farmington Valley Health District serves Barkhamsted, Colebrook, and New Hartford, and the Newtown Health District serves Bridgewater and Roxbury. The New Milford Health Department serves the town of New Milford. The county's two part-time health departments are located in Sharon and Washington. Phone, email, and website contact information for all health department/districts is available at https://www.han.ct.gov/local_health/localmap.asp?cfilter=litchfield&bar=1&debug

There are a wide variety of additional health-related resources within the county. United Way of CT Infoline 2-1-1 maintains an up-to-date online searchable community resource database of health and human service providers, agencies, and organizations, available at http://www.211ct.org/referweb/search.aspx . United Way also publishes an annual report, *The 2-1-1-Barometer - Identifying Unmet Needs in CT*, highlighting gaps between service requests and available resources in the community. This report can be accessed at: http://www.ctunitedway.org/Media/Barometer/June2011.pdf

The *2012 County Health Rankings* report indicates that Litchfield County has a ratio of 1 primary care physician to every 1,123 residents, which ranks second to last among CT counties and well below both the national benchmark of 1 primary care physician for every 631 persons and the state average of 1 primary care physician per 729. Geographic areas with lower population densities such as Litchfield County are more likely to have health professional shortages. http://www.countyhealthrankings.org

Environmental Assets

With its sizable land mass and low population density, the County abounds in open space areas for recreation. Seven state parks, five state forests, and one state recreation area lie within its borders. In addition, the county offers countless opportunities for year round outdoor recreation through greenways, trails, conservation areas, and numerous lakes, ponds, rivers, and streams. However, access to many of these resources is limited to residents with private transportation. In terms of public transportation, the Houstanic Area Regional Transit operates a fixed route bus system in New Milford, Torrington Transit Authority provides scheduled service in Torrington, and Dial-A-Ride services are available in the remainder of the county through the Northwestern CT Transit District. According to the Census 2006-2010 ACS, only 1.3% of Litchfield County residents use public transportation to commute to work.

Due to the rural character of many of the county's town centers and roadways, there is limited existing infrastructure such as sidewalks, street lights, or bike lanes to promote walking or biking as a transportation mode within and among county communities.

Special Populations

Vulnerable groups include county residents experiencing financial hardships, language and cultural barriers, and difficulty accessing health care; perinatal women; the very young and very old; persons with disabilities; and persons residing in group quarters. As shown in Figure 1, there has been considerable growth in the county population ages 85 and over, increasing needs for supported living environments and health care services.

Persons in group quarters are in a group living arrangement, that is owned or managed by an independent entity. Group quarters include such places as college residence halls, residential treatment centers, skilled nursing facilities, group homes, military barracks, and correctional facilities. Census 2010 reports a total of 2,804 persons living in group quarters in the county, including 1,566 individuals (503 males and 1,063 females) in institutions. The remaining 1,238 individuals (682 males and 556 females) reside in non-institutional settings.

Recent Census data on the extent and type of disabilities in county residents of all ages was not yet available at the time of publication. Disability information for school- age children as reported by CSDE indicate that in 2010-2011, overall 11.7% of CT K-12 students had one or more disabilities. The most common types of disabilities reported were learning disabilities, followed by speech/language impairments, other health impairments, autism, and emotional disurbances. Data for individual schools in Litchfield County for 2010 - 2011 show a wide variation in the proportion of K-12 students with disabilties by school, ranging from a low of 5.4% to a high of 25%. *http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationDT.aspx*

Related to maternal, infant, and child health, the DPH *Maternal, Infant, and Early Childhood Home Visiting Needs Assessment* examined existing services and compared data to relevant risk factors of families of young families. *http://www.ct.gov/dph/lib/dph/needs_assessment_complete_091510.pdf* Torrington and Winchester were found to have a very high need for services and Plymouth was found to be in moderate need. EDUCATION CONNECTION's Early Head Start and Head Start Program 2012 Community Assessment details the significant health and social service needs of the families it serves in New Milford, Torrington, and Winchester. In addition, The Torrington Early Childhood Collaborative's *Birth through 8 Community Plan*, a Graustein Discovery Community initiative, presents a community-designed plan to assure "All of Torrington's children from birth through age 8 are healthy and successful learners".

Health Status of County Residents

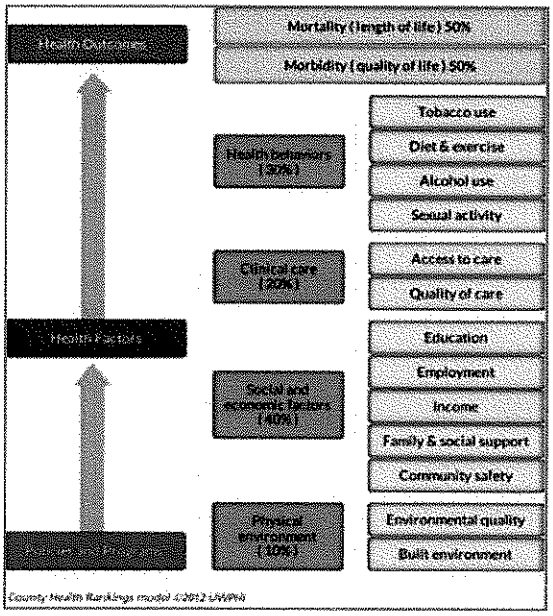
A number of indicators are used to describe the health status of residents in a specific geographic area. These include the presence or absence of health promoting behaviors; access to and utilization of health screenings, primary care and specialized health care services; the incidence and prevalence of chronic and communicable diseases; and the leading causes of premature death and disability.

State and County Health Rankings

According to the United Health Foundation, in 2011 Connecticut ranked third highest in health status in the nation, a continued positive trend from a rank of seventh in 2009 and fourth in 2010. Specific strengths cited include low rates of smoking, a lower prevalence of obesity when compared to other states in the nation, a low percentage of children in poverty, a low rate of uninsured population, high immunization coverage, and relatively high proportion of primary care physicians. Areas where improvements are needed include a high rate of binge drinking and moderate levels of air pollution. The report indicates that CT has demonstrated success in reducing deaths from cardiovascular disease and cancer and, in the past ten years, smoking prevalence has decreased dramatically. *Source: http://www.americashealthrankings.org/CT/2011*

The 2012 County Health Rankings, a collaboration of the University of Wisconsin's Population Health Institute and the Robert Wood Johnson Foundation, ranks CT counties based on health outcomes and health factors. Counties receive a Health Outcome rank based on mortality and morbidity and a Health Factor rank based on health behaviors, clinical care, social-economic factors, and the physical environment. Figure 9 shows the weighting structure used to calculate the rankings. This quantifies the interconnectedness of personal health behaviors, clinical care, social and economic factors and the physical environment in which we live.

Figure 9



Within CT, counties are ranked from 1 to 8 on health factors and outcomes, with a rank of one being the "healthiest". Health outcomes represent the overall health of the county; health factors represent what influences the health of the county.

Health outcomes are based on an equal weighting of mortality (how long people live) and morbidity (how healthy people feel) factors. Litchfield County ranked 4th out of the eight CT counties for health outcomes. Health factors rankings are based on the weighted average for the four different types of factors (% used for weighting are shown in parentheses in Figure 9). Litchfield County ranked 3rd out of the eight counties for health factors.

Rank	Health Outcomes	Rank	Health Factors
1	Tolland	1	Middlesex
2	Middlesex	2	Tolland
3	Fairfield	3	Litchfield
4	Litchfield	4	Fairfield
5	New London	5	New London
6	Hartford	6	Hartford
7	Windham	7	New Haven
8	New Haven	8	Windham

Selected findings specific to Litchfield County, with CT and U.S. comparisons follow.

Table 10 – Litchfield County Health Indicators, 2012

INDICATOR	Litchfield County	Error Margin	National Benchmark *	CT
Premature death	5,285	4,908-5,662	5,466	5,641
Poor or fair health	10%	8-12%	10%	11%
Poor physical health days	3.0	2.7-3.4	2.6	2.9
Poor mental health days	3.1	2.7-3.5	2.3	3.1
Adult smoking	18%	16-20%	14%	16%
Adult obesity	20%	18-23%	25%	23%
Physical inactivity	19%	17-22%	21%	23%
Excessive drinking	17%	15-19%	8%	18%
Preventable hospital stays	50	47-52	49	63
Diabetic screening	84%	80-88%	89%	83%
Mammography screening	74%	69-77%	74%	71%
Access to recreational facilities	12		16	14
Limited access to healthy foods	0%		0%	5%
Fast food restaurants	24%		25%	38%

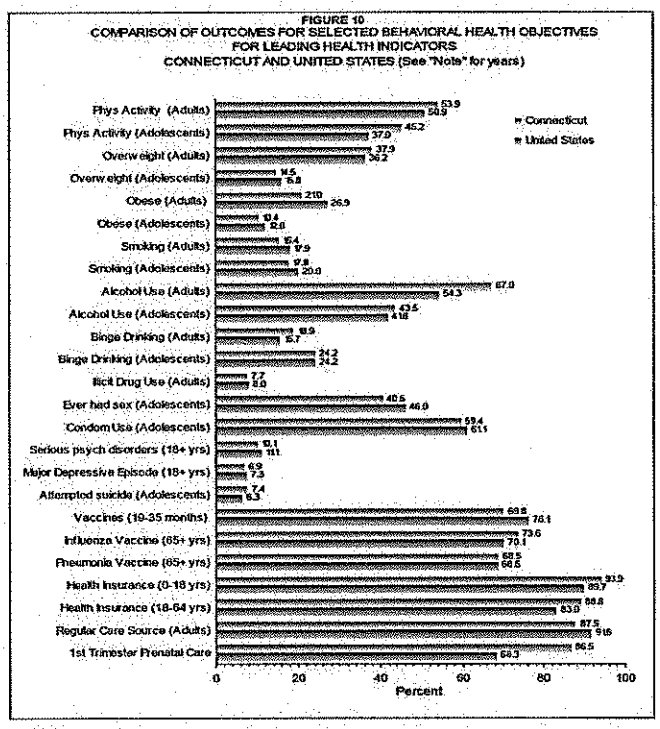
* 90th percentile, i.e., only 10% are better
Note: Blank values reflect unreliable or missing data
Source: http://countyhealthrankings.org

As noted in Table 10, Litchfield County meets National Benchmarks and compares favorably to the state on a number of indicators including: premature death, residents reporting poor or fair health, prevalence of adult obesity and physical inactivity, mammography screening, access to healthy foods, and percentage of fast food restaurants. The county also compares favorably to the state for preventable hospital stays and has comparable rates for excessive drinking and diabetic screening. County indicators that do *not* meet National Benchmarks include poor physical and mental health days, adult smoking, excessive drinking (county rate is more than double the National Benchmark), and preventable hospital stays.

Lifestyle Behaviors and Risk Factors

As stated in *Healthy People 2010*, individual behaviors and social-environmental factors account for about 70% of premature deaths in the U.S. Health promoting lifestyle behaviors such as avoiding tobacco, illicit drug, and excessive alcohol use; healthy eating; regular physical activity; and managing stress are key to reducing the burden of chronic disease and premature death in county residents.

The CT DPH report, *Healthy Connecticut 2010,* compares outcomes in U.S. and CT residents for selected behavioral health objectives related to *Healthy People 2010* leading health indicators - physical activity, overweight/obesity, tobacco use, substance abuse, sexual behaviors, mental health, injury and violence, environmental quality, immunization, and access to health care. Key findings are presented in Figure 10.



Sources: Behavioral Risk Factor Surveillance System, Connecticut School Health Survey, Youth Risk Behavior Survey, National Immunization Survey, National Survey on Drug Use and Health.

Notes: Data years: Physical Activity, Overweight, Obese, Smoking, Alcohol Use, Binge Drinking (Adults 2009, Adolescents 2009); Illicit Drug Use, Serious Psychological Disorders, Major Depressive Episode (2006-2007); Sex, Condom Use (during last sexual intercourse), Attempted Suicide (2009); Vaccines (2009); Health Insurance (Children 2007-2008, Adults 18-64 yrs 2009).

In general, CT residents had a lower prevalence of most behavioral risk factors than the average U.S. resident and were more likely to be physically active, not be obese, and not smoke. In contrast, there was a higher prevalence of alcohol use in both teens and adults, and overweight and binge drinking in adults.

The Centers for Disease Control and Prevention (CDC) Community Transformation and the national Million Hearts™ initiatives both target reduction of major risk factors for heart disease and stroke, which are leading causes of death and disability in the nation, state, and county. These risk factors include tobacco use, poor diet, physical inactivity, and unhealthy weight. In addition, control of high blood pressure and high cholesterol are imperative for maintaining cardiovascular health.

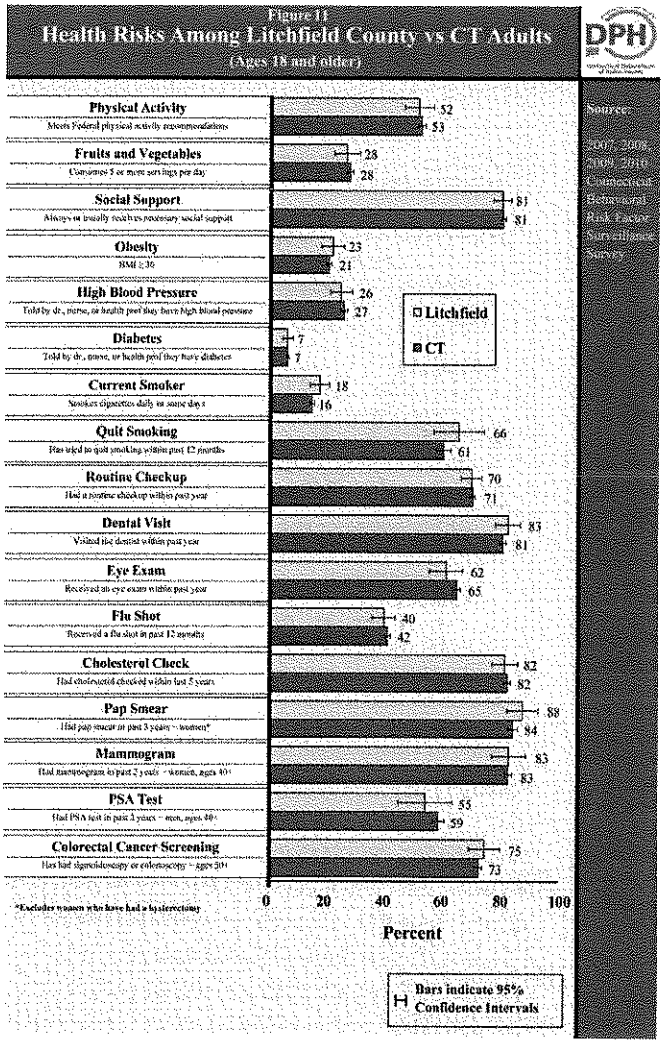
Behavioral Risk Factor Surveillance

The CDC Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random telephone survey of adults ages 18 and over conducted in all 50 states. The BRFSS originally collected data on health behaviors related to the leading causes of death, but has since expanded to include survey questions related to health care access, utilization of preventive health services, and emerging health issues.

Comparative BRFSS data for Litchfield County and the state for the years 2007-2010 are presented in Figure 11. In general, Litchfield County residents had similar rates (identical or within 1 point) to the state related to social support, physical activity, fruit and vegetable consumption, prevalence of high blood pressure and diabetes, having routine medical check-ups, cholesterol testing and mammography.

County residents reported more frequent attempts to stop smoking than state residents as a whole (with co-existing higher smoking rates), and more frequent participation in routine dental care, pap smears and colorectal cancer screening.

County residents were more likely to be obese or current smokers than CT residents overall, and were less likely to participate in routine eye exams, influenza vaccination, and PSA testing (in men). None of the differences were statistically significant.

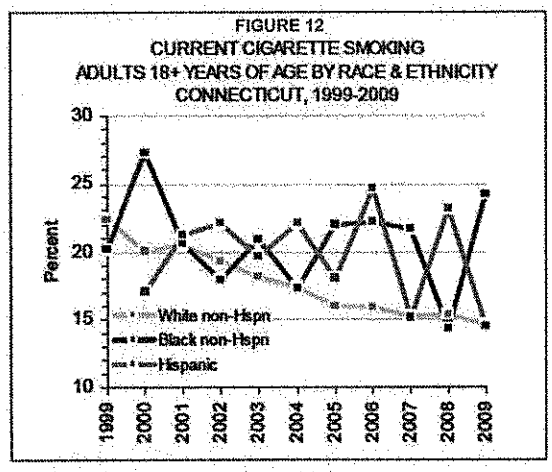


Tobacco Use

Smoking is the single most avoidable cause of chronic disease and death. Smoking increases the risk of lung, bronchus, trachea, and esophageal cancer as well as many other types of cancers, heart disease, stroke, and chronic lung diseases. As reported in *Healthy Connecticut 2010*, over 5,000 CT adults die each year due to smoking and from exposure to secondhand smoke. As reported in the *2011 United Health Foundation's Health Rankings*,

Connecticut has one of the lowest rates of current smoking in adults, and in 2011, ranked 3rd lowest among U.S. states (13.2% compared to 17.3% nationally).

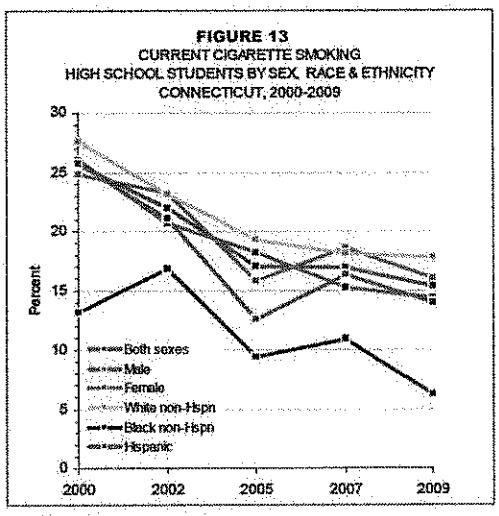
Smoking among Connecticut adults has declined by 40% over the past 20 years, with the greatest decrease occurring during the last decade. As shown in Figure 12, smoking prevalence has decreased for all adult groups other than Black non-Hispanics since 1999. *Source : http://www.ct.gov/dph/lib/dph/state_health_planning/healthy_people/hct2010_final_rep_jun2010.pdf.*



Source: Behavioral Risk Factor Surveillance System

In spite of these positive trends, continued efforts to avoid tobacco use are imperative to future reductions in morbidity and mortality from cancer, respiratory, and cardiovascular diseases. In CT adults, smoking prevalence is highest in males, persons ages 18-24, those with less than a high school education, and those with incomes below $25,000 (26.4%). Based on BRFSS age-adjusted rates, Litchfield County ranked third highest in smoking prevalence among CT counties in 2007-2009.

Healthy Connecticut 2010 reports smoking rates in adolescents have also shown a dramatic decline from 2000-2009 (66% among middle school and 40% among high school students). In middle school, Hispanic or Latino students had the highest smoking rates, while in high school, white non-Hispanics had the highest smoking rates.

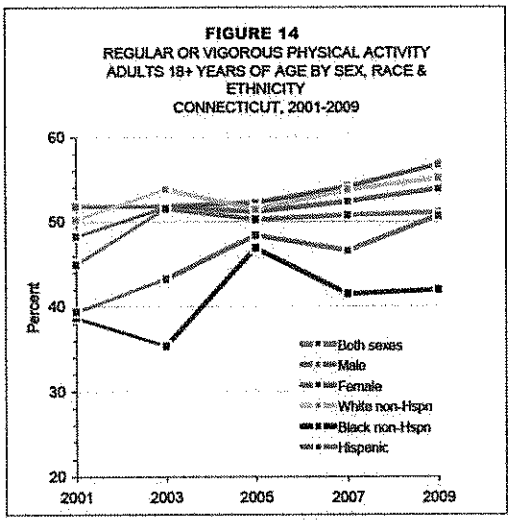


Source: Connecticut Youth Tobacco Survey

Physical Activity, Healthy Eating, and Healthy Weight

Regular or vigorous physical activity is important to overall health and weight management. Regular activity reduces the risk of obesity, heart disease and stroke, colorectal and breast cancers, type 2 diabetes and metabolic syndrome, high cholesterol, high blood pressure, and osteoporosis. Activity also improves mental health and mood and lowers the overall risk of premature death. As shown in Figure 14, physical activity among CT adults increased from 2001-2009, with the greatest gains in Hispanic residents. There was significant disparity in the reported level of activity for Black and White non-Hispanics.

Based on 2007-2009 BRFSS data, adults more likely to meet physical activity recommendations were male, white non-Hispanic, ages 18-24, and those with higher education and income levels. Based on age-adjusted data, Litchfield County ranked third highest among CT counties in the percentage of adults *not* meeting recommended requirements (moderate physical activity for 30 minutes or more 5 times per week or vigorous physical activity for 20 minutes or more 3 times a week).



Source: Behavioral Risk Factor Surveillance System

According to the National Survey of Children's Health, in 2007 CT children were more likely than their counterparts nationwide to be physically active for at least four days per week (36.2% versus 34.4%), and less likely to spend one hour or more a day in front of a television or computer screen (42.7% versus 50.1%). *Source: http://childhealthdata.org/docs/nsch-docs/connecticut-pdf.pdf*

The CT DPH *2009 CT School Health Survey - Youth Behavior Component* report indicates that the percentage of adolescents who are physically *inactive* increases by grade from 11.2% in grade 9 to 19.9% in grade 12; female and Black or Hispanic students are much more likely to be inactive.

Another measure of the level of physical fitness in youth is the percentage of students in local school districts passing all four components of state physical fitness tests. These standardized tests include four areas of fitness: aerobic endurance, flexibility, muscular strength and endurance.

The results for K-12 students enrolled in school districts within the county are presented in Table 11. In general, less affluent districts in the county scored lowest. There is also a trend towards lower percentages in regional middle schools and high schools when compared with their elementary school "home town" districts.

Table 11 – Percentage of K-12 Students Passing All Four Physical Fitness Test Components, 2010-2011

District	% K-12 Students Passing (Listed in Rank Order)
Cornwall School District	80.5
Regional School District 12 (Bridgewater, Roxbury, Washington)	76.9
Regional School District 6 (Goshen, Morris, Warren)	68.8
Kent School District	67.0
Canaan School District	65.2
Salisbury School District	64.6
Litchfield School District	60.1
Plymouth School District	58.6
Sharon School District	56.1
Thomaston School District	52.4
Colebrook School District	51.3
Watertown School District	50.1
Regional School District 14 (Bethlehem, Woodbury)	49.9
New Milford School District	46.9
New Hartford School District	45.9
Regional School District 7 (Barkhamsted, Colebrook, New Hartford, Norfolk)	43.8
Barkhamsted School District	43.2
Regional School District 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon)	35.1
Winchester School District	34.7
Norfolk School District	31.9
The Gilbert School	31.0
Torrington School District	30.4
North Canaan School District	28.7
State	51.0

Note: Data for Explorations unavailable. Source: CSDE http://sdeportal.ct.gov/Cedar/WEB/ct_report/PhysicalFitnessDTViewer.aspx

Available county level BRFSS survey data (2007-2010) on healthy eating are limited to fruit and vegetable consumption. Survey findings indicate that only 28% of adults consume the recommended 5 or more servings of fruits and vegetables per day. Eating the recommended amount of fruits and vegetables is more common in females, White non-Hispanics, persons ages 65 and over, and those with higher education and income levels. Based on age-adjusted data, Litchfield ranks fourth among CT counties in the percentage of persons

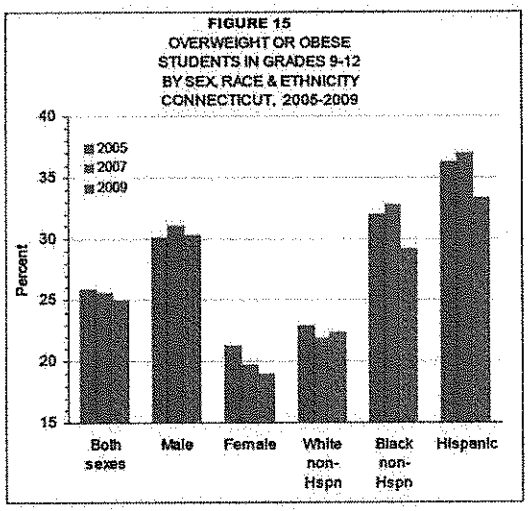
consuming less than the recommended quantity of fruits and vegetables. Related to healthy eating by youth, the *CT School Health Survey - Youth Behavior Component* (2009) reports that overall only 21% of CT high school students consume 5 or more servings of fruits and vegetables, and male students are more likely than female students to consume the recommended amounts (at statistically significant levels). *Source:* http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_2009_ybcreport.pdf

Obesity and overweight in children, adolescents, and adults have reached epidemic proportions in the U.S. According to CDC, the prevalence of childhood and adolescent obesity has more than tripled in the past 30 years. The percentage of children aged 6–11 years in the nation who were obese increased from 7% in 1980 to nearly 20% in 2008. Over this same time period, the percentage of adolescents aged 12–19 years who were obese increased from 5% to 18%.

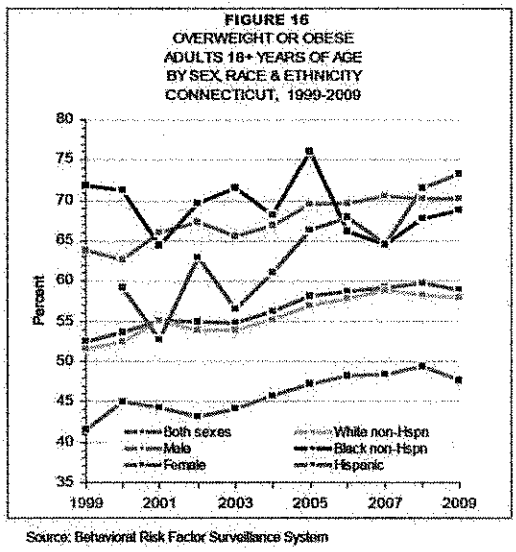
The long-term health consequences of childhood and adolescent obesity are serious. Youth who are obese are more likely to experience social and psychological problems due to poor self-esteem. They are more likely to be overweight adults, and consequently at a greater risk for developing heart disease, hypertension, type 2 diabetes, stroke, osteoarthritis, and certain types of cancer. *Source: CDC, Adolescent and School Health,* http://www.cdc.gov/healthyyouth/obesity/facts.htm.

According to the National Survey of Children's Health, in 2007 approximately 95,000 Connecticut children ages 10-17 years (25.7%) were considered overweight or obese according to Body Mass Index (BMI) for age standards. Hispanic/Latino (40.4%) and Black/African American (38.1%) children in Connecticut are almost two times more likely than White children (21.8%) to be overweight or obese.

Healthy Connecticut 2010 reports racial and ethnic disparities in overweight and obesity in adolescents and adults, as shown in Figures 15 and 16. In high school students, obesity is more prevalent in males and in Hispanic students followed by Black non-Hispanic students. In adults, obesity is more prevalent in these same groups, with rapid rise in obesity in Hispanic adults from 2007-2009.



Source: Youth Risk Behavior Survey



Source: Behavioral Risk Factor Surveillance System

Based on 2007-2010 BRFSS data, 23% of adults in the county are obese. Obesity is also more common in adults with lower educational and income levels. Litchfield County ranked third highest among CT counties in the age-adjusted rate of obesity in adults.

The Burden of Chronic Disease

According to the Centers for Disease Control and Prevention (CDC), 7 out of 10 deaths among Americans each year are the result of chronic diseases, and almost 1 out of every 2 adults has at least one chronic illness. Chronic diseases are also estimated to be responsible for 75% of health care costs in the U.S.

The burden of chronic disease is not shared equally among population subgroups in our nation, state or county – significant disparities exist. *Healthy People 2020* defines a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health.*

The burden of chronic disease in county residents is assessed in several ways – through examination of disease surveillance data, health care utilization data (such as emergency department visit and hospitalization rates by type of diagnosis), and mortality data.

The most prevalent category of chronic diseases in the U.S. is cardiovascular diseases (CVD). Major cardiovascular diseases include coronary heart disease (CHD), cerebrovascular disease (stroke), and heart failure. CVD is the leading cause of death in Connecticut, accounting for about one-third of all resident deaths. More than half (55%) of these deaths are among females. Risk factors for CVD may be modifiable or non-modifiable. Modifiable risk factors include high blood pressure, high blood cholesterol, smoking, diabetes, obesity, and physical inactivity. Non-modifiable risk factors include increasing age and family history of heart disease and stroke. The age-adjusted mortality rates for CVD have declined significantly for CT residents over the past decade. However, there are considerable disparities in mortality rates from CVD, with Black or African American residents having the highest rates. *Source: CTDPH, the Burden of Cardiovascular Disease in Connecticut, 2010 Surveillance Report, http://www.ct.gov/dph/lib/dph/hisr/pdf/2010cvd_burdendoc_final.pdf.*

High blood pressure and elevated cholesterol levels are both major risk factors for CVD. Data from the 2007-2010 BRFSS show that more than one in four (27%) CT adults have been told they have high blood pressure by a health professional. High blood pressure is more common in males, Black non-Hispanic adults, persons ages 65 and over, and in persons with lower education and income levels. Based on age-adjusted rates, Litchfield County ranks third lowest among CT counties in the prevalence of high blood pressure in adult residents (23.4%).

Data from the 2007-2010 BRFSS show that the majority of CT and county adults (82%) had their cholesterol checked in the past 5 years. BRFSS data from 2007-2009 indicate that adults most likely to have their cholesterol checked were female, white non-Hispanic, ages 65 and over, (95% vs. 40% in persons ages 18-24), and adults with higher education and income levels. Adults most frequently reporting they had *never* had their cholesterol checked were Hispanic or Latino (31%), and persons with less than a high school education and annual incomes below $25,000. Based on age-adjusted rates, Litchfield County ranked second to last in the percentage of adults who reported *never* having their cholesterol checked (20.8%).

Data on the prevalence of elevated cholesterol in adults compiled from the 2007-2009 BRFSS show that 37.8% of CT adults have been told by

a health professional that their blood cholesterol is high. High blood cholesterol is more common in males, White non-Hispanic residents, persons ages 65 and over, and persons with less education and income. Based on age-adjusted rates, Litchfield County residents have the lowest prevalence of high cholesterol among CT counties (29.3%).

The second most frequent type of chronic disease in CT is malignant neoplasms or cancer. The incidence rate of new cancer cases and mortality rates have been steadily decreasing. This is the result of increased primary prevention efforts, earlier detection and improved treatment options. *Source: CTDPH, Connecticut Comprehensive Cancer Control Program, Connecticut Cancer Plan 2009-2013, http://www.ct.gov/dph/lib/dph/comp_cancer/pdf_files/ctcancerplan_2009_2013_cdversion.pdf.* In 2008, the age-adjusted cancer incidence rate in Connecticut was estimated at 499.8 per 100,000 people, a decrease from the 2007 rate of 502.5 per 100,000 people. *Source: http://statecancerprofiles. cancer.gov.*

In Connecticut (2007-2009 BRFSS data), an estimated 6.9% or approximately 186,000 adults aged 18 and older reported being diagnosed with diabetes. An additional 93,000 adults are estimated to have undiagnosed diabetes. The prevalence of type 2 diabetes in CT and in the nation has increased significantly. Type 2 diabetes typically develops later in life and is strongly associated with overweight and obesity. *Source: CTDPH, The Burden of Diabetes in Connecticut, 2010 Surveillance Report, http://ct.gov/dph/lib/dph/hisr/pdf/2010diabetesburden_final.pdf.*

As reported in the 2007-2009 BRFSS, diabetes is twice as prevalent in Black non-Hispanic adults as in White non-Hispanic adults, and prevalence increases with age. Diabetes also occurs most frequently in adults with less education and lower incomes, who also experience disproportionately higher rates of obesity. The age-adjusted prevalence of diabetes in county adults ranks fifth among CT counties (6.7%).

Utilization of health care services, including emergency department (ED) visit and hospitalization rates are important measures of the burden of chronic disease. Frequent use of ED services for primary care conditions also indicates that a community may have an insufficient quantity of primary care providers or health providers serving the uninsured.

Table 12 depicts ED visit rates for CT and for Litchfield County. These rates represent ED visits by residents to any hospital within CT (visits to hospitals outside CT are excluded). Overall, ED visit rates for county residents are comparable to those for CT residents, however there are notable differences by race/ethnicity and diagnostic group. The ED visit rates for White and Black-non Hispanic residents are well above the state average, and those for Hispanics fall well below the state average. Lower ED visit rates for Hispanic residents may be explained in part due to underreporting of this ethnicity on ED intake records.

By diagnostic group, county residents overall had similar ED visit rates for cancer (all sites and lung/bronchus) and for liver disease, including cirrhosis. County residents had higher ED visit rates for major CVD, coronary heart disease, acute myocardial infarction (MI), congestive heart failure, and stroke. Black non-Hispanics had disproportionately high rates for diabetes, alcohol & drug abuse, major CVD, and congestive heart failure. County residents overall had lower ED visit rates for diabetes, drug and alcohol abuse, chronic obstructive lung disease and asthma, however again the rate for Black non-Hispanics was well above the state and county average. ED visits for most chronic conditions increased with advancing age, with the exception of asthma which is highest in children four years of age and under.

Table 12 - State and County Age-Adjusted ED Visit Rates per 100,000 Residents by Gender, Race, and Ethnicity, 2005-2009

Connecticut							Litchfield County						
Diagnostic Group*	Total	Female	Male	White N/H	Black N/H	Hispanic Latino	Diagnostic Group	Total	Female	Male	White N/H	Black N/H	Hispanic Latino
All	36,400.8	38,135.6	34,626.8	24,064.9	46,846.4	55,649.1	All	36,635.0	37,346.3	35,654.5	35,455.8	64,926.6	21,092.8
Cancer, all sites	11.7	10.4	13.6	7.8	17.2	19.0	Cancer, all sites	12.2	11.0	14.3	11.3	a	a
Oral Cavity & Pharynx	0.3	0.1	0.5	0.2	0.7	0.6	Oral Cavity & Pharynx	a	-	a	a	-	-
Lung & Bronchus	2.4	2.0	3.0	1.7	3.4	2.9	Lung & Bronchus	2.5	2.4	2.9	2.4	a	a
Diabetes	182.0	162.8	202.7	93.4	487.9	452.4	Diabetes	142.6	120.3	168.2	130.1	442.8	118.8
Alcohol & Drug Abuse	775.9	420.8	1,140.1	560.0	1,018.2	1,077.9	Alcohol & Drug Abuse	732.8	489.3	966.2	709.8	961.0	309.5
Major CVD	388.0	349.2	433.3	267.1	616.8	509.9	Major CVD	476.6	405.2	550.0	462.0	706.0	264.0
CHD	37.1	23.3	53.0	29.6	19.7	40.5	CHD	68.9	43.9	96.3	68.8	63.9	a
Acute MI	20.4	11.7	30.3	17.3	8.6	17.5	Acute MI	36.5	21.9	52.5	36.8	a	a
CHF	36.2	31.0	43.3	24.1	72.6	57.7	CHF	57.7	52.0	65.8	55.3	168.2	a
Stroke	19.0	16.9	21.6	14.6	15.2	18.8	Stroke	35.2	26.3	44.8	33.9	a	24.7
COPD	984.2	1,085.2	877.1	549.1	1,602.5	2,094.0	COPD	786.1	865.6	691.1	751.5	2,068.9	613.0
Asthma	663.2	732.3	587.7	320.6	1,218.6	1,545.2	Asthma	463.7	516.5	401.7	432.4	1,655.0	459.4
LD & Cirrhosis	5.2	2.7	7.8	3.5	4.0	12.7	LD & Cirrhosis	5.3	2.4	8.1	5.3	-	-

Notes: CVD = Cardiovascular Disease; CHD= Coronary Heart Disease; MI = Myocardial Infarction (Heart Attack); CHF = Congestive Heart Failure; COPD = Chronic Obstructive Pulmonary Disease; LD =Liver Disease. a= data suppressed due to confidentiality. A dash (-) represents the number zero. Source: Connecticut Department of Public Health. 2012. Connecticut Hospital Information Management Exchange (CHIME) Emergency Department Data Set, 2005-2009.

Table 13 shows hospitalization rates for the state and county for the same diagnostic categories. County rates are below the state rates for the majority of diagnostic categories, including all diagnostic groups, cancer (all sites and lung/bronchus), diabetes, major CVD, CHD, acute MI, CHF, stroke, COPD, asthma, and liver disease and cirrhosis.

Table 13 - State and County Age-Adjusted Hospitalization Rates per 100,000 Residents by Gender and Race/Ethnicity, 2005-2009

Connecticut							Litchfield County						
Diagnostic Group*	Total	Female	Male	White N/H	Black N/H	Hispanic Latino	Diagnostic Group	Total	Female	Male	White N/H	Black N/H	Hispanic Latino
All	10,036.5	11,180.6	9,078.6	9,114.1	14,351.4	11,583.8	All	8,845.3	9,952.5	7,910.5	8,822.8	10,268.2	3,886.7
Cancer, all sites	377.1	368.6	398.5	363.5	450.2	302.1	Cancer, all sites	351.0	329.5	388.3	346.4	293.1	115.9
Oral Cavity & Pharynx	6.4	3.8	9.4	6.2	8.3	4.1	Oral Cavity & Pharynx	9.1	4.6	14.6	9.1	-	a
Lung & Bronchus	42.9	38.4	49.6	42.7	46.7	26.2	Lung & Bronchus	38.6	31.3	47.7	38.2	a	a
Diabetes	132.9	112.6	157.1	97.3	403.5	249.6	Diabetes	86.7	60.0	116.5	87.8	180.9	23.9
Alcohol & Drug Abuse	139.3	84.8	196.4	143.3	160.1	129.5	Alcohol & Drug Abuse	165.5	97.8	235.7	173.3	233.3	37.0
Major CVD	1,401.8	1,111.2	1,773.9	1,313.4	1,986.6	1,509.6	Major CVD	1,177.0	918.0	1,488.7	1,152.2	1,425.4	476.3
CHD	406.5	265.9	578.4	392.3	396.8	427.1	CHD	338.6	206.2	492.0	323.0	231.3	129.3
Acute MI	163.0	115.9	221.9	158.0	153.0	180.0	Acute MI	146.2	101.4	197.8	141.9	96.6	75.9
CHF	172.8	144.3	214.2	154.6	306.7	230.6	CHF	115.6	102.6	133.0	114.2	226.4	32.1
Stroke	183.8	158.7	216.9	169.9	290.3	182.7	Stroke	166.0	146.9	189.4	162.9	170.5	45.4
COPD	277.8	297.6	258.2	222.8	515.9	548.5	COPD	207.2	230.9	182.5	210.5	266.2	78.8
Asthma	136.9	157.9	112.5	83.3	363.7	378.0	Asthma	69.5	83.5	54.0	69.8	170.3	52.0
LD & Cirrhosis	27.4	18.1	37.6	24.2	28.5	63.3	LD & Cirrhosis	21.1	14.3	28.3	21.7	a	17.0

Source: Connecticut Department of Public Health. 2012. Connecticut Hospital Information Management Exchange (CHIME) Hospital Discharge Data Set, 2005-2009.

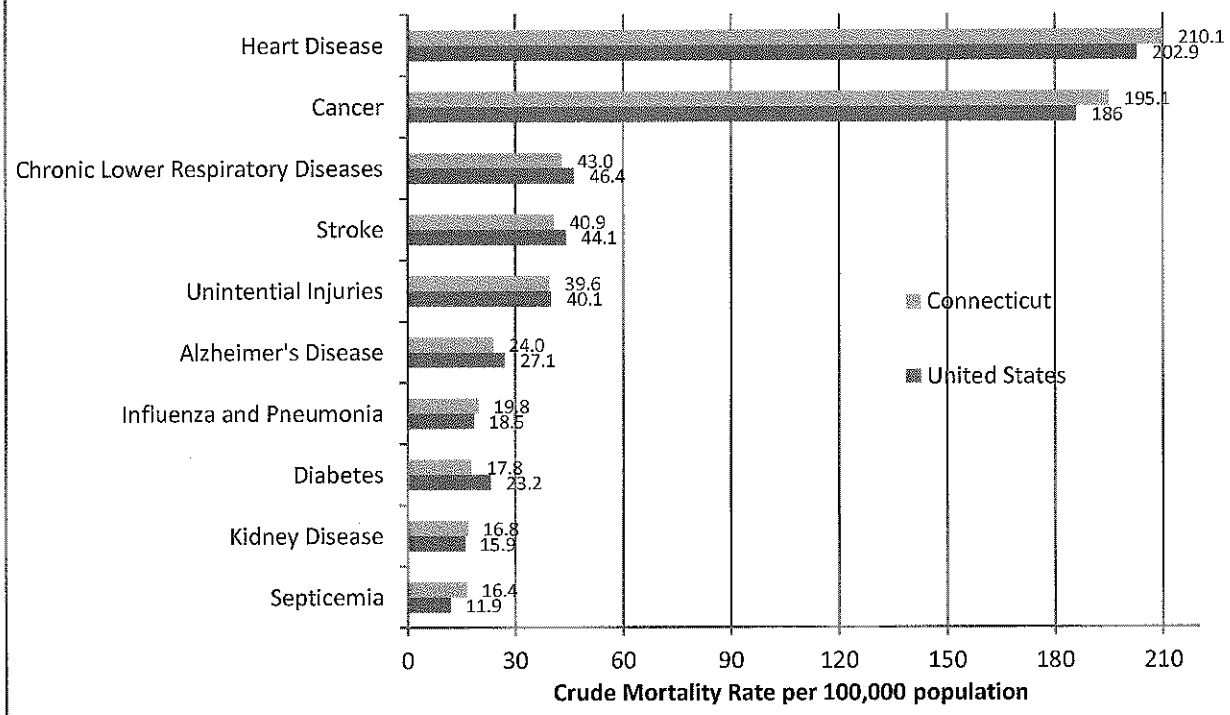
The rates provided in Table 13 represent admissions to any CT hospital. Hospitalization rates for county residents are higher than state rates for oral cavity/pharynx cancers and for alcohol and drug abuse. Within county hospitalization rates are higher for males for most diagnoses, and for Black non-Hispanic residents than other racial/ethnic groups. The low hospitalization rates for Hispanic county residents may in part reflect underreporting of Hispanic ethnicity on hospital records. As expected, hospitalization rates for chronic diseases generally rise with advancing age and are highest in persons ages 65 and over. The notable exception is again asthma, with the highest rates in children ages birth to four.

Mortality and Leading Causes of Death

Mortality data is highly useful in providing insight about priority health issues in a community by identifying the underlying causes of disease and monitoring changes in the leading causes of death over time. The leading causes of death in the county, state, and nation are closely linked to personal health behaviors, environmental and social factors, and the availability, accessibility, and utilization of quality preventive, primary, and specialty health care services.

Figure 17 presents the leading causes of death in the United States and Connecticut for 2008, based on crude rates. Although the 10 causes of death are not in the same exact rank order, the underlying causes remain chronic conditions which are related to behavioral risk factors. This is especially true of physical activity; healthy eating; avoiding tobacco use, alcohol abuse, and drugs; managing stress; and other preventive lifestyle behaviors.

Figure 17: Leading Causes of Death in Connecticut and the U.S. , 2008



Source: Centers for Disease Control and Prevention, National Center for Health Statistics http://www.cdc.gov/nchs/data/dvs/LCWK9_2008.pdf.

It is noteworthy that there are differences in the rank order of the leading causes of death in CT by gender and race/ethnicity. For example, in 2009 the leading cause of death for males of all races/ethnicities was cancer and for females it was heart disease. For both White males and females, the leading cause of death was heart disease, followed by cancer. For Black or African American and Hispanic or Latino residents, the leading cause of death was cancer for both genders, followed by heart disease. *Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ebappa.cdc.gov/cgi-bin/broker.exe.*

Figure 17 reflects crude mortality rates, which have not been age-adjusted. Crude mortality rates are useful in assessing the magnitude of the absolute number of deaths in a population, however they do not account for differences in rates that are attributable to differences in the age composition of the resident population.

Municipalities in Litchfield County with a higher proportion of older residents, such as Salisbury, would be expected to have higher crude mortality rates from chronic diseases, as the incidence and prevalence of these diseases increase with age. Age-adjusted mortality rates (AAMR) correct for differences in age distribution of communities, and therefore give a more accurate representation of excess disease mortality.

Significant disparities in health status, including mortality rates from the leading causes of death and premature death, measured as Years of Potential Life Lost (YPLL) exist in the U.S., CT, and the county. A major goal of *Healthy People 2020* is to achieve health equity, eliminate disparities, and improve the health of all population groups.

AAMR and YPLL data for Litchfield County for the five year period 2005-2009, with state and county comparisons, follow in Tables 14 and 15.

Table 14 - State and County Age-Adjusted Mortality Rates per 100,000 Residents by Gender and Race/Ethnicity, 2005-2009

Connecticut							Litchfield County						
Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino	Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino
All	687.7	829.0	583.1	679.5	809.3	529.0	All	689.8	823.1	586.6	696.6	572.8	425.3
Malignant Neoplasms	170.1	206.2	147.1	171.9	190.5	108.4	Malignant Neoplasms	164.3	201.4	140.4	166.2	128.9	81.3
Diabetes Mellitus	16.7	19.7	14.4	15.1	35.9	24.5	Diabetes Mellitus	13.6	16.3	11.4	13.3	17.9	37.0
Alzheimer's Disease	16.6	13.8	17.8	17.1	15.1	8.9	Alzheimer's Disease	14.6	12.6	15.4	14.5	42.1	26.9
Major CVD	217.4	264.4	182.1	216.4	253.2	157.5	Major CVD	230.5	267.1	199.8	232.4	152.0	151.6
Pneumonia & Influenza	17.2	21.0	15.0	17.2	18.0	13.7	Pneumonia & Influenza	19.7	21.6	18.5	20.0	0.0	11.2
CLRD	34.5	38.9	31.9	35.9	24.4	20.5	CLRD	40.3	45.9	37.8	41.0	37.6	11.2
CLD & Cirrhosis	7.2	10.0	4.7	7.1	6.3	11.0	CLD & Cirrhosis	7.0	9.8	4.6	7.0	6.5	11.9
Nephritis, nephrotic syndrome, nephrosis	13.3	17.8	10.7	12.3	26.9	12.3	Nephritis, nephrotic syndrome, nephrosis	12.4	15.6	10.5	12.6	22.7	0.0
Accidents	32.9	47.1	20.4	33.9	32.0	29.4	Accidents	35.0	48.9	21.8	36.0	18.0	32.5
Alcohol Induced	5.1	7.8	2.6	5.2	4.6	5.2	Alcohol Induced	5.7	9.2	2.4	5.9	0.0	2.4
Drug Induced	11.1	15.1	7.1	12.2	10.3	10.0	Drug Induced	11.8	15.8	7.8	12.3	5.9	9.1

Source: Connecticut Department of Public Health. 2012. Vital Records Mortality Files, 2005-2009.

Age-adjusted all-cause mortality rates for the county and state are comparable, including rates for males and females. County all-cause mortality rates for White non-Hispanics (both genders) are higher, and rates for Black non-Hispanics and Hispanics are considerably lower than the state rates.

County rates are lower than state rates for many causes of death including malignant neoplasms (cancer), diabetes mellitus, Alzheimer's disease and kidney diseases, and comparable to the state for chronic liver disease and cirrhosis. County mortality rates are above the state for major CVD, pneumonia and influenza, chronic lower respiratory disease (CLRD), accidents, and alcohol and drug-induced deaths.

Within county AAMR comparisons by gender and race/ethnicity indicate higher mortality rates for males for all causes of death, and for White non-Hispanics (both genders) for all causes, malignant neoplasms, major CVD, pneumonia & influenza, chronic lower respiratory disease, accidents, and alcohol and drug-induced deaths. These same trends are evident statewide. Within the county, Black non-Hispanic residents have higher mortality rates from diabetes, Alzheimer's disease and kidney disease. Hispanic or Latino residents have higher mortality rates from diabetes.

Table 15 represents the years of potential life lost to age 75, or premature death, based on the leading causes of death in the state and county. By cause of death, the largest impact in the state and county is manifested by malignant neoplasms, followed by accidents, major CVD, and drug-induced deaths. Males and Hispanic or Latino residents have the highest rate of premature death in the county overall.

Table 15 - State and County Age-Adjusted Years of Potential Life Lost to Age 75 by Gender and Race/Ethnicity, 2005-2009

Connecticut							Litchfield County						
Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino	Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino
All	5,315.0	6,710.9	3,956.3	4,766.3	8,827.5	5,705.6	All	4,986.0	6,426.9	3,549.6	5,025.2	3,782.6	5,051.5
Malignant Neoplasms	1,161.6	1,208.5	1,121.5	1,149.3	1,579.0	954.4	Malignant Neoplasms	1,114.1	1,151.2	1,081.2	1,129.7	541.5	936.9
Diabetes Mellitus	103.9	136.5	73.0	86.9	254.8	144.3	Diabetes Mellitus	102.2	138.9	67.3	97.8	261.7	54.4
Alzheimer's Disease	7.1	8.3	6.0	7.4	2.2	11.3	Alzheimer's Disease	4.3	8.3	0.5	4.5	0.0	0.0
Major CVD	904.6	1,273.9	557.5	830.1	1,757.1	888.8	Major CVD	888.5	1,185.7	599.1	893.2	1,298.0	959.7
Pneumonia & Influenza	51.5	58.3	45.5	42.1	108.5	70.2	Pneumonia & Influenza	50.0	41.4	59.6	51.7	0.0	0.0
CLRD	108.9	113.2	105.1	105.7	160.5	76.7	CLRD	100.7	90.6	110.4	104.2	143.8	0.0
CLD & Cirrhosis	110.2	154.5	68.2	110.5	93.4	160.8	CLD & Cirrhosis	104.9	146.6	64.4	104.0	189.6	125.5
Nephritis, nephrotic syndrome, nephrosis	53.7	66.4	41.9	38.5	170.0	94.9	Nephritis, nephrotic syndrome, nephrosis	43.4	55.5	31.9	45.2	84.2	0.0
Accidents	840.5	1,243.9	435.3	870.8	832.7	837.1	Accidents	989.9	1,503.3	466.9	1,034.6	297.6	900.9
Alcohol Induced	110.5	162.1	61.4	116.2	80.8	112.4	Alcohol Induced	144.2	228.0	61.7	146.9	0.0	131.1
Drug Induced	397.8	557.8	237.8	454.8	312.1	330.2	Drug Induced	454.8	617.6	291.3	474.0	297.6	334.6

Source: Connecticut Department of Public Health. 2012. Vital Records Mortality Files, 2005-2009.

Examination of mortality data over time and by municipality offers additional insight as to improvements in health status and emerging health issues. Reliable AAMR data is, however, unavailable for most towns in the county due to their small population size, and the corresponding low numbers of deaths, which causes the rates to be very unstable.

Five-year average AAMR data for 2000-2004 and 2005-2009 for the 5 most populated municipalities in Litchfield County, the 'rest of county' (excluding these municipalities) and the county and state as a whole for the 10 leading causes of death (with the addition of trachea, bronchus & lung cancer) are provided in Tables 16a and 16b. In order to permit rate comparisons across municipalities with the county and state, Census 2000 was used as the reference population base in calculating the state and county rates, to be consistent with the methodology used for municipal rates. This artificially inflates the rates for 2005-2009, as the Census 2000 population base is less than the 2005-2009 ACS population base used to calculate the state and county AAMR rates found in Table 14. Even with these limitations, review of this data does provide some useful comparisons across geographic areas within the county, and trends over time.

Table 16a: Leading Causes of Death, Five-Year Average Age Adjusted Mortality Rates, 2000-2004

Community	All Causes	Diseases of the Heart	Cancer	Trachea, Bronchus & Lung Cancer	Stroke	Chronic Lower Respiratory Diseases	Accidents	Alzheimer's Disease	Influenza & Pneumonia	Diabetes	Kidney Disease	Septicemia
Torrington	800.5	204.3	196.0	62.9	49.9	47.0	40.8	8.9	27.6	16.1	17.0	12.5
New Milford	796.4	193.4	192.5	51.6	41.3	47.5	41.5	25.4	34.8	20.8	--	20.1
Plymouth	827.5	232.1	192.8	46.5	43.6	47.0	37.7	--	40.4	--	--	--
Watertown	775.8	255.0	185.1	52.4	33.5	42.4	31.7	--	19.2	19.9	13.3	14.2
Winchester	904.2	217.7	229.7	59.7	69.0	51.7	29.1	--	29.4	--	--	22.4
Rest of County	724.3	207.4	177.3	40.3	45.4	45.7	37.7	12.0	24.4	11.2	9.5	11.8
Litchfield County	763.4	210.1	186.0	48.9	46.1	45.7	36.8	11.5	26.5	15.2	11.7	14.1
Connecticut	744.7	206.7	183.9	49.3	44.7	36.7	31.0	13.6	20.4	17.9	14.0	13.7

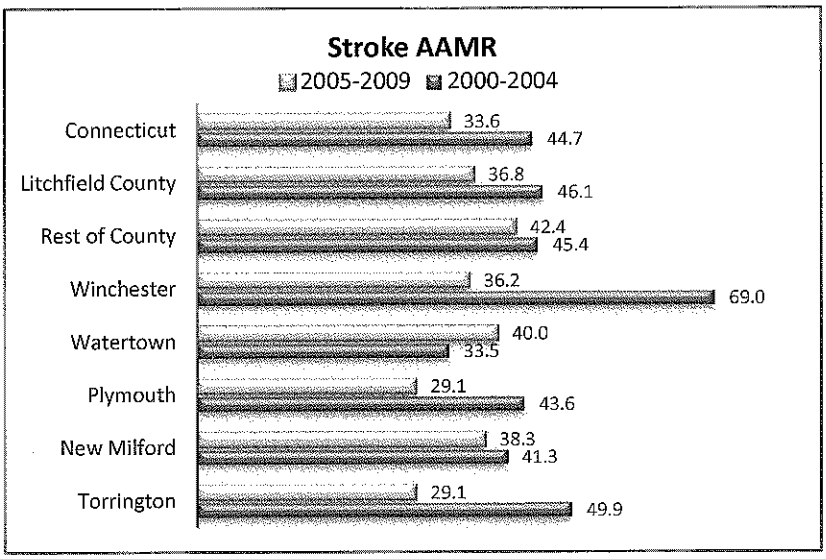
Table 16b: Leading Causes of Death, Five-Year Average Age Adjusted Mortality Rates, 2005-2009

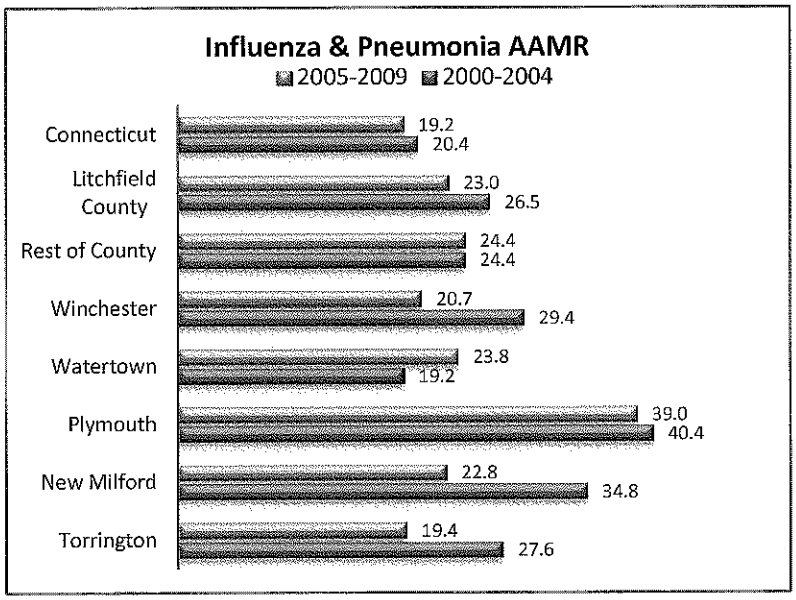
Community	All Causes	Diseases of the Heart	Cancer	Trachea, Bronchus & Lung Cancer	Stroke	Chronic Lower Respiratory Diseases	Accidents	Alzheimer's Disease	Influenza & Pneumonia	Diabetes	Kidney Disease	Septicemia
Torrington	736.1	203.8	162.6	47.2	29.1	41.3	40.4	10.1	19.4	20.8	21.9	12.0
New Milford	817.6	163.1	199.6	59.3	38.3	48.0	37.5	34.8	22.8	13.1	--	20.8
Plymouth	959.4	289.0	211.8	58.3	29.1	68.4	46.4	--	39.0	--	--	--
Watertown	793.4	206.7	199.0	51.2	40.0	38.1	40.6	14.1	23.8	14.5	14.6	24.1
Winchester	849.5	212.5	204.0	43.0	36.2	39.1	55.1	--	20.7	23.7	--	--
Rest of County	765.3	218.7	182.0	42.4	42.4	46.7	36.6	19.7	24.4	12.6	9.7	14.1
Litchfield County	771.5	208.5	182.2	46.8	36.8	44.3	38.7	16.8	23.0	15.2	14.0	14.9
Connecticut	745.4	184.9	181.4	47.6	33.6	36.8	34.9	18.8	19.2	18.0	14.5	15.1

Source: Connecticut Department of Public Health, 2012 Age-Adjusted Mortality Rates, 2005-2009. Note: To permit comparisons at the municipal and 'rest of county' level, all rates were age-adjusted to Census 2000 population, to be consistent with the reference population used to calculate town AAMR rates. Use of the Census 2000 reference population inflates the CT mortality rates for 2005-2009 above those shown in Table 14 and those published on the CTDPH website.

In reviewing municipal level data for 2000-2004 and 2005-2009, all-cause AAMR rates for the 'rest of county', which consists of more rural towns, are lower than those for the county as a whole and with one exception for the 5 most populated municipalities as well. For the county overall, a favorable decline in AAMR is evident from 2000-2004 to 2005-2009 for diseases of the heart, cancer (all sites and trachea, bronchus & lung), stroke, CLRD, and influenza and pneumonia.

Among county municipalities, both Torrington and Winchester show a decline in all-cause AAMR, and most of the five most populated municipalities show a reduction in AAMR for diseases of the heart, stroke, and influenza & pneumonia in 2005-2009 when compared with 2000-2004. It should be noted that additional AAMR reductions may have occurred but are masked by the rate calculation methodology used.





Healthy People 2020 Leading Health Indicators

Healthy People 2020 includes 26 Leading Health Indicators (LHIs) which will be tracked, measured, and reported regularly throughout the next decade at the national and state level. Baseline data and targets related to the Community Transformation Strategic Directions are provided below for future reference.

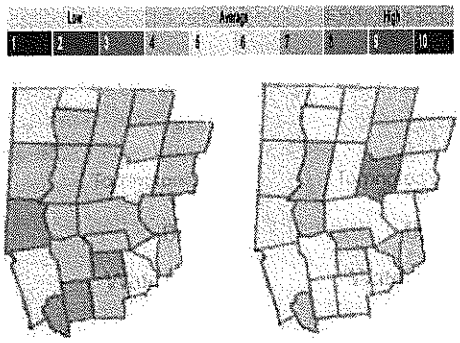
The most recent available county and/or state baseline data indicate that the following *Healthy People 2020* LHI targets have been met: 1) persons with a primary care provider, 2) adult colorectal screening, 3) children exposed to secondhand smoke (proxy measure), 4) adults meeting current physical activity guidelines, 5) adult obesity, 6) adolescent obesity, 7) high school graduation rates, 8) adult binge drinking, and 9) adolescents smoking cigarettes in the past 30 days. Data indicate the following targets have not yet been achieved: 1) persons with medical insurance, 2) adolescents using alcohol or any illicit drugs during the past 30 days, and 3) current adult cigarette smokers.

HEALTHY PEOPLE 2020 **INDICATOR** (LHI Reference Number)	Target	National Baseline	CT/County Baseline
Access to Health Services:			
Persons with medical insurance (AHS-1.1)	100.0	83.2	90.8/91.2
Persons with a usual primary care provider (AHS-3)	83.9	76.3	87.5 (CT) Adults
Clinical Preventive Services:			
Adults who receive a colorectal cancer screening based on the most recent guidelines (C-16)	70.5	54.2	73.0/75.0
Adults with hypertension whose blood pressure is under control (HDS-12)	61.2	43.7	n/a
Adult diabetic population with an A1c value greater than 9 percent (D-5.1)	14.6	16.2	n/a
Environmental Quality:			
Children aged 3 to 11 years exposed to secondhand smoke (TU-11.1)	47.0	52.2	37.1 (CT) MS students
Nutrition, Physical Activity, and Obesity:			
Adults who meet current Federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity (PA-2.4)	20.1	18.2	53.1/52.2
Adults who are obese (NWS-9)	30.6	34.0	21.4/22.7
Children and adolescents who are considered obese (NWS-10.4)	14.6	16.2	10.4 (CT) HS students
Total vegetable intake for persons aged 2 years and older (NWS-15.1)	1.1 cup equivalent/ 1,000 calories	0.8 cup equivalent/ 1,000 calories	n/a
Social Determinants:			
Students who graduate with a regular diploma 4 years after starting 9th grade (AH-5.1)	82.4	74.9	92.1 (CT)
Substance Abuse:			
Adolescents using alcohol or any illicit drugs during the past 30 days (SA-13.1)	16.5	18.3	43.5 (CT) HS Students
Adults engaging in binge drinking during the past 30 days (SA-14.3)	24.3	27.0	18.0/17.0
Tobacco:			
Adults who are current cigarette smokers (TU-1.1)	12.0	20.6	18.0/16.0
Adolescents who smoked cigarettes in the past 30 days (TU-2.2)	16.0	19.5	15.3 (CT) HS Students

Sources: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=1#11; CTDPH Healthy Connecticut 2010; BRFSS 2007-2010; 2009 CT Youth Behavior and Tobacco Components; 2012 County Health Rankings. MS= Middle School; HS=High School.

Overview of Health Disparities & Inequities in Litchfield County

Litchfield County



Social Determinants **Health Outcomes**

In spite of the overall favorable health status in the county, health disparities and inequities are apparent, as they are in municipalities throughout CT. As noted in the previous sections of this report, health-related lifestyle behaviors, health status and outcomes are all strongly influenced by the social conditions that exist within a given community.

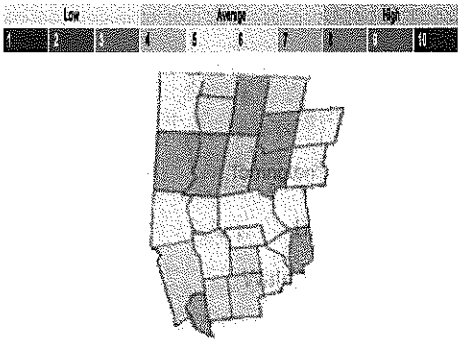
These conditions, also known as the social determinants of health, include such factors as civic involvement, community safety, economic security, education, employment, environmental quality, and housing. The Health Equity Index (Index) is a web-based assessment tool developed by the Connecticut Association of Directors of Health (CADH) that can be used to identify the social, economic, political, and environmental conditions within a community that are most strongly associated (or correlated) with specific health outcomes. Use of the Index findings facilitates collaboration among public health, community and civic leaders and residents to collectively develop and implement strategies to improve community-level policies and practices affecting health.

The Index provides data, scores, correlations and GIS mapping for all 169 communities in Connecticut. The scores for each social determinant and health outcome are calculated on a 10-point scale (based on decile values) with 1 (red) indicating the least desirable community social conditions or health outcomes, and 10 (green) indicating the most desirable. A score of 5 is the median value for the state.

For Litchfield County, the overall average social determinant score is 7, well above the state average. Of the 26 municipalities in the county, only Plymouth and Winchester score below the state average. A detailed narrative of community social conditions was previously presented in the Population and Demographics Overview section of this report, including education, economic stability, employment, housing, demographic trends, health insurance coverage, and community safety. Health outcome scores within the county vary widely, however the county average for all health outcome indicators is 5, equivalent to the state median.

For this report, the Health Equity Index was used to provide additional insight on the health outcomes most closely related to the five CTG health-related strategic directions: tobacco free living; active living & healthy eating; quality, high impact clinical and other preventive services; social & emotional wellness; and healthy & safe physical environments. The Index health outcomes include: Accidents & Violence, Cancer, Cardiovascular Disease, Diabetes, Health Care Access, Life Expectancy, Liver Disease, Mental Health, Renal Disease, and Respiratory Illness.

Accidents and Violence



The composite Index health outcome score for Accidents and Violence in a community include statistical data on: Age-Adjusted Mortality Rates (AAMR) and Years of Potential Life Lost (YPLL) for intentional and unintentional injuries, and for homicides and legal interventions. While most Litchfield County municipalities score either close to the state average (score of 5) or above, those for Plymouth, Torrington, and Winchester are lower (score of 3).

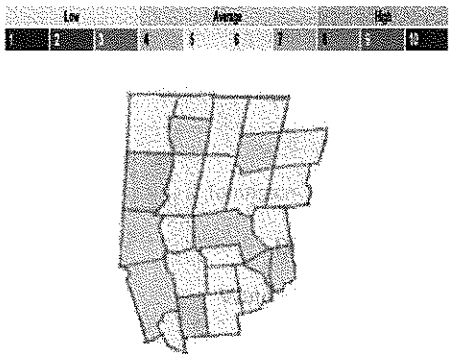
The prevalence of injuries and violence in a community are correlated with a number of social determinants. While these correlations do not imply a cause and effect relationship, a strong correlation indicates an association between a specific health outcome and a specific social determinant. Spearman's Rank Correlation Coefficient (R_s) values above 0.3 (either positive or negative) are considered statistically significant and could warrant further exploration of contributing factors.

Social Determinants Related to Accidents and Violence in Litchfield County	
Determinant	**R_s**
Civic Involvement	0.57
Education	0.55
Economic Security	0.53
Community Safety	0.48
Environmental Quality	0.42
Housing	0.40
Employment	0.37

Interpretation of Index scores becomes even more meaningful when Census tracts or block groups within a specific municipality are examined. Scores can be compared at the sub-town level to determine higher risk geographic areas and population groups.

Index Accident & Violence Data Sources: CTDPH, Office of Vital Records - Death Certificates (2005-2008). Population estimates - Nielsen Claritas Population Facts Demographic Report for 2007

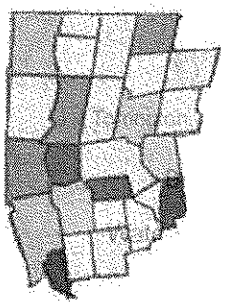
Cancer



The overall Index score for cancer is a composite of the incidence, age-adjusted mortality (AAMR), and premature death rates (YPLL) for a number of types of cancer, including: cervical, uterine, or ovarian; colorectal; female breast; lung; non-Hodgkins Lymphoma, pancreatic; prostate and skin cancer. Index scores within the county vary by community, however all fall within the average range of 4-7. According to the National Cancer Institute, personal lifestyle behaviors that contribute to cancer risk include: tobacco use and exposure to secondhand smoke, exposure to UV radiation, excessive alcohol use, risky sexual practices, poor diet, lack of physical activity, and overweight/obesity. The Litchfield County Community Transformation Coalition goals of tobacco-free living, active living and healthy eating, and quality clinical and other preventive services aim to reduce risk for prevalent chronic diseases, such as cancer and cardiovascular disease.

Index Cancer Data Sources: CTDPH, Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Cardiovascular Disease

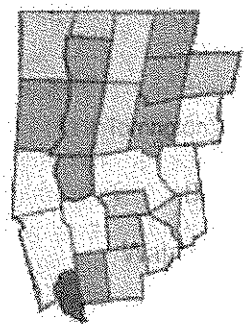


Index scores for cardiovascular disease are calculated using mortality (AAMR) and premature death rates (YPLL). Of the communities in Litchfield County, only Plymouth and Colebrook score lower than the state as a whole for this health outcome (town scores of 2 and 3 respectively vs. state score of 5). The rates of cardiovascular disease in county municipalities are correlated with a number of social determinants, with education and economic security being the strongest.

Social Determinants Related to Cardiovascular Disease in Litchfield County	
Determinant	**R_s**
Education	0.51
Economic Security	0.47
Civic involvement	0.42
Environmental Quality	0.36
Community Safety	0.33

Index Cardiovascular Disease Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Diabetes

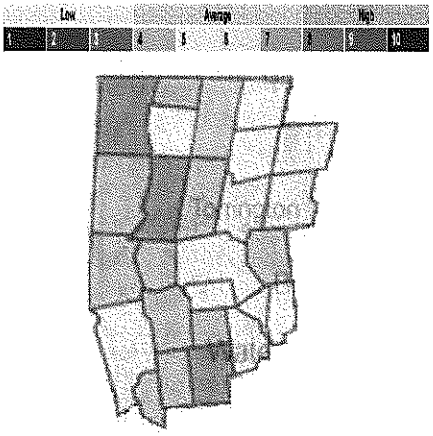


The Diabetes Index score for each municipality represents the age-adjusted mortality and premature death rates for the disease. Bridgewater has the least favorable health outcome score in the county at 2, with Colebrook, Roxbury, Winchester and Torrington all having scores that are less desirable than the state. Diabetes is correlated to a number of community conditions, with education levels having the strongest correlation.

Social Determinants Related to Diabetes in Litchfield County	
Determinant	**R_s**
Education	0.38
Economic Security	0.33
Community Safety	0.32
Environmental Quality	0.31

Index Diabetes Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Health Care Access

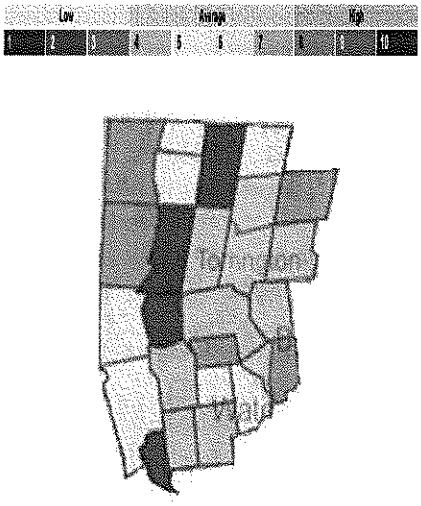


Indicators of health care access in the Index include: the number of emergency department visits without insurance, the number of emergency department visits for primary care services, and the number of births that have had delayed or non-adequate prenatal care. The vast majority of Litchfield County municipalities score favorably in this category, exceeding the state average. The town with the lowest Index score for health care access is Norfolk, at 4. A number of community conditions strongly correlate to a lack of health care access in the county.

Social Determinants Related to Health Care Access in Litchfield County	
Determinant	R_s
Economic Security	0.60
Education	0.52
Housing	0.51
Community Safety	0.50
Civic Involvement	0.49
Employment	0.47

Index Health Care Access Data Source: Connecticut Hospital Association, CHIME Hospital Discharge Data, FY 2005-2010.

Life Expectancy



For most of Litchfield County, life expectancy is greater than or equal to the state average. The community with the lowest life expectancy score in the county is Plymouth, followed by Torrington, Thomaston, and Winchester.

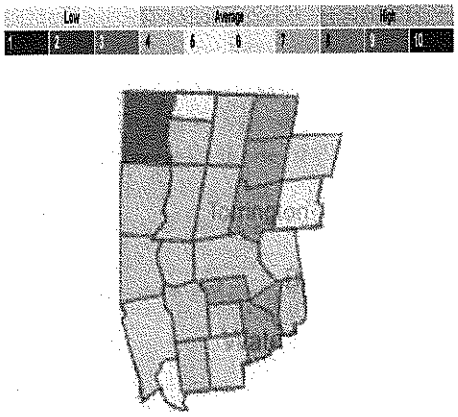
The highest life expectancy scores are found in Bridgewater, Cornwall, Norfolk, and Warren.

Life expectancy is correlated to all 7 of the social determinants included in the Index, with education and economic security having the strongest associations.

Social Determinants Related to Life Expectancy in Litchfield County	
Determinant	R_s
Education	0.64
Economic Security	0.60
Civic Involvement	0.50
Community Safety	0.41
Employment	0.35
Environmental Quality	0.34
Housing	0.31

Index Life Expectancy Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Liver Disease

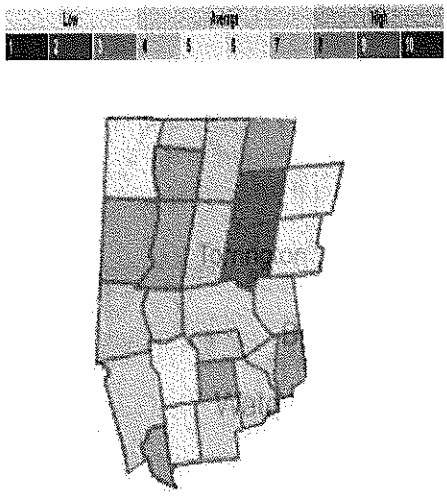


Low Index scores due to AAMR and premature deaths from chronic liver disease and cirrhosis are concerns for a number of communities in Litchfield County, with Salisbury having the least favorable Index score of any municipality in the area at 2. Social determinants associated with liver disease include those listed below:

Social Determinants Related to Liver Disease in Litchfield County	
Determinant	R_s
Civic Involvement	0.33
Environmental Quality	0.32
Community Safety	0.31

Index Liver Disease Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Mental Health

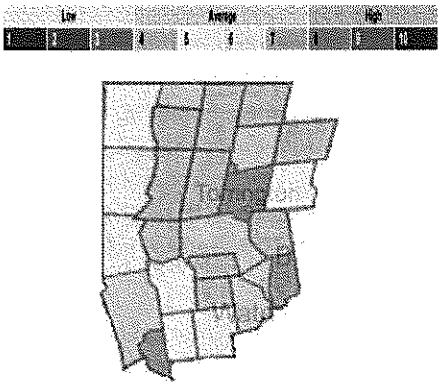


Mental health scores are determined by the emergency department visit and hospitalization rates for mental illness as well as alcohol and drug induced deaths. In Litchfield County, both Torrington and Winchester score below the state average for mental health (score of 2 vs. state average of 5). Both community safety and economic security are strongly associated with mental health, however numerous other community social conditions also play a role.

Social Determinants Related to Mental Health in Litchfield County	
Determinant	R_s
Community Safety	0.55
Economic Security	0.49
Environmental Quality	0.45
Civic Involvement	0.45
Education	0.42
Housing	0.37

Index Mental Health Data Sources: Connecticut Hospital Association, CHIME Hospital Discharge Data, FY2005-2010.

Renal Disease

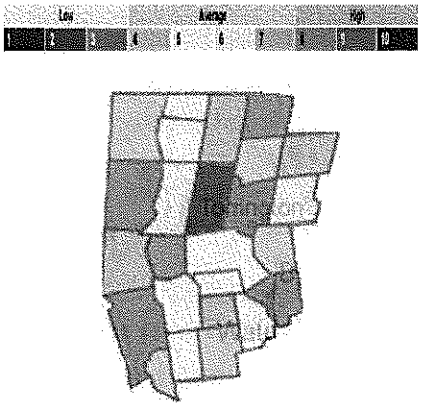


Social Determinants Related to Renal Disease in Litchfield County	
Determinant	R_s
Community Safety	0.47
Environmental Quality	0.45
Education	0.39
Housing	0.33
Civic Involvement	0.32
Economic Security	0.30

Index Renal Disease Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Scores for renal disease are calculated from the mortality and premature death rates for nephritis, nephrotic syndrome, and nephrosis. Index health outcome scores for renal disease in Litchfield County are least favorable in Bridgewater, Plymouth and Torrington. Renal disease is most strongly associated with community safety and environmental quality.

Respiratory Illness



Index scores for death rates and YPLL from chronic lower respiratory disease are slightly below the state average for a large portion of Litchfield County, with the lowest score (2) being found in Goshen, and the highest score found in Warren (8). The community conditions that more strongly correlate with respiratory illness are economic security and education.

Social Determinants Related to Respiratory Illness in Litchfield County	
Determinant	R_s
Economic Security	0.42
Education	0.41
Civic Involvement	0.31

Index Respiratory Illness Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Description of Local Health-Related Programs and Services

As previously noted, Connecticut lacks a county governance structure, therefore health-related programs and services are provided at the municipal, regional, or state level. This includes a diversity of public health programs and services provided by health departments and districts serving Litchfield County (districts serve two or more municipalities). The majority of the county's communities are served by the Torrington Area Health District, including Bethlehem, Canaan, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, Norfolk, North Canaan, Plymouth, Salisbury, Thomaston, Torrington, Warren, Watertown, and Winchester. Within the county, the Pomperaug Health District serves Woodbury; the Farmington Valley Health District serves Barkhamsted, Colebrook, and New Hartford; and the Newtown Health District serves Bridgewater and Roxbury. The New Milford Health Department serves the town of New Milford. Two part-time health departments are located in Sharon and Washington.

Local health departments and districts provide essential public health services at the municipal level throughout Connecticut. These governmental entities are separate from the CT Department of Public Health (CTDPH), however they are linked by state statute in several important ways: approval of appointments of local directors of health by the Commissioner of Public Health; mandates to carry out critical public health functions in the areas of infectious disease control, environmental health, etc.; legal authority to levy fines and penalties for public health code violations and to grant and rescind license permits (such as for food services establishments or septic systems); as well as funding for prevention and education programs and services to promote and improve the health of residents in their communities.

Core services provided by all local health departments and districts serving county residents (either directly or by contract) include: immunization services; childhood lead poisoning prevention and control; communicable disease prevention and control (TB , STD, etc.); licensing and inspections for food service establishments and vendors; public health emergency planning including mass dispensing/vaccination; enforcement of public health codes and regulations, including inspections for compliance with health standards; and health information, education, and screening services.

There is a wide variety of additional health-related programs and services provided by other agencies and organizations within the county. As previously mentioned, United Way of CT Infoline 2-1-1 maintains an online searchable community resource database of health and human service providers, agencies, and organizations. This database contains information for over 4,600 health and human service providers and 48,000 service sites in CT. Infoline 2-1-1 is the most comprehensive database available and is updated regularly. The system is, however, dependent on service providers supplying comprehensive and up-to-date information. As part of the Litchfield County CTG Coalition assessment activities, the Steering Committee collaborated with United Way Infoline's 2-1-1 research and evaluation team to design a framework for asset mapping aligned with the 5 CTG Strategic Directions:

- *Tobacco Free Living*
- *Active Living and Healthy Eating*
- *High Impact Quality Clinical and Other Preventive Services*
- *Social & Emotional Wellness*
- *Healthy & Safe Physical Environment*

Infoline produced an electronic database of programs and services aligned with each strategic direction, and an accompanying series of GIS maps which integrate information on population density and transportation services. In addition, analysis of the most frequent calls by municipality related to unmet needs and top service requests by jurisdiction was conducted. *Highlights by Strategic Direction follow:*

Tobacco Free Living

Tobacco Free Living programs and services listed with Infoline 2-1-1 are limited to three tobacco cessation programs in the county. The attached GIS asset maps include the service locations, which are concentrated in the northern part of the county. Although these services are available to residents countywide, personal transportation is required, and two of the three charge fees. Tobacco cessation services are provided at Charlotte Hungerford and Sharon Hospitals and at an addiction treatment center. In addition, there are school-based tobacco prevention efforts underway at selected schools in Torrington and Winchester as an outgrowth of the Healthy & Tobacco Free Schools grant initiative previously funded by CTDPH. School nurses and health/PE teachers in each district have been trained as cessation counselors, and the libraries/media resource centers have tobacco prevention resource centers for students.

Phone and online resources for smoking cessation are also available to county residents through the CT QuitLine (1-800-QUIT-NOW), the American Lung Association in CT http://www.lung.org/stop-smoking/, and American Cancer Society http://www.cancer.org/Healthy/StayAwayfromTobacco/index.

Regarding tobacco use prevention, on a countywide level, tobacco free public and private school campuses are required pursuant to CGS Sec. 19a-342. In addition, The Child Nutrition and WIC Reauthorization Act of 2004 and Public Law 108-265 Section 204 - Local Wellness Policy mandate schools establish a school wellness committee and policies focused on a comprehensive approach to school health, which include tobacco free living.

Furthermore, in accordance with Indoor Clean Air Act provisions, CT statutes also prohibit tobacco use in all municipal facilities, health care facilities, child care centers, group day care facilities, public college dormitories, theaters, buses and trains, restaurants and bars, and businesses employing 5 or more employees. Additional information on policies relating to all five Strategic Directions, including tobacco free living, will be included in the Policy Scan section of this report once completed.

Active Living and Healthy Eating

Active Living and Healthy Eating programs and services included in the Infoline 2-1-1 database include obesity prevention programs and services, nutrition education programs for all ages, exercise and fitness programs, and eating disorder programs. As noted in the accompanying GIS asset maps (see Appendix A), service providers are primarily municipal parks and recreation departments, YMCAs, nature centers, municipal community centers and Police Athletic Leagues, hospital-sponsored community health promotion programs, private non-profit eating disorder treatment programs and recreation programs for persons with disabilities. Services span the county, and many are town-based. Additional resources for physical activity not noted on the maps are school district recreational facilities, often open for public use when not in use for school sports events. Joint use agreements, which promote use of existing school facilities such as outdoor tracks and playing fields, tennis courts, and indoor gymnasiums by community residents of all ages, are discussed in the Policy Scan section of this report.

As previously noted, there are abundant opportunities for outdoor physical activities in the county's seven state parks, five state forests, and one state recreation area. There are countless opportunities for year round outdoor recreation through greenways, walking and biking trails, and conservation areas. However, access to many of these resources is limited to residents with private transportation.

Importantly, local health departments and districts, hospitals, community health centers, voluntary health agencies, and visiting nurse

associations actively participate in health outreach and education events and provide information and guidance related to obesity prevention, healthy eating and physical activity at sites throughout the county. Fit Together is a multi-sector community-driven healthy eating and active lifestyles intitiative in Torrington and Winchester focused on health improvement in 5 target groups: pre-school children, school age children, workplaces, older adults, and the community-at-large. This initiative is further described in the CTG Coalition Overview and Activity section of this report.

High Impact Quality Clinical and Other Preventive Services

Quality clinical and other preventive services included in the Infoline 2-1-1 database include screening and detection services, as well as diagnostic, treatment and rehabilitation services for prevalent chronic diseases (private provider listings are not included). Health screening and chronic disease detection services are provided primarily by the 3 acute care hospitals in the county, 7 public health departments/districts described previously, 8 visiting nurse associations/services (Farmington Valley VNA, Foothills Visiting Nurse & Homecare, VNS of CT, VNA of Northwest CT, New Milford VNA, Salisbury VNA, VNA Health at Home, and Western CT Home Care), and one community health center (Community Health & Wellness Center of Greater Torrington). Oral health preventive services are provided by the Community Health & Wellness Center and the Brooker Memorial Children's Dental Centers. The most frequently listed screening and detection services include cancer screenings (mammography, cervical, colorectal cancer screening, etc.), and HIV testing. Chronic disease outpatient services most closely related to the strategic directions include those for cardiac, stroke, and pulmonary diseases. The accompanying asset map shows the service sites by type of chronic disease, and by type of service. Of note is the concentration of clinical and preventive services in New Milford, Torrington, and Sharon, the sites of the three acute care hospitals in the county.

Social & Emotional Wellness

Programs and services related to this Strategic Direction include Infoline 2-1-1 database listings for mental health and substance abuse/addiction prevention, screening, counseling and treatment; youth enrichment/leadership programs; family support services, as well as community support and support groups targeted to a variety of needs (youth, religious, GLBT, aging/seniors, women, families, health-related, persons with disabilities, and mental-health related). The most frequently listed types of support services available within the county include: Information/Referral Services for Older Adults, Child Abuse Prevention and Counseling, Latchkey/Home Alone Safety Programs, Parenting Education/Support, Caregiver Support, Bereavement Support, and Adoption and Foster/Kinship Support. Major providers of services include: Municipal Senior Centers/Offices for the Aging, Youth Service Bureaus and Social Service Departments, Hospitals, Substance Abuse Treatment Facilities, Family Resource Centers, Resident State Troopers, Non-profit Agencies, Regional Educational Service Centers, Visiting Nurse Associations/Services, and YMCAs. The accompanying GIS asset maps focus on health and mental health-related programs and services. Health-related support groups include hospital-based cancer, stroke, and diabetes programs. Mental health-related support groups include those for child and spouse/partner bereavement, child abuse, and sexual assault; these services are concentrated in New Milford, Torrington, and Sharon. Mapping of Mental Health and Substance Abuse/Addiction programs and services shows both a wider geographic availability and diversity of providers, i.e., hospitals, visiting nurse and non-profit mental health and substance abuse agency providers.

Healthy & Safe Physical Environment

Information related to this Strategic Direction will be captured in large part in the pending Policy Scan Section of this report, which will be informed by data, focus group, and key informant interview information collected and analyzed via the CDC CHANGE Tool. This will include such data as community design features such as the "complete streets" model that make streets safe for all users (vehicular traffic, public transit, biking, and pedestrian for people of all ages and abilities); presence and use of modes of transportation that require physical activity (walking and biking); existing or planned community development which promotes healthy and active lifestyles (green belts/trails, walking/biking paths, locally accessible and safe parks and recreation areas); joint use agreements for school recreation and athletic facilities; reduction in the number of alcohol and fast food retail outlets; and outreach and education programs to promote healthy homes, free of radon, asthma triggers, and lead.

In reviewing the Infoline 2-1-1 database, the following were determined to be aligned with this Strategic Direction: availability of food pantries, soup kitchens, and farmer's markets; home delivered meals; summer food service programs; disabled, medical, and senior transportation services; existence of emergency, supportive, and elder/disabled housing; and domestic violence victim support services and shelters. Major providers of services include: municipal senior centers and social services, regional transportation services, local public housing authorities, non-profit community service agencies, youth service bureaus, school districts, and Regional Educational Service Centers.

Related to *Food-Related Basic Needs*, there are 17 food pantries identified in the 2-1-1 database, serving 13 different communities. Communities without food pantries in general were more affluent. It should be noted that additional smaller faith-based pantries may exist, but not be captured in the database. In addition to food pantries, there are two soup kitchens in Torrington. There are eight congregate meal/home delivered meal programs in the county, operated primarily by municipalities. Summer school meal programs exist in two high need communities - Torrington and Winchester. Litchfield County has a number of local farms; there are 11 farmer's markets identified in the database.

In terms of *Transportation-Related Basic Needs*, disability and medical transportation services are provided by 14 municipal and non-profit providers in 12 communities, leaving many communities in the county inadequately covered for these services.

The availability of *Housing* for vulnerable population groups, including the elderly, the disabled, and residents in need of emergency or supportive housing is a growing concern in the county. GIS maps demonstrate a lack of parity in access to these services, with a number of municipalities having no available resources for residents located within their borders. The most common housing service providers include municipal housing authorities, and non-profit housing and mental health agencies. There are four homeless shelters in the county, and two additional shelters that serve runaway youth. As previously noted, there are two shelters for victims of domestic violence in the county, located in Sharon and Torrington.

Infoline 2-1-1 Top Requests and Unmet Needs for Services

Although not as closely aligned with the strategic directions, examination of FY 2012 Infoline 2-1-1 data related to the most frequent call requests and unmet needs (calls to Infoline 2-1-1 for which no services are listed in the database) shed additional insight on prevalent community needs, both health-related and other. It should be noted that the high volume of disaster service calls stems from the weather-related emergencies experienced by county residents in the summer- fall of 2011.

United Way 2-1-1 Top 20 Requests for Services in Litchfield County

Request Categories	FY 12 Requests for Services
Total Calls	**9,930**
Total Requests for Services	**14,159**
Utilities/Heat	1,763
Disaster Services	1,221
Public Assistance Programs	1,132
Financial Assistance	1,096
Outpatient Mental Health Care	1,085
Housing/Shelter	959
Information Services	899
Substance Abuse Services	666
Legal Services	601
Health Supportive Services	531
Holiday Assistance	449
Food	431
Individual and Family Support Services	305
Tax Organizations and Services	278
Transportation	267
Employment and Training Programs	262
Personal/Household Goods	205
Community Services	128
Consumer Complaints	120
Social Insurance Programs	105

Examining community-specific requests for services show that the call volume is not proportionate to the population size in all cases, with Canaan, Plymouth, Torrington, and Winchester showing a higher than "expected" number of calls, based on the county average. This may indicate a higher need for services and/or better awareness of Infoline 2-1-1 as a resource by residents in these communities.

The most common health-related requests received by 2-1-1 include outpatient mental health care, substance abuse services, food assistance, and health supportive services such as insurance information and referrals. Requests for outpatient mental health care services ranked first or second in call volume from residents of Goshen, Harwinton, Morris, New Milford, Plymouth, Torrington, and Woodbury.

The most common unmet needs for service requests by county residents are provided below; examination by municipality shows over 50% of the unmet need calls originate in Torrington and Winchester.

United Way 2-1-1 Unmet Needs Report for Litchfield County – FY12

				Reason for Unmet Need			
Top 20 Unmet Needs - Litchfield County	**Total Met & Unmet Needs**	**Total Unmet Needs**	**% Unmet Needs**	**Service Unavail-able**	**Caller Not Eligible**	**Fee Too High**	**No Transport**
Rental Deposit Assistance	102	98	96%	81	17	0	0
Rent Payment Assistance	207	93	45%	44	49	0	0
Utility Assistance	1,289	88	7%	65	23	0	0
Disaster Food Stamps	254	80	31%	70	10	0	0
Temporary Financial Assistance	547	63	12%	28	35	0	0
Disaster Claims Information	497	47	9%	10	37	0	0
Holiday Gifts/Toys	125	35	28%	35	0	0	0
Christmas Baskets	142	35	25%	33	2	0	0
Thanksgiving Baskets	136	25	18%	22	3	0	0
Section 8 Housing Choice Vouchers	68	10	15%	10	0	0	0
Food Stamps/SNAP	435	10	2%	0	10	0	0
Specialized Information and Referral	136	9	7%	3	6	0	0
Household Goods	27	8	30%	8	0	0	0
Transportation Expense Assistance	6	6	100%	5	1	0	0
Diapers	21	6	29%	6	0	0	0
General Assistance/SAGA	33	6	18%	0	6	0	0
General Clothing Provision	86	6	7%	6	0	0	0
Homeless Shelter	248	4	2%	1	1	1	4
Fans/Air Conditioners	5	3	60%	3	0	0	0
Food Cooperatives	10	3	30%	2	0	1	0
Total (All requests for services)	**12,490**	**753**	**6%**	**517**	**227**	**4**	**10**

CTG Coalition Overview and Collaborative Activities

The Litchfield County CTG Coalition was created in the fall of 2011 to collaboratively assess and prioritize health needs in our community and to collectively develop a community action plan and mobilize resources to improve the health of county residents. As the lead and fiduciary agent for the Litchfield County grant CDC CTG initiative, Torrington Area Health District (TAHD) convened leadership from the United Way of Northwest CT, Northwest CT YMCA, Charlotte Hungerford Hospital and the local health departments/districts serving the county to form the initial Steering Committee. TAHD subsequently signed a Memorandum of Understanding with Charlotte Hungerford Hospital, Northwest CT YMCA, and the United Way of Northwest CT to leverage one another's resources for contracted professional services from the *Center for Healthy Schools and Communities at EDUCATION CONNECTION* to design and prepare this Community Health Needs Assessment.

Representatives from these four organizations became the foundation of the Steering Committee, which, to date, has expanded to include representatives from Western CT Health Care Network, Sharon Hospital, the CT Office of Rural Health, and EDUCATION CONNECTION, the Regional Educational Service Center in western CT. The Coalition membership continues to evolve over time, with the goal of involvement by all major community sectors, especially those serving underrepresented groups in the county.

The CTG Coalition start-up has benefited greatly from the prior work of Charlotte Hungerford Hospital, which led the organization of a core group of health, social and educational agencies in the greater Torrington area to inventory existing and planned community programming efforts, identify gaps, and leverage knowledge and resources.

In early 2011, the Northwest CT YMCA received a grant from Pioneering Healthier Communities to address policy and system barriers to healthy living in its service area. Northwest CT YMCA is one of 118 communities nationwide to receive such funding.

Recognizing the parallelism of their efforts, the groups combined to form Fit Together, co-led by Stephanie Barksdale, Executive Director, United Way of Northwest Connecticut, and Greg Brisco, Chief Executive Officer, Northwest CT YMCA. Also on the Steering Committee of Fit Together are Leslie Polito, Assistant Director, TAHD, and Brian Mattiello, Vice President of Organizational Development, Charlotte Hungerford Hospital. These same individuals serve on the CTG Coalition Steering Committee, fostering coordination and communication in community assessment, planning, implementation, and evaluation activities.

The mission of Fit Together is to build the healthiest kids, families and communities in Torrington and Winchester through sustainable strategies that foster healthy eating and active living. Although concentrated in these two communities, the CTG Coalition benefits greatly from the forward-thinking and innovative approaches undertaken by this existing coalition. The Fit Together community action plan is well aligned with CTG objectives and strategic directions, and centers on policy, systems, and environmental changes to:

- *increase opportunities for healthy eating;*
- *increase opportunities for physical activity as a part of everyday life;*
- *improve community collaboration and assessment capacity; and*
- *improve community-wide communication to advance healthy eating and active living.*

Key accomplishments to date that advance CTG Coalition community assessment and action plan development include:

- Completed health surveys at Torrington & Winchester Senior Centers;

- Collaborated with Torrington School District to write a comprehensive school wellness policy;
- Completed community-wide, pre-school, school, afterschool, childcare, and worksite Community Healthy Living Index (CHLI) assessments;
- Coordinated a two-day Healthy Community Design Summit (October 16-17, 2012) in Torrington and Winchester featuring nationally-acclaimed community planning expert Mark Fenton. This initiative focused on creating healthier and more livable and walkable communities.

In addition, Pomperaug Health District, whose Health Director Neal Lustig serves on the CTG Steering Committee, is an ACHIEVE grantee. Although the specific ACHIEVE community reached by the Health District is not located within Litchfield County, (Southbury), the CTG Coalition benefits greatly from the best practices and lessons learned from this initiative, which is well-aligned with the CTG strategic directions. In addition, ACHIEVE uses CDC's CHANGE Tool for Community Health Improvement Action Planning.

Key ACHIEVE current and planned activities that advance CTG Coalition and action plan development include:

- The creation of Southbury's first-ever community garden. The Garden group strategically partnered with a variety of local organizations, including: Girl and Boy Scouts; Roots and Shoots; Garden Club; Master Gardeners Association; and an existing community garden group in Southbury's Heritage Village. The Southbury Community Garden is in full bloom with a variety of crops, some of which will be donated weekly to the Southbury Food Bank.
- Target projects for year two of the Southbury ACHIEVE Initiative include: 1) assessing the regional school district's school lunch program(s) and making recommendations for better nutrition; 2) creating a comprehensive map and facilities guide for the Southbury Parks and Recreation Department, outlining the vast resources offered to residents, and encouraging increased exercise; and 3) addressing Southbury's lack of bike trails, and exploring potential funding sources to address the need for designated trails/lanes.

The CTG Coalition Steering Committee meets monthly and serves as the Litchfield County CTG grant management team. Project activities, accomplishments, and challenges are reviewed at these meetings for Committee input and resolution. In addition, mentors from DPH and other CT CTG Coalitions provide education and training at these meetings on such topics as Coalition Building and use of the CHANGE Tool. Coalition meetings are organized and facilitated by Sharon McCoy, CTG Project Director.

Key Findings & Recommendations

Achieving major improvement in the health of county residents involves reducing the incidence and prevalence of chronic disease, which account for 7 of the 10 leading causes of death. CDC estimates that nearly 50% of Americans are living with at least one chronic disease.

The solution to this challenge is multi-dimensional, as chronic diseases result from a number of interconnected factors. Harmful individual lifestyle behaviors such as smoking, overeating, poor nutrition, lack of physical activity, tobacco use, and substance abuse greatly increase risk for developing chronic disease. Lack of health insurance, limited English proficiency, transportation and cultural factors present barriers to access and utilization of quality preventive health and screening services which delay or prevent the onset of disease. Social determinants of health such as income, employment status, educational attainment, housing, environmental quality, and community safety strongly impact access to care and health outcomes.

Developing a community action plan for health improvement involves collective action and leveraging of expertise and resources across agencies and organizations from many different sectors. The planning process involves identification of priority health needs and opportunities for action by all stakeholders. To assist this process, a summary of key findings from previous sections of this report follows.

Demographics

- ✓ The county has the highest proportion of residents ages 50+ in CT and the median age of county residents is rising. This carries significant implications for health, housing, and human service planning.
- ✓ The overall population size of the county continues to increase at a rate similar to the state as a whole.
- ✓ County residents overall have higher education and income levels and lower poverty rates than the state average, however income levels have recently declined in many communities and disparities are evident by municipality and household type.
- ✓ Most school districts in the county have recently experienced an increase in minority student enrollment and in students eligible for free/reduced price meals.
- ✓ The county has become more racially and ethnically diverse, and the growth in the Hispanic or Latino population from 2000-2010 was twice the state rate. Torrington, New Milford, and Watertown show the greatest gains in diversity.
- ✓ Overall community safety data compare favorably to the state; within the county, Plymouth, Thomaston, Torrington, and Winchester have higher crime rates.

Behavioral and Lifestyle Factors

- ✓ Rates of obesity and current smoking in county residents exceed the state average.
- ✓ County residents have *more frequent* smoking cessation attempts (with higher smoking rates), and are *more likely* to participate in routine dental care, and cervical and colon cancer screening. County residents are *less likely* to participate in routine eye exams, influenza vaccination, and PSA screening.
- ✓ County rates are *similar* to the state for: social support, activity, fruit & vegetable intake, prevalence of hypertension (high blood pressure) and diabetes, routine medical check-ups, cholesterol testing & mammography.
- ✓ Disparities in personal lifestyle behaviors are apparent across the state. Residents with lower education and income levels are *less likely* to access health screenings and practice healthy lifestyle choices.

- ✓ Overweight and obesity are *most common* in Hispanic or Latino, followed by Black or African American children and adults.
- ✓ Smoking prevalence in CT adults has *declined* 40% over the past 20 years, across all groups except Black non-Hispanics. Prevalence is *higher* in males and persons with lower education and income levels.
- ✓ In CT adolescents, smoking has *declined* 66% among middle school students and 40% among high school students.
- ✓ Students in *nearly half* of the school districts serving the county scored below the state average in standardized physical fitness tests.
- ✓ County residents did not meet national benchmarks for poor physical and mental health days, adult smoking, excessive drinking, and preventable hospital stays.

Burden of Chronic Disease

- ✓ Cardiovascular disease (CVD) accounts for one-third of CT resident deaths; over 50% of these are in women. Hypertension and elevated cholesterol are *major risk factors* for CVD.
- ✓ Nearly one in four county residents has hypertension. This condition is *more common* in males, Black non-Hispanic adults, persons ages 65 and over and those with lower socioeconomic status (SES).
- ✓ Nearly 40% of county residents have been told by a health professional that their cholesterol is high. Elevated cholesterol is *more common* in males, white non-Hispanic adults, persons ages 65+ and those with lower SES. Blood pressure screening is *least common* in Hispanic/Latinos (nearly one-third have *never* been screened), and in persons with low SES.
- ✓ Diabetes is *twice as prevalent* in Black non-Hispanics than whites, and in persons with low SES. Obesity is a *major risk factor* for Type II Diabetes.

Primary Care, ED Visits & Hospitalizations

- ✓ The county has a ratio of 1 primary care physician to every 1,123 residents, which falls well below both state and national benchmarks.
- ✓ Overall, county residents had *higher ED visit rates* than the CT average for major CVD, coronary heart disease, myocardial infarction (heart attack), congestive heart failure, and stroke.
- ✓ County residents had *lower ED visit rates* for diabetes, alcohol & drug abuse, chronic obstructive pulmonary disease, and asthma.
- ✓ ED visit rates for Black non-Hispanic residents were *well above* the state and county averages across most diagnostic categories.
- ✓ Hospitalization rates for county residents were *below* the state average for the majority of diagnostic categories, but *above* the state average for oral cavity/pharynx cancers and for alcohol and drug abuse.

Mortality Data

- ✓ Age-adjusted all-cause mortality rates for the county and state are *comparable*. County all-cause mortality rates for White non-Hispanics (both genders) are *higher*, and rates for Black non-Hispanics and Hispanics are considerably *lower* than the state rates.
- ✓ County AAMRs are *lower than* state rates for many causes of death including malignant neoplasms, diabetes mellitus, Alzheimer's disease and kidney diseases. County mortality rates are *above* the state for major CVD, pneumonia and influenza, CLRD, accidents, and alcohol & drug-induced deaths.
- ✓ Mortality rates from diabetes are highest in Hispanic or Latino residents, and above the state rate.
- ✓ The largest contributor to premature death in the state and county is malignant neoplasms (cancer), followed by accidents, major CVD, and drug-induced deaths.

- ✓ Males and Hispanic or Latino residents have the *highest* rate of premature death in the county overall.

Health Disparities & Inequities

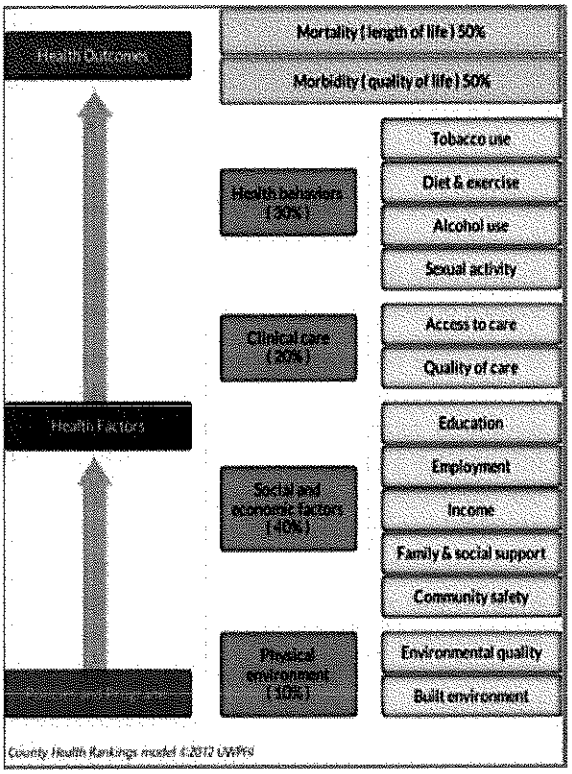
- ✓ Compared with the state, municipalities in the county rank *favorably* overall for social determinants of health and are *comparable* for health outcomes.
- ✓ Overall, municipalities in the county rank *most favorably* for health care access and life expectancy health outcomes.
- ✓ Health outcomes with *more frequent* low scores were diabetes, liver disease, mental health & respiratory illness.
- ✓ There is a wide variation in health outcome scores among municipalities. Those *most frequently* scoring low for health outcomes are: Plymouth, Torrington, Colebrook, and Winchester.
- ✓ The *most consistent correlations* between health outcomes and social determinants are found for: education, economic security, community safety, and civic involvement.

Health-Related Programs & Services

- ✓ Tobacco cessation programs in the county are extremely limited, and the Infoline 2-1-1 database lists no currently available tobacco use prevention programs.
- ✓ Opportunities for physical activity appear to be available in most communities; however limited accessibility due to transportation may be a factor for many residents.
- ✓ According to Infoline 2-1-1 data, there are no healthy eating/nutrition education programs presently available in the county.
- ✓ Clinical and preventive health services are concentrated in the three communities with acute care hospitals (New Milford, Torrington & Sharon); access to these services may be a factor for many residents.
- ✓ The geographic availability of health screening services in the county is limited as is the type.
- ✓ Health and mental health-related support groups are again concentrated in the three communities with acute care hospitals.
- ✓ The availability of mass transportation services in general, as well as medical transportation services and services for disabled persons is limited in many communities.
- ✓ Housing for vulnerable population groups, including the elderly, disabled, and residents in need of emergency or supportive housing is limited and non-existent in many communities.

In spite of the favorable health status enjoyed by most Litchfield County residents, health disparities exist and are concentrated in the uninsured and low income population groups. Families and individuals who live in poverty or are uninsured are more likely to have poor health status. Poverty underlies many of the social factors that contribute to poor health. Differences for many health status indicators are also apparent by gender, race/ethnicity, age, and place of residence. This information should be used to determine subgroups in the community in need of further assessment, as well as to guide the development of programs and services to meet identified health needs.

Developing a community action plan for improving health requires coordinated and systemic efforts among all stakeholders: health care providers; state, regional, and local health and human service agencies; community and faith-based organizations and groups; policy makers; schools; businesses and the residents they serve. All stakeholders need to consider policy, environmental, and systems changes to ***make the healthy choice the easy choice*** in their communities. As noted in the 2012 County Health Rankings report, social and economic factors and the physical environment are estimated to account for 50% of health status.



With this in mind, in Year 2 of the Community Transformation Grant (October 2012 - September 2013), the Litchfield County CTG Steering Committee will coordinate a strategic health planning process to guide the development of a Community Health Improvement Plan. This process will include environmental, systems, and policy scans to better define priority health needs, and opportunities for action for health improvement.

The CDC's Community Health Assessment aNd Group Evaluation (CHANGE) tool will be used to facilitate this process. CHANGE is a data collection tool and strategic planning resource which enables local stakeholders and community team members to survey and identify community strengths and areas for improvement regarding current policy, systems, and environmental change strategies. Five different community sectors are assessed: Community-At-Large, Community Institutions/Organizations, Health Care, Schools, and Work Sites.

The CHANGE tool assists communities to: 1) define improvement areas to guide the community toward implementing and sustaining policy, systems, and environmental changes around healthy living strategies (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management); 2) prioritize community needs and consider appropriate allocation of available resources; and 3) focus and mobilize cohesive action in the health priority areas selected to improve health and reduce health disparities.

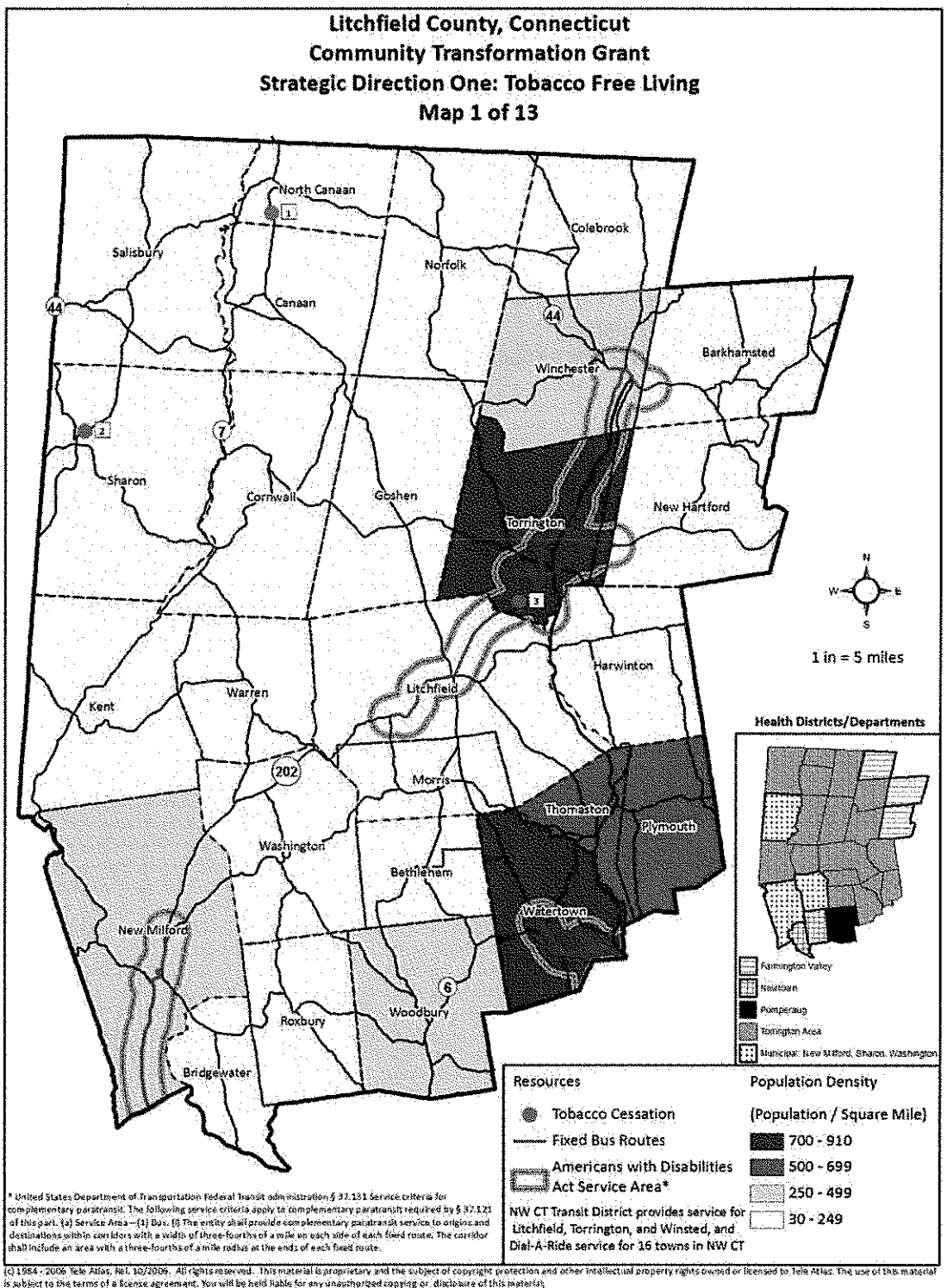
CHANGE will be used to facilitate community health planning by all five sectors. Findings from the CHANGE Strategic Planning process will be appended to this report in CTG Project Year 2.

Appendix A - Asset Maps of Programs & Services by Strategic Direction

The following GIS Asset Maps of Health-Related Programs & Services located within the county were compiled by the United Way of CT Infoline 2-1-1 Research & Evaluation Unit. Population density and transportation routes are included on each map. Each map aligns with a specific CTG Strategic Direction, and has an accompanying Resource Listing. The Resource Listings include the types of services provided, provider agency or organization names, and addresses. More detailed information on the programs and services included is available at www.infoline.org or by calling Infoline at 2-1-1.

Infoline is the most comprehensive online searchable database of health and human service providers, agencies, and organizations available in CT. This database contains information for over 4,600 health and human service providers and 48,000 service sites in CT.

It should be noted that private, for-profit service providers are not included in the database. In addition, although United Way Infoline 2-1-1 makes concerted efforts to assure the database is as complete and up-to-date as possible, service providers must supply the required information. Any omissions of programs or services in the following maps are unintentional, and may be the result of a particular provider not being registered with Infoline.


Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction One: Tobacco Free Living
Map 1 of 13
North Canaan
Colebrook
Salisbury
Norfolk
Canaan
Barkhamsted
Winchester
Sharon
Cornwall
Goshen
Torrington
New Hartford
Harwinton
Litchfield
Warren
Kent
Morris
Thomaston
Plymouth
Washington
Bethlehem
Watertown
New Milford
Roxbury
Woodbury
Bridgewater
1 in = 5 miles
Health Districts/Departments
Farmington Valley
Naugatuck
Pomperaug
Torrington Area
Municipal: New Milford, Sharon, Washington
Resources
Tobacco Cessation
Fixed Bus Routes
Americans with Disabilities Act Service Area*
NW CT Transit District provides service for Litchfield, Torrington, and Winsted, and Dial-A-Ride service for 16 towns in NW CT
Population Density
(Population / Square Mile)
700 - 910
500 - 699
250 - 499
30 - 249
* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.
(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

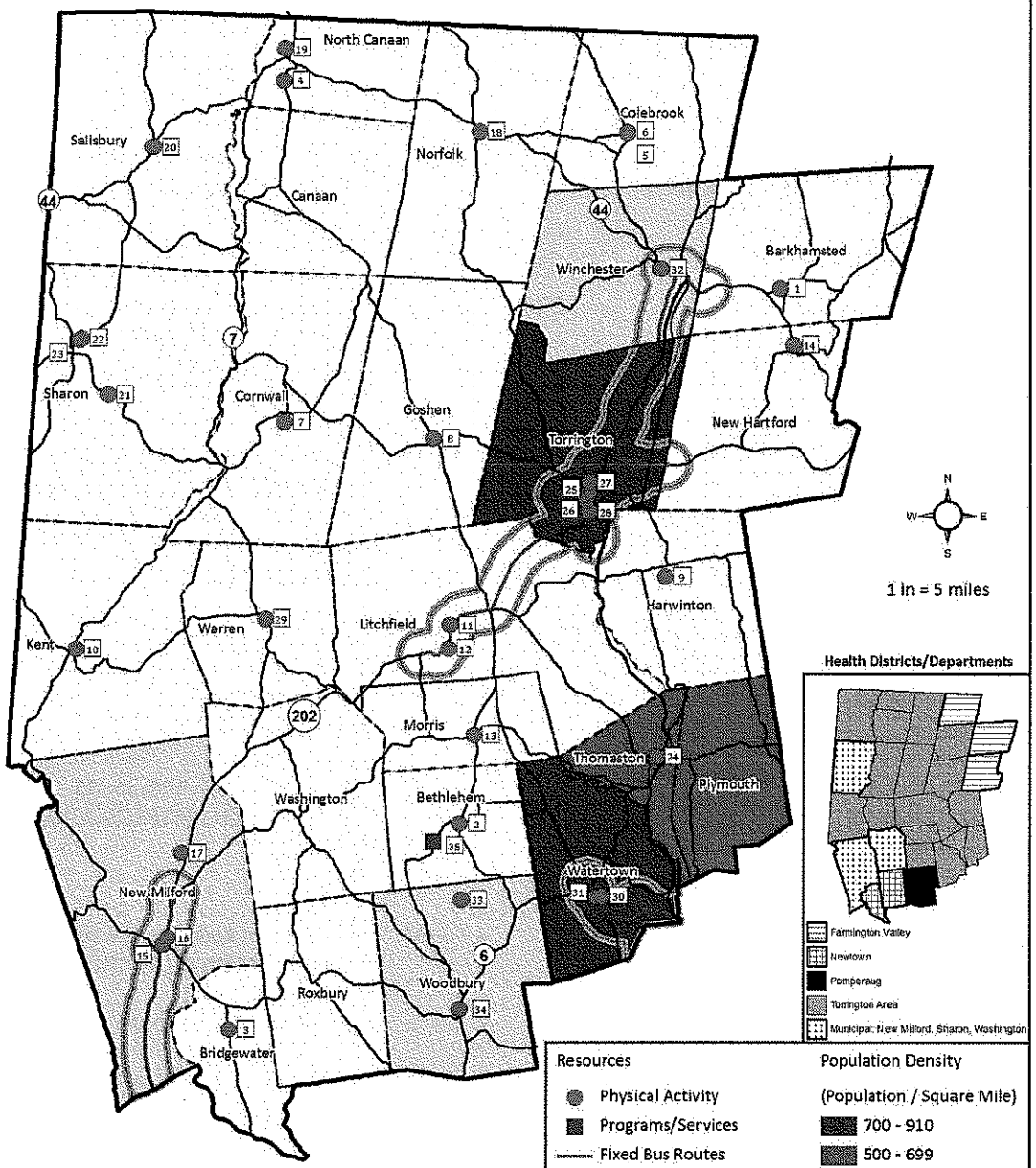
Litchfield County, CT
Community Transformation Grant
Strategic Direction One: Tobacco Free Living
Map 1 of 13 – Resource Listing

1. Smoking Addiction Support Groups
   MOUNTAINSIDE TREATMENT CENTER
   187 South Canaan Road, Route 7
   North Canaan, CT 06018
   Nicotine Anonymous

2. Smoking Cessation
   SHARON HOSPITAL - GOOD NEIGHBORS -
   THE COMMUNITY HEALTH PROMOTION PROGRAM
   One Low Road
   Sharon, CT 06069
   Smoking Cessation Program

3. Smoking Cessation
   CHARLOTTE HUNGERFORD HOSPITAL - PULMONARY EDUCATION
   780 Litchfield Street
   Torrington, CT 06790
   Freedom from Smoking

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Two: Active Living and Healthy Eating
Map 2 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material;
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Two: Active Living and Healthy Eating
Map 2 of 13 – Resource Listing

PHYSICAL ACTIVITY

1. Recreational Activities/Sports
   BARKHAMSTED PARKS AND RECREATION
   67 Ripley Hill Road
   Barkhamsted, CT 06063

2. Recreational Activities/Sports
   BETHLEHEM RECREATION
   36 Main Street South
   Bethlehem, CT 06751

3. Recreational Activities/
   Sports
   BRIDGEWATER RECREATION COMMISSION
   PO Box 216
   Bridgewater, CT 06752

4. Recreational Activities/Sports, Swimming/Swim Lessons
   NORTHWEST CT YMCA/ CANAAN FAMILY YMCA
   77 South Canaan Road
   Canaan, CT 06018

5. Recreational Activities/Sports
   COLEBROOK, TOWN OF
   562 Colebrook Road Route 183
   Colebrook, CT

6. Recreational/Leisure/Arts Instruction
   COLEBROOK SENIOR/COMMUNITY CENTER
   2 School House Road
   Colebrook, CT 06021

7. Recreational Activities/
   Sports
   CORNWALL PARKS AND RECREATION
   PO Box 205
   Cornwall, CT 06753

8. Recreational Activities/Sports
   GOSHEN RECREATION
   42A North Street
   Goshen, CT 06756

9. Recreational Activities/Sports
   HARWINTON RECREATION
   100 Bentley Drive
   Harwinton, CT

10. Recreational Activities/Sports
    KENT PARK AND RECREATION
    41 Kent Green Boulevard
    Kent, CT 06757

11. Neighborhood Centers, Personal Enrichment,
    Recreational Activities/Sports, Rec./Leisure/Arts
    LITCHFIELD COMMUNITY CENTER
    421 Bantam Road
    Litchfield, CT 06759

12. Nature Centers/Walks
    WHITE MEMORIAL CONSERVATION CENTER
    80 Whitehall Road
    Litchfield, CT 06759

13. Recreational Activities/Sports
    MORRIS BEACH AND RECREATION
    3 East Street
    Morris, CT

14. Recreational Activities/Sports
    NEW HARTFORD RECREATION
    580 Main Street
    New Hartford, CT 06057

15. Recreational Activities/Sports,
    Swimming/Swim Lessons
    NEW MILFORD PARKS AND RECREATION
    47 Bridge Street
    New Milford, CT 06776

16. Recreational Activities/Sports * Youth
    NEW MILFORD YOUTH AGENCY
    50 East Street
    New Milford, CT 06776

Litchfield County, CT
Community Transformation Grant
Strategic Direction Two: Active Living and Healthy Eating
Map 2 of 13 – Resource Listing

PHYSICAL ACTIVITY (Cont.)

17. Nature Centers/Walks, Recreational Activities/Sports
PRATT NATURE CENTER, THE
163 Papermill Road
New Milford, CT 06776

18. Recreational Activities/Sports
NORFOLK, TOWN OF
19 Maple Avenue
Norfolk, CT 06058

19. Recreational Activities/Sports
NORTH CANAAN, TOWN OF
100 Pease Street, #1
North Canaan, CT 06018

20. Recreational Activities/Sports
SALISBURY RECREATION
PO Box 548
Salisbury, CT 06039

21. Nature Centers/Walks
AUDUBON CT - AUDUBON SHARON
325 Cornwall Bridge Road
Sharon, CT 06069

22. Recreational Activities/Sports
SHARON YOUTH AND RECREATION CENTER
99 North Main Street
Sharon, CT 06069

23. Personal Enrichment
SHARON HOSPITAL - GOOD NEIGHBORS
THE COMMUNITY HEALTH PROMOTION PROGRAM
One Low Road
Sharon, CT 06069

24. Recreational Activities/Sports
THOMASTON PARK AND RECREATION
158 Main Street
Thomaston, CT

25. Rec Activities/Sports * Disabilities/ Health Conditions
LARC
314 Main Street
Torrington, CT 06790

26. Physical Fitness
NORTHWEST CT YMCA - TORRINGTON BRANCH
259 Prospect Street
Torrington, CT 06790

27. Recreational Activities/Sports * Youth
TORRINGTON POLICE ATHLETIC LEAGUE
576 Main Street
Torrington, CT 06790

28. Rec Activities/Sports, Playgrounds, Swim Lessons
TORRINGTON, CITY OF - PARKS AND RECREATION
153 South Main Street
Torrington, CT 06790

29. Recreational Activities /Sports
WARREN, TOWN OF
50 Cemetery Road
Warren, CT 06754

30. Rec. Activities/Sports * Disabilities/Health Conditions
FAMILY OPTIONS
76 Westbury Park Road Suite 200E
Watertown, CT 06795

31. Recreational Activities/Sports, Swim Lessons
WATERTOWN PARKS
AND RECREATION
51 Depot Street Suite 108
Watertown, CT 06795

32. Recreational Activities/Sports, Swim Lessons
NORTHWEST CT YMCA - WINSTED BRANCH
480 Main Street
Winchester, CT 06098

Litchfield County, CT
Community Transformation Grant
Strategic Direction Two: Active Living and Healthy Eating
Map 2 of 13 – Resource Listing

PHYSICAL ACTIVITY (Cont.)

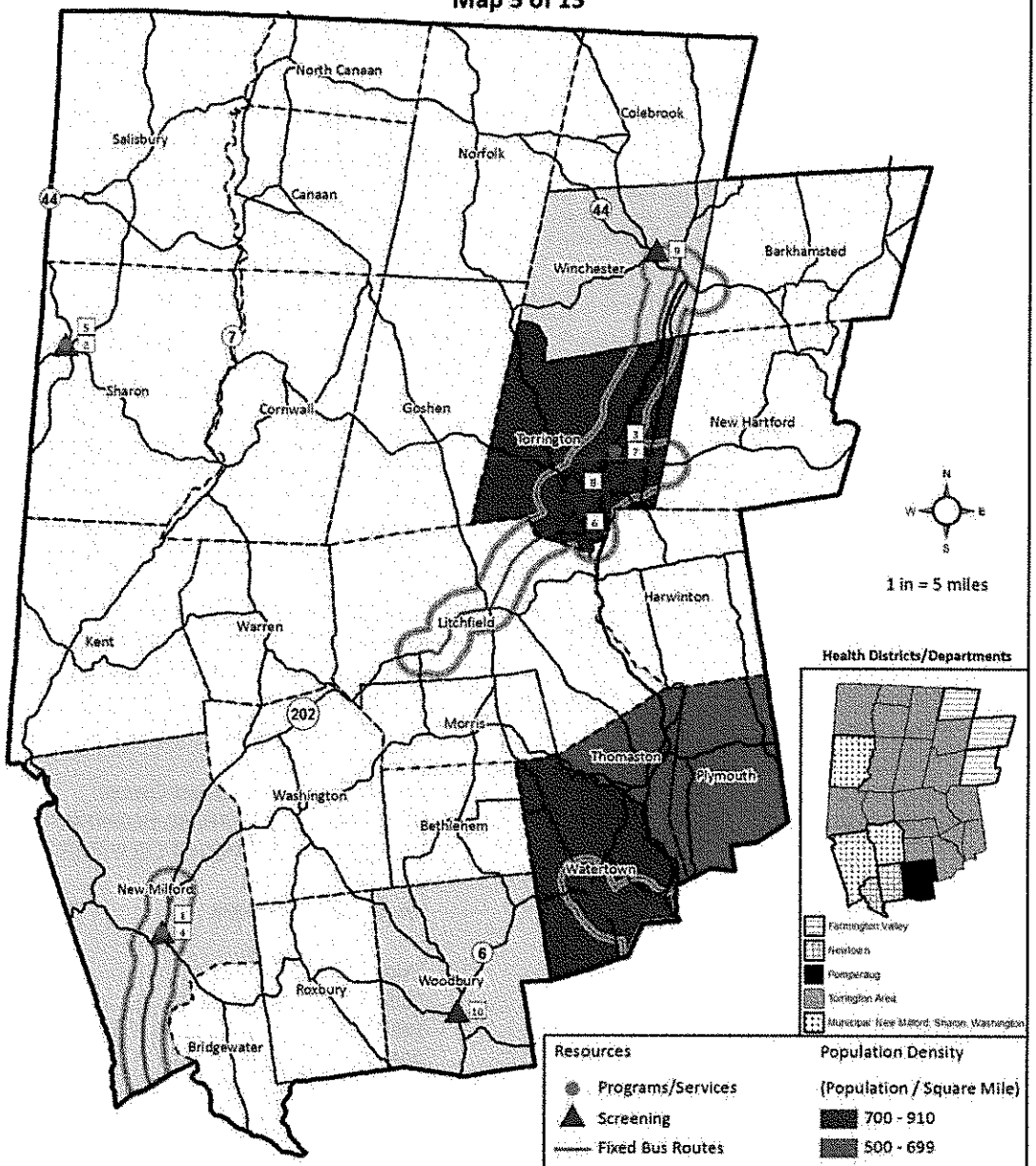
33. Nature Center/Walks
    FLANDERS NATURE CENTER AND LAND TRUST
    5 Church Hill Road
    Woodbury, CT 06798

34. Recreational Activities/Sports, Swimming/Swim Lessons
    WOODBURY PARK AND RECREATION
    7 Mountain Road
    Woodbury, CT 06798

PROGRAMS AND SERVICES

35. Specialized Treatment * Eating Disorders
    WELLSPRING
    21 Arch Bridge Road
    Bethlehem, CT 06751

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services - Leading Causes: Cancer
Map 3 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.

U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 Infoline, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services – Leading Causes
Map 3 of 13 – Resource Listing

CANCER – PROGRAMS AND SERVICES

1. Specialized Treatment * Cancer
   NEW MILFORD HOSPITAL
   REGIONAL CANCER CENTER
   21 Elm Street
   New Milford, CT 06776

2. Breast Cancer, Specialized Treatment
   SHARON HOSPITAL
   CANCER CARE
   50 Hospital Hill Road
   Sharon, CT 06069

3. Specialized Treatment * Cancer
   CHARLOTTE HUNGERFORD HOSPITAL
   CENTER FOR CANCER CARE
   200 Kennedy Drive
   Torrington, CT 06790

CANCER – SCREENING

4. Cancer Detection
   NEW MILFORD HOSPITAL
   REGIONAL CANCER CENTER
   21 Elm Street
   New Milford, CT 06776

5. Cancer Detection, Breast Cancer
   SHARON HOSPITAL
   CANCER CARE
   50 Hospital Hill Road
   Sharon, CT 06069

6. Cancer Detection * Breast Cancer, Cervical Cancer
   CHARLOTTE HUNGERFORD HOSPITAL - BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM
   540 Litchfield Street
   Torrington, CT 06790

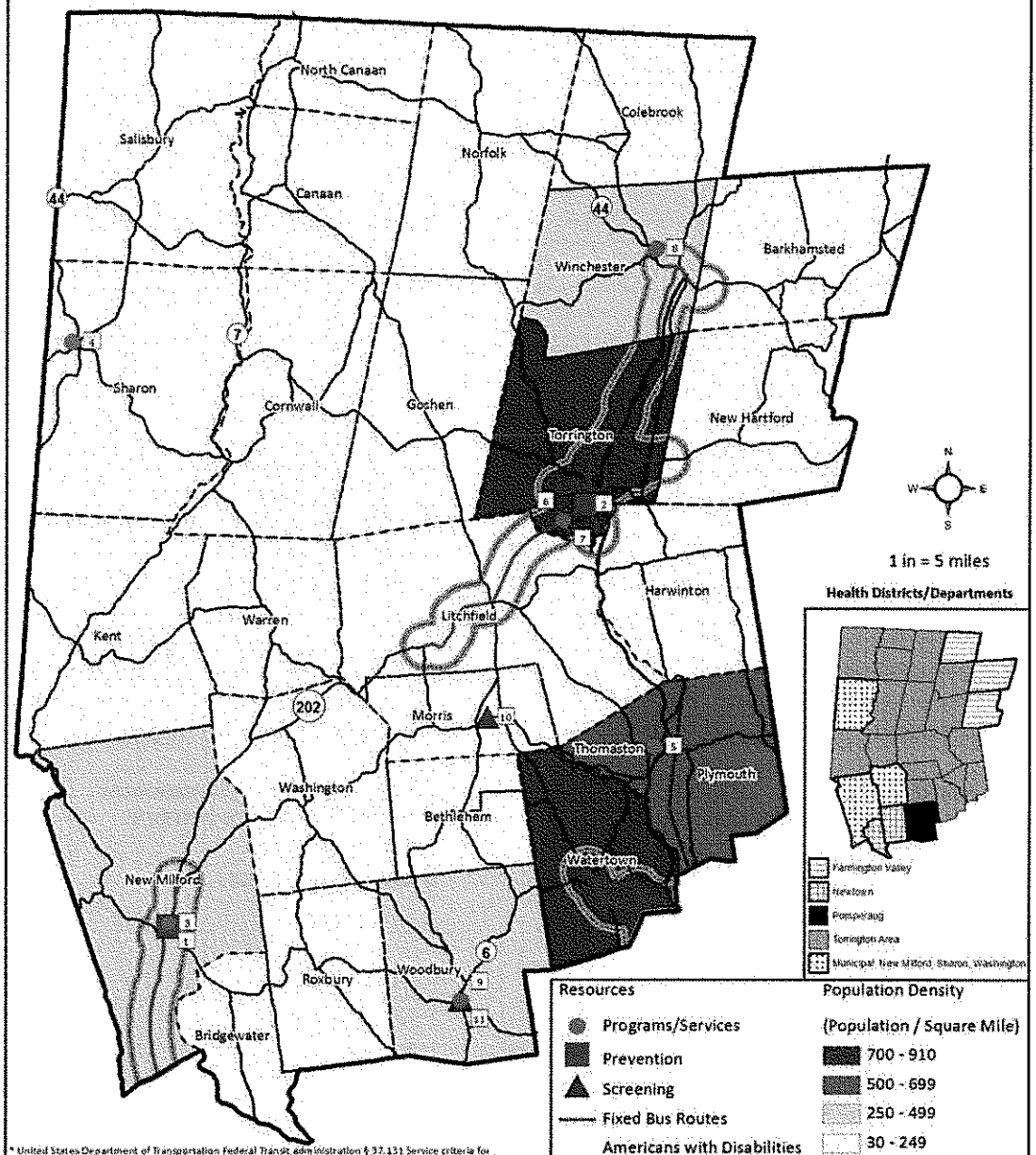
7. Cancer Detection * Breast Cancer
   CHARLOTTE HUNGERFORD HOSPITAL
   MAMMOGRAPHY CENTER
   220 Kennedy Drive
   Torrington, CT 06790

8. Cancer Detection * Colorectal Cancer
   COMMUNITY HEALTH AND WELLNESS CENTER OF GREATER TORRINGTON - COLORECTAL CANCER CONTROL PROGRAM
   459 Migeon Avenue
   Torrington, CT 06790

9. Cancer Detection * Breast Cancer
   CHARLOTTE HUNGERFORD HOSPITAL - HUNGERFORD EMERGENCY AND MEDICAL SERVICES
   115 Spencer Street
   Winchester, CT 06098

10. Skin Cancer Screening
    POMPERAUG HEALTH DISTRICT
    275 Main South St.
    Woodbury, CT 06798

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services - Leading Causes: Cardiovascular
Map 4 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.

U.S Bureau of the Census (2010) Summary File 3 (SF 3) : Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services – Leading Causes - Cardiovascular
Map 4 of 13 – Resource Listing

CARDIOVASCULAR – PROGRAMS AND SERVICES

PREVENTION

1. CPR Instruction
   AMERICAN RED CROSS - CT CHAPTER
   40 Main Street
   New Milford, CT 06776

2. CPR Instruction
   AMERICAN RED CROSS - CT CHAPTER
   21 Prospect Street Suite B
   Torrington, CT 06790

PROGRAMS AND SERVICES

3. Cardiac Rehab, Specialized Treatment * Heart Disease
   NEW MILFORD HOSPITAL - REGIONAL HEART CENTER/CARDIAC REHABILITATION
   21 Elm Street
   New Milford, CT 06776

4. Cardiac Rehabilitation
   SHARON HOSPITAL CARDIOLOGY
   50 Hospital Hill Road
   Sharon, CT 06069

5. Stroke Rehabilitation
   ACCESS REHAB CENTERS - THOMASTON SITE
   131 Main Street Suite 105B
   Thomaston, CT 06787

6. Cardiac Rehabilitation
   CHARLOTTE HUNGERFORD HOSPITAL
   CARDIAC REHABILITATION
   780 Litchfield Street
   Torrington, CT 06790

7. Pulmonary Rehabilitation
   CHARLOTTE HUNGERFORD
   PULMONARY EDUCATION
   780 Litchfield Street
   Torrington, CT 06790

8. Cardiac and Pulmonary Rehabilitation
   CHARLOTTE HUNGERFORD EMERGENCY & MEDICAL SVCS.
   115 Spencer Street
   Winchester, CT 06098

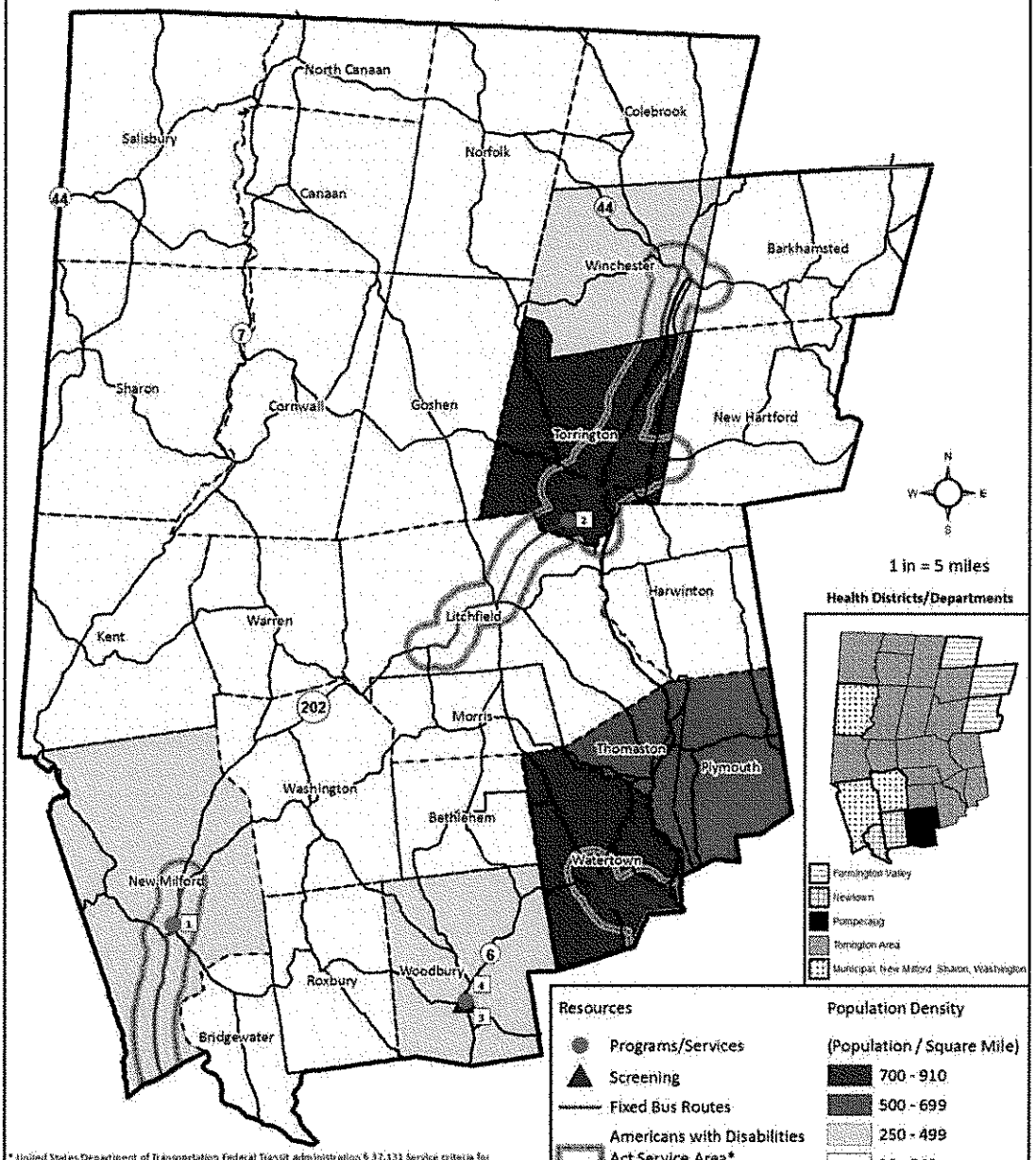
9. Chronic Disease Self-Management
   POMPERAUG HEALTH DISTRICT
   275 Main South St.
   Woodbury, CT 06798

SCREENING

10. Cardiovascular
    Health Screening/Diagnostic Services
    MORRIS SENIOR CENTER
    109-21 East Street
    Morris, CT 06763

11. Cardiovascular
    Health Screening/Diagnostic Services
    POMPERAUG HEALTH DISTRICT
    275 Main South St.
    Woodbury, CT 06798

Litchfield County, Connecticut
Community Transformation Grant
Strategic DirectionThree: High Impact Quality Clinical and Other Preventive Services - Leading Causes: Diabetes
Map 5 of 13



* United States Department of Transportation Federal Transit Administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area - (1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services – Leading Causes - Diabetes
Map 5 of 13 – Resource Listing

DIABETES – PROGRAMS AND SERVICES

1. Specialized Treatment * Diabetes
   NEW MILFORD HOSPITAL - DIABETES EDUCATION
   21 Elm Street
   New Milford, CT 06776

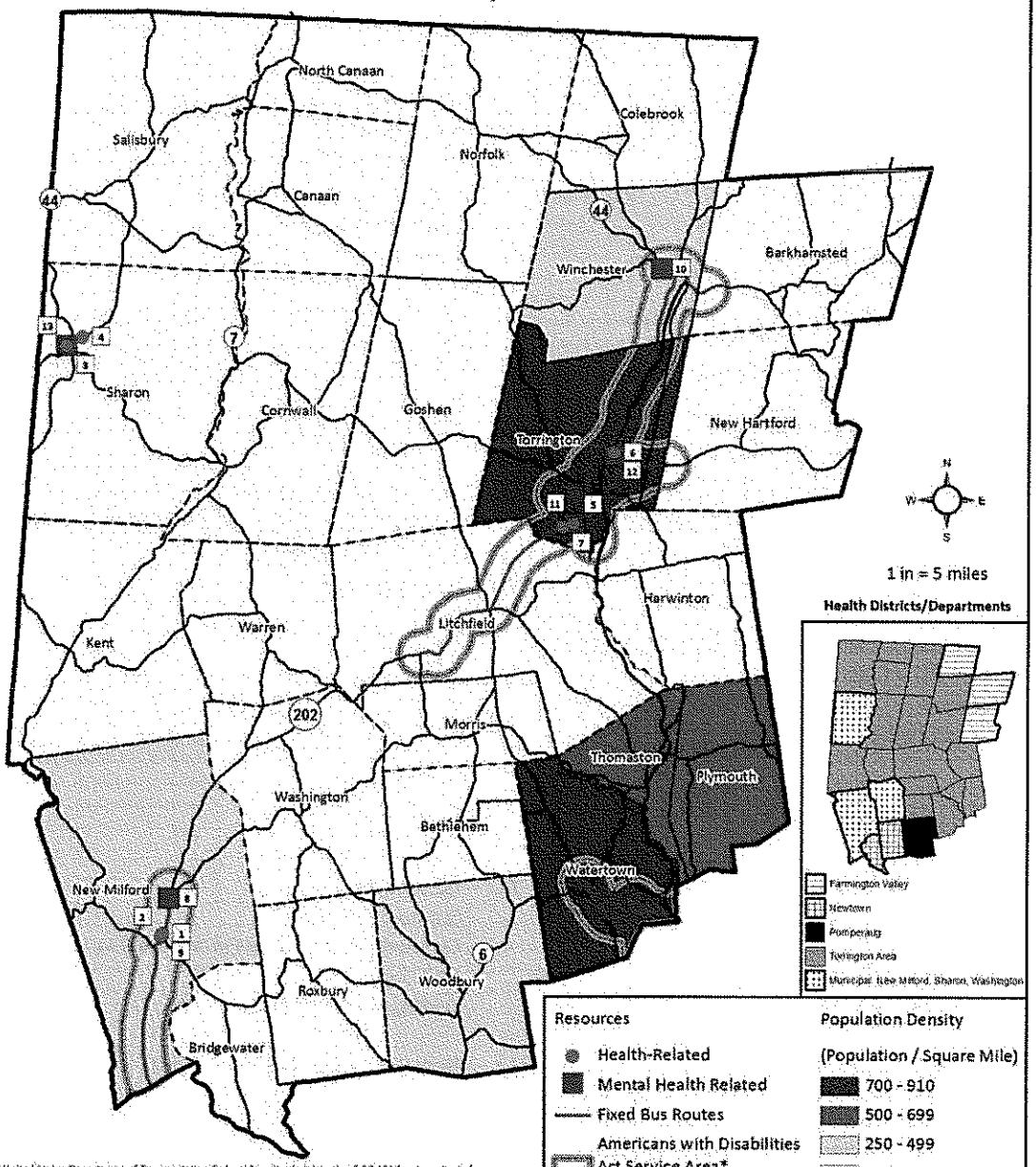
2. Specialized Treatment * Diabetes
   CHARLOTTE HUNGERFORD HOSPITAL
   DIABETES CENTER
   780 Litchfield Street
   Torrington, CT 06790

3. Chronic Disease Self-Management Program
   POMPERAUG HEALTH DISTRICT
   275 Main South St.
   Woodbury, CT 06798

DIABETES – SCREENING

4. Diabetes Control and Screening Programs
   POMPERAUG HEALTH DISTRICT
   275 Main South St.
   Woodbury, CT 06798

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness -
Community Support and Support Groups - Health and Mental Health-Related
Map 6 of 13



Resources
- Health-Related
- Mental Health Related
- Fixed Bus Routes
- Americans with Disabilities Act Service Area*

Population Density (Population / Square Mile)
- 700 - 910
- 500 - 699
- 250 - 499
- 30 - 249

NW CT Transit District provides service for Litchfield, Torrington, and Winsted, and Dial-A-Ride service for 16 towns in NW CT

* United States Department of Transportation Federal Transit Administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.

U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Community Support and Support Groups – Health and Mental Health-Related
Map 6 of 13 – Resource Listing

HEALTH RELATED

1. Health/Disability Related Support Groups
   * Cancer
   NEW MILFORD HOSPITAL -
   CARES SUPPORT GROUP
   21 Elm Street
   New Milford, CT 06776

2. Health/Disability Related Support Groups
   * Visual Impairments
   NEW MILFORD RICHMOND CITIZEN CENTER
   40 Main Street
   New Milford, CT 06776

3. Caregiver/Care Receiver Support Groups
   SHARON HOSPITAL - CAREGIVER SUPPORT GROUP
   50 Hospital Hill Road
   Sharon, CT 06069

4. Health/Disability Support Groups Stroke, Cancer
   SHARON HOSPITAL
   1 Low Road
   Sharon, CT 06069

5. Health/Disability Related Support Groups * Breast Cancer, Prostate Cancer
   CHARLOTTE HUNGERFORD -
   CANCER SUPPORT GROUPS
   540 Litchfield Street
   Torrington, CT 06790

6. Health/Disability Related Support Groups
   * Cancer
   CHARLOTTE HUNGERFORD CENTER FOR CANCER CARE
   200 Kennedy Drive
   Torrington, CT 06790

7. Health/Disability Related Support Group * Diabetes
   CHARLOTTE HUNGERFORD HOSPITAL - DIABETES CENTER
   780 Litchfield Street
   Torrington, CT 06790

MENTAL HEALTH RELATED

8. Bereaved Child Support Groups,
   General Bereavement Support Groups
   NEW MILFORD VISITING NURSE ASSOC.
   68 Park Lane Road, Route 202
   New Milford, CT 06776

9. Planning/Coordinating/Advisory Groups
   UNITED WAY OF NORTHWEST CT
   16 Bird Street Suite 1
   Torrington, CT 06790

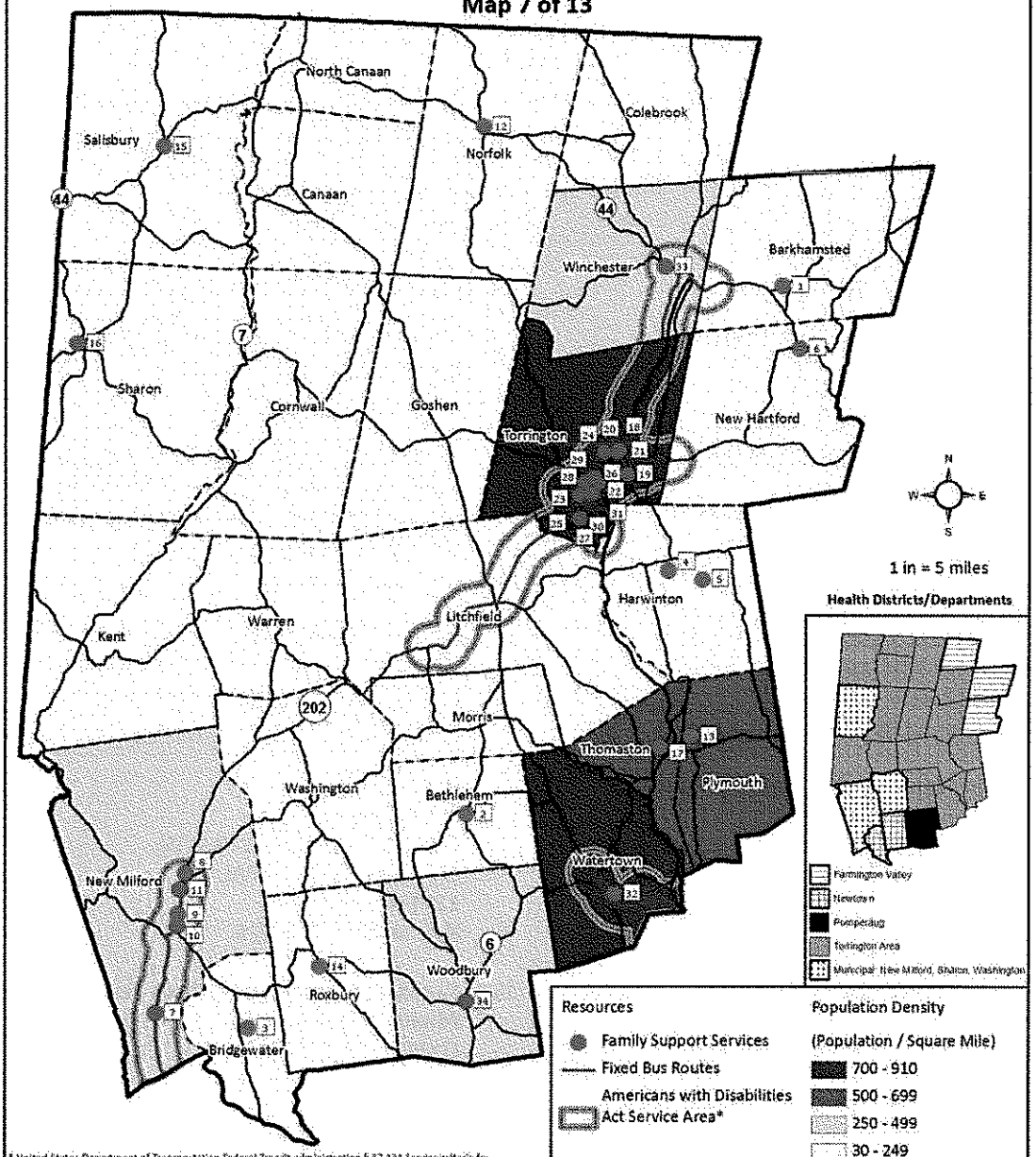
10. General Bereavement Support Groups
    FOOTHILLS VISITING NURSE AND HOME CARE
    32 Union Street
    Winchester, CT 06098

11. General Bereavement
    Support Groups
    CHARLOTTE HUNGERFORD HOSPITAL - BEHAVIORAL HEALTH
    540 Litchfield Street
    Torrington, CT 06790

12. Bereaved Child Support Groups
    VISITING NURSE SERVICES OF CT - TORRINGTON OFFICE
    65 Commercial Boulevard
    Torrington, CT 06790

13. Bereaved Parent, General Bereavement Support Groups
    SHARON HOSPITAL
    50 Hospital Hill Road
    Sharon, CT 06069

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness -
Family Support Services
Map 7 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 Info Line, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Family Support Services
Map 7 of 13 – Resource Listing

FAMILY SUPPORT SERVICES

1. Latchkey/Home Alone
   Safety Programs
   BARKHAMSTED RESIDENT STATE TROOPER
   67 Ripley Hill Road
   Barkhamsted, CT 06063

2. Latchkey/Home Alone
   Safety Programs
   BETHLEHEM RESIDENT STATE TROOPER
   36 Main Street South
   Bethlehem, CT 06751

3. Foster Homes for Dependent Children
   BRIDGE FAMILY CENTER,
   THE - HARWINTON SHELTER
   25 Plymouth Road
   Harwinton, CT 06791-2418

4. Latchkey/Home Alone Safety Programs
   BRIDGEWATER RESIDENT STATE TROOPER
   132 Hut Hill Road
   Bridgewater, CT 06752

5. Adoption Counseling and Support/Placement,
   Co-Parenting Workshops
   CATHOLIC CHARITIES - ARCHDIOCESE OF HARTFORD
   TORRINGTON
   132 Grove Street
   Torrington, CT 06790

6. Child Abuse Counseling, Children's
   Protective Services
   CHARLOTTE HUNGERFORD HOSPITAL
   CENTER FOR YOUTH AND FAMILIES
   1061 East Main Street
   Torrington, CT 06790

7. Parenting Education * Parents of Infants/Toddlers
   CHARLOTTE HUNGERFORD HOSPITAL
   NURTURING CONNECTIONS
   540 Litchfield Street
   Torrington, CT 06790

8. Adoption and Foster Parents, Children's Protective Services,
   Foster Homes,, Home Based Parenting Ed * Child Abuse Issues
   DEPT OF CHILDREN AND FAMILIES
   62 Commercial Boulevard
   Torrington, CT 06790

9. Children's Rights Groups, Guardians ad Litem, Individual
   Advocacy * Child Abuse, Juvenile Delinquency Prevention
   CHILDREN IN PLACEMENT - TORRINGTON
   410 Winsted Road
   Torrington, CT 06790

10. Co-Parenting, Family Preservation, Home Based Parenting Ed
    COMMUNITY MENTAL HEALTH AFFILIATES –
    NORTHWEST CENTER FOR FAMILY SERVICE
    100 Commercial Boulevard
    Torrington, CT 06790

11. Case/Care Management * At Risk Families
    NEW MILFORD VISITING NURSE ASSOCIATION
    68 Park Lane Road, Route 202
    New Milford, CT 06776

12. Co-Parenting
    Workshops
    COMMUNITY MENTAL HEALTH
    PARK LANE BEHAVIORAL
    120 Park Lane Road
    New Milford, CT 06776

13. Kinship Caregivers, Home Based Parenting Education,
    Parents of Infants/Toddlers
    EDUCATION CONNECTION
    TORRINGTON SITE
    57 Forest Court
    Torrington, CT 06790

14. Adoption and Foster/Kinship Care Support Groups
    EDUCATION CONNECTION
    TORRINGTON SITE
    57 Forest Court
    Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Family Support Services
Map 7 of 13 – Resource Listing

FAMILY SUPPORT SERVICES (Cont.)

15. Child Abuse Counseling
FAMILY AND CHILDREN'S AID NEW MILFORD SITE
325 Danbury Road
New Milford, CT 06776

16. Case Management * At Risk Families, Teen Parents, Parenting Ed, Fathers, Home Based Parenting Ed
FAMILY STRIDES
350 Main Street Suite D
Torrington, CT 06790

17. Latchkey/Home Alone
Safety Programs
HARWINTON RESIDENT STATE TROOPER
100 Bentley Drive
Harwinton, CT 06791-2231

18. Home Based Parenting Education
* At Risk Families
MCCALL FOUNDATION
58 High Street
Torrington, CT 06790

19. Latchkey/Home Alone
Safety Programs
NEW HARTFORD, RESIDENT STATE TROOPER
530 Main Street
New Hartford, CT 06057-0316

20. Case Management, At Risk Families, Teen Parents /Fathers, Home Based Parenting Ed
NEW MILFORD VISITING NURSE ASSOCIATION
68 Park Lane Road, Route 202
New Milford, CT 06776

21. Latchkey/Home Alone Safety Programs
NEW MILFORD POLICE
49 Poplar Street
New Milford, CT 06776

22. Juvenile Diversion, Parenting Education
NEW MILFORD YOUTH AGENCY
50 East Street
Torrington, CT 06790

23. Latchkey/Home Alone
Safety Programs
NORFOLK RESIDENT STATE TROOPER
14 Shepard Road
Norfolk, CT 06058

24. Child Care Referrals, Family Support Centers, Home Based Parenting Ed, Parenting Ed/Infants/Toddlers
PLYMOUTH FAMILY RESOURCE CENTER
107 North Street
Plymouth, CT 06782

25. Latchkey/Home Alone
Safety Programs
ROXBURY RESIDENT STATE TROOPER
27 North Street
Roxbury, CT 06783

26. Latchkey/Home Alone
Safety Programs
SALISBURY RESIDENT STATE TROOPER
27 Main Street
Salisbury, CT 06068-0365

27. Parenting Education
Parents of Infants/Toddlers
SHARON HOSPITAL - NURTURING CONNECTIONS
50 Hospital Hill Road
Sharon, CT 06069

28. Juvenile Delinquency Programs
SUPERIOR COURT, CT - JUVENILE MATTERS AT TORRINGTON
410 Winsted Road
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Family Support Services
Map 7 of 13 – Resource Listing

FAMILY SUPPORT SERVICES (Cont.)

29. Latchkey/Home Alone
Safety Programs
THOMASTON POLICE
158 Main Street
Thomaston, CT 06787-1720

30. Juvenile Diversion
TORRINGTON AREA YOUTH SERVICE BUREAU (TAYSB)
8 Church Street
Torrington, CT 06790

31. Latchkey/Home Alone Safety Programs
TORRINGTON, CITY OF - POLICE
576 Main Street
Torrington, CT 06790

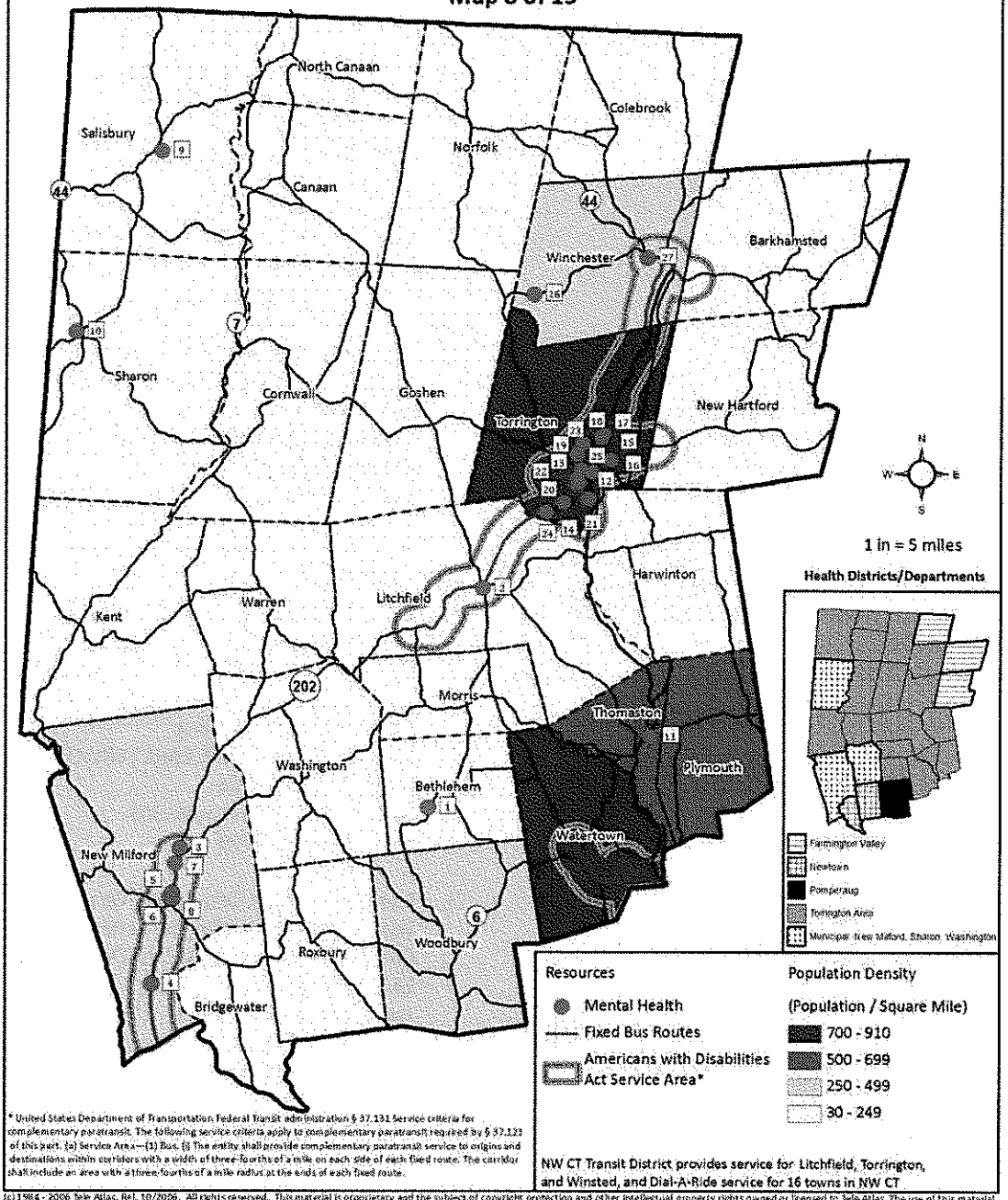
32. Home Based Parenting Ed, Parenting Ed, Family Support Centers/Outreach, Child Care Provider Referrals
VOGEL-WETMORE FAMILY RESOURCE CENTER
68 Church Street
Torrington, CT 06790

33. Latchkey/Home Alone Safety Programs
WATERTOWN POLICE
195 French Street
Watertown, CT 06795

34. Home Based Parenting Education, Parenting Ed
WINCHESTER YOUTH SERVICE BUREAU (WYSB)
480 Main Street
Winchester, CT 06098

35. Latchkey/Home Alone
Safety Programs
WOODBURY RESIDENT STATE TROOPER
271 Main Street South
Woodbury, CT 06798-0369

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness -
Mental Health Resources
Map 8 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.123 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Mental Health Resources
Map 8 of 13 – Resource Listing

MENTAL HEALTH

1. General Counseling Services
   WELLSPRING
   21 Arch Bridge Road
   Bethlehem CT 06751

2. Therapy Referrals
   GREENWOODS COUNSELING REFERRALS
   25 South Street
   Litchfield CT

3. Adolescent/Youth Counseling,
   General Counseling Services
   COMMUNITY MENTAL HEALTH AFFILIATES - PARK LANE BEHAVIORAL HEALTH
   120 Park Lane Road
   New Milford, CT 06776

4. Adolescent/Youth Counseling, Child Guidance, Mental Health Evaluation, Psychiatric Disorder Counseling
   FAMILY AND CHILDREN'S AID - NEW MILFORD SITE
   325 Danbury Road
   New Milford, CT 06776

5. Adolescent/Youth Counseling General Counseling
   NEW MILFORD HOSPITAL
   BEHAVIORAL HEALTH SERVICES
   23 Poplar Street
   New Milford, CT 06776

6. Psychiatric Emergency
   Room Care
   NEW MILFORD HOSPITAL EMERGENCY DEPARTMENT
   21 Elm Street
   New Milford, CT 06776

7. Psychiatric Home Nursing
   NEW MILFORD VISITING NURSE ASSOCIATION
   68 Park Lane Road, Route 202
   New Milford, CT 06776

8. Adolescent/Youth Counseling,
   NEW MILFORD YOUTH AGENCY
   50 East Street
   New Milford, CT 06776

9. Psychiatric Home Nursing
   SALISBURY VISITING NURSE ASSOCIATION
   30A Salmon Kill Road
   Salisbury, CT 06068

10. Adult Psychiatric Inpatient Units, Mental Health Evaluation, Psychiatric Emergency Room Care
    SHARON HOSPITAL
    SENIOR BEHAVIORAL HEALTH
    50 Hospital Hill Road
    Sharon, CT 06069

11. Therapeutic
    Group Homes
    NAFI CT - THOMASTON GROUP HOME
    273 Prospect Street
    Thomaston, CT 06787

12. Psychiatric Home Nursing
    ALL ABOUT YOU HOME CARE SERVICES
    TORRINGTON OFFICE
    507 East Main Street Suite 305
    Torrington, CT 06790

13. Adolescent/Youth Counseling, General Counseling Services, Mental Health Evaluation
    CATHOLIC CHARITIES - ARCHDIOCESE OF HARTFORD -
    132 Grove Street
    Torrington, CT 06790

14. Adult Psychiatric Inpatient Units
    CHARLOTTE HUNGERFORD HOSP. BEHAVIORAL HEALTH
    540 Litchfield Street
    Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Mental Health Resources
Map 8 of 13 – Resource Listing

MENTAL HEALTH (CONT.)

15. Psychiatric Day Treatment * Youth
CHARLOTTE HUNGERFORD HOSPITAL - BRIDGES CHILD EXTENDED DAY TREATMENT PROGRAM
241 Kennedy Drive
Torrington, CT 06790

16. Adolescent/Youth Counseling, Child Guidance,
CHARLOTTE HUNGERFORD
CENTER FOR YOUTH AND FAMILIES
1061 East Main Street
Torrington, CT 06790

17. Case/Care Management
* Youth Emotional Disturbance
CT DEPARTMENT OF CHILDREN AND FAMILIES
62 Commercial Boulevard
Torrington, CT 06790

18. Adolescent/Youth Counseling, Case/Care Management
COMMUNITY MENTAL HEALTH AFFILIATES - NORTHWEST CENTER FOR FAMILY SERVICE
100 Commercial Boulevard
Torrington, CT 06790

19. Individual Advocacy * Chronic/Severe Mental Illness
CT LEGAL RIGHTS PROJECT – TORRINGTON SATELLITE
810 Main Street
Torrington, CT 06790

20. Therapy Referrals
LITCHFIELD COUNTY MEDICAL ASSOCIATION (LCMA)
PO Box 416
Torrington, CT 06790

21. Pastoral Counseling
SALVATION ARMY - TORRINGTON CORPS COMMUNITY CENTER
234 Oak Avenue
Torrington, CT 06790

22. Adolescent/Youth Counseling,
TORRINGTON AREA YOUTH SERVICE BUREAU (TAYSB)
8 Church Street, Lower Level
Torrington, CT 06790

23. Psychiatric Home Nursing
VISITING NURSE SERVICES OF CT
TORRINGTON OFFICE
65 Commercial Boulevard
Torrington, CT 06790

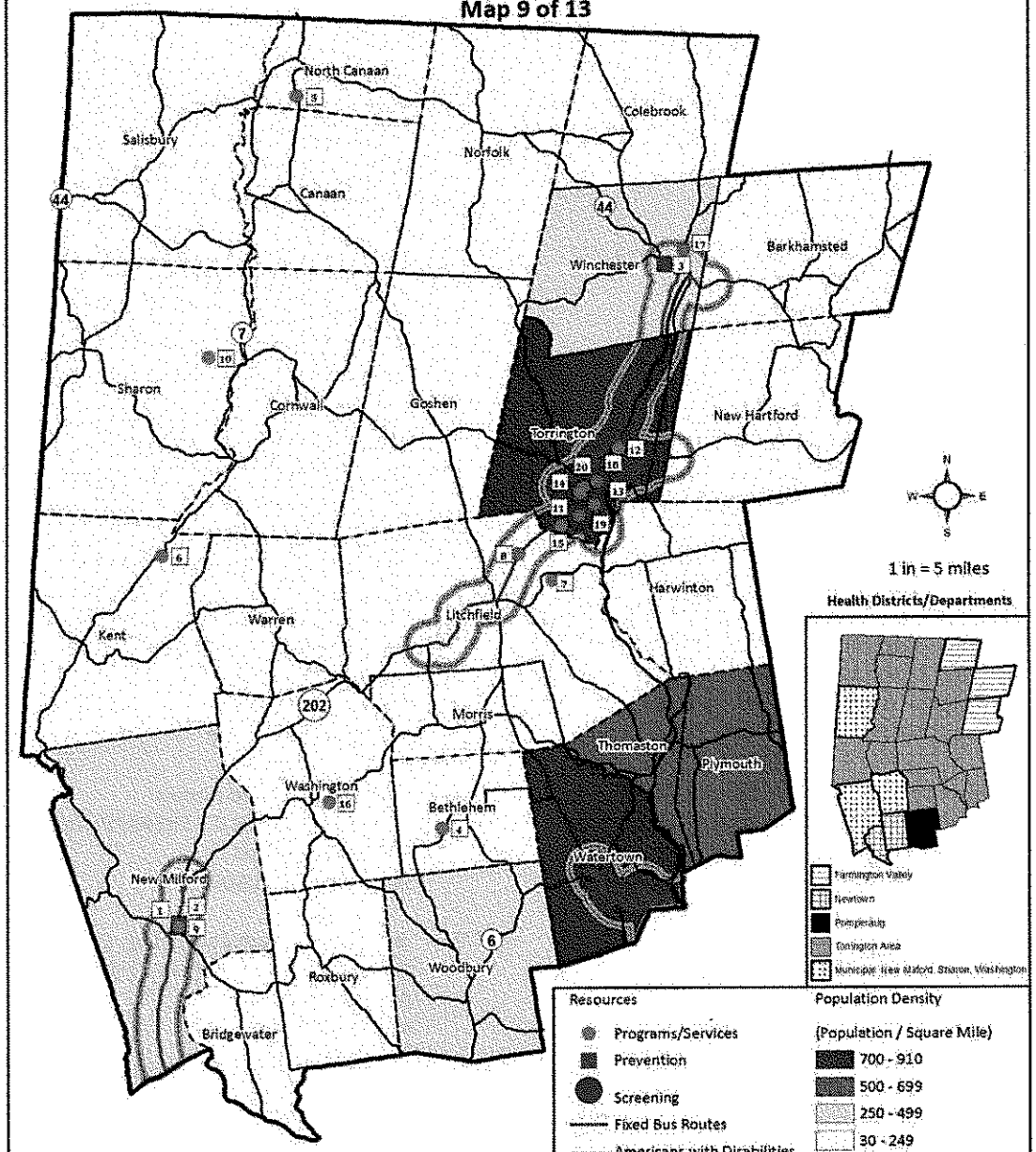
24. Case/Care Management * Children and Youth with Emotional Disturbance, Home Based Mental Health
WELLMORE BEHAVIORAL HEALTH
30 Peck Road Suite 2203
Torrington, CT 06790

25. Case/Care Management * Chronic/Severe Mental Illness,
WESTERN CT MENTAL HEALTH NETWORK – TORRINGTON AREA
249 Winsted Road
Torrington, CT 06790

26. Therapeutic Group Homes
CT JUNIOR REPUBLIC - THERAPEUTIC GROUP HOME
131 Ashleigh Road
Winchester, CT 06098

27. Adolescent/Youth Counseling, Outreach Programs * Youth
WINCHESTER YOUTH SERVICE BUREAU (WYSB)
480 Main Street
Winchester, CT 06098

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness -
Substance Abuse and Addiction
Map 9 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

NW CT Transit District provides service for Litchfield, Torrington, and Winsted, and Dial-A-Ride service for 16 towns in NW CT

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 Infoline, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Substance Abuse and Addiction
Map 9 of 13 – Resource Listing

PREVENTION

1. Substance Abuse Counseling, Substance Abuse Intervention Programs, DUI Offender Programs
MCCA - NEW MILFORD SATELLITE OFFICE
17 East Street
New Milford, CT 06776

2. Substance Abuse Education/Prevention
NEW MILFORD YOUTH AGENCY
50 East Street
New Milford, CT 06776

3. Substance Abuse Education/ Prevention
WINCHESTER YOUTH SERVICE BUREAU (WYSB)
480 Main Street
Winchester, CT 06098

PROGRAMS AND SERVICES

4. Children's/Adolescent Residential Treatment Facilities
WELLSPRING
21 Arch Bridge Road
Bethlehem CT 06751

5. Residential Substance Abuse Treatment Facilities
MOUNTAINSIDE TREATMENT CENTER
187 South Canaan Road Route 7
Canaan, CT 06018

6. Recovery Homes/Halfway Houses
HIGH WATCH RECOVERY CENTER
62 Carter Road
Kent, CT 06757

7. Children's/Adolescent Residential Treatment Facilities
NAFI CT – TOUCHSTONE
11 Country Place
Litchfield, CT 06759

8. Alcohol Dependency Support Groups, Drug Dependency Support Groups
RECOVERY GROUP
441 Torrington Road
Litchfield, CT 06750

9. DUI Offender Programs * Court Ordered Individuals
MCCA - NEW MILFORD SATELLITE OFFICE
17 East Street
New Milford, CT 06776

10. Residential Substance Abuse Treatment Facilities
MCCA - TRINITY GLEN
149 West Cornwall Road
Sharon, CT 06069

11. Inpatient Alcohol Detox
CHARLOTTE HUNGERFORD HOSPITAL EMERGENCY
540 Litchfield Street
Torrington, CT 06790

12. Case/Care Management * Substance Abusers * Youth
DEPT OF CHILDREN AND FAMILIES - TORRINGTON
62 Commercial Boulevard
Torrington, CT 06790

13. Home Based Mental Health Services * Children and Youth with Emotional Disturbance
CT JUNIOR REPUBLIC - TORRINGTON AREA
168 South Main Street
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Substance Abuse and Addiction
Map 9 of 13 – Resource Listing

PROGRAMS AND SERVICES (CONT.)

14. Recovery Homes/Halfway Houses
MCCALL FOUNDATION - MCCALL HOUSE
127 Migeon Avenue
Torrington, CT 06790

15. Case/Care Management * Substance Abusers * Youth
WELLMORE BEHAVIORAL HEALTH FOR CHILDREN & FAMILIES - TORRINGTON CLINICAL SERVICES
30 Peck Road Suite 2203
Torrington, CT 06790

16. Children's/Adolescent Residential Treatment Facilities
GLENHOLME SCHOOL, THE
81 Sabbaday Lane
Washington, CT 06793

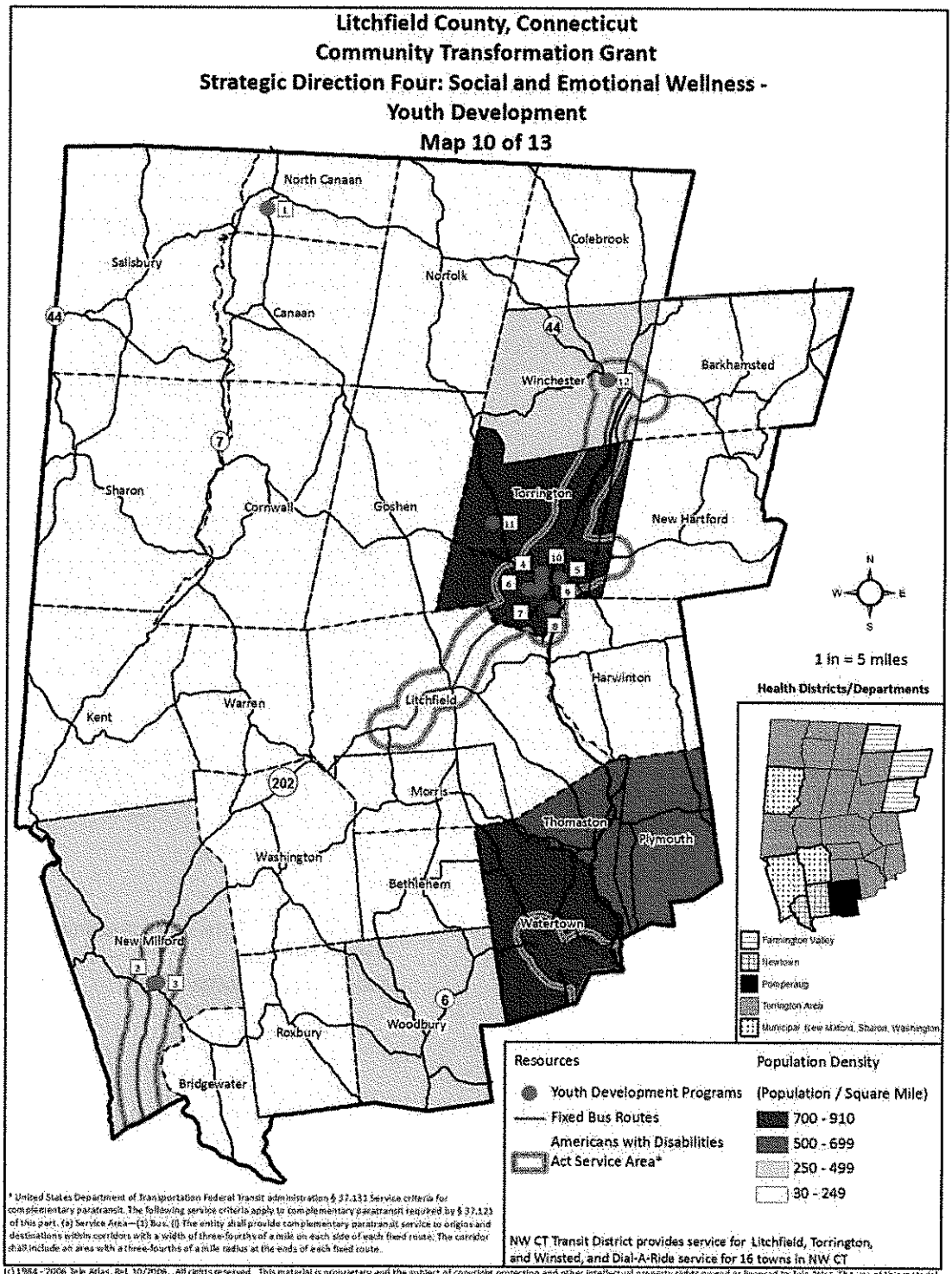
17. Substance Abuse Counseling
MCCALL FOUNDATION
WINSTED SATELLITE OFFICE
231 North Main Street
Winchester, CT 06098

SCREENING

18. General Assessment for Substance Abuse, General Assessment for Substance Abuse * Court Ordered Individuals, Substance Abuse Counseling
CATHOLIC CHARITIES - ARCHDIOCESE OF HARTFORD
132 Grove Street
Torrington, CT 06790

19. General Assessment for Substance Abuse, Inpatient Alcohol Detox, * Pregnant Women, Sub. Abuse Counseling
CHARLOTTE HUNGERFORD HOSPITAL – BEHAVIORAL HEALTH SERVICES
540 Litchfield Street
Torrington, CT 06790

20. Case/Care Management * Substance Abusers, Central Intake/Assessment for Substance Abuse * Older Adults, Families/Friends of Alcoholics Support Groups, General Assessment for Substance Abuse, Residential Substance Abuse Treatment Facilities, Substance Abuse Counseling, Substance Abuse Day Treatment, Substance Abuse Day Treatment * Dual Diagnosis, Substance Abuse Day Treatment * Youth, Substance Abuse Education/Prevention
MCCALL FOUNDATION
58 High Street
Torrington, CT 06790


Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness -
Youth Development
Map 10 of 13
North Canaan
Colebrook
Salisbury
Norfolk
Canaan
Barkhamsted
Winchester
Sharon
Cornwall
Goshen
Torrington
New Hartford
Harwinton
Litchfield
Kent
Warren
Morris
Thomaston
Plymouth
Washington
Bethlehem
Watertown
New Milford
Roxbury
Woodbury
Bridgewater
1 in = 5 miles
Health Districts/Departments
Farmington Valley
Newtown
Pomperaug
Torrington Area
Municipal (New Milford, Sharon, Washington)
Resources
Youth Development Programs
Fixed Bus Routes
Americans with Disabilities Act Service Area*
Population Density
(Population / Square Mile)
700 - 910
500 - 699
250 - 499
30 - 249
NW CT Transit District provides service for Litchfield, Torrington, and Winsted, and Dial-A-Ride service for 16 towns in NW CT
* United States Department of Transportation Federal Transit Administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.
(c) 1984 - 2006 Tele Atlas. Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Youth Development
Map 10 of 13 – Resource Listing

1. Leadership Development * Youth, Youth Enrichment
   NORTHWEST CT YMCA
   CANAAN FAMILY YMCA
   77 South Canaan Road
   Canaan, CT 06018

2. Youth Enrichment
   NEW MILFORD SOCIAL SERVICES
   40 Main Street
   New Milford, CT 06776

3. Youth Enrichment
   NEW MILFORD YOUTH AGENCY
   50 East Street
   New Milford, CT 06776

4. Youth Enrichment
   FAMILY STRIDES
   350 Main Street Suite D
   Torrington, CT 06790

5. Leadership Development * Youth, Youth Enrichment
   GIRL SCOUTS OF CT - TORRINGTON SERVICE CENTER
   663 East Main Street
   Torrington, CT 06790

6. Youth Enrichment
   MCCALL FOUNDATION
   58 High Street
   Torrington, CT 06790

7. Leadership Development * Youth, Youth Enrichment
   NORTHWEST CT YMCA - TORRINGTON BRANCH
   259 Prospect Street
   Torrington, CT 06790

8. Youth Enrichment
   SALVATION ARMY - TORRINGTON CORPS COMMUNITY CENTER
   234 Oak Avenue
   Torrington, CT 06790

9. Youth Enrichment
   TORRINGTON AREA YOUTH SERVICE BUREAU (TAYSB)
   8 Church Street Lower Level
   Torrington, CT 06790

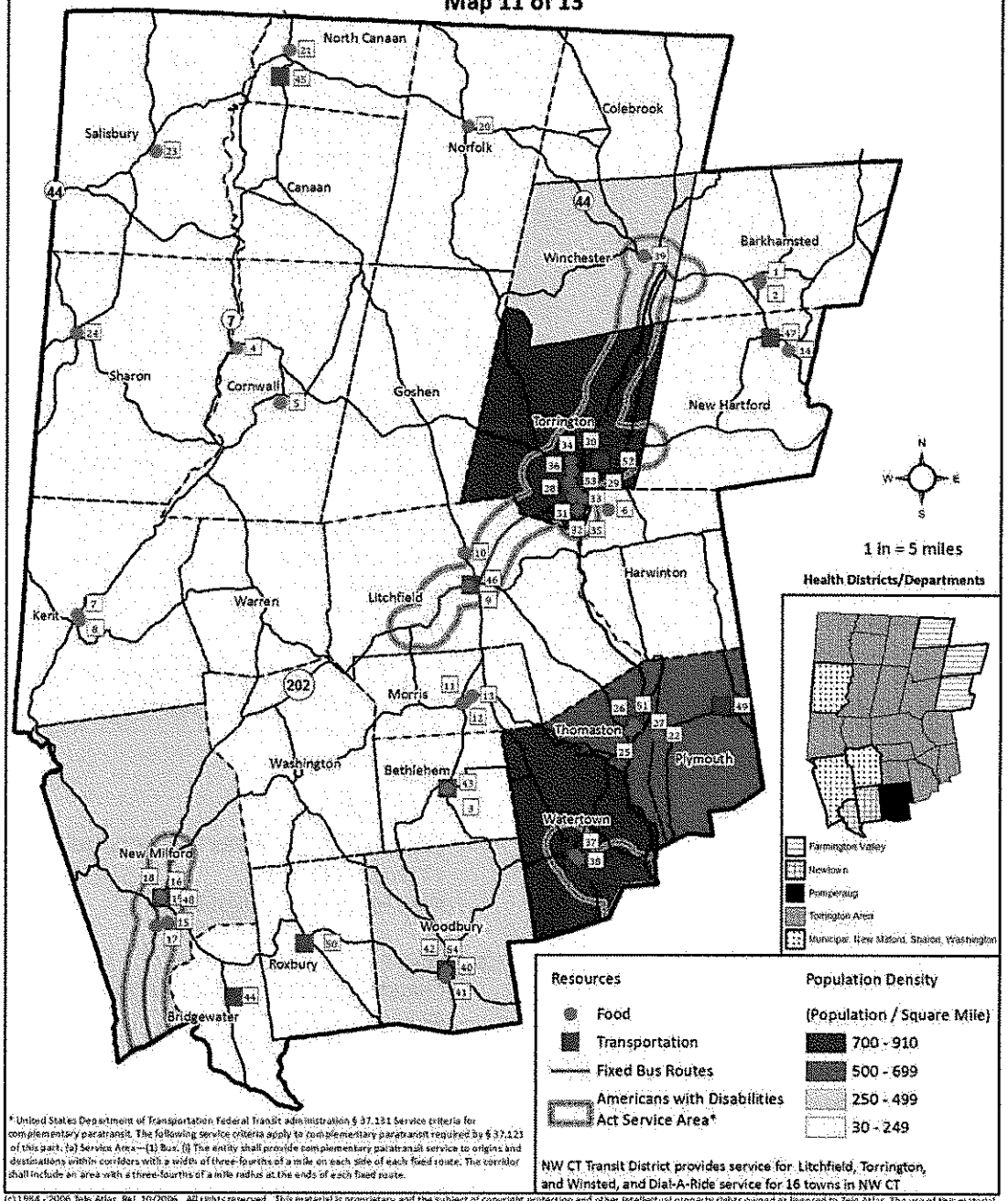
10. Youth Enrichment
    TORRINGTON POLICE ATHLETIC LEAGUE
    576 Main Street
    Torrington, CT 06790

11. Youth Enrichment
    UCONN COOPERATIVE EXTENSION - LITCHFIELD COUNTY
    843 University Drive
    Torrington, CT 06790

12. Leadership Development * Youth, Youth Enrichment
    NORTHWEST CT YMCA - WINSTED BRANCH
    480 Main Street
    Winchester, CT 06098

13. Youth Enrichment
    WINCHESTER YOUTH SERVICE BUREAU (WYSB)
    480 Main Street
    Winchester, CT 06098

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment-
Basic Needs - Food and Transportation
Map 11 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.123 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 InfoLine, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

FOOD

1. Congregate Meals/Nutrition Sites
   BARKHAMSTED, TOWN OF - SENIOR CENTER
   109 West River Road
   Barkhamsted, CT 06063

2. Food Pantries
   COMMUNITY FOOD BANK
   BARKHAMSTED/NEW HTFD
   93 River Road
   Barkhamsted, CT 06063

3. Food Pantries
   BETHLEHEM, TOWN OF
   36 Main Street South
   Bethlehem, CT 06751

4. Farmers Markets
   CONNECTICUT FARMERS' MARKETS - CORNWALL
   413 Sharon Goshen Turnpike
   Cornwall, CT 06753

5. Food Pantries
   CORNWALL, TOWN OF - SOCIAL SERVICES
   26 Pine Street
   Cornwall, CT 06753-0097

6. Congregate Meals/Nutrition Sites
   HARWINTON, TOWN OF - SENIOR CENTER
   209 Weingart Road
   Harwinton, CT 06791

7. Farmers Markets
   CONNECTICUT FARMERS' MARKETS – KENT
   Kent Green
   Kent, CT 06757

8. Congregate Meals/Nutrition Sites, Food Pantries
   KENT, TOWN OF - PARK AND RECREATION
   41 Kent Green Boulevard
   Kent, CT 06757

9. Farmers Markets
   CT FARMERS' MARKETS - LITCHFIELD/LITCHFIELD HILLS
   125 West Street
   Litchfield, CT 06759

10. Summer Food Service Programs
    SUMMER FOOD SERVICE
    LITCHFIELD/TORRINGTON
    355 Goshen Road
    Litchfield, CT 06759-0909

11. Farmers Markets
    CONNECTICUT FARMERS' MARKETS - MORRIS
    31 East Street
    Morris, CT 06763

12. Food Pantries
    MORRIS, TOWN OF
    3 East Street
    Morris, CT 06763-0066

13. Congregate Meals/Nutrition Sites
    MORRIS, TOWN OF - SENIOR CENTER
    109-21 East Street
    Morris, CT 06763

14. Farmers Markets
    CONNECTICUT FARMERS' MARKETS - NEW HARTFORD
    17 Church Saint No 1
    New Hartford, CT 06057

15. Food Pantries
    CHRISTIAN LIFE FELLOWSHIP - FOOD PANTRY
    48 Anderson Road
    New Milford, CT 06776

16. Farmers Markets
    CONNECTICUT FARMERS' MARKETS - NEW MILFORD
    1209 Main Street
    New Milford, CT 06776

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

FOOD (CONT.)

17. Food Pantries
NEW MILFORD UNITED METHODIST
OUR DAILY BREAD FOOD PANTRY
68 Danbury Road
New Milford, CT 06776

18. Congregate Meals/Nutrition Sites
NEW MILFORD RICHMOND CITIZEN CENTER
40 Main Street
New Milford, CT 06776

19. Food Pantries
NEW MILFORD, TOWN OF - SOCIAL SERVICES
40 Main Street
New Milford, CT 06776

20. Farmers Markets
CT FARMERS' MARKETS - NORFOLK
19 Maple Avenue
Norfolk, CT 06058

21. Food Pantries
FISHES & LOAVES FOOD PANTRY - NORTH CANAAN
30 Granite Avenue
North Canaan, CT 06024

22. Home Delivered Meals
COOK WILLOW HEALTH CENTER
81 Hillside Avenue
Plymouth, CT 06782

23. Food Pantries/Vouchers
SALISBURY, TOWN OF - FAMILY SERVICES
30A Salmon Kill Road
Salisbury, CT 06068

24. Food Pantries
SHARON SOCIAL SERVICES
63 Main Street
Sharon, CT 06069

25. Farmers Markets
CT FARMERS' MARKETS
THOMASTON
South Main Street
Thomaston, CT 06787

26. Food Pantries
THOMASTON FOOD PANTRY
158 Main Street
Thomaston, CT 06787-1720

27. Congregate Meals/Nutrition Sites
THOMASTON HOUSING AUTHORITY - GREEN MANOR
63 Green Manor
Thomaston, CT 06787

28. Soup Kitchens
COMMUNITY SOUP KITCHEN - TORRINGTON
220 Prospect Street
Torrington, CT 06790

29. Farmers Markets
CT FARMERS' MARKETS - TORRINGTON
12 Daycoeton Place
Torrington, CT 06790

30. WIC
FAMILY STRIDES
350 Main Street
Torrington, CT 06790

31. Food Pantries
FISH OF TORRINGTON
332 South Main Street
Torrington, CT 06790

32. Food Pantries
FRIENDLY HANDS FOOD BANK – TORRINGTON
50 King Street
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

FOOD (CONT.)

33. Congregate Meals/Nutrition Sites, Home Delivered
LITCHFIELD HILLS/NORTHWEST ELDERLY NUTRITION
88 East Albert Street
Torrington, CT 06790

34. Soup Kitchens
SAINT MARON'S CHURCH HOT DINNER PROGRAM
613 Main Street
Torrington, CT 06790

35. Food Pantries
SALVATION ARMY - TORRINGTON CORPS
234 Oak Avenue
Torrington, CT 06790

36. Community Gardening
TORRINGTON COMMUNITY GARDENS
c/o Trinity Episcopal Church
Torrington, CT 06790

37. Farmers Markets
CT FARMERS' MARKETS - WATERTOWN
470 Main Street
Watertown, CT 06795

38. Food Pantries
WATERTOWN, TOWN OF - SOCIAL SERVICES
51 Depot Street
Watertown, CT 06795

39. Summer Food Service Programs
SUMMER FOOD SERVICE PROGRAM WINCHESTER
30 Elm Street
Winchester, CT 06098

40. Food Pantries
COMMUNITY SERVICES COUNCIL OF WOODBURY
PO Box 585
Woodbury, CT 06798

41. Farmers Markets
CT FARMERS' MARKETS - WOODBURY
43 Hollow Road
Woodbury, CT 06798

42. Congregate Meals/Nutrition Sites, Home Delivered Meals
WOODBURY, TOWN OF - SENIOR CENTER
265 Main Street South
Woodbury, CT 06798

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

TRANSPORTATION

43. Medical Transportation, Senior Ride Programs
BETHLEHEM MUNICIPAL AGENT FOR THE ELDERLY
32 Main Street South
Bethlehem, CT 06751

44. Disability Related/Medical Transportation, Senior Rides
BRIDGEWATER HILLTOP FARM SENIOR CENTER
132 Hut Hill Road
Bridgewater, CT 06752

45. Disability Related/Medical Transportation, Senior Rides
GEER NURSING-REHABILITATION CENTER
83 South Canaan Road
Canaan, CT 06018

46. Escort Programs
COMPANIONS & HOMEMAKERS
LITCHFIELD OFFICE
82 West Street
Litchfield, CT 06759

47. Senior Ride Programs
NEW HARTFORD SENIOR CTR/
Elderly MUNICIPAL AGENT
530 Main Street
New Hartford, CT 06057

48. Disability Related/Medical Transportation, Senior Rides
NEW MILFORD - RICHMOND CITIZEN CENTER
40 Main Street
New Milford, CT 06776

49. Medical Transportation
COOK WILLOW HEALTH CENTER - COOK'S
81 Hillside Avenue
Plymouth, CT 06786

50. Medical Transportation, Senior Ride Programs
ROXBURY ELDERLY SERVICES/ MUNICIPAL AGENT
7 South Street
Roxbury, CT 06783

51. Disability Related/Medical Transportation, Senior Rides
THOMASTON - SOCIAL SERVICES/ MUNICIPAL AGENT
158 Main Street
Thomaston, CT 06787-1720

52. Disability/Medical Transportation, General Paratransit/Community Ride Programs, Senior Rides
NW CT TRANSIT DISTRICT
957 East Main Street
Torrington, CT 06790

53. Disability/ Medical Transportation
TORRINGTON SERVICES FOR THE ELDERLY
/SULLIVAN SENIOR CENTER
88 East Albert Street
Torrington, CT 06790

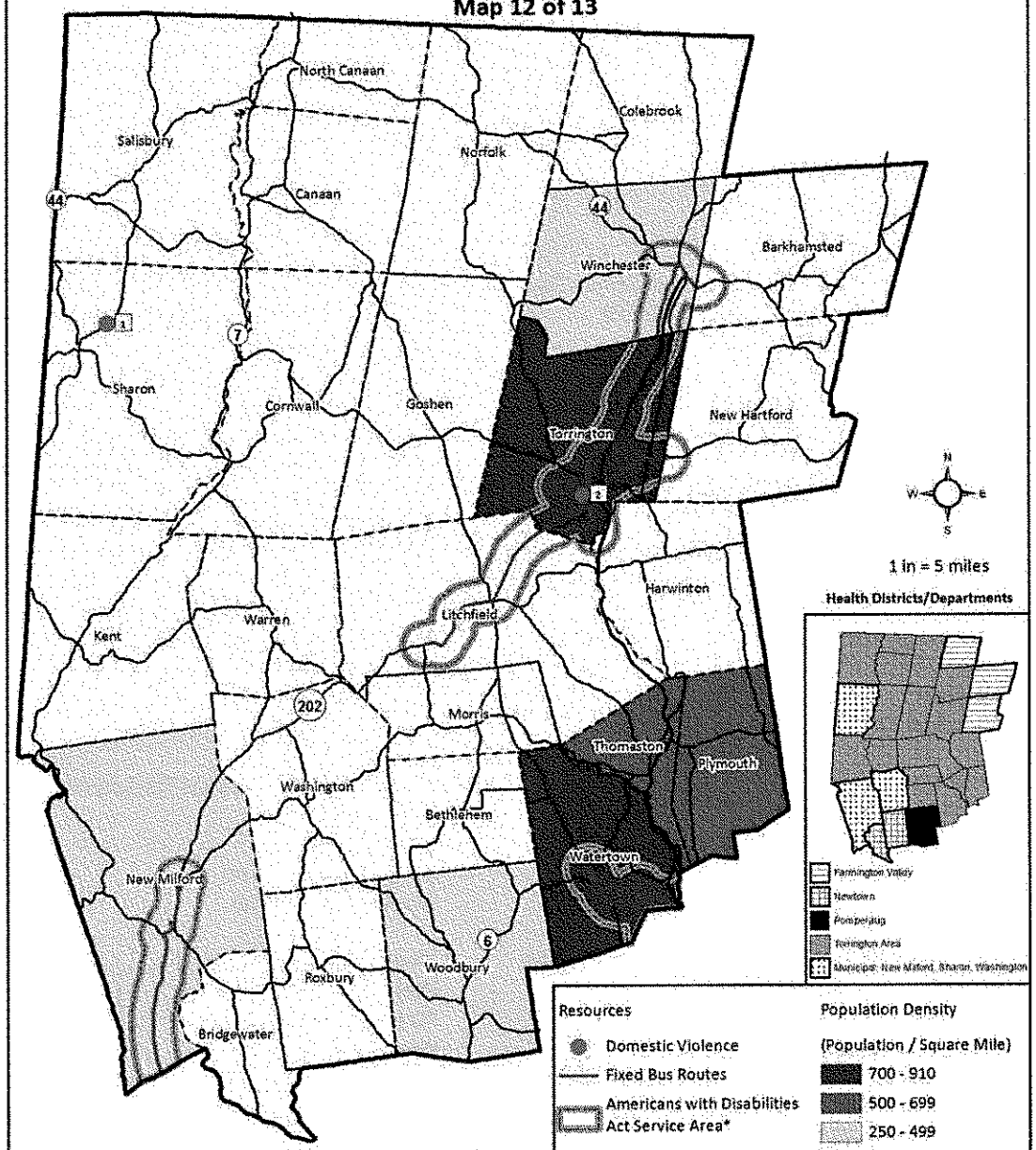
54. Disability Related/Medical Transportation, Senior Rides
WOODBURY
SENIOR CENTER
265 Main Street South
Woodbury, CT 06798

Medical Transportation
FISH OF WOODBURY
PO Box 216
Woodbury, CT 06798

Medical Transportation
FISH OF KENT
PO Box 852
Kent, CT 06757

NO STREET ADDRESS

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment-
Domestic Violence
Map 12 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part: (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 Infoline, United Way of Connecticut

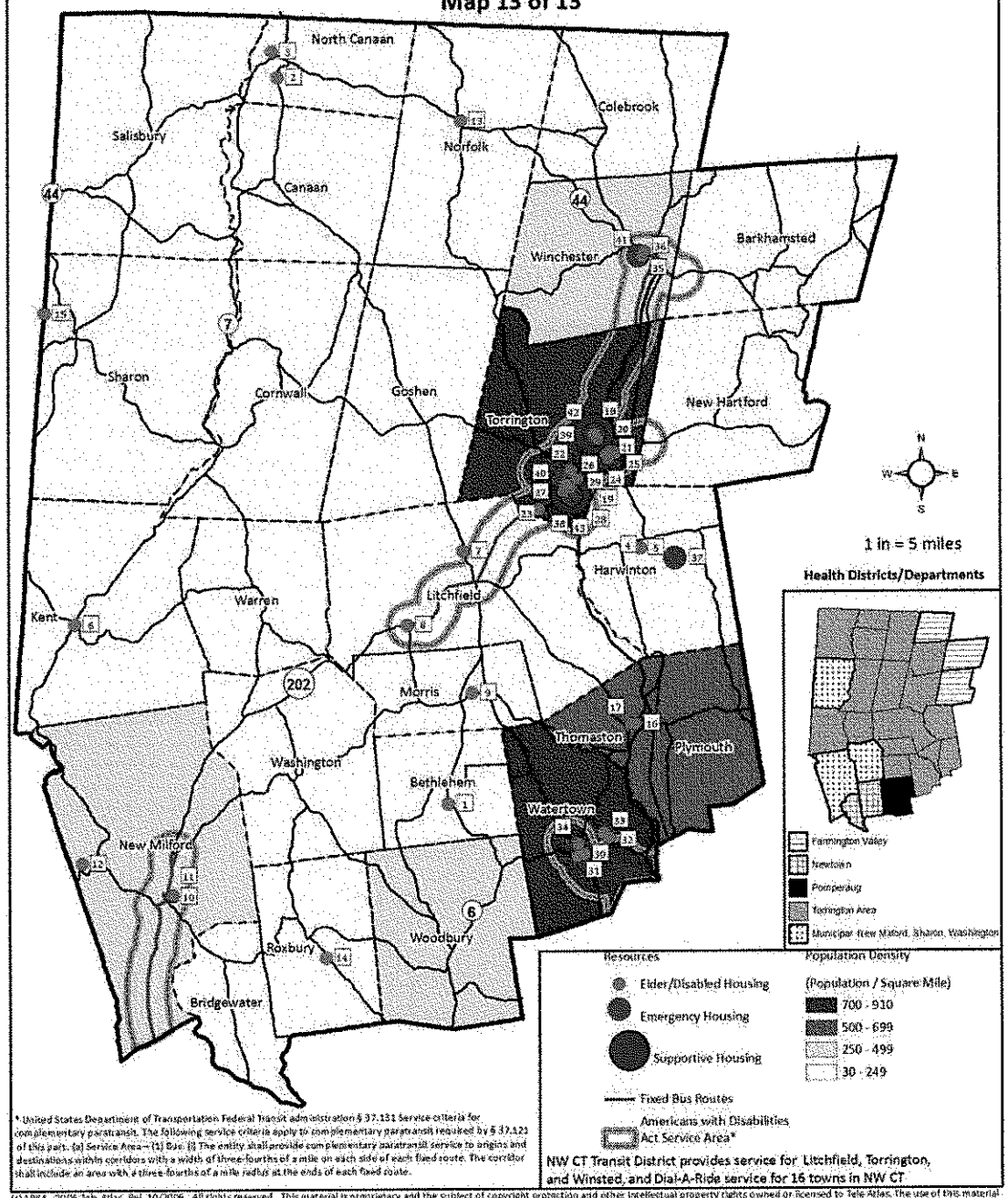
Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Domestic Violence
Map 12 of 13 – Resource Listing

DOMESTIC VIOLENCE

1. DV Shelter, Crime Victim Support, DV Hotlines/Dating Violence, DV Support Groups * Families/Friends of Battered Women/Men/ Battered Women, Spouse/Domestic Partner Abuse Counseling/Prevention
   WOMEN'S SUPPORT SERVICES
   158 Gay Street
   Sharon, CT 06069

2. DV Shelter, Crime Victim Support, DV Hotlines/Dating Violence, DV Support Groups * Families/Friends of Battered Women/Men Spouse/Domestic Partner Abuse Counseling/Prevention
   SUSAN B. ANTHONY PROJECT - DV SERVICE
   179 Water Street
   Torrington, CT 06790

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment - Housing
Map 13 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part. (a) Service Area—(1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

(c) 1984 - 2006 Tele Atlas, Rel. 10/2006. All rights reserved. This material is proprietary and the subject of copyright protection and other intellectual property rights owned or licensed to Tele Atlas. The use of this material is subject to the terms of a license agreement. You will be held liable for any unauthorized copying or disclosure of this material.
U.S Bureau of the Census (2010) Summary File 3 (SF 3) ; Kelley Transit; CT Transit; 2-1-1 Infoline, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

ELDER/DISABLED

1. Low Inc./Sub. Rental Housing * Dis./Health, Older Adults
   ELDERLY HOUSING MANAGEMENT - NORTH PURCHASE
   11 Jackson Lane
   Bethlehem, CT 06751

2. Low Inc./Subsidized Private Rental Housing * Older Adults
   ELDERLY HOUSING MANAGEMENT - BECKLEY HOUSE
   85 South Canaan Road
   Canaan, CT 06018

3. Public Housing * Dis. & Health Conditions* Older Adults
   NORTH CANAAN HOUSING AUTHORITY – WANGUM VILLAGE
   132 Quinn Street
   Canaan, CT 06018

4. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions * Older Adults
   ELDERLY HOUSING MANAGEMENT - WINTERGREEN
   21 Wintergreen Circle
   Harwinton, CT 06791

5. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions* Older Adults
   HARWINTON WINTERGREEN ELDERLY HOUSING
   21 Wintergreen Circle/Litchfield Road
   Harwinton, CT 06791

6. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions* Older Adults
   ELDERLY HOUSING MNGMT TEMPLETON FARM APTS
   16 Swifts Lane
   Kent, CT 06757

7. Group Residences for Adults with Disabilities, Supported Living Services for Adults with Disabilities
   EDUCATION CONNECTION
   355 Goshen Road
   Litchfield, CT 06759-0909

8. Public Housing, Disabilities/Health Conditions * Older Adults
   LITCHFIELD HOUSING AUTHORITY - BANTAM FALLS
   Doyle Road
   Litchfield, CT 06759

9. Public Housing, Disabilities/Health Conditions, Older Adults
   MORRIS HOUSING AUTHORITY
   109 East Street
   Morris, CT 06763

10. Low Inc./Sub. Private Rental Housing Older Adults
    DEMARCO MANAGEMENT - BUTTER BROOK HILL APTS
    105 Butter Brook Hill
    New Milford, CT 06776

11. Low Inc./Subsidized Private Rental Housing
    Older Adults
    ELDERLY HOUSING MANAGEMENT - GLEN AYRE
    One Glen Ayre Drive
    New Milford, CT 06776

12. Home Barrier Evaluation
    /Removal Services
    REBUILDING TOGETHER - LITCHFIELD COUNTY
    122 Stilson Hill Road
    New Milford, CT 06776

13. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions * Older Adults
    NORFOLK SENIOR HOUSING CORPORATION
    9 Shepard Road
    Norfolk, CT 06058

14. Low Inc./Subsidized Private Rental Housing
    * Older Adults
    ELDERLY HOUSING BERNHARDT MEADOW
    19 Bernhardt Meadow Lane
    Roxbury, CT 06783

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

ELDER/DISABLED (CONT.)

15. Public Housing * Disabilities
& Health Conditions, Older Adults
SHARON HOUSING AUTHORITY
12E Sharon Ridge Road
Sharon, CT 06069

16. Public Housing
Older Adults
THOMASTON HOUSING AUTHORITY - GREEN MANOR
63 Green Manor
Thomaston, CT 06787

17. Public Housing, Disabilities/ Health Conditions
Older Adults
THOMASTON HOUSING AUTHORITY - GROVE MANOR
11 Grove Street
Thomaston, CT 06787

18. Supported Living Adults with Disabilities * Dual Diagnosis
CENTER FOR HUMAN DEVELOPMENT
51 Commercial Boulevard
Torrington, CT 06790

19. Supported Living Services/Group Residences for Adults
with Disabilities * Chronic/Severe Mental Illness
CENTRAL NAUGATUCK VALLEY HELP - WYNNEWOOD
44 Cook Street
Torrington, CT 06790

20. Supported Living Services / Group Residences
Adults/Disabilities * Chronic/Severe Mental Illness
COMMUNITY SYSTEMS
295 Alvord Park Road
Torrington, CT 06790

21. Low Inc./Subsidized Private Rental Housing * Older Adults
GEORGETOWN GARDENS
109 Sunny Lane
Torrington, CT 06790

22. Supported Living
Group Residences Disabilities
LARC
314 Main Street
Torrington, CT 06790

23. Supported Living Services for Adults with Disabilities *
Chronic/Severe Mental Illness
MENTAL HEALTH ASSOC. OF CT TORRINGTON
30 Peck Road
Torrington, CT 06790

24. Low Inc./Subsidized Private Rental Housing * Disabilities &
Health Conditions * Older Adults
TORRINGFORD WEST APARTMENTS
356 Torringford West Street
Torrington, CT 06790

25. Public Housing/Disabilities/Health Conditions * Older Adults
TORRINGTON HOUSING AUTHORITY - LAUREL ACRES
523 Torringford West Street
Torrington, CT 06790

26. Public Housing/Disabilities/Health Conditions
Older Adults
TORRINGTON HOUSING AUTHORITY MICHAEL KOURY
Tucker Drive
Torrington, CT 06790

27. Public Housing/Disabilities/Health Conditions
Older Adults
TORRINGTON HOUSING AUTHORITY - THOMPSON HEIGHTS
301 Litchfield Street
Torrington, CT 06790

28. Public Housing/Disabilities/Health Conditions * Older Adults
TORRINGTON HOUSING AUTHORITY - TORRINGTON TOWERS
52 Summer Street
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

ELDER/DISABLED (CONT.)

29. Public Housing/Disabilities/Health Conditions * Older Adults
TORRINGTON HOUSING AUTHORITY WILLOW GARDENS
52 Willow Street
Torrington, CT 06790

30. Group Residences for Adults with Disabilities
FAMILY OPTIONS
76 Westbury Park Road
Watertown, CT 06795

31. Supported Living Services for Adults with Disabilities * Developmental Disabilities
INSTITUTE OF PROFESSIONAL PRACTICE- WATERTOWN
680 Main Street
Watertown, CT 06795

32. Public Housing/Disabilities/Health Conditions * Older Adults
WATERTOWN HOUSING AUTHORITY - BUCKINGHAM
935 Buckingham Street
Watertown, CT 06795

33. Public Housing/Disabilities/Health Conditions * Older Adults
WATERTOWN HOUSING AUTHORITY - COUNTRY RIDGE
1091 Buckingham Street
Watertown, CT 06795

34. Public Housing/Disabilities/Health Conditions * Older Adults
WATERTOWN HOUSING AUTHORITY - TRUMAN TERRACE
100 Steele Brook Road
Watertown, CT 06795

35. Low Income/Subsidized Private Rental Housing * Older Adults
MILLENIUM REAL ESTATE SERVICES - THE GLEN
Maple & Willow Streets
Winchester, CT 06098

36. Public Housing/Disabilities/Health Conditions * Older Adults
WINCHESTER HOUSING AUTHORITY GREENWOODS GARDEN
Gay Street
Winchester, CT 06098

Subsidized Private Rental Housing/Disabilities/Older Adults
STATION PLACE APARTMENTS
Whitford Court
Canaan, CT 06018

NO STREET NUMBER

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

EMERGENCY HOUSING

37. Runaway/Youth Shelters
BRIDGE FAMILY CENTER, THE - HARWINTON SHELTER
25 Plymouth Road
Harwinton, CT 06791-2418

38. Homeless Shelter
FISH OF TORRINGTON
332 South Main Street
Torrington, CT 06790

39. Homeless Shelter
STATE DEPT OF SOCIAL SERVICES - TORRINGTON
62 Commercial Boulevard
Torrington, CT 06790

40. Transitional Housing/Shelter
SUSAN B. ANTHONY PROJECT - DV SERVICE
179 Water Street
Torrington, CT 06790

41. Homeless Shelter, Runaway/Youth Shelters
NW CT YMCA - WINCHESTER EMERGENCY SHELTER
480 Main Street
Winchester, CT 06098

Homeless Shelter
NEW MILFORD SHELTER COALITION
PO Box 1016
New Milford, CT 06776

NO STREET ADDRESS

SUPPORTIVE HOUSING

42. Homeless Permanent Supportive Housing
CENTER FOR HUMAN DEVELOPMENT
51 Commercial Boulevard
Torrington, CT 06790

43. Case/Care Management * Homeless People
FISH OF TORRINGTON
332 South Main Street
Torrington, CT 06790

Appendix B – Glossary of Abbreviations

Abbreviation	Full Name/Title
AAMR	Age-Adjusted Mortality Rate
ACS	American Community Survey
BRFSS	Behavioral Risk Factor Surveillance System
CADH	Connecticut Association of Directors of Health
CDC	Centers for Disease Control and Prevention
CHANGE	Community Health Assessment aNd Group Evaluation
CHD	Coronary Heart Disease
CHF	Congestive Heart Failure
CHLI	Community Healthy Living Index
CHNA	Community Health Needs Assessment
CLRD	Chronic Lower Respiratory Disease
CLD	Chronic Liver Disease
COPD	Chronic Obstructive Pulmonary Disease
CSDE	Connecticut State Department of Education
CTDPH	Connecticut Department of Public Health
CTG	Community Transformation Grant
CVD	Cardiovascular Diseases
DECD	Department of Economic and Community Development
DPH	Department of Public Health
ED	Emergency Department
FQHC	Federally Qualified Health Center
Index	Health Equity Index
LD	Liver Disease
LHI	Leading Health Indicators
MI	Myocardial Infarction
RPO	Regional Planning Organization
TAHD	Torrington Area Health District
URC	Uniform Crime Reporting Program
YPLL	Years of Potential Life Lost

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 20, 2014 VIA FAX ONLY

Sally Herlihy
Vice President Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application; Docket Number: 13-31859-CON
Western Connecticut Health Network, Inc., New Milford Hospital and The Danbury Hospital
The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut of Department of Public Health and Operation of it Under The Danbury Hospital's Current General Acute Care Hospital License
Closure of Public Hearing

Dear Ms. Herlihy:

Please be advised, by way of this letter, the public hearing held on February 19, 2014 in the above referenced matter is hereby closed and OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Steven W. Lazarus at (860) 418-7012.

Sincerely,

Kevin T. Hansted
Hearing Officer

KH:swl

* * * COMMUNICATION RESULT REPORT (FEB. 20. 2014 2:59PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FEB. 20. 2014 2:58PM FILE MODE OPTION	ADDRESS	RESULT	PAGE
103 MEMORY TX	912037391974	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HERLIHY

FAX: 203.739.1974

AGENCY: NEW MILFORD HOSPITAL

FROM: OHCA

DATE: 2/20/14 **Time:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
Docket Number: 13-31859, Hearing Closure Letter enclosed.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

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

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

* * * COMMUNICATION RESULT REPORT (FEB. 20. 2014 2:58PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FEB. 20. 2014 2:58PM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
102 MEMORY TX		918602758299	OK	2/2

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: THEODORE TUCCI

FAX: 860-275-8299

AGENCY:

FROM: OHCA

DATE: 2/20/14 **Time:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Docket Number: 13-31859, Hearing Closure Letter enclosed.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

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

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

THE NEWS-TIMES

Classified

SOUTHERNCTJOBS.COM

monster®

203-330-6556 | classified@newstimes.com | Hours: 8:30 a.m. – 5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

HOUSING AUTHORITY OF THE CITY OF DANBURY
NOTICE OF INVITATION FOR BID
Electricity Provider
IFB No. B14001

HA CONTACT PERSON	Benjamin R. Gold, , Director of Legal and Contract Administration Telephone (203)744-2500 x141
HOW TO OBTAIN THE RFP DOCUMENTS ON THE APPLICABLE INTERNET SITE	1. Access www.hacdct.org. 2. Click on the "BIDS/RFP'S" icon on left side and follow the directions. 3. Problems accessing system or registering? Call customer support, 1/866/526-9266.
BID SUBMITTAL RETURN LOCATION	Housing Authority of the City of Danbury, 2 Mill Ridge Rd. Danbury, CT 068114
BID RELEASE DATE	Tuesday, February 4, 2014
QUESTIONS DUE	Tuesday, February 11, 2014
BID SUBMITTAL DEADLINE	Tuesday, February 18, 2014

[Minority- and/or women-owned businesses are encouraged to respond]

PUBLIC NOTICE
Office of Health Care Access Public Hearing

Statute Reference:
19a-638
Applicant(s):
Western Connecticut Health Network
The Danbury Hospital
New Milford Hospital
Town:
New Milford
Docket Number:
13-31859-CON
Proposal:
The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and to operate it under The Danbury Hospital's Current General Acute Care Hospital License
Date:
February 19, 2014 (Rescheduled from February 5, 2014)
Time:
4:00 p.m.
Place:
New Milford High School
388 Danbury Road, 2nd Floor Lecture Hall
New Milford, CT 06776

Any person who wishes to request status in the above listed public hearing may file a written petition no later than February 14, 2014 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

LIQUOR PERMITS

LIQUOR PERMIT

Notice of Application

This is to give notice that I,
ELMER PALMA
9 APPLE BLOSSOM LANE
DANBURY, CT 06811-4912

have filed an application placarded 02/04/2014 with the Department of Consumer Protection for a RESTAURANT WINE & BEER PERMIT for the sale of alcoholic liquor
on the premises at

123 WEST STREET
DANBURY, CT 06810-6358

The business will be owbned by:
CHAPARRO'S LATIN FAMILY RESTAURANT LLC

Entertainment will consist of:
None

Objections must be filed by:
03/18/2014

ELMER PALMA

INVITATION TO BID
Sealed Bids will be received by the Purchasing Agent of the City of Danbury at the Purchasing Agent's Office, City Hall, Danbury, CT until 10:00 A.M. on:

Tuesday, February 18, 2014 for:
Bid #01-13-14-02
"Gravel Fill Borrow & Topsoil"

Thursday, February 20, 2014 for:
Bid #01-13-14-06
"Flowers & Plants - Parks Department"

Bid #01-13-13-04
"Paving in Place"

Tuesday, February 25, 2014 for:
Bid # 02-13-14-04
"Janitorial Supplies"

Specifications may be obtained at the Purchasing Agent's Office, City Hall, 155 Deer Hill Avenue, Danbury, CT 06810, (203) 797-4571.

The City of Danbury is an equal opportunity and affirmative action purchaser, and bids from all vendors, including those from enterprises owned by minorities and women, are encouraged.

The City of Danbury reserves the right to accept or reject any or all Bids, and unless specified otherwise, to award the contract within thirty working days to the Bidder deemed to be for the best interest of the City of Danbury.

Dated: February 4, 2014
Charles J. Volpe, Jr.
Purchasing Agent
City of Danbury

STATE OF CONNECTICUT
SUPERIOR COURT
ORDER OF NOTICE
Notice to Brian W. Burlinson, father of a female child born to Victoria P. in Waterbury, CT on 12/20/00 of parts unknown.
A petition has been filed seeking: Commitment of minor child(ren) of the above named or vesting of custody and care of said child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person.
The petition, whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on: 2/27/14 at 9:00 am. at 239 Whalley Avenue New Haven.
Therefore,ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the: Danbury News Times or other publication a newspaper having a circulation in the town/city of: Danbury, CT. Hon. Judge Cronan, Signed 1/30/14
Right to Counsel:
Upon proof of inability to pay for a lawyer, the court will make sure that an attorney is provided to you by the Chief Public Defender. Request for an attorney should be made immediately in person, by mail, or by fax at the court office where your hearing is to be held.

THE NEWS-TIMES
CLASSIFIED
IS NOW OPEN FOR
PHONE CALLS...
MONDAY-FRIDAY
'TIL 5PM
FOR MORE INFO CALL
797-1414 OR
1-800-268-1441

STATE OF CONNECTICUT
SUPERIOR COURT
ORDER OF NOTICE
Judicial Distr. of Danbury at Danbury-Return date 2/18/14
Vizhco, Karen L. v
Vizhco, Jorge
NOTICE TO: VIZHCO, JORGE
The Court has reviewed the Motion for Order of Notice and the Complaint/Application/Motion which asks for: Divorce (dissolution of marriage).
The Court finds that the current address of the party to be notified is unknown and that all reasonable efforts to find him have failed. The Court finds that the last known address of the party to be notified was:
6 Division Street,
Danbury, CT 0810
The Court Orders that notice be given to the party to be notified by having a State Marshal place a legal notice in the NEWS TIMES a newspaper having circulation in Danbury, CT contacting a true and attested copy of this Order of Notice. and if accompanying a complaint for divorce (dissolution of marriage) complaint for dissolution of civil union, legal separation or annulment or if accompanying an application for custody or visitation, statement that Automatic Court Orders have been issued in the case as required by Section 25-5 of the CT Practice Book and are a part of the Complaint/Application on file with the Court. The notice should appear before February 6, 2014, and proof of service shall be filed with this Court.
Hon. Heidi G. Winslow, Judge of the Superior Court. - Robert A.Jackson, Asst.Clerk - 1/21/14.
A true copy, with and in my hands for publication.
TRUE AND ATTEST COPY
JAMES E. SULLIVAN,
CT. State Marshal

CLASSIFIED ADVERTISING
CALL
797-1414
or
1-800-268-1441
THE
NEWS-TIMES

Ask About Our Specials

GENERAL HELP WANTED

BRIDGEPORT

ACCOUNTS RECEIVABLE SPECIALIST

Bridgeport Fittings is an industry leader in the manufacture of conduit and cable fittings. This A/R position requires proficiency with numbers, the ability to handle daily A/R functions accurately and timely, strong customer service and multitasking skills.
Requires: 2+ years of experience; some college coursework completed; and advanced Excel and Word. We offer competitive compensation, comprehensive benefits to include 401K with company match. Please forward resume with salary requirements, to: Jim Connor, Director, H/R, Bridgeport Fittings, 705 Lordship Blvd., Stratford, CT 06615, Fax: 203-378-9818, Email: **jimc@bptfittings.com** EOE

ADMINISTRATIVE ASSISTANT
Stamford law firm that limits its practice to family law is looking for a discrete, articulate, polished administrative assistant/receptionist. Responsibilities include "meet and greet" at front desk reception, maintaining confidentiality, calendar management, dictation, court filings, attention to incoming and outgoing mail, and filing and project help as needed. Applicant must have at least two years of reception experience in a professional office and be able to work well with clients and other support staff. College degree, reliable transportation (for which expenses will be reimbursed), proficiency in Microsoft Office, and a "can do" attitude are essential. Prior law firm experience a plus. Monday through Friday, 8:30am to 5:30pm. Email resumes to: stamfordmlaw@gmail.com

ASSISTANT GROUP HOME MGR.
FT Greater Danbury area. Assist Manager with program administration, direct care of clients, community networking, staff supervision, reports/documentation. B.A. Human Services/related field preferred. DD knowledge & experience. Strong oral/written communication.
Send resume to
Forsberg@educationconnection.org

AUTO TECH - FT. for busy independent repair shop. ASE Certification. Factory Training. Diagnostic skills & Foreign car exp preferred. Call Robert Motorcars at 203-266-4746 or fax res to 203-266-9145

CLASSES AVAILABLE TO LEARN
FREE CPR CLASS WITH ALL OUR CLASSES
NEW • PATIENT CARE TECHNICIAN IN 10 WEEKS
• CERTIFIED NURSING AIDE IN 4 WEEKS
• DENTAL ASSISTING IN 4 WEEKS
NEW • PHLEBOTOMY
NEW • EKG
DAY, EVENING & SAT. CLASSES
NEW Bridgeport Location: 4637 Main Street
The Brookside Professional Bldg.
91 Shraffts Dr., Waterbury
203-378-2210 • 1-800-886-8773
valleymedicalinstitute.com
• JOB ASSISTANCE •
EASY PAYMENT PLANS • AS LITTLE AS $150 DOWN

GENERAL HELP WANTED

CUSTOMER SERVICE ASST. PT
to handle AR, bank deposits, CSR and phone tasks. M-F, appx. 20 hours/week. Fax 203-362-3348, **englishj@santaenergy.com**

rYna
RIDGEFIELD VISITING NURSE ASSOCIATION

DIRECTOR OF PRIVATE DUTY HEALTHCARE SERVICES
Ridgefield Visiting Nurse Association (RVNA), a Medicare certified home healthcare agency serving 20 towns in Western CT, is seeking a motivated executive to develop and manage a non-certified, private duty home healthcare subsidiary business to augment the services RVNA provides. The position requires a degree in business and appropriate experience in the non - medical healthcare industry. The ideal candidate must have proven ability to market, manage and grow a business, preferably from a start-up position and to maintain a satisfied and well cared for client base. The Director will have responsibility for managing staff, developing policies and procedures for private duty services and developing and meeting budgets. The Director must effectively market the new business through participation in area organizations and professional groups and must liaison with related businesses and referral sources. The Director reports to the Vice President of Business Operations and sits on the RVNA Executive Leadership Team. The position offers a competitive salary and benefits package.
Submit cover letter and resume to mwilkes@ridgefieldvna.org.

DRIVER - FT/ PT for Danbury LIMO Co. Must have knowledge of NYC & airports. 203-743-1537

DRIVER - CDL Driver
Immediate opening. Must have clean driving record and all endorsements including TWIC card. Must have exp. Excellent pay! Call 203-367-0083 or 203-414-6150

DRIVER Commercial construction company in Danbury looking for reliable driver to deliver materials to job sites. Must have valid drivers license. Call 203-792-9382

ELECTRICAL JR. Estimator for immed. FT hire. Knowledge of elec plans and symbols a must. Call 203-790-6425 or fax 203-798-8670

ELECTRICIANS CT Lic. E2 & Exp'd Apprentices for immed. hire. Some rate jobs. Call 203-790-6425 or fax 203-798-8670

FOOD SERVICE POSITIONS
Available; Fairfield County locations with Chartwells School Dining Services; General food service worker duties include; product preparation, meal service, cashier duties, general sanitation practices and various other areas of production and service. For consideration email resume to: CW2013rps@yahoo.com
AA, EOE, M/F/V/D www.cgnad.com

GENERAL OFFICE HELP, P/T, M-F, 9-12. Must know Office & Excel. No quick learners. Near West Conn. Call 203-470-1876

HOSPITALITY
The City of Stamford is accepting applications for the following positions:
•Dishwasher,
•Laundry Aide and
•Housekeeping Aide
Applications and Information can be obtained at www.stamfordct.gov.

HOUSEKEEPER / FRONT DESK
MOTEL FT/PT- All shifts needed.
Apply at Super 8 Motel
3 Lake Ave Ext. Danbury or
Call 203-743-0064

GENERAL HELP WANTED

HOUSEKEEPERS- LIVE-IN OR OUT
Throughout CT: Must be professional, 2+ yrs exp, driver's license, cook, iron, 2 references. $700-1000/week. Apply at www.lifeworx.com

LANDSCAPE CO. in Wilton seeking experienced landscapers in Lawn Care (Supervisor, 3A license), Maintenance & Construction. Must have Soc. Sec. & CT drivers license. Call Ellen at 203-994-0106.

PLUMBERS-LIC'D Benefit package includes medical, dental, LTD, 401K, sick, holiday and vacation pay. Call 800-304-4924.

PROPANE GAS INSTALLER
Brewster area Propane Co seeks a qualified Service Technician.
Duties include: install, service, & safety checks on propane related products such as residential & light commercial propane gas equipment. PAY BASED ON EXP so this could be an outstanding opportunity for someone already possessing yrs of propane installation exp. Position requires a strong work ethic, ability to work in a team environment, & a commitment to safety.
To apply, you may submit your resume materials online at hrcarmelterminals@gmail.com or fax to 845-279-8062.

SALES REPS
High Volume Dealer
Some exp. preferred - Will train the right candidate. Leaders now earning over $100k a year.
Call Jack 203-730-5600 or walk-in
423 Rubber Ave. Naugatuck CT

SEWING OPERATOR
Part or full time sewing positions available immediately in Danbury, CT working for a fabric display company . We require a punctual & responsible employee, compensation $16 to $19 per hour depending on experience. Full benefits Call 203-748-5111 ask for Jim.

SPRINKLER FITTERS, F2 lic. & Apprentices-Benefit pkg includes med, dental, LTD, 401k, sick, holiday & vac pay. Call 800-304-4924

WELDER fabrication shop in Danbury CT seeks precision tig welder, able to fab & weld to exact drawing specs. Need a min of 5yrs exp in alum & stainless steel w/ ver - ifiable ref's. F/T w/ benefits. Call weekdays, after 1pm. 797-739-0179
Call Danbury Animal Control 203-748-6456

HEALTHCARE & EMPLOYMENT OPS

Companions & Homemakers, Inc.
CAREGIVERS WANTED
Immediate Openings
We are looking for responsible, mature individuals who enjoy working with the elderly & making a difference in someone's life.
• Good Pay
• Choose Your Own Hours
• Medical Benefits- 80% Co Paid
Positions Available Throughout the State.
Must have car available (except live-ins)
Apply Online Today at www.caregiverjobscr.com or call 888-844-4442
DCP HCA 0000101

DENTAL OFFICE
Danbury area seeks mature professionals for FT & PT
CHAIRSIDE DENTAL ASSISTANT . Experience pref'd. Flexibility a must. Email dental987np@yahoo.com

MEDICAL RECEPTIONIST-
F/T, Temporary position.
Danbury medical office seeks independent, highly motivated individual. Duties include heavy phones, computers, scheduling and customer service. Medical office experience preferred. Fax resume - 203 791-9899

HEALTHCARE & EMPLOYMENT OPS

MEDICAL ASSISTANT
Busy well established pediatric practice seeks medical assistant. Pediatric exp. a plus. Send resume to Willows Pediatric Group, 1563 Post Rd. East, Westport, CT 06880 or Fax to Susan 203-319-3966.

ORDERLY WANTED
Hard working & dedicated person to work as needed at a busy Medical Center in the Danbury area. M-F, no weekends/holidays.
Fax resume to 1-866-202-8187.

SITUATIONS WANTED

ATTENTION
The advertisers in this classification are providing a service.

PRIVATE CARE for sick or elderly, 15 yeas exp., own transportation, excellent references.
347-728-2285

BUSINESS OPPORTUNITIES

★★★

OIL BURNER SERVICE BUSINESS $65,000. (Bethel, Ct.) Make $90,000 plus in 6 months. 600 to 700 Repeat customers (Danbury, Bethel, Ridgefield, Redding, Brookfield, Bridgewater, New Milford area) 50+ with Service Contracts of $299.00 per year worth approx. $16,500.00, annual tune up for $170.00 ser-vice rates are $130.00hr day and $175.00hr at night per call plus parts. Plus "shoe in" with local Oil only company. In business since 2001 and now looking to retire. I do only yearly maintenance and emergency service. This business could be expanded greatly since I do not do no installs of new equipment. 2011 White Ford E250 Van/49,000 miles unlettered (with $7000.00 parts included. Serious inquiries only. call 203-994-5355.

LOST AND FOUND

IMPOUND
#076. Shepherd mix, male, Black & Tan, found on North St.
Call Danbury Animal Control 203-748-6456

LOST KINDLE IN BRIGHT pink case, on Sunday 2/2/2014 in area of New Fairfield High School or roads near by. Reward!!! 203-942-6017

HEATING AND FIREWOOD

SEASONED FIREWOOD
$200/per cord. 860-868-7529

SEASONED FIREWOOD
for sale $180/cord, split and delivered. Please call Northern Tree & Construction Company.
203-770-4267

MERCHANDISE FOR SALE

★★★

3D PUZZLE, GAMES: Scene It, Guess Hue, Harry Potter, New or like new. Prices vary. 203-270-5560.

NEW AD!

A+ QUEEN PILLOWTOP MATTRESS,new, still in plastic. $150.00 Mike 860 601 3101

$IGN-ON ROUTE BONUSES!
EARN CA$H!
TIP$ FOR GOOD SERVICE
WANTED
Newspaper Delivery Carriers

7-DAY EARLY MORNING independent contractor newspaper carrier routes* available in:
• DANBURY • BETHEL
• BROOKFIELD

** WE PREFER TO MATCH ROUTES WITH PEOPLE WHO LIVE CLOSE TO THE TOWNS WHERE THE ROUTES ARE LOCATED.*

A valid CT drivers license and reliable insured vehicle is required.

To apply call: 203-731-3474
Include: Name • email • phone • town you live in • type of vehicle newspaper delivery experience.
A Route Manager will contact you.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 13-31859-CON

Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital

The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and Operation of it Under The Danbury Hospital's Current General Acute Care Hospital License

February 19, 2014, at 4:00 p.m.
(rescheduled from February 5, 2014)

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (15 minutes)

III. OHCA's Questions

IV. Public Comment

V. Closing Remarks

VI. Public Hearing Adjourned

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

Applicat Exhibit 1.

Community Report Card for Western Connecticut

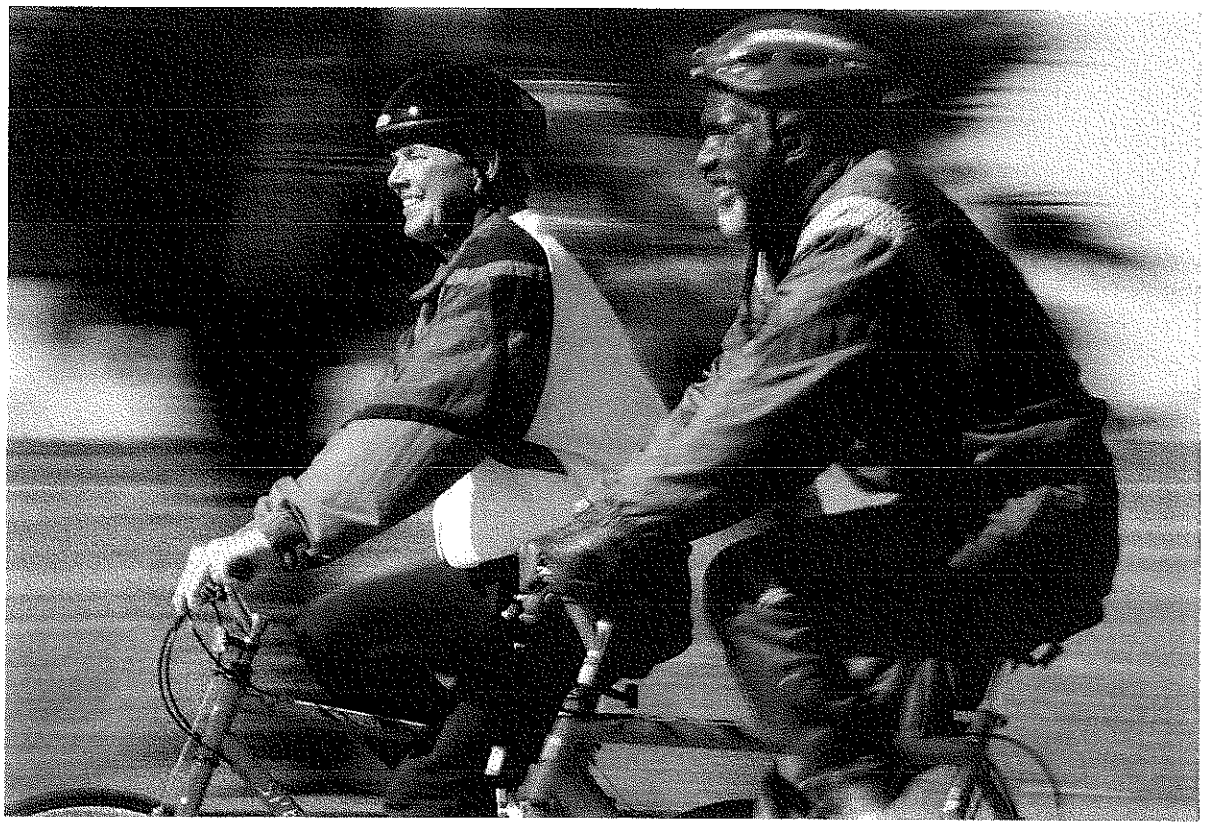


Table of Contents

Introduction **5**
Objectives **6**
Methods **6**
Health: A Definition **7**
Findings and Recommendations **8**
Looking Back **8**
Moving Forward **11**
Our Community **12**
Population 11
Demographic Profile 13
Age 13
Population Trends 14
Economic Stability: Indicators and Findings **16**
Income and Poverty 16
Employment Status 18
Free and Reduced Price School Meals 18
Homelessness 19
Education: Indicators and Findings **21**
High School Graduation and Higher Educational Attainment 22
Special Education and Students with Disabilities 24
English and a Second Language (ESL) 25
Health Status: Indicators and Findings **26**
Health Insurance Coverage 26
Factors Influencing Coverage 27
Emergency Department Visits 29
Mental or Behavioral Health 32
Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings **33**
Leading Health Indicator Behavioral Risk Overview 33
Childhood and Adolescent Obesity 34
Preventive Dental Care 37
Teen Births 38
Prenatal Care 39
Low Birth Weight 40
Colorectal Cancer Screening 41
Mammography Screening and Papanicolaou Smear 42
Tobacco, Alcohol and Drugs 43
Tobacco Use 43
Alcohol Use 44
Drug Use 46
Child Abuse 47
Diseases: Indicators and Findings **49**
Chronic Diseases 49
Cardiovascular Disease, Cancer and Diabetes 49
Asthma 51
Infectious Diseases 53
Tuberculosis 53
Tick-Borne Illness 54
Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs) 56
Leading Causes of Death and Mortality Rates 58
Infant Mortality 60
Suicide Mortality 61
Older Adult Health: Survey and Focus Group Findings **63**
Older Adult Health Surveys 63
Key Findings 64
Housing 64
Support Services 65
Quality of Life 65
Physical and Mental Health 65
Older Adult Focus Groups 66
Overall Perceptions 66
Housing and Living Environment 67
Quality of Life 68
Social Support 69
Physical and Mental Health 69
Representative Focus Group Quotes 70
Older Adults 70
Health Care Providers 71
Conclusions 71
Conclusions and Recommendations **72**

Introduction

The first release of the *Community Report Card for Western Connecticut* in 2009 established a baseline profile of community health in the Housatonic Valley Region (HVR) by assessing key demographic, socioeconomic, and health status indicators. The HVR is comprised of ten distinct municipalities (herein referred to as the "community") including: Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman. The *2009 Community Report Card* focused on indicators in the following areas:

- *Economic Stability*
- *Education*
- *Health Status*
- *Health and Lifestyle Behaviors and Risk Factors*
- *Diseases*

The *2012 Community Report Card for Western Connecticut* contains an update of the original key indicators, and integrates relevant findings from selected national and state health assessments and surveys, and the U.S. Census. Comparison of trends for the same indicators over time permits health, human services, and community leaders to measure improvements, identify disparities, and establish priorities to improve the health-related quality of life and well-being of residents throughout the region. This includes collaboration among health and community leaders to identify opportunities to improve access to health-related services, cost-effectiveness of services, and service quality.

This report was commissioned by the City of Danbury Health and Human Services Department, Western CT Health Network/ Danbury Hospital-New Milford Hospital, United Way of Western Connecticut, and Western Connecticut State University (WCSU). The collective thoughts, opinions, and expertise of a regional Steering Committee – including health care providers, educational institutions, community-based providers, and local government agencies – guided the development of this report. The Community Report Card represents a collaborative effort of community members, leaders, and organizations whose mission is to identify priority health needs in the region and mobilize resources to address those needs.

This update was prepared by a team of WCSU experts, led by Dr. Robyn Housemann, Associate Professor and Co-Chair of WCSU's Department of Health Promotion & Exercise Science. Final editing and updating, focus group planning and administration, and survey analysis and reporting were conducted by Mary Bevan, M.P.H and Mhora Lorentson Ph.D., of *The Center for Healthy Schools & Communities at EDUCATION CONNECTION*.

Funding for this report was provided by Aetna Foundation, the CT Department of Public Health, Western CT Health Network/ Danbury Hospital-New Milford Hospital, the Peter and Carmen Lucia Buck Foundation, Inc., Savings Bank of Danbury, Union Savings Bank, and United Way of Western Connecticut with in-kind support from Western Connecticut State University.

Objectives

The major objectives of the *2012 Community Report Card for Western Connecticut* are to:

1. Provide a narrative and statistical update of key indicators in the areas of economic stability, education, health status, behavioral risk factors, and diseases for HVR residents.
2. Provide current recommendations on how provider and community partnerships could improve the health and well-being of HVR residents.
3. Provide more in-depth insight on the health and social needs of older adults living in our community.

Methods

The *Report Card* combines narrative information and statistical data (tables, charts, and graphs) drawn from local, state, and federal sources. The report is intended to be descriptive and not analytical; therefore data is presented for general reference and, in most instances, has not been analyzed for statistical significance. Whenever possible, indicators are presented at the municipal (town or city) level. In the case of certain indicators, the statistical data is not available for lesser populated towns. In addition, health data is not published at the town level when there are a very small number of events, due to validity and confidentiality concerns. State and federal statistics are also included for certain indicators to provide a perspective on how the Housatonic Valley Region compares to the state and nation. The process of how the indicators were selected is described in the initial version of the Report Card (2009). For this Report, the data was obtained from the original sources when available. If the data was no longer available from the original source then searches were conducted and the new source is noted. There are some indicators where the data was collected in a different manner; in these instances an explanation is included to describe the changes and any implications.

With the growth in the population ages 65 and over in the region, the 2012 version of the Community Report Card contains a section specifically dedicated to the health of older adults. "Seniors in our communities are healthy and thrive" is the vision statement crafted by the Steering Committee for the older adult component of the *2012 Community Report Card*. Four topics were identified to enable public health, hospitals, human service providers, and the general public to better assess if older adults in the region exemplify this vision statement:

- *Housing.* This includes availability of housing options, skilled nursing, assisted living, and hospice facilities.
- *Support Services.* This includes services which promote access to health care and human services, such as public transportation, fuel assistance, Meals on Wheels, senior centers, etc.
- *Quality of Life.* This includes demographics, socioeconomic status, social supports, recreation, and spirituality.
- *Physical and Mental Health.* This includes risk factors, disease (morbidity) and death (mortality) rates.

Methods, cont'd.

The survey design team at WCSU reviewed published senior health report cards to select indicators for an Older Adult Health Survey. These included the Naugatuck Valley 2007 *Senior Needs Assessment* http://www.valleyunitedway.org/2007/SeniorNeedsExecutiveSummary.pdf, *Seniors in Canada 2006 Report Card* http://dsp-psd.pwgsc.gc.ca/Collection/HP30-1-2006E.pdf, and *Improving Health Literary for Older Adults, 2009* http://www.cdc.gov/healthmarketing/healthliteracy/reports/olderadults.pdf.

After selection of relevant indicators, Senior Center and Social Services Directors from HVR municipalities reviewed both the topics and the indicators and commented on the usefulness of compiling information on these indicators. Feedback confirmed that the needs of older adults are covered by the four topics and the indicators were then finalized.

Older Adult Health surveys were developed by the project team at WCSU from validated survey instruments for completion by older adults throughout the region. Long and short versions were developed for a general health and a general health plus dental survey. An effort was made to distribute surveys equally across all 10 HVR municipalities based on the population ages 65 and older. The target population was older adults who had the ability to complete the survey and also had an understanding of the needs in their community. Ninety-one sites were identified for survey administration. Although many sites were interested in receiving the results of the survey, permission to conduct the surveys was obtained from only 20 of these sites and completed surveys were received from only 10 sites. A total of 123 surveys were received. The majority of these surveys were collected at a regional volunteer recognition luncheon. Although this is not a representative sample of the older adult population in the HVR, as community volunteers, survey respondents are potentially more aware of available services and service gaps. Survey results are presented in The Older Adult Health Survey and Focus Group Summary section of this report.

Health: A Definition

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (http://www.who.int/governance/eb/who_constitution_en.pdf)

The phrase "health status" refers to the current condition of wellness and illness in our community, which is defined by measures of both positive and harmful behaviors, the existence of symptoms and conditions of illness and wellness, and the prevalence of specific diseases.

Findings and Recommendations

The findings and recommendations presented in this report are designed to promote discussion among all stakeholders on the health and well-being of the community as well as access and quality of health delivery systems in the region. The overarching intent is to identify priority needs for health improvement within the Housatonic Valley Region and provide a starting point for a more comprehensive health assessment in the future.

Looking Back

In April 2011, health care provider agencies and community members were asked to participate in a brief questionnaire as past recipients of the *2009 Community Report Card for Western Connecticut*. This survey was designed to capture perspectives on the value of the Report Card, i.e., how its content was used to support grant requests and funding, foster alignment of programs and services and partnerships, and advance a particular community health improvement initiative. Assessment of progress towards the five key consensus recommendations of community stakeholders presented in the *2009 Community Report Card* was also part of the survey. A 29% response rate was achieved (133 distributed surveys with 38 completed) and respondents included health care providers, community agencies, and community members.

The majority of respondents (63%; 24 individuals) indicated that they had received a copy of the *2009 Community Report Card for Western Connecticut*. Of the individuals who indicated they did not receive a copy, nearly half noted they had heard of the Report Card. An overwhelming majority (97%) indicated they would like to receive a future version of the Report Card. A summary of all survey respondent findings, including reported progress towards the 2009 Report Card's consensus recommendations, follows.

1. Use of the Community Report Card

More than half of the respondents (54%) indicated they had utilized information provided in the Report Card during the past two years. The primary use was for discussion purposes, followed by facilitation of program development/ implementation and funding requests, and education about community needs.

2. Five Key Recommendations

Recommendation # 1 - The community should capitalize on existing collaborations, initiatives, partnerships and programs to develop and embrace educational strategies across a broad continuum of providers that will expand and strengthen the focus on prevention, particularly targeting childhood obesity, heart disease, cancer, diabetes, and tick-borne illness.

Twenty-two (22) respondents indicated they had developed or partnered with another entity to address one of the recommended programs: Childhood Obesity (18), Diabetes (9), Heart Disease (8), Tick-borne Illness (8) and Cancer (7).

Highlights of programs and/or partnerships cited include the United Way Obesity initiative; HVCEO Tick Illness Prevention Task Force; Ridgefield BLAST Lyme program; WCSU Health Service "biggest loser" program; Connecticut Institute for Communities, Inc. colorectal cancer screening and establishment of a

Looking Back, cont'd.

Federally Qualified Community Health Center; Danbury Public Schools School-Based Health Centers and American Heart Association and American Cancer Society's awareness activities targeting the school age population; Ann's Place partnership with the Hispanic Center to address the needs of Hispanic/Latino cancer survivors; Americas Free Clinic emphasis on outreach and care for uninsured diabetics; Town of New Milford Walking Project; Town of Bethel 2-1-1 referral program; Regional YMCA of Western Connecticut Coalition for Healthy Kids and Diabetes Self-Management Education program with Danbury Hospital; and Danbury Hospital's Healthy Heart screening and education initiatives.

Recommendation # 2 – Data indicates the Greater Danbury area generally is very healthy across many indicators, including the 10 leading causes of death. Public health, hospitals and human services providers should be recognized for their efforts toward preventive, interceptive and ongoing care and supports for our community. They should also continue to strive for ways to maintain existing and pertinent programs and to find new and creative solutions to address emerging needs.

Nearly two-thirds (65%) of respondents indicated they implemented ways to maintain existing and pertinent programs. Seventeen (17) individuals indicated they found solutions to address emerging needs.

Recommendation # 3 – While indicators show the community has fairly substantial access to care in our region, lacking health insurance should not be a barrier to receiving care. The community should continue to work toward ensuring access to quality, affordable care for residents. The community should make the public better aware of state health insurance initiatives such as HUSKY and Charter Oak in a continuing effort to bridge barriers to care.

The majority of respondents (72%) indicated they have undertaken efforts to make the community more aware of health insurance initiatives.

Activities identified include evaluating clients for eligibility for public assistance and increasing awareness of state insurance initiatives. Specifics cited include Newtown's parent awareness of HUSKY programs as part of Free and Reduced Lunch programs; Danbury Department of Health and Human Services TB clinic referrals to Danbury Hospital's Financial Counseling; Danbury Housing Partnership educating the public on housing and homeless issues; the 3Rs collaborative and Danbury Children First's dissemination of information about HUSKY and pediatric clinics at events and through their Parent to Parent Newsletter; Women's Center of Greater Danbury referrals for resources; Boys & Girls Club of Ridgefield newsletter link to the no-cost and anonymous screener: www.qualify4care.com; Town of Bethel referral to 2-1-1 if the health department does not have the specific referral information sought; and Danbury Hospital's Families Network at Children's Day.

Recommendation # 4 - The community should develop a plan to better promote 2-1-1 (United Way Info Line) as a source for available services for the general provider populations.

Approximately 75% of respondents have not yet developed a plan to promote Info Line. Ten (10) individuals noted they provided

Looking Back, cont'd.

specific presentations at networking meetings, written identification in communications such as program directories, workplace campaigns, electronic communication, newsletters and annual reports, Development of referral procedures for handling information requests and a reference directory of current health information, subject matter experts and agency information to provide residents/others to assure they receive the information they need to help themselves was also noted.

Recommendation # 5 - The Community Report Card for Western Connecticut should be used as a source of information and a forum for education that spurs discussion and moves all stakeholders into action, and it should be revised biennially.

An overwhelming majority indicated support for ALL of the initiatives for helping the community prepare for future reports. These include collecting community-specific data where there is none; determining "target" populations and collecting relevant data for these populations; conducting focus groups with target populations; prioritizing needs; conducting a Resource Assessment (scan of what resources are available) and identifying unmet needs and creating a plan to address them; identifying evidence-based strategies/programs to meet the needs and evaluating programs and monitoring indicators.

Respondents noted that while all of the activities are possible and desirable, sufficient human and financial resources and the right leadership are needed to implement and sustain these activities. Highlights include:

- *Success is dependent on key stakeholders being on board and adequate resources being available.*
- *This requires organization, motivation and support.*
- *Collaborative, facilitated community conversations can lead to prioritization of needs, joint data gathering exercises, and resource assessments.*
- *There are many services in our area but there are many who are not aware of them. Efforts should be made to broaden awareness and utilize many of the individual agency efforts as a starting point.*
- *The community should and can prepare for future reports, by expanding the Steering Committee (in numbers and scope) and build on the foundation of the first Community Report Card.*
- *To improve health disparities, it is important to collect more in-depth data especially through focus groups to better align community resources with gaps identified by the community.*
- *The Community Health Committee representing the towns and cities should use a community health linkages model to obtain data and support to refine what the area health problems are and the priority list with a targeted plan of action.*

Moving Forward

Connecticut Health Rankings

According to the United Health Foundation, in 2011 Connecticut ranks third in health status in the country overall, a continued positive trend from the 2009 seventh rank and 2010 fourth rank. Strengths include low rates of smoking, a lower prevalence of obesity when compared to other states in the nation, a low percentage of children in poverty, a low rate of uninsured population, high immunization coverage, and relatively high proportion of primary care physicians. Areas where improvement is needed include a high prevalence of binge drinking and moderate levels of air pollution. The report indicates that Connecticut has demonstrated success in reducing deaths from cardiovascular disease and cancer and, in the past ten years, smoking prevalence has decreased dramatically. Although Connecticut has a relatively low rate of uninsured, the percent uninsured has increased from 9.7% in 2009 to 11.1% in 2011. Highlights include:

- While Connecticut has one of the lowest obesity rates in the U.S., 634,000 adults in Connecticut are obese, an increase of 188,000 individuals in the past 10 years.
- In the past year, smoking decreased from 15.4 percent to 13.2 percent of adults. There are 364,000 adults in Connecticut who still smoke.
- In the past year, diabetes increased from 6.6 percent to 7.3 percent of adults. There are 201,000 adults in Connecticut who have diabetes.
- Compared to other health measures, the rate of preventable hospitalizations remains high in Connecticut at 63.1 discharges per 1,000 Medicare enrollees.
- Health Disparities - In Connecticut, obesity is more prevalent among non-Hispanic blacks at 39.5 % than non-Hispanic whites at 20.8 %. Diabetes also varies by race and ethnicity in the state; 11.5 % of non-Hispanic blacks have diabetes compared to 6.7 % of non-Hispanic whites.

Source: United Health Foundation (2011) *"America's Health Rankings®: A Call to Action for Individuals and Their Communities" 22nd edition* http://www.americashealthrankings.org/CT/2011, *accessed 1/12/12).*

Healthy People 2010 and 2020

Any report of community health indicators should include *Healthy People 2010* and *Healthy People 2020*. This comprehensive set of national disease prevention and health promotion goals for the nation targets measureable health objectives in 28 focus areas. The final Healthy People 2010 report and the newly released objectives for Healthy People 2020 can be accessed at http://www.healthypeople.gov.

The overarching goal of *Healthy People 2020* is to increase both the quality and years of healthy life, and eliminate health disparities. A report on statewide progress towards achievement of *Healthy People 2010* targets was compiled by the CT Department of Public Health in June 2010. Findings from this report, *Healthy Connecticut 2010*, are incorporated into the Report Card sections as relevant. The entire report is available at: http://www.ct.gov/dph/lib/dph/state_health_planning/healthy_people/hct2010_final_rep_jun2010.pdf.

Our Community

Population

The Housatonic Valley Region (HVR) comprises ten municipalities in western Connecticut in close proximity to the New York metropolitan area.

Data from the United States Census Bureau shows that as of 2010, the population of this region was 224,616, an increase of 12,368 since Census 2000. The HVR has grown at a faster rate than any other region in Connecticut. In the 1950s these 10 communities represented only 2.9% of Connecticut's population; in 2000 they represented 6.2% of the state population. This growth trend continued through 2010 at which time they represented 6.6% of the state population. By 2030, the HVR is projected to be at 7.1% of the state population. Table 1 outlines projections to the year 2030 compiled by the Connecticut State Data Center. It is important to note that these projected population numbers are derived from historical patterns of population change and that there is no guarantee that past patterns will hold constant in the future.

Table 1: Population Projections for HVR Municipalities, 2015-2030

Town	Census 2010 Population	2015	2020	2025	2030
Bethel	18,584	22,486	24,223	25,779	26,878
Bridgewater	1,727	2,057	2,134	2,216	2,271
Brookfield	16,452	17,756	18,424	19,065	19,644
Danbury	80,893	79,403	81,665	83,813	85,754
New Fairfield	13,881	15,196	15,624	16,012	16,249
New Milford	28,142	31,156	32,562	33,953	35,173
Newtown	27,560	30,147	32,242	34,242	36,161
Redding	9,158	8,092	7,721	7,436	7,225
Ridgefield	24,638	25,676	26,483	27,142	27,729
Sherman	3,581	4,430	4,586	4,724	4,823
HVR Totals	224,616	236,399	245,664	254,382	261,907
Connecticut	3,408,029	3,573,885	3,622,774	3,669,990	3,702,400

Source: Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html, accessed 5/28/2011

Our Community cont'd.

Demographic Profile

Ethnicity and Race

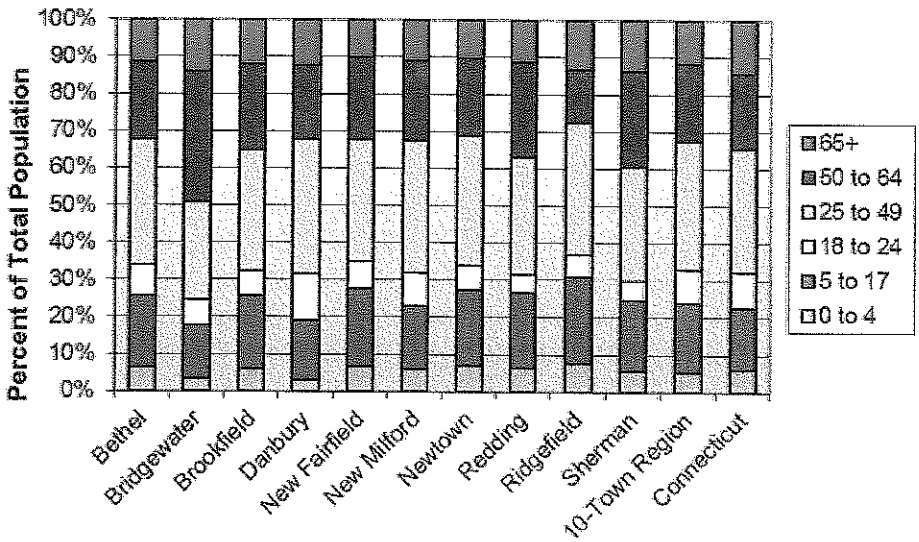
The Housatonic Valley Region has become much more ethnically diverse in recent years. From 2000 to 2010, the Black/African American population in the region increased from 6,527 to 7,671, or 17.5% of the total population. In 2010, 75.6% of the region's Black/African American population resided in Danbury. The Hispanic/Latino population in the region nearly doubled from 2000 to 2010, and currently comprises 12% of the region's population. Three-fourths of the Hispanic/Latino population in the region resides in Danbury. In 2000, Hispanic/Latino residents in the region represented many nationalities; the groups with the largest populations in the region are Puerto Rican (19% of the total Hispanic/Latino population), Ecuadorian (15%), Dominican (14%), and Mexican (12%). The region also had a substantial population of residents of Irish, Italian, German, and Polish ancestry in 2000 – 23%, 20%, 17%, and 6% respectively. (Source: Housatonic Valley Council of Elected Officials, http://hvceo.org/tables/TABLE_P18.php http://hvceo.org/tables/TABLE_P20.php Accessed 8/7/11.)

Note: At the time of publication, Census 2010 data on ancestry was not yet available, so no comparisons of growth in specific nationalities are available.

Age

The population distribution among age groups in the region is similar to the distribution in the state and in the nation. However, four communities in our region have a larger percentage of adults in the 50 and over range than either the state (34.4%) or the nation (33.3%). Bridgewater has the highest percentage of adults over the age of 50 with 49.1% of the population in this category, followed by Sherman (39.4%), Redding (36.8%), and Brookfield (35.3%). As expected, the median age in these communities is also higher than the state average. Communities with older populations usually have a greater demand for health care services, in the present and in the future. The proportion of each HVR municipality population by age range in 2010 is shown graphically below:

Figure 1: HVR Municipality Population by Age, 2010

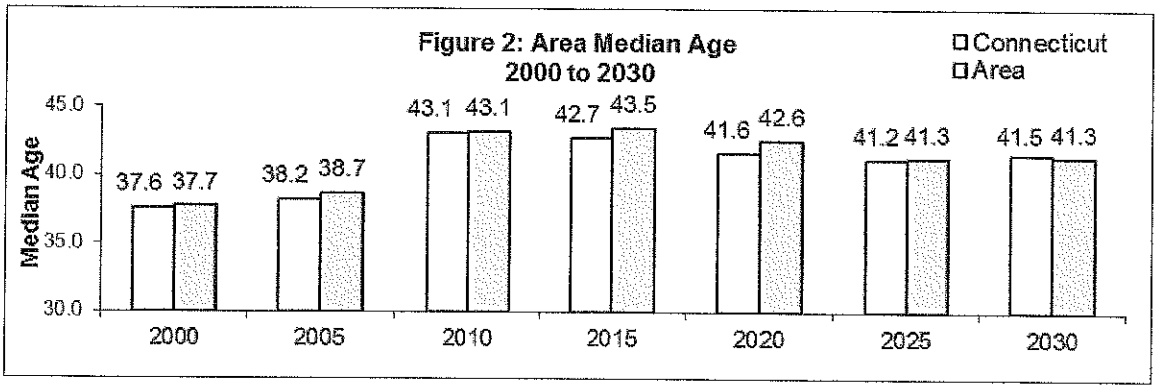


Source: Connecticut Economic Resource Center http://www.cerc.com/townprofiles/ accessed 4/11/2011

Our Community cont'd.

Age, cont'd.

Median age projections for the HVR as compiled by the CT Data Center for 2000-2030 show an overall increasing trend through 2015, influenced by factors such as aging in the "baby boomer" generation and the state's declining birth rate.



Population Trends

Careful examination of changes in population statistics over time, or temporal trends, is an important component of community health assessment and planning. A summary of population trends in HVR municipalities over the past decade by race/ethnicity follows.

Table 2: HVR Municipality Census 2000 and 2010 Population Counts by Race/Ethnicity

Municipality	Total Census Population*		White Population		Black/African American Population		Asian Population		Hispanic/Latino Population	
	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010
Bethel	18,067	18,584	16,692	16,504	228	343	641	833	669	1,419
Brookfield	15,664	16,452	14,926	15,285	119	177	388	598	372	710
Danbury	74,848	80,893	56,853	55,202	5,060	5,803	4,082	5,474	11,791	20,185
New Fairfield	13,953	13,881	13,511	13,161	54	149	177	232	393	611
Newtown	25,031	27,560	23,815	25,914	437	444	351	648	590	1,033
Redding	8,270	9,158	7,952	8,693	62	63	147	200	122	237
Ridgefield	23,643	24,683	22,726	23,147	146	179	492	788	465	941
Sherman	3,827	3,581	3,726	3,469	21	15	26	35	66	76
Bridgewater	1,824	1,727	1,779	1,681	17	14	13	16	9	26
New Milford	27,121	28,142	25,583	25,809	383	484	518	779	751	1,693
HVR Total	**212,248**	**224,661**	**187,563**	**188,865**	**6,527**	**7,671**	**6,835**	**9,603**	**14,477**	**26,931**

Source: CT State Data Center, University of Connecticut, http://ctsdc.uconn.edu/.../2010_2000_PL_Census_data_comparison_towns, accessed 1/12/12

** Note - subgroup population numbers do not equal the total population numbers as ethnic/racial subgroups with fewer than 10 residents for one or more municipalities and "other" were not included.*

Our Community, cont'd.

Population Trends, cont'd.

In interpreting the significance of the percentage change in population by racial/ethnic subgroup, it is important to also reference the absolute change in population numbers from 2000 to 2010 to gain perspective. Even small numeric changes in events with fewer occurrences may result in large percentage changes. This is referred to as small numbers effect or phenomenon. For example, a numeric increase of 10 from 10 to 20 represents a 100% increase, as does a numeric increase of 1,000 from 1,000 to 2,000.

Table 3: HVR Municipality Census 2000 and 2010 Number and Percentage Population Change

Municipality	Total Population		White Population		Black/African American Population		Asian Population		Hispanic/ Latino Population	
	Number Change	% Change	Number Change	% Change	Number Change	% Change	Number Change	% Change	Number Change	% Change
Bethel	517	2.9	-188	-1.1	115	50.4	192	30.0	750	112.1
Brookfield	788	5.0	359	2.4	58	48.7	210	54.1	338	90.9
Danbury	6,045	8.1	-1,651	-2.9	743	14.7	1,392	34.1	8,394	71.2
New Fairfield	-72	-0.5	-35	-2.6	95	175.9	55	31.1	218	55.5
Newtown	2,529	10.1	2,099	8.8	7	1.6	297	84.6	443	75.1
Redding	888	10.7	741	9.3	1	1.6	53	36.1	115	94.3
Ridgefield	995	4.2	421	1.9	33	22.6	296	60.2	476	102.4
Sherman	-246	-6.4	-257	-6.9	-6	-28.6	9	34.6	10	15.2
Bridgewater	-97	-5.3	-98	-5.5	-3	-17.7	3	23.1	17	188.9
New Milford	1,021	3.8	226	0.9	101	26.7	261	50.4	942	125.4
HVR Total	12,413	5.9	1,302	0.7	1,144	17.5	2,768	40.5	12,454	86.0

Source: CT State Data Center, University of Connecticut, http://ctsdc.uconn.edu/.../2010_2000_PL_Census_data_comparison_towns, accessed 1/12/12

Overall, review of population changes from 2000 to 2010 indicate that there is considerable variation in population growth rates among HVR municipalities as well as increasing ethnic and racial diversity throughout the region. The most consistent population growth in the region has occurred in Asian and Hispanic/Latino subgroups. In addition, the population growth rate for the region has slowed over the past decade at 5.8% compared with 13% from 1990 to 2000. Additional population statistics for the region are available at http://www.hvceo.org/areainfo.php.

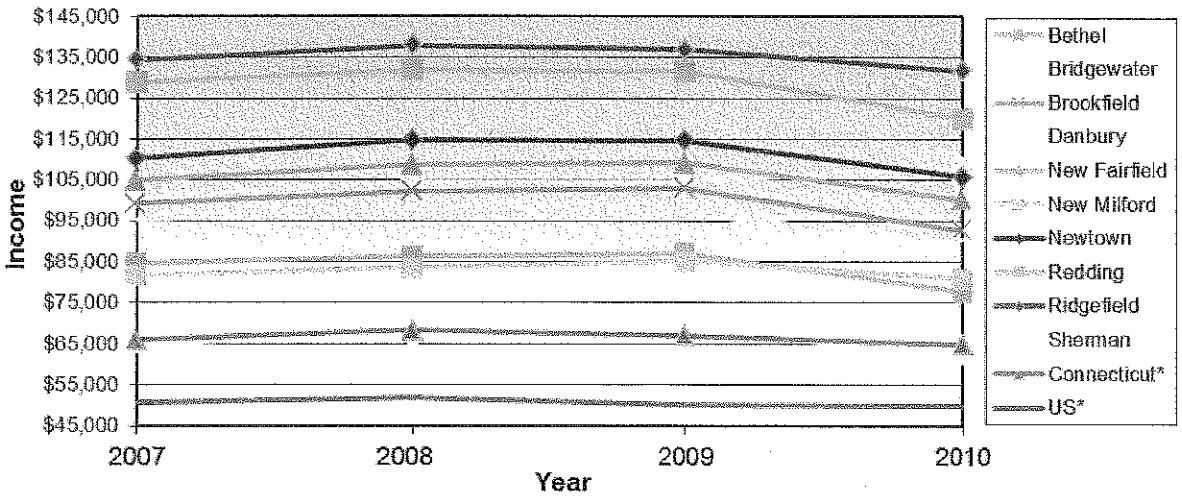
Economic Stability: Indicators and Findings

It is well documented that persons of higher socioeconomic status are more likely to have health insurance, participate in health screenings and regular health care, obtain a higher level of education, reside in safer neighborhoods, and exhibit healthier personal lifestyle habits. In sharp contrast, persons living in poverty tend to have fragmented health care; low educational attainment; live in substandard housing and unsafe neighborhoods; and experience higher rates of unemployment, crime, tobacco use, substance abuse, mental illness, and certain chronic health conditions such as obesity and diabetes. *Healthy People 2010 and 2020* both emphasize the inseparable connections among individual health status and the social factors and physical conditions in the environment in which people are born, live, learn, play, work, and age.

Income and Poverty

The median household income in the region varies widely. In 2010, the annual household median income in HVR municipalities ranged from a low of $62,582 in Danbury to a high of $131,677 in Ridgefield. All municipalities except Danbury have median household incomes well above the state and national average. As indicated in Figure 3, since 2009 there has been a decline in the median household income in all HVR communities with the exception of Bridgewater. Danbury and New Milford experienced the smallest decline.

Figure 3: Median Household Income, 2007 - 2010



Source: Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 3/23/2011 + e-mail communication from Dale Shannon, Senior Economist CERC 6/6/2011
* United States Census Bureau Median Household Income 1-year Estimates http://www.census.gov/did/www/saipe/county.html accessed 6/9/2011

Economic Stability: Indicators and Findings, cont'd.

Income and Poverty, cont'd.

In 2012, the official U.S. federal poverty level for a family of four was set at an annual income of $23,050 or less. (Source: US Department of Health and Human Services http://aspe.hhs.gov/ poverty/ 12poverty.shtml, accessed 1/27/2012). In geographic areas with a high cost of living such as our region, even persons living above 200% of the poverty level struggle to make ends meet. The federal poverty guidelines, or percentage multiples of them (such as 130 percent, 150 percent, or 185 percent), are used to determine eligibility for a number of federal and state assistance programs, including the National School Lunch Program, Supplemental Nutrition Assistance Program (formerly the Food Stamp Program), the Temporary Assistance for Needy Families Program, and the WIC Program.

With the current economic downturn, a growing number of individuals and families in the region are entering the ranks of the "working poor." These individuals, underemployed and/or employed in low wage jobs, earn too much money to qualify for federal or state assistance programs, but not enough money to experience a decent quality of life or meet many of their basic needs. The working poor are also more likely to not receive health insurance benefits through their employers.

According to the U.S. Census Bureau, 42.9 million Americans (14.3% of the US population) lived in poverty in 2009 (Source: US Census Bureau, "Poverty: 2008 and 2009, American Community Survey Briefs" http://www.census.gov/ prod/ 2010pubs/acsbr09-1.pdf accessed 8/12/2011). The proportion of Americans living in poverty has increased over the past decade. Table 4 shows that our community poverty rates fall below both the state and national rates. Danbury's level of poverty is considerably higher than the other municipalities in the region and comparable to the state. It should be noted that throughout the state and region, significant disparities exist with minority populations disproportionately living in poverty.

Table 4: Economic Characteristics of HVR Municipalities

Town	Median Household Income in 2010 ($)	Poverty Rate in 2009 (percent)
Bethel	$77,625	4.8%
Bridgewater	$107,934	2.9%
Brookfield	$92,731	2.4%
Danbury	$62,582	8.5%
New Fairfield	$100,202	2.9%
New Milford	$80,887	2.1%
Newtown	$105,744	2.2%
Redding	$119,788	1.6%
Ridgefield	$131,677	1.8%
Sherman	$90,638	2.2%
Connecticut*	$64,851	8.7%
United States*	$49,777	14.3%

Source: Connecticut Economic Resource Center, Inc. Town Profiles 2011 www.cerc.org accessed 8/17/2011
* United States Census Bureau Median Household Income 1-year Estimates http://www.census.gov/did/www/saipe/county.html accessed 6/9/2011

Economic Stability: Indicators and Findings, cont'd.

Employment Status

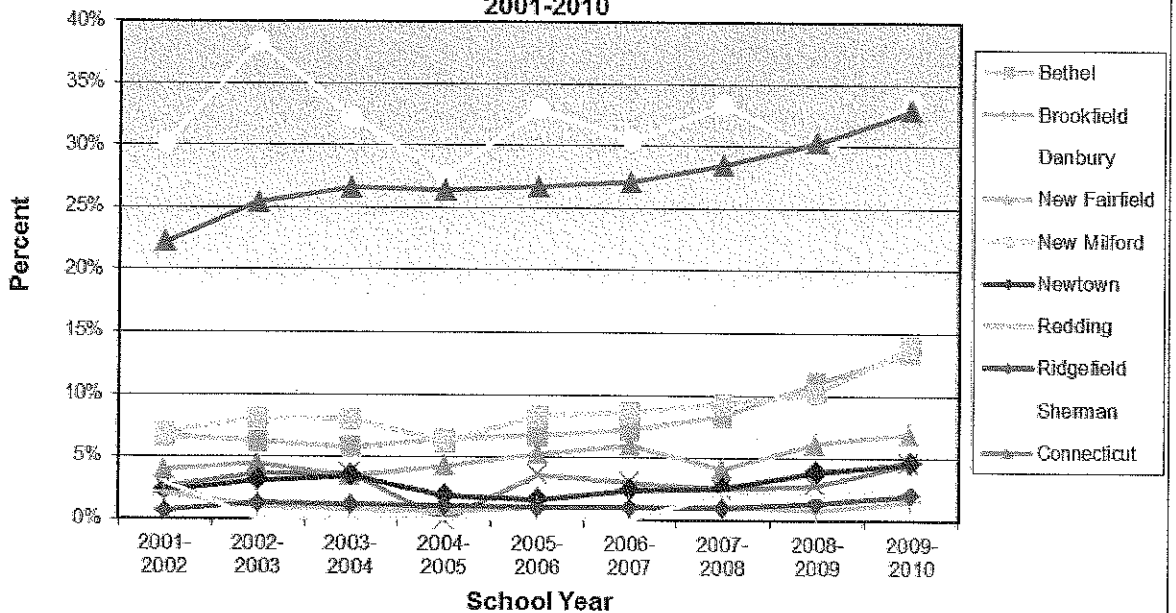
According to State Department of Labor data reports, Connecticut and the HVR municipalities have recently experienced a decline in the unemployment rate. The state's unemployment rate in July 2011 was 9.1%, and as of December 2011 this had declined to 7.6%, below the national unemployment rate of 8.5%. In December 2011, unemployment rates in the region ranged from a low of 4.4% in Bridgewater to a high of 6.4% in Sherman. (Source: Connecticut Department of Labor, http://www.ctdol.state.ct.us/ accessed 8/18/2011 & 1/27/12).

Free and Reduced Price School Meals

Free or reduced price school meals are available for all children attending public schools whose families are income eligible. The income eligibility for free meals is 130% or below the federal poverty level; for reduced meals it is more than 130% up to 185% of the federal poverty level. The percentage of children receiving free or reduced price school meals is a highly useful indicator of the extent of poverty and economic stability in our community.

Since 2000, data indicate that the region tends to fall below the statewide average for free or reduced price meal eligibility. This is consistent with the region's overall higher average median household income. Danbury is the exception with the percentage of students eligible for free/reduced price meals generally exceeding the state average. In 2009-2010, one out of every three Danbury children was eligible to receive free/reduced price meals. The Danbury Promise for Children Partnership's *2011 Community Report Card on Danbury's Young Children* states this had increased to 46% in 2010-2011. It is notable that over the past two years, there has been an increase in the number of eligible children in all HVR communities.

Figure 4: Percent of Students Eligible for Free/Reduced Price Meals, 2001-2010



Source: Connecticut State Department of Education, Student Need Data http://sdeportal.ct.gov/Cedar/WEB/ct_report/StudentNeedDT.aspx accessed 3/23/2011

Economic Stability: Indicators and Findings, cont'd.

Homelessness

The National Alliance to End Homelessness defines homelessness as a complex problem with a simple solution - housing. People become homeless when they cannot find housing that they can afford. It is estimated that there are 643,067 people experiencing homelessness on any given night in the United States with 238,110 people in families, and 404,957 individuals. These numbers are from point-in-time counts conducted in communities throughout the country on a single night in January every other year. (Source: The National Alliance to End Homelessness, Snapshot of Homelessness, http://www.endhomelessness.org/section/about_homelessness/snapshot_of_homelessness accessed 8/29/2011).

Homelessness results from many factors. Economics is a major driver of homelessness across the nation. In Connecticut, the economic pressures are particularly acute with the relatively high cost of living and scarcity of low cost housing. In the Danbury metropolitan area, the estimated 2011 living wage to afford a one bedroom apartment was $24.27 per hour; the minimum wage in 2012 is only $8.25 per hour. (Source: Fiscal Year 2011 Final Fair Market Rents for Existing Housing, http://www.universallivingwage.org, accessed 1/30/12).

The data in Table 5 indicates that 4,451 people were homeless in Connecticut on January 27, 2011. Table 5 shows the Point-in-Time Count of homeless in the Greater Danbury area and Connecticut from January 2008 through January 2011.

Table 5: Homelessness Point-in-Time Counts for Connecticut and Greater Danbury, 2008-2011

		January 30, 2008		January 30, 2009		January 27, 2010		January 27, 2011		Total Percent Change from 2008 to 2011	
		Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide
Total	Total	123	3,444	103	2,824	127	3,829	158	4,451	28.5%	29.2%
	Single Adults	115	2,847	91	2,414	96	2,508	130	3,064		
	Families	10	482	12	423	11	521	11	533		
	Unaccompanied Youth	0	119	0	17	0	18	0	0		
	Children in Families	16	873	23	793	20	782	17	854		

Note: an unsheltered homeless person resides in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street, and a sheltered homeless person resides in an emergency shelter or transitional housing for homeless persons who originally came from the streets or emergency shelters.

Source: CT Coalition to End Homelessness http://www.cceh.org/publications/, 2010-2011 data update accessed 1/27/12.

Economic Stability: Indicators and Findings, cont'd.

Homelessness, cont'd.

In 2005 Danbury Mayor Mark D. Boughton commissioned a Task Force to develop a comprehensive and detailed plan to end homelessness in Danbury within 10 years. The plan was unveiled in February 2006 with four objectives:

1. Increase the supply of permanent housing units to meet the projected need of homeless persons.
2. Keep people housed and reduce the number of people becoming homeless and specifically reduce the number of people being discharged into homelessness by state and local institutions and agencies.
3. Ensure that there are adequate, appropriate and sufficient services to assist homeless or at-risk persons in accessing and retaining housing.
4. Develop a strategy to ensure that the plan is both implemented and monitored to completion.

The Task Force's report stresses urgency in ending homelessness. The cost of long-term homelessness is "most acutely felt by the health and mental health systems. A recent study found that hospitalized homeless people stay an average of more than four days longer than other inpatients and that almost half of medical hospitalizations of homeless people were directly attributable to their homeless condition and therefore preventable." Homeless individuals "are three times more likely to use hospital emergency rooms than the general population, and are at higher risk for emergency department services because of their poor health." The American Academy of Pediatrics has found that homeless children are more likely than other children to experience trauma-related injuries, developmental delays, chronic disease, and poor academic achievement. (Source: The Mayor's Task Force to End Homelessness, www.ci.danbury.ct.us, accessed 11/9/08.)

The Greater Danbury Continuum of Care and the Danbury Housing Partnership are working with a broad range of partners throughout the region to address the multifaceted needs of the homeless population. The Partnership website can be accessed at: www.danbury housing partnership.org.

Education: Indicators and Findings

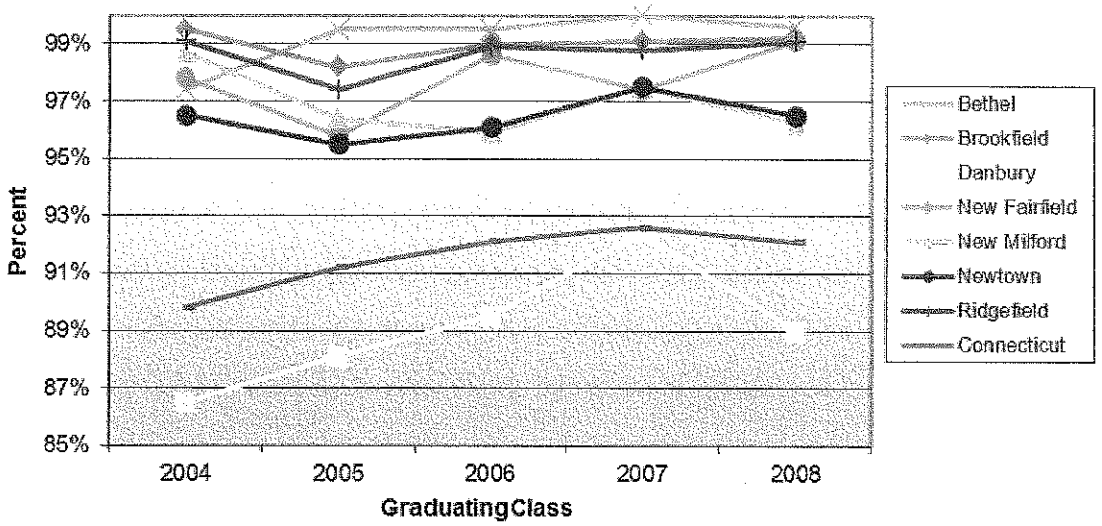
According to the National Center for Education Statistics (NCES), an individual's level of education is highly correlated with specific socioeconomic outcomes. For example, a high school graduate tends to achieve more stable employment and a higher income level than a high school dropout. According to the NCES, students who do not graduate from high school are more likely to rely on public assistance and have poorer physical health than individuals who completed graduation requirements. Data also indicates that the socioeconomic and quality of life benefits of education continue with further advances in educational attainment. Higher education is strongly associated with improved health status, access to health care, increased income, and job opportunities. Persons with higher educational attainment are more likely to live in safe neighborhoods, be employed in higher paying jobs with health benefits, and practice healthy lifestyle habits.

The Connecticut State Department of Education has established three priorities in their 2006 – 2011 Comprehensive Plan for Education to address gaps in educational achievement.

1. High-quality preschool education for all students.
2. High academic achievement for all students in reading, writing, mathematics and science.
3. High school reform so that all students graduate and are prepared for lifelong learning and careers in a competitive global economy.

The ability to achieve these priorities within our local schools will have a direct impact on the future quality-of-life for our students and the economic well-being of our communities.

Figure 5: High School Graduation Rate, 2004-2008



Source: Connecticut State Department of Education, CEDAR , http://sdeportal.ct.gov/Cedar/WEB/ct_report/GraduationDT.aspx accessed 3/24/2011
Note: Bridgewater, Redding, and Sherman are excluded as their students attend high schools located in other towns.

Education: Indicators and Findings

High School Graduation and Higher Educational Attainment

As indicated in Figure 5, the graduation rate for most HVR municipalities is well above the state rate. Danbury, a priority school district, is the exception with a graduation rate consistently below the state average. According to the NCES, the national graduation rate in 2008-2009 was 75.5%, compared with Connecticut's rate of 92%. This rate varies greatly by race/ethnicity and was highest for Asian/Pacific Islanders at 91.8%, followed by White students at 82%, Hispanic students at 65.9%, Native American students at 64.8% and African-American students at 63.5%. (Source: National Center for Education Statistics, www.nces.ed.gov, accessed 8/16/2011).

Four-year cumulative data for the 2009 cohort of high school students in Connecticut shows an overall decline in graduation rates and considerable disparities in these rates by socio-demographic group: Hispanic/Latino (58.1%), African American/Black (66.2%), low income (59.9%), limited English proficiency (53.4%), and special education students (53.4%) compared with (86.8%) for White students. (Source: Connecticut Department of Education. Commissioner Calls for Action. *"New Formula, Unique Student Data Produce More Accurate State Graduation Rates"*, Press Release. March 23, 2010).

Table 6 summarizes existing data relating to the level of educational attainment by HVR residents age 25 and over in the last decade. During this period of time, the overall level of education has consistently increased. With the exception of Danbury, residents ages 25 and over throughout the region were more likely to graduate from high school and to receive advanced degrees than the average Connecticut resident. Residents in eight out of ten HVR municipalities exceeded the state average for attainment of a bachelor's degree or higher.

Table 6: Educational Attainment in HVR Residents Ages 25 and Over, Census 2000 and 2010

Municipality	High School Graduate or Higher		Bachelor's Degree or Higher	
	Census 2000	Census 2010	Census 2000	Census 2010
Bethel	89%	91%	37%	40%
Bridgewater	93%	96%	48%	52%
Brookfield	93%	94%	44%	46%
Danbury	77%	84%	27%	33%
New Fairfield	94%	96%	41%	44%
New Milford	91%	95%	31%	35%
Newtown	93%	95%	50%	53%
Redding	97%	98%	63%	65%
Ridgefield	96%	97%	66%	67%
Sherman	94%	95%	42%	45%
State (CT)	84%	89%	31%	35%

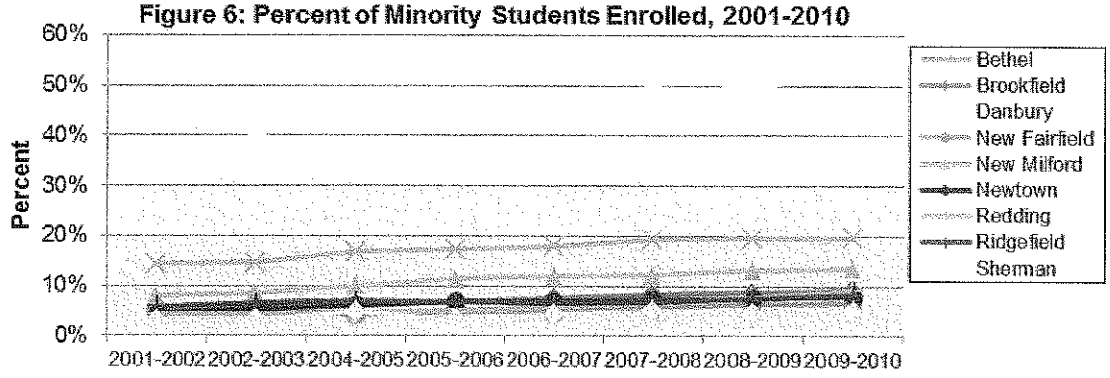
Sources: CERC 2011 Town Profiles and Census 2000: Summary Social, Economic and Housing Characteristics (Table 4).

Education: Indicators and Findings, cont'd.

High School Graduation and Higher Educational Attainment, cont'd.

Among the public school districts in our region, in 2009-2010 Danbury had the highest concentration of racial/ethnic diversity with over half of the students enrolled being minority (52%), followed by Bethel at 19.7%. Figure 6 shows the percentage of minority students from 2001-2002 through the 2009-2010 school years. This growth trend in the proportion of minority students in public schools is consistent across all HVR municipalities.

Figure 6: Percent of Minority Students Enrolled, 2001-2010

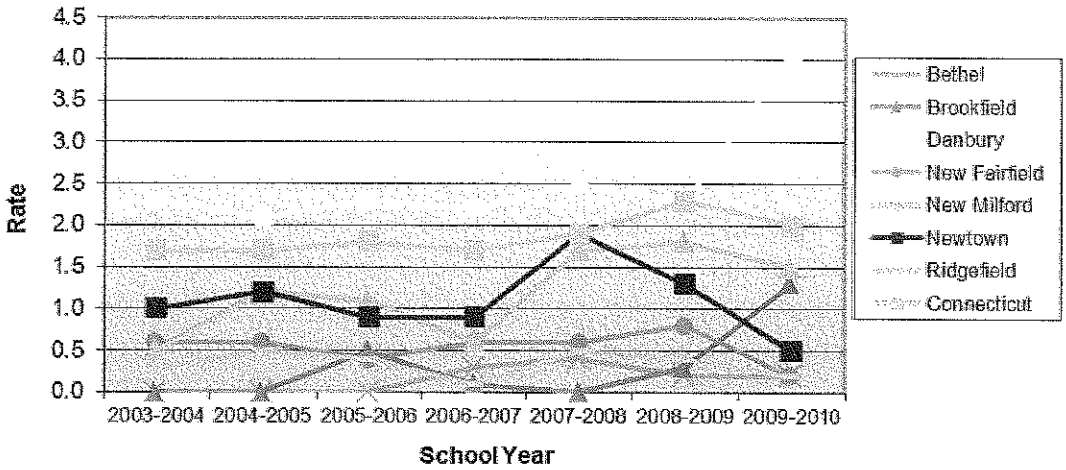


Source: Connecticut State Department of Education, Strategic School Profiles, http://sdeportal.ct.gov/Cedar/WEB/ResearchandReports/SSPReports.aspx accessed 5/31/2011
Note: Bridgewater is included in the Region 12 School District.

High School Dropout Rate

As shown in Figure 7, many municipalities in the region have on average maintained a low dropout rate with the exception of Brookfield, Danbury, and New Milford where the dropout rates remain above the regional average (and exceed the state average in the case of Danbury).

Figure 7: High School Dropout Rate, Grades 9 - 12, 2003-2010



Source: Connecticut State Department of Education, Dropout Rate http://sdeportal.ct.gov/Cedar/WEB/ct_report/DropoutDT.aspx accessed 3/24/2011
Note: Bridgewater is included in the Region 12 District

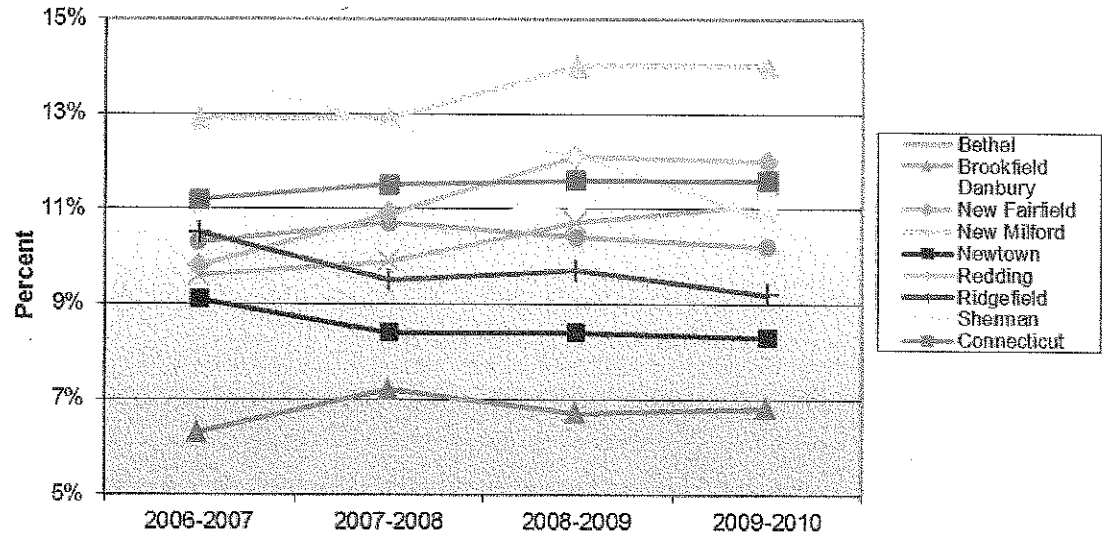
Education: Indicators and Findings, cont'd.

Special Education and Students with Disabilities

Special education involves the provision of individualized educational services for students with a wide range of disabilities. Special education is provided to a child with an identified disability who needs specially designed instruction to meet his/her unique needs and to enable the child to access the general curriculum of the school district. A child who is eligible for special education services is entitled by federal law to receive a free appropriate public education (FAPE). FAPE ensures that all students with disabilities receive an appropriate public education at no cost to the family.

The percentage of K-12 students with disabilities by HVR municipality is presented in Figure 8. This percentage has held fairly constant for many municipalities over the past four years. Sherman has experienced a steady decline in the percent of students with disabilities and there has been an overall increase in the percent of students with disabilities in New Milford, Danbury, and Redding.

Figure 8: Prevalence Rate Students with Disabilities*, 2006-2010



Source: Connecticut State Department of Education, Students for Whom District is Fiscally Responsible, http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationResourseDT.aspx Accessed 3/23/2011
* Past reports used title "Percent of Students with Disabilities for Whom the District is Fiscally Responsible"

Education: Indicators and Findings, cont'd.

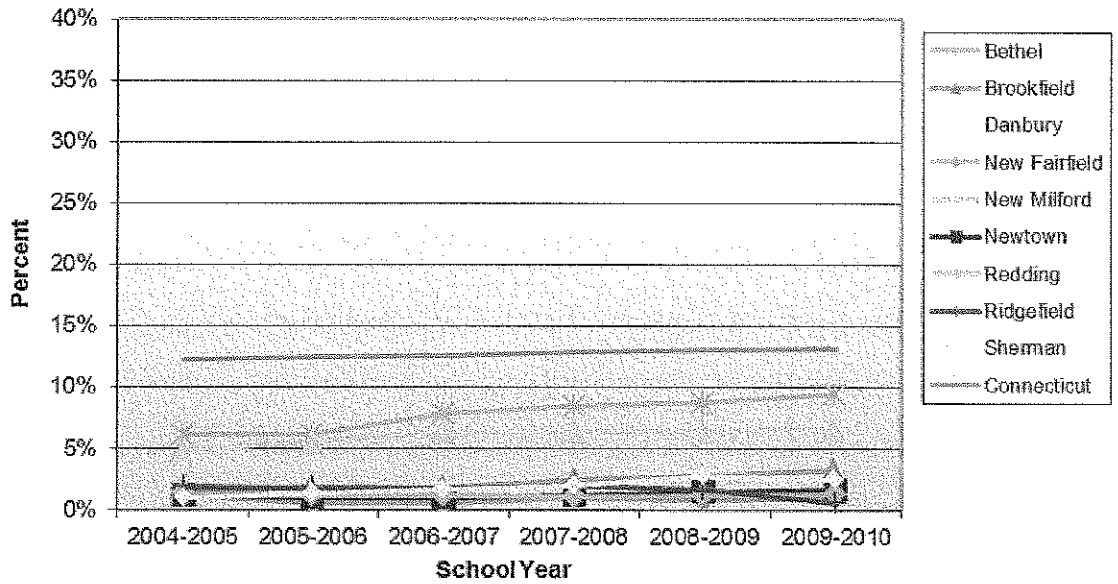
English as a Second Language (ESL)

There are frequently socioeconomic disparities between ESL residents and residents whose primary language is English. Disparities are seen in both children and adults and are reflected in many of the other issues examined within this report.

Students with limited English proficiency, or English Language Learners, tend to have poorer academic performance than children who are fluent in English. Children residing in ESL homes are also less likely to have health insurance and more likely to be living in poverty.

Although the percent of students with a non-English home language is increasing in the majority of municipalities in our region, it is clearly impacting Danbury to a far greater degree. As presented in Figure 9, Danbury's level is considerably higher than the state, while all other municipalities fall below the state percentage.

Figure 9: K-12 Students with a Non-English Home Language, 2004-2010



Source: Connecticut State Department of Education, Students for Whom District is Fiscally Responsible, http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationResourseDT.aspx Accessed 3/23/2011
* Past reports used title "Percent of Students with Disabilities for Whom the District is Fiscally Responsible"

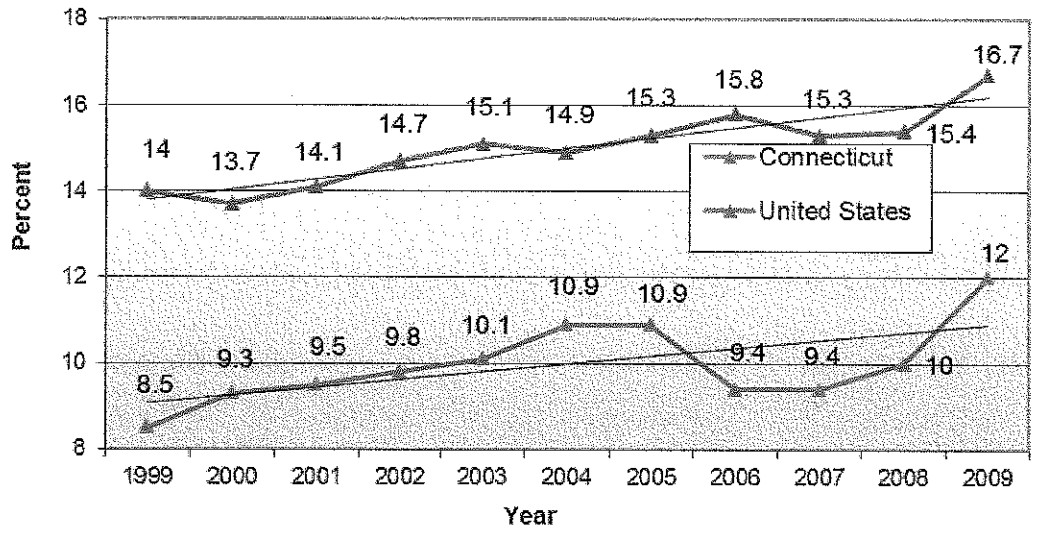
Health Status: Indicators and Findings

Health Insurance Coverage

Having public or private health insurance coverage is a potent predictor of both access to and regular use of all types of health care services - preventive, screening, and diagnostic and treatment.

Studies demonstrate that individuals without health insurance are far more likely to receive fragmented health care and experience delayed access to health screenings and treatment for disease. In addition to the negative impact of delayed access to care on individual health, the economic costs to society are high. Research has shown that delayed access to care results in overuse of costly emergency department services and premature death and disability. As shown in Figure 10, Connecticut falls well below the national average in the percentage of residents who are uninsured. During the past few years, however, this percentage has been increasing at a faster rate in CT than in the U.S. as a whole.

Figure 10: CT and U.S. Percent Uninsured Population, 1999-2009



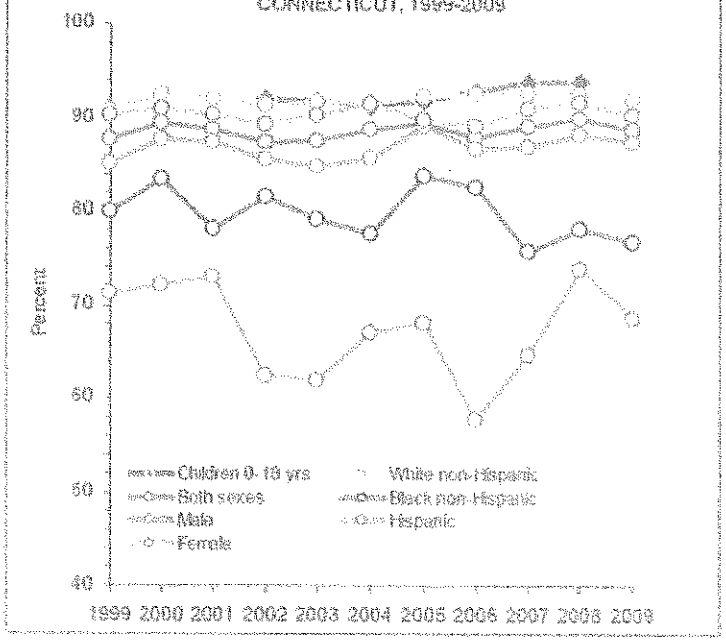
Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/data/historical/index.html, accessed 3/24/2011
Note: Population as of March of the following year.

Health Status: Indicators and Findings, cont'd.

Health Insurance Coverage, cont'd.

According to the CT Department of Public Health's report, *Healthy Connecticut 2010*, the likelihood of being insured in our state varies considerably for different population subgroups. As shown in Figure 11, children in Connecticut are more likely than adults to have health insurance, females are more likely than males, and white non-Hispanic residents are significantly more likely than non-Hispanic Black and Hispanic residents to have health insurance coverage.

FIGURE 11
PERSONS WITH HEALTH INSURANCE
CHILDREN 0-18 YRS OF AGE AND
ADULTS 18-64 YRS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 1999-2009



Source: Behavioral Risk Factor Surveillance System as cited in *Healthy Connecticut 2010*
Note: Data for children 0-18 years of age not available until 2002.

Factors Influencing Insurance Status

There are several key reasons why individuals and families may or may not be insured, most notably employment status and availability of employer-sponsored health insurance, eligibility for public health insurance, and affordability of insurance for persons who are self-insured.

HUSKY Health is Connecticut's comprehensive public health insurance program for children, parents, relative caregivers, senior citizens, individuals with disabilities, adults without children and pregnant women who meet income and citizenship eligibility guidelines. HUSKY Health is designed to reduce the number of uninsured families in Connecticut and increase access to preventive care and diagnostic and treatment services. It is important to note that our region has a growing number of undocumented residents. These individuals are categorically ineligible for public health insurance programs, such as Medicaid, which require proof of citizenship (natural-born citizen,

Health Status: Indicators and Findings, cont'd.

Factors Influencing Insurance Status, cont'd.

naturalized citizen, or U.S. national).

HUSKY A (Medicaid) provides benefits to CT children under the age of 19 and their parents or a relative caregiver with incomes at or below 185% of the federal poverty level and low income pregnant women. HUSKY B, also known as the Children's Health Insurance Program or CHIP, provides benefits to children under the age of 19 who are not eligible for HUSKY A and live in households with incomes between 185-300% of the poverty level. HUSKY A provides free health care coverage for children under the age of 19 and parents or relative caregivers who live with a child under the age of 19. HUSKY B plans include co-payments and/or premiums based on family composition and income.

Both plans cover comprehensive preventive and illness-related health care, including physician visits, emergency and hospital care, immunizations, prescriptions, and vision care. Dental care is provided through the Dental Health Partnership. Children with mental health and substance abuse concerns are served through the Connecticut Behavioral Health Partnership. For children with special physical health needs, the program provides coverage for additional services.

HUSKY C, formerly known as Title 19, or Medicaid for the for the Aged/Disabled, provides coverage to income-eligible CT residents ages 65 or older, and ages 18 to 64 who are blind or have another qualifying disability. HUSKY D, formerly known as Medicaid for Low Income Adults, provides coverage for persons ages 19-64 who do not qualify for HUSKY A and do not receive Supplemental Security Income or Medicare. (Sources: United Way of CT 2-1-1 HUSKY Health Plans, http://infoline.org, and www.huskyhealth.com, accessed 1/31/12).

In 2009, 10% of Connecticut's population was uninsured, which is considerably below the U.S. average at 16.7%. Data for individual municipalities in the HVR region are not available, however according to the U.S. Census Bureau, Fairfield County's uninsured population was 10.8% in 2007 for persons under the age of 65 (Source: U.S. Census Bureau, Small Area Health Insurance Estimates, http://www.census.gov/did/www/sahie/index.html accessed 7/7/2011). Interestingly, from 2008-2009 there was a reported decrease in the percent of persons covered by public insurance in the state in contrast to an increase in the country.

Table 7: Health Insurance Coverage by Type, Percent of Total Population, 2007 - 2009

	Connecticut			United States		
Type	2007	2008	2009	2007	2008	2009
Covered by Private or Government	90.6%	90.0%	88.0%	84.7%	84.6%	83.3%
Private	76.3%	74.9%	75.3%	67.5%	66.7%	63.9%
Employment-based	68.0%	65.7%	66.3%	59.3%	58.5%	55.8%
Direct Purchase	9.4%	9.4%	9.6%	8.9%	8.9%	8.9%
Government	25.8%	27.0%	24.7%	27.8%	29.0%	30.6%
Medicaid	11.2%	11.8%	9.6%	13.2%	14.1%	15.7%
Medicare	14.3%	14.9%	14.7%	13.8%	14.3%	14.3%
Military Health Care	1.9%	2.1%	2.2%	3.7%	3.8%	4.1%

Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/data/historical/index.html, accessed 3/24/2011

Note: Population as of March of the following year.

Health Status: Indicators and Findings, cont'd.

Factors Influencing Insurance Status, cont'd.

Overall enrollment of CT children in the HUSKY A and B Plans has increased from 2010 to 2011, holding relatively constant during 2011. The data in Table 8 shows the number of children enrolled in the region and in the state for January 2009, January 2010 and for January and December 2011. Seven of the ten HVR municipalities experienced an increase in HUSKY A child enrollment in 2011; five experienced an increase in HUSKY B enrollment.

Table 8: Number of Children Enrolled in HUSKY A and B Comparison, 2009 - 2011

	January 1, 2009		January 1, 2010		January 1, 2011		December 1, 2011	
	Husky A	Husky B	Husky A	Husky B	Husky A	Husky B	Husky A	Husky B
Bethel	584	120	695	127	777	130	792	123
Bridgewater	27	<5	32	6	35	*	30	*
Brookfield	277	52	295	93	395	61	400	70
Danbury	5,620	542	6,348	561	7,174	499	7,426	518
New Fairfield	266	73	354	63	397	63	408	67
New Milford	915	167	1,121	188	1,237	181	1,220	182
Newtown	383	81	494	154	619	93	604	99
Redding	80	18	99	42	130	27	139	22
Ridgefield	37	31	203	36	224	39	242	32
Sherman	76	17	97	19	112	24	115	18
Connecticut	331,519	13,654	239,531	15,657	256,808	14,874	256,052	14,874

Source: State of Connecticut Department of Social Services, Healthcare for UninSured Kids and Youth (HUSKY), http://www.ct.gov/hh/ and http://www.huskyhealth.com/hh/lib/hh/pdf/Reports/HUSKYBEnrollment0110.pdf, accessed 3/24/2011 and 1/31/12
* indicates < 5

Findings: Although publicly-funded insurance programs are in place in the region and state to serve low income children and adults, they are not available for persons who do not meet income or citizenship eligibility requirements. Income thresholds for HUSKY are also more stringent for non-pregnant adults without children, and access to providers is limited in some areas. In addition, the enrollment process may be challenging for those with language and/or literacy barriers. Ongoing enrollment assistance at such sites as community and faith-based organizations, social and human services offices, community health centers, hospitals, and WIC offices would help encourage enrollment by eligible adults and children.

Emergency Department Visits

When individuals have health insurance they are more likely to access either a private health provider's office or a primary care clinic when they or their children are ill. Without insurance, the alternatives are community-based health centers with a sliding fee schedule for self-pay patients based on income, and hospital emergency departments. Tracking the frequency of emergency department visits for non-emergent conditions is one way to evaluate if hospitals are inappropriately being used for primary care. Frequent use of the emergency department services for primary care indicates that a community may have an insufficient quantity of primary care providers or health providers serving the uninsured population

Health Status: Indicators and Findings, cont'd.

Emergency Department Visits, cont'd.

such as Federally Qualified Community Health Centers.

Table 9 provides the number of emergency department visits for community residents at Western CT Health System's Danbury and New Milford Hospitals and emergency department visits at all Connecticut hospitals for Connecticut residents only. The number of emergency department visits as a percent of the total population (2010 Census data) for each municipality was calculated for comparative purposes. It should be noted these percentages are a rough approximation, as the visit counts are not unduplicated, i.e., one individual may have multiple visits, and the percentages do not capture hospital visits occurring outside of the state. The proportion of emergency visits by resident population varies greatly across the region, and is highest in Danbury (41.7%) and lowest in Ridgefield at 14.2%. In 2007, all HVR municipalities were below the state percentage (41.5%). Some factors that may explain the variance include: resident geographic proximity to the hospital (percentages are highest in Danbury and New Milford where the hospitals are physically located), the proportion of residents who are uninsured, and the proportion of residents seeking care outside CT.

Table 9: Emergency Visits by Municipality[1] compared to statewide data (2007) [3], FY 2010

	Inpatient (Admitted from Emergency Department)	Outpatient (Discharged from Emergency Department)	Total	Population Census 2010[2]	Emergency Department visits as % of population
Bethel	1,046	4,705	5,751	18,584	30.9%
Bridgewater	78	425	503	1,727	29.1%
Brookfield	725	3,345	4,070	16,452	24.7%
Danbury	4,652	29,069	33,721	80,893	41.7%
New Fairfield	545	2,768	3,313	13,881	23.9%
New Milford	1,149	9,936	11,085	28,142	39.4%
Newtown	1,108	3,654	4,762	27,560	17.3%
Redding	316	1,067	1,383	9,158	15.1%
Ridgefield	857	2,643	3,500	24,638	14.2%
Sherman	102	870	972	3,581	27.1%
HVR Total	10,578	58,482	69,060	224,616	30.7%
Connecticut[3]	1,223,641	230,244	1,453,885	3,502,309	41.5%

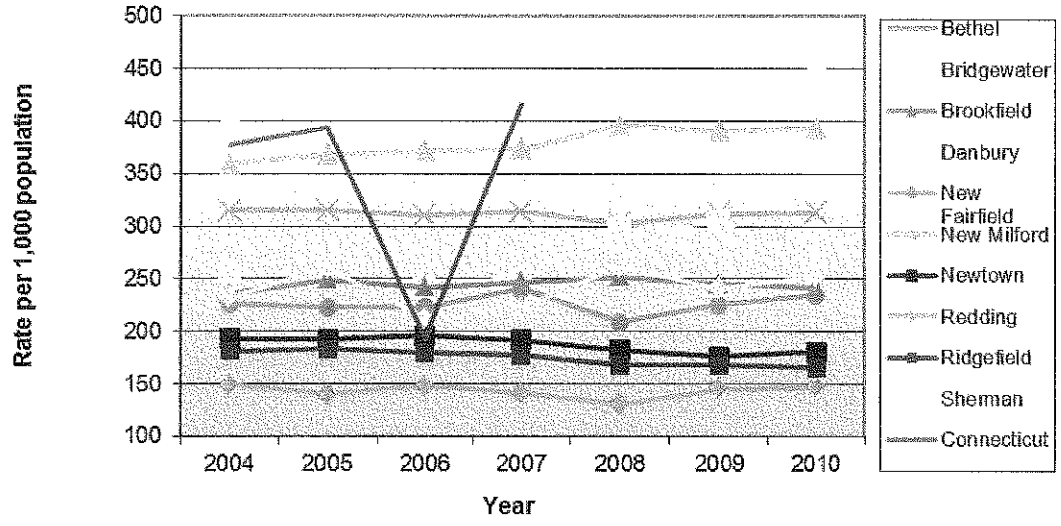
Sources:
[1] Danbury and New Milford Hospital, data received July 31, 2008 and August 26, 2008
[2] Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html, accessed 5/28/2011.
[3] CHIME (Connecticut Health Information and Management Exchange) data received from Danbury Hospital 1/8/2009

Health Status: Indicators and Findings, cont'd.

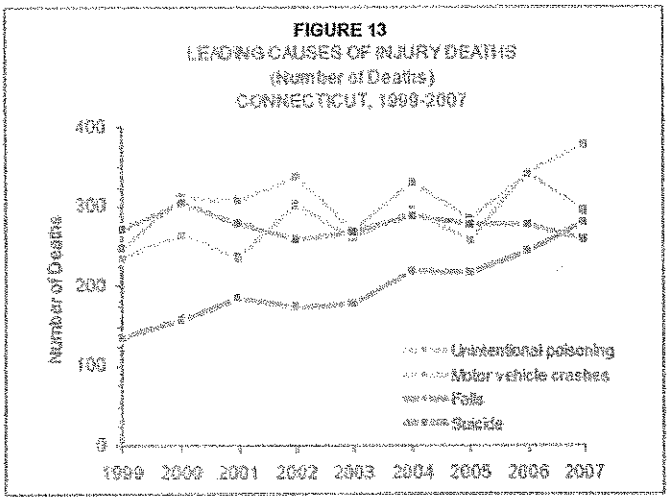
Emergency Department Visits, cont'd.

The trend data in Figure 12 show the rate of emergency room visits per 1,000 population (based on 2010 Census data) from 2004 to 2010. Local trends have remained fairly constant. Danbury has the highest rate, followed by New Milford.

Figure 12: Emergency Visits per 1,000 population*, FY 2004-2010



Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population - Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011. Data for CT available only through 2007.



Source: Connecticut Death Registry (Registration Reports) as cited in *Healthy Connecticut 2010*

Emergency department visits for intentional and unintentional injuries are additional important indicators of community health. The most prevalent unintentional injuries vary by age group and include: accidental poisonings in infants and children, motor vehicle accidents in adolescents and young adults (many of which are alcohol-related), and falls in the elderly. Intentional injuries include those that are self-inflicted such as suicide attempts. As shown in Figure 13, the leading causes of injury-related deaths in the state include unintentional poisoning, motor vehicle accidents, falls, and suicide.

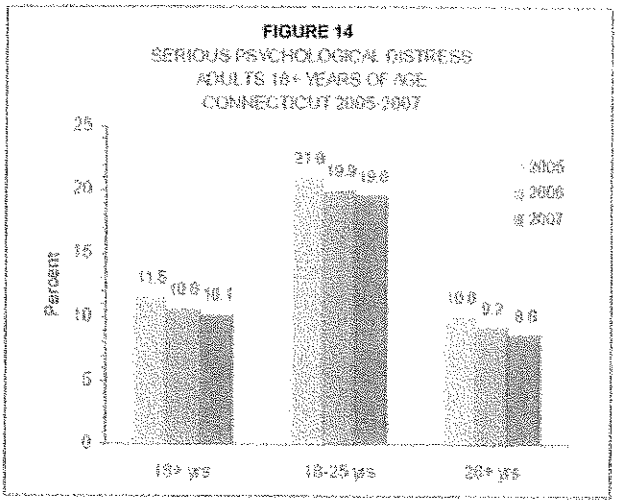
Health Status: Indicators and Findings, cont'd.

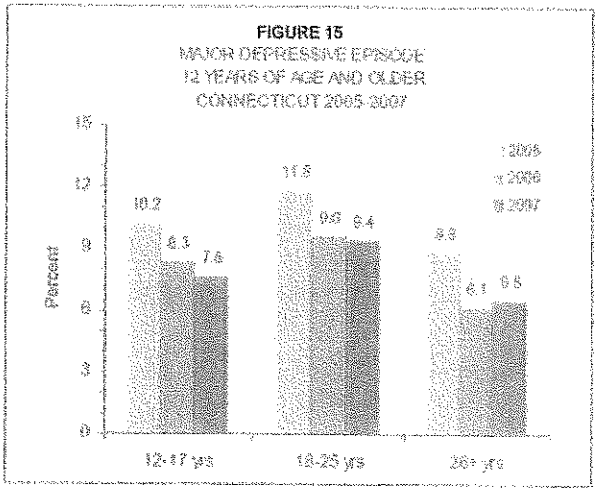
Mental or Behavioral Health

The World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." Furthermore, as noted in *Healthy Connecticut 2010*, WHO reports that mental health disorders, including substance use/abuse, anxiety disorders, impulse-control disorders, and mood disorders account for more disability than other chronic diseases, such as heart disease and cancer.

Access to appropriate counseling and treatment for mental health concerns and disorders is critical to a community's overall well-being. High rates of crime, homelessness, suicide, and substance abuse are all distress signals. Behavioral health is often overlooked as a priority community health issue and there is a lack of current and comprehensive community level assessment data in this area. Figures 14 and 15 provide insight on the prevalence of two mental health disorders - serious psychological distress in CT adults and major depressive episodes in CT residents ages 12 and older - from 2005-2007, respectively.

Serious psychological distress is defined by mental health experts as having a score of 13 or higher on The Kessler 6 (K6) screening scale. Major depressive episode is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of symptoms for depression as described in the DSM-IV. Overall, there has been a downward trend in the prevalence of these disorders in CT adolescents and adults for the three year period shown. More recent data was not available for inclusion in this report.





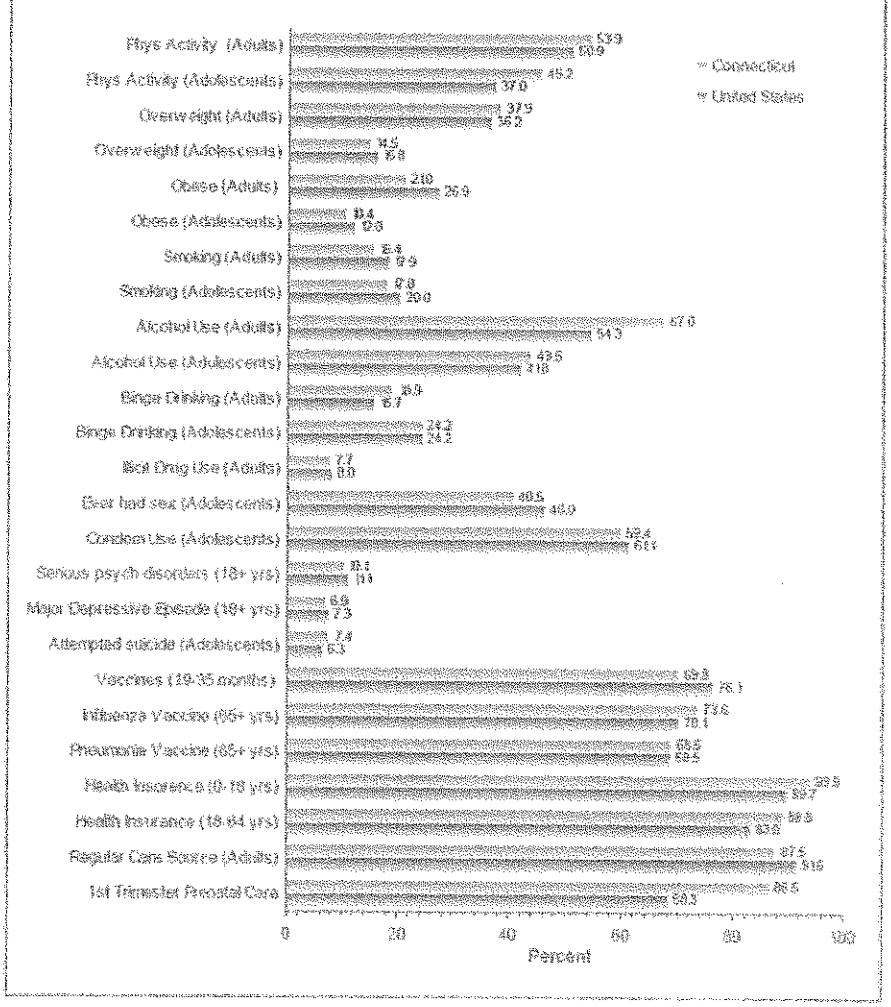
Source: SAMHSA National Survey on Drug Use and Health as cited in *Healthy Connecticut 2010*

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings

Leading Health Indicator Behavioral Risk Overview

A comparison of outcomes in U.S. and CT residents for selected behavioral health objectives related to the *Healthy People 2010* leading health indicators – physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care – are presented in Figure 16. Behavioral risk factor data is only available at the state level, due to the sampling framework used for the Behavioral Risk Factor Surveillance Survey, or BRFSS.

FIGURE 16
COMPARISON OF OUTCOMES FOR SELECTED BEHAVIORAL HEALTH OBJECTIVES FOR LEADING HEALTH INDICATORS
CONNECTICUT AND UNITED STATES (See "Note" for years)



Sources: Behavioral Risk Factor Surveillance System, Connecticut School Health Survey, Youth Risk Behavior Survey, National Immunization Survey, National Survey on Drug Use and Health

Notes: Data years: Physical Activity, Overweight, Obese, Smoking, Alcohol Use, Binge Drinking (Adults 2009; Adolescents 2009), Illicit Drug Use, Serious Psychological Disorders, Major Depressive Episode (2006-2007), Sex, Condom Use (during last sexual intercourse), Attempted Suicide (2009), Vaccines (2009), Health Insurance (Children 2007-2008, Adults 18-64 yrs 2009)

Source: Healthy Connecticut 2010

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Leading Health Indicator Behavioral Risk Overview, cont'd.

As shown in Figure 16, compared to the U.S. as a whole, Connecticut had a lower prevalence of most risk factors. CT residents under the age of 65 were more likely to have health insurance coverage and have a regular source of health care; pregnant women were more likely to receive early prenatal care; adults and teens were more likely to be physically active, not be obese, and not smoke. Negative findings include the higher prevalence of alcohol use in CT adults and teens and binge drinking in CT adults than in the U.S. as a whole.

Childhood and Adolescent Obesity

According to the Centers for Disease Control and Prevention, the prevalence of childhood obesity has more than tripled in the past 30 years. The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 20% in 2008. Over this same time period, the percentage of adolescents aged 12–19 years who were obese increased from 5% to 18%. In 2008, more than one-third of children and adolescents were overweight or obese. (Source: Centers for Disease Control and Prevention, Adolescent and School Health, http://www.cdc.gov/healthyyouth/obesity/facts.htm, accessed 2/20/12).

Although not representative of the general pediatric population, the 2010 Pediatric Nutrition Surveillance System (PedNSS) assesses weight status of children from low-income families participating in the Special Supplemental Food Program for Women, Infants and Children (WIC). PedNSS reports that 30.5% of low-income children ages 2 to 5 years are overweight or obese nationwide.
(Source: Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System, http://www.cdc.gov/pednss/ accessed 8/9/2011).

The long-term health implications of childhood and adolescent obesity are serious. Youth who are obese are more likely to experience social and psychological problems due to poor self-esteem. They are more likely to be overweight adults, and consequently at a greater risk for developing heart disease, hypertension, type 2 diabetes, stroke, osteoarthritis, and certain types of cancer. (Source: Centers for Disease Control and Prevention, Adolescent and School Health, http://www.cdc.gov/healthyyouth/obesity/facts.htm, accessed 2/20/12).

According to the National Survey of Children's Health:

- Approximately 95,000 Connecticut children ages 10-17 years (25.7%) are considered overweight or obese according to Body Mass Index (BMI) for age standards.
- Hispanic/Latino (40.4%) and Black/African American (38.1%) children in Connecticut are almost two times more likely than white children (21.8%) to be overweight or obese.
- CT children are more likely than their counterparts nationwide to be physically active for at least four days per week (36.2% versus 34.4%), and less likely to spend one hour or more a day in front of a television or computer screen (42.7% versus 50.1%).

More information on obesity and other health issues for CT children are available at: www.nschdata.org.

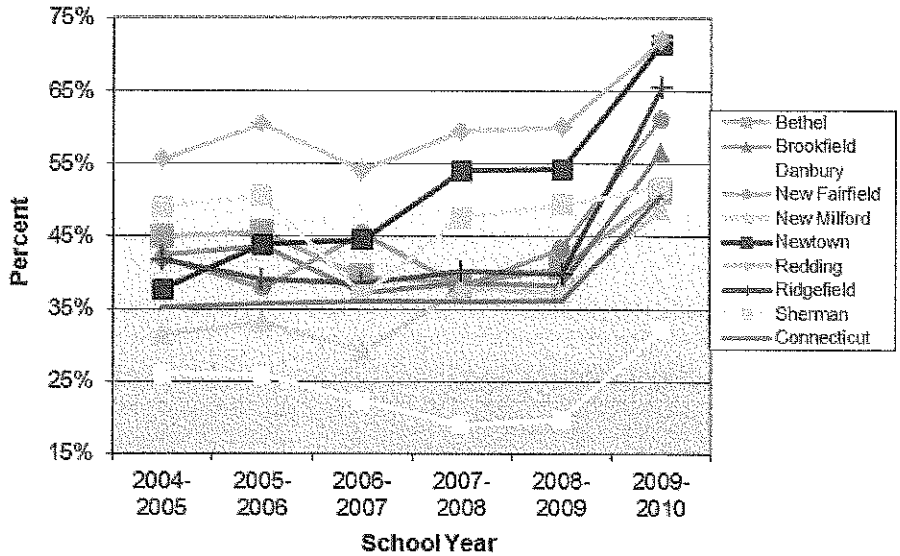
Lack of physical activity is a major contributing factor to overweight and obesity. Figure 17 provides information about the percentage of school age children in our community who have passed the state physical fitness test. Students are tested according to the standards presented in Figure 18. In the past, students were tested in

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

all four areas of fitness: aerobic endurance, flexibility, muscular strength and endurance, and body composition. In the 2009-2010 school year, the requirement for testing body composition was removed. This has likely resulted in a falsely elevated number of students meeting the requirements.

Figure 17: Percent of CT Public School Students Meeting State Standards on All Four Fitness Assessments, 2004-2010



Source: Connecticut State Department of Education, Physical Fitness Assessment, http://sdeportal.ct.gov/Cedar/WEB/ct_report/PhysicalFitnessDT.aspx Accessed 4/5/2011
*Previous title was Percent of Students Passing the Fitness Test
Note: 2nd Generation Test 2002-2009 3rd Generation Test 2009-2010
Bridgewater students attend the Region 12 school district.

Figure 18: Physical Fitness Assessment Guidelines

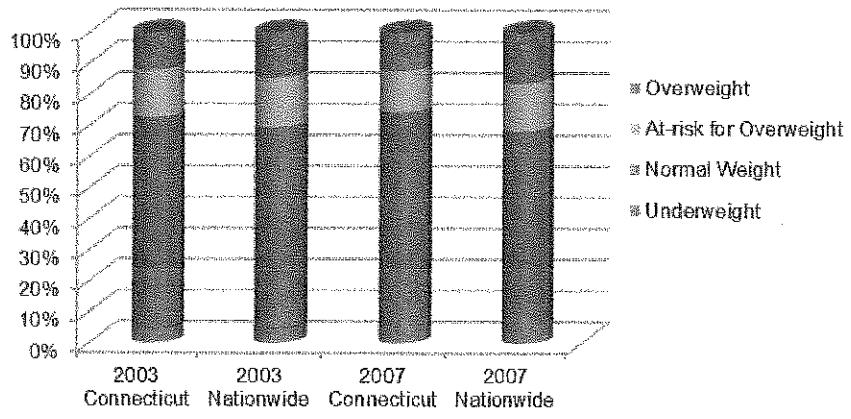
Health-related Component	2nd Generation (1999)	3rd Generation (2009)	Change
• Flexibility	• Back-saver sit-and-reach	• Back-saver sit-and-reach (improved version) • Shoulder stretch (optional)	• Adjusted for lower back • Addition of shoulder flexibility check
• Upper body muscle • Strength and endurance	• Right-angle push- up	• 90° push-up	• None • Name changed for consistency with research and literature
• Abdominal muscle strength and endurance	• Curl-up	• Curl-up • (improved version)	• Adjusted for limb length and neck comfort
• Aerobic endurance	• Mile run	• Mile run or P.A.C.E.R.	• District option, focus on VO_2max
• Body composition	• BMI		• BMI not included

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

Figure 19 provides information on the weight status of children in CT and the U.S. for 2003 and 2007. Children are classified as underweight, normal weight, at-risk for overweight or overweight based on the Body Mass Index (BMI) for their age. BMI is a proxy measure for body composition that is calculated based on the child's height and weight. Overall, more children in CT were reported to be of a healthy weight than the national average.

Figure 19: Weight Status of Children/Youth Ages 10-17 based on Body Mass Index for Age, 2003 and 2007



Source: Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. http://www.nschdata.org/Content/07ObesityReportCards.aspx Accessed 1/19/2010.

According to the 2007 National Survey of Children's Health, Connecticut ranks fifth in the nation for overweight or obese children (first is best). This is an improvement from the 2003 rank of 17th. This report indicates only 58.3% of Connecticut children ages 6-17 engage in 4 or more days of vigorous activity per week. This percentage is slightly lower than the national average of 64.3%. However, Connecticut children engage in less screen time (includes TV, video games, etc.) per week when compared to the national average. Overall, 10.7% of children ages 1 to 5 and 8.5% of children ages 6 to 17 engage in 4 or more hours per weekday compared to the national averages of 12.8% and 10.8%, respectively. It is interesting to note that children with public health insurance were considerably more likely to be overweight or obese than children with private health insurance at both the state and national level (Connecticut: 35.1% versus 21.9%; U.S.: 43.2% versus 27.3%). (Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/, accessed 1/19/2010).

As reported in *Healthy Connecticut 2010*, adolescent obesity prevalence data for 2005-2009 from the Youth Risk Behavior Survey also show a favorable decline in obesity for teens in grades 9-12. Analysis of 2009 data shows a higher prevalence of obesity in males and in Hispanic/ Latino teens.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

Findings: As shown in Figure 19, the prevalence of overweight and obesity increased across the U.S. from 2003-2007. It is notable that, during this same period of time, the prevalence of overweight *decreased* in CT. Specifically, the proportion of overweight and obese children 10-17 years of age in CT decreased from 27.3% in 2003 to 25.7% in 2007. Unfortunately, there is no representative data on weight status of children or adolescents at the municipal level. As noted previously, BMI is no longer included in the standard physical fitness assessment measures for public school children in CT, and there is no BMI surveillance system in place in CT. Three potential BMI surveillance methods include school-based, registry-based, and hybrid (de-identified extraction of height and weight measurements from school health record forms). (Source: Altarum Institute, Registry-Based BMI Surveillance: A Guide to System Preparation, Design, and Implementation, http://www.altarum.org, accessed 2/14/12) BMI surveillance methodologies should be further evaluated to advance the quality and representativeness of overweight and obesity prevalence data available in CT.

Preventive Dental Care

The Pew Charitable Trusts issued a report in 2011 which assessed each state's ability to serve insured children. In this report, states were graded on eight benchmarks assessing dental health policies. The report states that tooth decay is the most common disease of childhood; it is five times more common than asthma. In spite of this, most children do not have dental insurance. There are three times as many children without dental insurance compared to those without medical insurance. (Source: Pew Charitable Trusts, The State of Children's Dental Health http://www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=85899359680 accessed 8/25/2011).

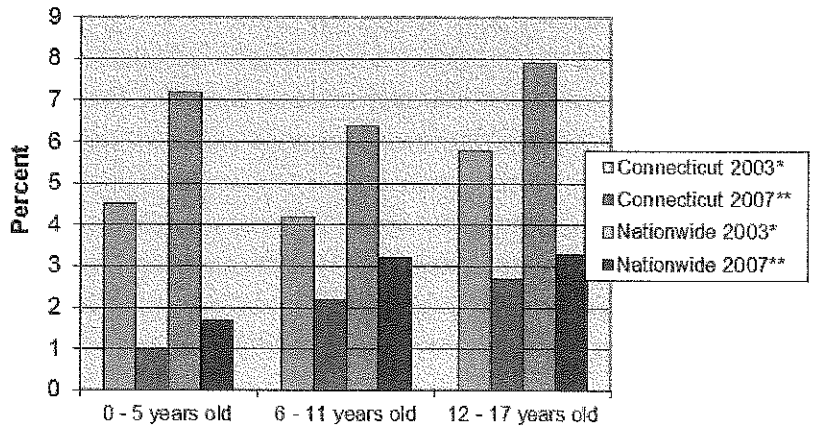
Connecticut is one of seven states that received an "A" in 2011 by meeting six of the eight policy benchmarks for strengthening children's dental health. This is the result of a concerted, joint effort of a number of entities to improve the status of dental care in Connecticut and increase access to oral health care services. The full report can be accessed on the Pew website listed above; the Connecticut Fact Sheet can be accessed at: http://www.pewcenteronthestates.org/uploadedFiles/www.pewcenteronthestatesorg/Initiatives/Childrens_Dental_Health/048_11_DENT_50_State_Factsheets_Connecticut_052311_web.pdf.

Figure 20 shows state and national levels of children by age group who did not receive needed preventive dental care during the past 12 months in 2003 and 2007. Data are not available at the community level. Overall, children in Connecticut are more likely to receive dental care than the general U.S. population.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Preventive Dental Care, cont'd.

Figure 20: Percent of Children/Youth Ages 1-17 Needing Dental Care in the past 12 months and Did Not Receive it, Connecticut vs. Nationwide, 2003 and 2007



Sources: *Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Accessed [06/27/2008] from www.nschdata.org
**Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org accessed 4/6/2011

Findings: There has been a marked improvement in Connecticut and the nation in the proportion of children who received required dental care in 2003 and 2007. Connecticut has experienced a 50% or more reduction in those who needed care but did not receive it across all age groups. These findings provide support for the effectiveness of statewide initiatives to improve children's access to and utilization of dental health services.

Teen Births

The teen birth rate is an important health indicator as teen mothers are more likely to have poor birth outcomes such as low birth weight and prematurity. Infants of teen mothers are also at risk of be raised in an economically unstable environment, since teen mothers have a greater likelihood of being a single parent and not completing high school. Their children tend to exhibit poorer health, are more likely to be abused, and more likely to become single parents themselves. Often the infant is born into poverty and from that stems a cycle of dependence for both mother and child in addition to many other socioeconomic challenges. (Source: March of Dimes Medical Resources - Teenage Pregnancy. http://www.marchofdimes.com/professionals/medicalresources_teenpregnancy.html accessed 2/20/12.)

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Teen Births, cont'd.

Table 10: Teen Births Ages 15 -17, 2004, 2006, and 2008

	2004		2006		2008	
	Number	Rate	Number	Rate	Number	Rate
Bethel	3	*	1	*	0	0
Bridgewater	0	0	0	0	0	0
Brookfield	1	*	1	*	1	*
Danbury	18	14.4	13	10.2	12	9.5
New Fairfield	2	*	2	*	0	0
New Milford	3	*	2	*	2	*
Newtown	0	0	1	*	0	0
Redding	0	0	0	0	0	0
Ridgefield	0	0	1	*	0	0
Sherman	0	0	0	0	0	0
Connecticut	917	13.8	912	13.7	846	12.8
United States	133,980	22.0	133,943	22.0	135,664	22.0

Sources: Connecticut Association for Human Services Connecticut Kids Count
http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
National KIDCOUNTS Data Center
http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011

Rate is number of births to females ages 15-17 per 1,000 females for that age group in a town
* Rates for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers.

Births to teen mothers and teen pregnancy also create serious financial consequences. Statistics compiled from the National Campaign to Prevent Teen Pregnancy show that teen pregnancy cost Connecticut taxpayers about $137 million in 2008 up from $98 million in 2004. This number covers public health costs, public welfare, loss of income, and incarceration. On a positive note, the teen birth rate in Connecticut has declined 43% between 1991 and 2008, a savings to Connecticut taxpayers of approximately of $162 million in 2008. (Source: The National Campaign to Prevent Teen Pregnancy, http://www.thenationalcampaign.org/, accessed 8/19/2011).

Findings: The teen birth rates in our region are well below the state and national rate, with a positive downward trend.

Prenatal Care

Adequate and timely prenatal care can significantly impact the quality of a woman's pregnancy and birth outcomes. The detrimental effects of late or no prenatal care to both maternal and infant health are well documented. Table 11 indicates that the rates of late or no prenatal care in most HVR municipalities are lower than the state average but higher than the national average. As reported in *Healthy Connecticut 2010*, statewide, non-Hispanic white females are most likely to begin prenatal care early; Black non-Hispanic and Hispanic females were the least likely.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Prenatal Care, cont'd.

Findings: The rates for delayed or lack of prenatal care in Danbury for 2008 are higher than in other HVR communities however, Danbury rates have shown a favorable decline from those in 2004 and 2006. Danbury is considerably more ethnically diverse than the other communities, with the highest proportion of undocumented immigrants who may not receive timely prenatal care due to cultural, health insurance, and deportation issues.

Table 11: Late Or No Prenatal Care, 2004, 2006, and 2008

	2004		2006		2008	
	Number	Percent	Number	Percent	Number	Percent
Bethel	12	6.2%	25	11.9%	18	9.5%
Bridgewater	2	*	0	0.0%	0	0.0%
Brookfield	17	9.6%	19	11.6%	8	5.8%
Danbury	193	19.0%	233	19.6%	182	14.8%
New Fairfield	10	6.1%	5	3.9%	6	5.0%
New Milford	24	6.6%	22	6.8%	24	7.8%
Newtown	14	5.1%	17	7.1%	20	10.0%
Redding	3	*	2	*	7	11.1%
Ridgefield	20	7.8%	18	7.7%	12	6.6%
Sherman	1	*	4	*	1	*
Connecticut	5,302	12.8%	5,858	14.0%	4,947	12.4%
United States	114,916	3.6%	97,420	4.0%	51,889	4.0%

Sources: Connecticut Association for Human Services Connecticut Kids Count
http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
National KIDCOUNTS Data Center
http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011
Percent of All Live Births
* Percentages for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers

Low Birth Weight

Low birth weight is a term used for infants who are born weighing less than 2,500 grams or 5½ pounds. Low birth weight is a major risk factor for infant mortality and long term disability. Prevention of low birth weight is a major focus of public health and prenatal care programs. As defined in the Institute of Medicine's report, *Preventing Low Birthweight*, risk factors for LBW include: low socioeconomic status, low education level, non-white race (particularly Black/African American), childbearing at extremes of age, inadequate weight gain, smoking, substance abuse, absent or inadequate prenatal care, and preterm delivery or multiple pregnancies. Low birth weight infants are at increased risk for complications and related health care costs are escalated due to the need for highly specialized care, including neonatal intensive care units. The rates of low birth weight for HVR municipalities are presented in Table 12.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Low Birth Weight, cont'd.

Table 12: Low Birth Weight, 2004, 2006, and 2008

	2004		2006		2008	
	Number	Percent	Number	Percent	Number	Percent
Bethel	9	4.6%	14	6.7%	13	6.8%
Bridgewater	2	*	0	0%	0	0%
Brookfield	7	3.9%	12	7.3%	13	9.4%
Danbury	69	6.8%	78	6.6%	77	6.3%
New Fairfield	8	4.9%	5	3.9%	7	5.7%
New Milford	21	5.8%	20	6.2%	22	7.1%
Newtown	10	3.6%	11	4.6%	9	4.5%
Redding	5	5.9%	0	0%	3	*
Ridgefield	13	5.1%	18	7.7%	7	3.8%
Sherman	1	*	6	18.2%	0	0%
Connecticut	3,078	8.0%	3,389	8.1%	3,004	8.1%
United States	331,772	8.1%	351,974	8.3%	347,209	8.2%

Source: Connecticut Association for Human Services Connecticut Kid Count http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011

Percent of All Live Births

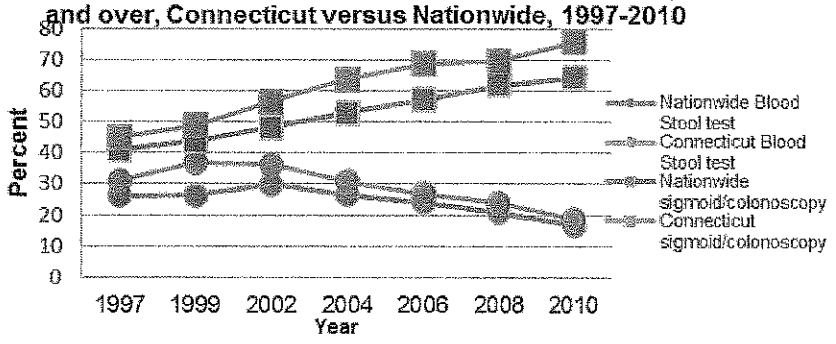
* Percentages for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers

Findings: The data for 2004-2008 in Table 9 shows the rates for low birth weight in all HVR municipalities except Danbury remained lower than the state and national rates.

Colorectal Cancer Screening

Colorectal cancer occurs most frequently in men and women over the age of 50. It is the third leading cause of cancer death among both genders. Early detection is the best defense in overcoming this disease. The American Cancer Society (http://www.cancer.org) and National Cancer Institute (http://cancer.gov) recommend first screening at age 50 if there are no risk factors other than age; an individual with family history of colorectal cancer, polyps or other risk factors should begin screening at an earlier age.

Figure 21: Colorectal Cancer Screening Among Adult Ages 50 and over, Connecticut versus Nationwide, 1997-2010



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/brfss/index.htm, accessed 6/9/2011

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Colorectal Cancer Screening, cont'd.

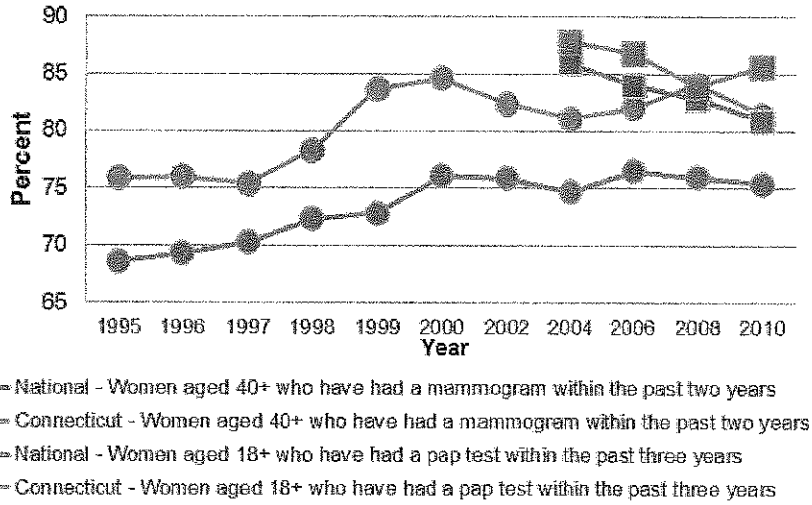
Findings: Early detection and treatment are key to reducing deaths from colorectal cancer. The data in Figure 21 indicates that Connecticut has been consistently above the national average in the rate of colorectal screening for adults age 50 and older across all testing methods. There has been a positive upward trend in the sigmoid/colonoscopy screening rate, and the *Healthy People 2020* goal of 70.5% was achieved in 2010. The steady decline in reported blood stool test screening is likely due to many physicians now using colonoscopy/sigmoidoscopy as the primary screening method for colorectal cancer.

Mammography Screening and Papanicolaou Smear

Early detection of breast and cervical cancer improves the likelihood that these cancers are diagnosed at an early stage and treated successfully. The American Cancer Society and National Cancer Institute recommend routine mammography screening for early detection of breast cancer among women ages 40 and over. One of the risk factors for cervical cancer is the Human Papilloma Virus (HPV), which can be detected with a Papanicolaou Smear (Pap test). Recent data show a highly favorable decrease in both incidence (declined from 146.7 cases per 100,000 residents in 1998 to 136.5 cases per 100,000 residents in 2008) and mortality (declined from 29 deaths per 100,000 residents in 1997 to 21.7 deaths per 100,000 residents in 2007) for breast cancer in Connecticut. Similar trends are seen for cervical cancer and both are in line with national trends. (Source: National Cancer Institute, State Cancer Profiles Historical Trend Data, http://statecancerprofiles.cancer.gov/ accessed 8/5/2011).

Findings: Figure 22 shows that Connecticut exceeds the national average for participation in each of these cancer screening procedures. It is noteworthy that there has been a consistent downward trend in the percent of women reporting they had a Pap test in the past three years. This may be related to changes in the routine screening periodicity recommendations to every two to three years.

Figure 22: Mammography Screening and Papanicolou Smear Prevalence Among Women, Connecticut Versus Nationwide, 1995-2010



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

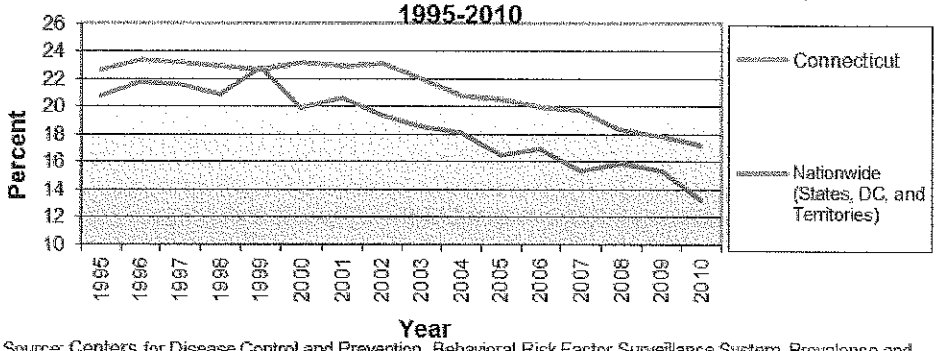
Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs

Cardiovascular disease, cancer and diseases of the lung are among the most common causes of death and can be directly attributed to unhealthy behaviors, most notably tobacco use. Alcohol and drug abuse are major factors in premature death and disability. While drug abuse often receives a great deal of media attention, the impact of alcohol and tobacco on morbidity and mortality far exceed all other drugs and accidents combined. Other chronic conditions such as diseases of the lungs, liver and kidneys, as well as intentional and unintentional injuries, are related to tobacco, alcohol and/or drug abuse.

Tobacco Use

Figure 23: Current Smokers, CT Adults (ages 18 and over), 1995-2010



Source: Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System, Prevalence and Trends Data. http://apps.nccd.cdc.gov/BRFSS/index.asp, accessed 4/6/2011

Figure 23 shows that adult tobacco use has been declining in Connecticut and nationwide; Figure 24 indicates a slight decrease in smoking among youth. In 2010, the prevalence of use among adults was much lower in Connecticut (13.2%) when compared to the national average (17.2%). Highlights from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) and the 2009 Youth Risk Behavior Survey (YRBS) for Connecticut include:

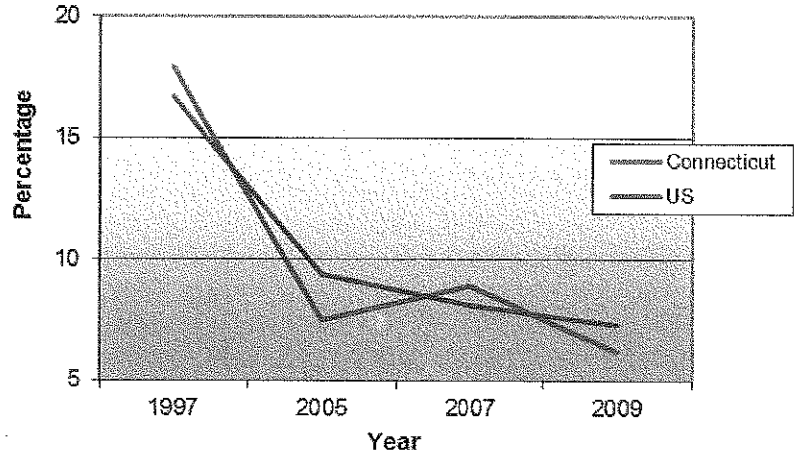
- Men are slightly more likely to smoke than women (15.4% versus 11.1%).
- Younger adults, age 18-24 (20.4%), are much more likely to smoke than older adults (25-34 years: 18.5%, 35-44 years: 13.0%, 45-54 years: 12.5%, 55-64 years: 13.2%, and 65+ years: 5.0%).
- Hispanic/Latinos (14.0%) are more likely to smoke than whites or Black/African-Americans (13.4% and 9.9% respectively). The percent of Black/African-American smokers decreased dramatically from 21.7% in 2007 to 9.9% in 2010.
- People with lower incomes are much more likely to smoke than those with higher incomes (< $15,000: 23.7%, $15,000-24,999: 24.2%, $25,000-34,999: 17.8%, $35,000-49,999: 20.5%, and >$50,000: 9.4%).
- Adults with a lower education are much more likely to smoke than those with more education (< high school: 24.2%, high school or GED: 19.3%, some post high school: 16.6%, and college graduate: 6.9%).
- Among female high school students in the 12th grade, whites are more likely to smoke.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Tobacco Use, cont'd.

Figure 24: Percentage of students in grades 9 - 12 who smoked cigarettes on 20 or more days during the 30 days before the survey, 1997-2009



Source: Centers for Disease Control and Prevention Youth Risk Behavior Surveillance System, http://apps.nccd.cdc.gov/yrbss, accessed 4/7/2011

Findings: Although tobacco use has been declining in Connecticut, use among youth is just slightly below the national average. Data indicate a need for interventions targeted toward younger, less-educated, and lower-income adult audiences and teenage girls.

Alcohol Use

A major issue with alcohol use is binge drinking. Binge drinking — drinking to get drunk — is defined as consuming five or more drinks in a row for males and four or more drinks in a row for females. Binge drinking is especially a problem for young drinkers and can result in unintentional injuries and death. The drinker may be unable to make rational decisions, may be more likely to engage in acts of violence or be a victim, and more likely to be in a motor vehicle accident.

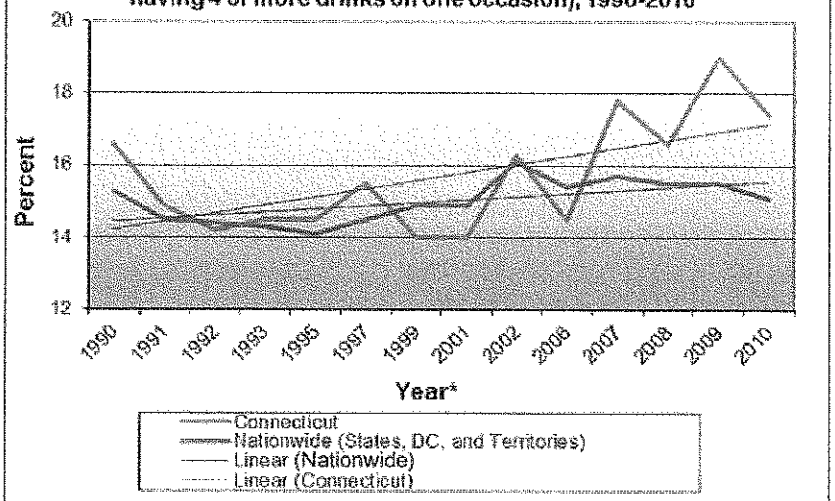
Although alcohol use is decreasing, binge drinking is increasing. The rate of binge drinking spiked in 2002 and in 2007, and reached almost 20% in 2009. The Connecticut Legislature changed the underage drinking laws in 2006 to include prosecution for underage drinking on private property in addition to public places specifically to address this problem. When compared with the nation, Connecticut has been close to the national average. In 2007, the percentage of binge drinking increased in Connecticut, surpassing the national average and it has since continued to be above the national average. People with an income of $30,000 or more and those with a high school degree or some college are likely to participate in binge drinking. Males are twice as likely as females (23.9% versus 11.5%); young adults (age 18-24) are twice as likely as 25-34 year olds and 9 times more likely than those over age 65; and Hispanic/Latinos are more likely to binge drink. Binge drinking interventions should focus on college students and younger adults in the work force.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Alcohol Use, cont'd.

Figure 25: Binge Drinkers (males having 5 or more drinks on one occasion, females having 4 or more drinks on one occasion), 1990-2010



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/brfss/index.htm, Accessed 8/9/2011
* Data were not available for all years

Alcohol-related hospitalizations, whether into the emergency department for acute intoxication or into the inpatient unit for alcohol withdrawal and alcohol-related consequences, have risen slightly or are leveling off in most communities as Figure 26 illustrates. The exception to this is the rise in alcohol-related hospitalizations in Danbury in 2008 and in Bethel in 2010. The Danbury numbers remained high for 2009 and 2010.

Missing from alcohol-related hospitalizations is data on the lengths of stay and readmission rates, which would reveal a more important story regarding both the severity of those with alcohol-related problems and the success or lack thereof regarding access and response to treatment for those problems upon discharge.

Findings: Certain community characteristics could help to explain the higher rates of alcohol-related hospitalizations in Danbury and Bethel. When compared to the other towns, Danbury and Bethel have the lowest median incomes, have school districts in lower District Reference Groups (DRGs), and, in 2006, had higher numbers of liquor permits per square mile. (Sources: Connecticut State Department of Education, http://www.sde.ct.gov/sde/LIB/sde/PDF/dgm/report1/cose2006/appndxa.pdf and University of Connecticut Health Center, Department of Mental Health and Addiction Services, http://www.commed.uchc.edu/healthservices/sew/files/SI_MAP_Compendium.pdf accessed 9/2/2011).

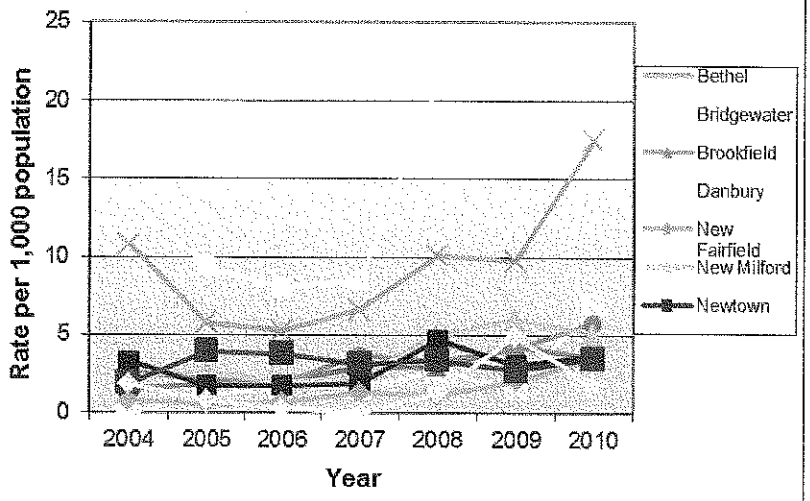
Changes in the underage drinking laws could be a catalyst for increased use of emergency department services for intoxication. In addition, Danbury Hospital closed its detoxification center in 2008 and Midwestern Connecticut Council on Alcoholism (MCCA) opened an outpatient center in Danbury and transitional centers (one in Bethel and one in Danbury). The increased use of the hospital emergency department could potentially be a result of transports from the MCCA facilities to the hospital. (Source: Sharon Guck, Director CHOICES Program, WCSU, personal communication 9/1/2011).

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Alcohol Use, cont'd.

Figure 26: Alcohol-related Hospitalizations per 1,000 population*, FY 2004-2010

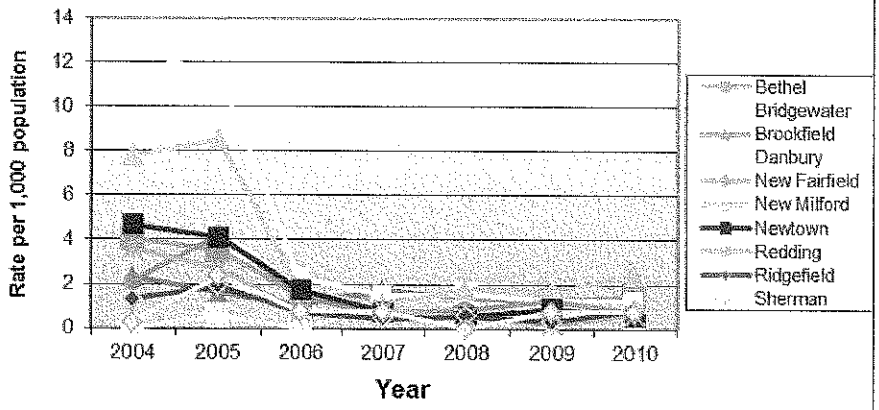


Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Drug Use

Figure 27 indicates a decline in drug-related hospitalizations for Danbury residents and a slight decline or leveling for the other HVR communities.

Figure 27: Drug-Related Hospitalizations per 1,000 Population*, FY 2004-2010



Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Findings: As Figure 27 demonstrates, overall there has been a substantial decline in drug-related hospitalizations for residents in the region from 2004-2006; with trends remaining relatively stable since 2007.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse

Although child abuse is not a lifestyle behavior or risk, it may be the outcome of other health and lifestyle factors, such as substance abuse. The term "child abuse" encompasses definitions categorized by two headings: abuse and neglect. The Connecticut Department of Children and Families (DCF) defines abuse as a non-accidental injury to a child that, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care. This abuse primarily includes physical and sexual abuse. Neglect is the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education. A child is defined as anyone younger than 18. Table 13 presents the 2010 Census tally of children aged 18 and under in each town, the state of Connecticut, and the nation.

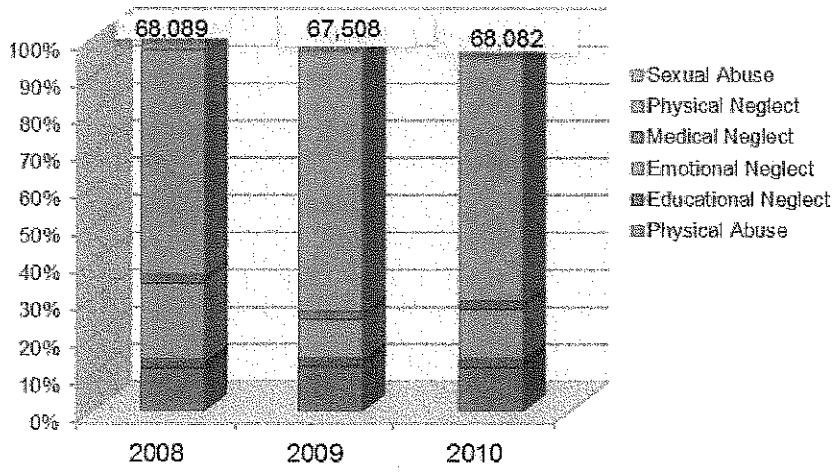
Table 13: Percent of Total Population Aged 18 and Under, 2010

Town	Percentage	Town	Percentage
Bethel	25.70%	New Milford	23.07%
Bridgewater	17.83%	Newtown	27.28%
Brookfield	25.47%	Redding	26.52%
Danbury	19.09%	Ridgefield	30.93%
New Fairfield	27.65%	Sherman	24.68%
Connecticut	22.74%	U.S.	23.69%

Source: Calculated based on data retrieved from Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Figure 28 shows statewide data on child abuse for 2008 through 2010 and presents the number of substantiated child abuse allegations per type of abuse for the state.

Figure 28: Number of Statewide Allegations to DCF, 2008-2010



Source: State of Connecticut Department of Children and Families, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2010.pdf accessed 4/3/2011

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse, cont'd.

Our community's statistics indicate that, for the most part, HVR municipalities fall below the state's average for the percent of children with substantiated allegations of child abuse. According to Childhelp®, the national average on a yearly basis of substantiated child abuse reports is 12.3 per thousand children. This mirrors the child abuse rates in our community. It is important to note that both local and national statistics reflect only child abuse cases that are reported. Experts estimate that the actual number of child abuse cases is three times higher than those reported. (Source: ChildHelp®, National Child Abuse Statistics, http://www.childhelp.org/pages/statistics accessed 8/6/2011).

Table 14 provides local data for child abuse claims for the community for 2009-2010. The table indicates the total child abuse allegations, the substantiated allegations, and the substantiation rate for the entire state. This data is not available for all towns each year.

Table 14: Child Abuse Cases Reported to Department of Children and Families, 2009 - 2010

Community	Total	Substantiated	Number of Children Substantiated	Substantiation Rate	Percent of Children[1]
2009					
Bethel	146	26	19	18.0%	0.10%
Bridgewater					0.00%
Brookfield	77	22	13	29.0%	0.08%
Danbury	1,134	262	180	23.0%	0.23%
New Fairfield	81	20	12	25.0%	0.09%
New Milford	358	80	44	22.0%	0.15%
Newtown	117	20	14	17.0%	0.05%
Redding					0.00%
Ridgefield	104	24	16	23.0%	0.07%
Sherman	9	--	--	--	--
Connecticut	67,508	19,495	9,828	29%	0.28%
2010					
Bethel	183	56	40	31.0%	0.22%
Bridgewater					0.00%
Brookfield	89	16	11	18.0%	0.07%
Danbury	1,038	291	197	28.0%	0.25%
New Fairfield	98	35	23	36.0%	0.16%
New Milford	344	77	42	22.0%	0.15%
Newtown	125	34	21	27.0%	0.08%
Redding					0.00%
Ridgefield	120	18	14	15.0%	0.06%
Sherman					0.00%
Connecticut	68,082	19,315	9,873	28%	0.28%

Source: CT Department of Children and Families town pages, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2010.pdf accessed 4/3/2011
Notes: For confidentiality reasons, data for towns with 10 or less Children Substantiated as Abuse/Neglect/Uncared For will not be reported as an individual town
Data are reported for Department of Children and Family's Fiscal Year (July 1 - June 30)
[1]Based on 2007 population estimates from Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/Projections.html, accessed 1/9/2009

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse, cont'd.

Findings: While there should be zero tolerance for any incident of child abuse, the data indicates that local substantiation rates (the number of reported incidents substantiated) are in line or better and the rate of substantiated is lower for our region than for Connecticut as a whole.

Diseases: Indicators and Findings

The incidence and prevalence of infectious and chronic diseases are major indicators of personal and community health. The 2009 Community Report Card for Western CT identified selected infectious diseases of high interest in our region including: Tuberculosis (TB), HIV/AIDS, Sexually Transmitted Diseases (STDs), and tick-borne illnesses. Chronic diseases identified as high interest include: asthma, diabetes, cancer, and cardiovascular disease. Although this is not an exhaustive list of diseases of concern to our community, it represents selected conditions of high interest to monitor improvements in health over time.

The data and narrative which follow provide an update of the impact of these diseases in the community – including such factors as hospitalization rates, incidence, prevalence, and mortality (death) rates. The results of disease-specific surveillance reports for the state and municipalities in our region are also included as relevant to these selected diseases. Examination of the diseases most impacting health is important to determining methods to minimize premature illness and death by enhancing primary, secondary, and tertiary prevention efforts targeted to priority health concerns.

Chronic Diseases

Cardiovascular Disease, Cancer, and Diabetes

These three chronic diseases are leading causes of death in the country, state, and region. Risk for developing these diseases can be greatly reduced through healthy lifestyle choices.

Table 15: Number of Deaths per 100,000 Population, 2005-2007

	2005			2006			2007		
	Diabetes[1]	Heart Disease[2]	Cancer[3]	Diabetes[1]	Heart Disease[2]	Cancer[3]	Diabetes[1]	Heart Disease[2]	Cancer[3]
Connecticut	20	173	179	19.2	177.3	177.8	15.8	171	170.7
United States	25	211	184	23.3	200.2	180.7	22.5	190.9	178.4

Source: Data were retrieved from : http://statehealthfacts.org/ accessed 4/1/2011, the following were the primary sources for these data:
[1] Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 2005, Series 20 No. 2K, 2008.
[2] Source: The Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, National Vital Statistics Report Volume 56, Number 10, April 24, 2008, Table 29. Available at http://www.cdc.gov/nchs/pro Note: Cerebrovascular disease or stroke deaths are not included in Heart Disease rates.
[3] Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 1999-2005, CDC WONDER On-line Database

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Cardiovascular Disease, Cancer, and Diabetes, cont'd.

Cardiovascular diseases (CVD) are the leading cause of death in the United States and world-wide. Cardiovascular diseases include coronary heart disease (CHD), cerebrovascular disease (stroke), and heart failure. CVD is the leading cause of death in Connecticut, accounting for about one-third of all Connecticut resident deaths. More than half (55%) of these deaths are among females. Risk factors for CVD may be modifiable or non-modifiable. Modifiable risk factors include high blood pressure, high blood cholesterol, smoking, diabetes, obesity, and physical inactivity. Non-modifiable risk factors include increasing age and family history of heart disease and stroke. The age adjusted mortality rates for CVD declined significantly for CT residents from 1999-2008. There are considerable disparities in mortality from CVD, with Black/African American residents having the highest age-adjusted mortality rates. (Source: State of Connecticut, Department of Public Health, the Burden of Cardiovascular Disease in Connecticut, 2010 Surveillance Report, http://www.ct.gov/dph/lib/dph/hisr/pdf/2010cvd_burdendoc_final.pdf accessed 8/21/2011).

The second leading cause of death in the United States and Connecticut is cancer. The death rate and the annual rate of new cancer cases have been decreasing. This is the result of increased primary prevention efforts, earlier detection (secondary prevention) and improved treatment options. (Source: State of Connecticut, Department of Public Health, Connecticut Comprehensive Cancer Control Program, Connecticut Cancer Plan 2009-2013, http://www.ct.gov/dph/lib/dph/comp_cancer/pdf_files/ctcancerplan_2009_2013_cdversion.pdf accessed 8/21/2011).

In 2008, the age-adjusted cancer incidence rate in Connecticut was estimated at 499.8 per 100,000 people, a decrease from the 2007 rate of 502.5 per 100,000 people. (Source: National Cancer Institute, State Cancer Profiles, http://statecancerprofiles.cancer.gov/ accessed 8/21/2011). As noted in the CT DPH *2009 Connecticut Health Disparities Report*, Black/African American residents have the highest cancer mortality rate, followed by white residents. Hispanic/Latino and Asian/Pacific Islander residents have the lowest cancer mortality rates.

In 2008, diabetes was the eighth leading cause of death in Connecticut. In Connecticut (2007-2009 data), an estimated 6.9% or approximately 186,000 adults aged 18 and older reported being diagnosed with diabetes. An additional 93,000 adults are estimated to have undiagnosed diabetes. The prevalence of type 2 diabetes in Connecticut and in the nation has increased significantly. This is the most common form of diabetes and was previously known as adult onset diabetes. Type 2 diabetes typically develops later in life and is strongly linked to overweight and obesity. In type 2 diabetes, either the body does not produce enough insulin or the cells ignore the insulin. In contrast, type 1 diabetes is usually diagnosed in children and young adults, and was previously known as juvenile onset diabetes. Type 1 diabetes, the body does not produce insulin.

Risk factors for diabetes are both modifiable with primary prevention (physical activity and healthy eating) and non-modifiable (genetic). In addition to practicing healthy lifestyle behaviors, persons with insulin-dependent diabetes must control their diabetes with medication. The impact of diabetes on a person's health can be minimized with regular medical care and self-monitoring of blood glucose levels. (Source: State of Connecticut, Department of Public Health, the Burden of Diabetes in Connecticut, 2010 Surveillance Report, http://ct.gov/dph/lib/dph/hisr/pdf/2010diabetesburden_final.pdf accessed 8/21/2011).

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Cardiovascular Disease, Cancer, and Diabetes, cont'd.

As stated in the *2009 Connecticut Health Disparities Report*, lower income and Hispanic/Latino and Black/African American residents have a higher prevalence of diabetes and a higher mortality rate from this disease.

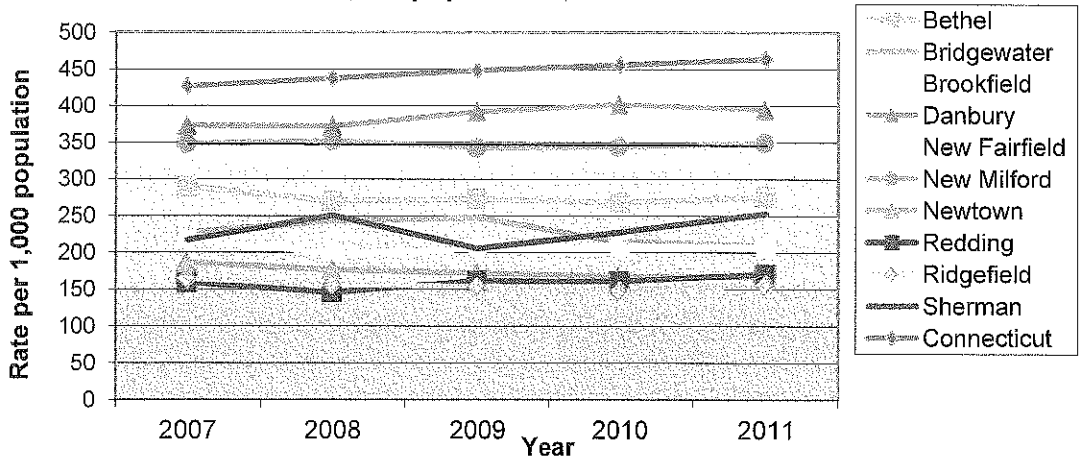
Findings: CT age-adjusted rates for Heart Disease, Cancer, and Diabetes compare favorably with those for the U.S. as a whole, however the rates for Cancer and Heart Disease remain above *Healthy People 2020* targets. Due to their prevalence, these conditions are major causes of premature disability and death, and result in significant health care costs. Disparities in disease prevalence and mortality rates by racial/ethnic group and socioeconomic status are also evident.

Asthma

Asthma is a chronic respiratory condition that inflames the airways which restricts the flow of air in and out of the lungs. Asthma is one of the most common chronic diseases in children, and a major cause of school absenteeism. Asthma is associated with exposure to allergens, indoor pollutants (such as tobacco smoke), and ambient air pollutants. Asthma is more common in persons living in poverty. These individuals are generally less likely to receive regular or specialized medical care, and are more likely to smoke and live in substandard housing, therefore experiencing greater exposure to asthma irritants. (Source: American Lung Association. http://www.lung.org/lung-disease/asthma/, accessed 2/20/12).

Figure 29 provides local data for asthma-related hospital emergency department visit rates for the years 2007 to 2011. The rates have remained relatively consistent over time. The rates in Danbury and New Milford are higher than those for other HVR municipalities, however all HVR rates fall below those for the state.

Figure 29: Asthma-Related Emergency Department Visits per 1,000 population*, 2007-2011



Source: CT Hospital Association, CHIME PCR Reports
* Rate based on 2010 population Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Asthma, cont'd.

As reported by CT DPH in the *Connecticut School-based Asthma Surveillance Report for 2010*, asthma prevalence rates among Connecticut public school students have remained fairly constant since 2006, measured most recently at 13.1% for school year 2008-2009. Asthma prevalence rates during this time were higher among students in grade PK or K than for students in either grades 6-7 or grades 9-11 and higher among male students than female students. For example, during the school year 2008-2009, the asthma rates were 14.5% among male students and 11.6% among female students.

Students from racial and ethnic subgroups experienced different rates of asthma during this same time period. Hispanic/Latino students had the highest rates of asthma followed by Black/African American students, other race/ethnicity students, and white students. Specifically, during 2008-2009, the asthma rates were 16.9% among Hispanic/Latino students, 14.8% among Black/African American students, 12.2% among students of other race/ethnicity, and 10.6% among white students. In general, asthma rates increased with decreasing socioeconomic status as measured by school District Reference Group or DRG. Asthma prevalence rates by public school district for HVR communities are provided in Table 16.

Table 16: Asthma Prevalence Rates by School District, 2006-2009 Average

Town	Percentage	Town	Percentage
Bethel	12.4%	Newtown	10.4%
Brookfield	9.7%	Redding	8.5%
Danbury	11.2%	Ridgefield	6.8%
New Fairfield	9.4%	Sherman	13.5%
New Milford	15.2%	Connecticut	13.2%

Source: CT DPH Connecticut School-based Asthma Surveillance Report 2010 http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/schoo_base_asthma_surveillance_report_2010.pdf, assessed 2/20/12 Note: Bridgewater is included in Region 12.

Findings: Asthma tends to be more prevalent in urban areas, so it is expected that Danbury and New Milford would have the highest emergency department visit rate in our region. The rates for all HVR municipalities are consistently lower than the rate for the state.

Asthma prevalence in school children is higher than the state three year average in two HVR communities – New Milford and Sherman. As Sherman is a rural and relatively affluent K-8 district, this higher rate may reflect the younger age distribution of students in the district.

Diseases: Indicators and Findings, cont'd.

Infectious Diseases

Tuberculosis

Tuberculosis (TB) is a disease caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, however TB bacteria can attack any part of the body. Tuberculosis remerged as a public health issue in the 1980's, peaking in 1992. In 2010, 60% of reported TB cases in the United States occurred in foreign-born persons. There are a number of foreign countries which are endemic for Tuberculosis, most notably in sub-Saharan Africa and Asia. The case rate among foreign-born persons (18.1 cases per 100,000) in 2010 was approximately 11 times higher than among U.S.-born persons (1.6 cases per 100,000). In 2010, both the number of TB cases reported and the case rate decreased compared to 2009. In 2010, the number of reported TB cases in 2010 was the lowest recorded since national reporting began in 1953. CT's TB case rate ranked 24th out of the 50 states in 2010. (Sources: Centers for Disease Control and Prevention. Reported Tuberculosis in the United States, 2010 http://www.cdc.gov/tb/statistics/reports/210/table20.htm and Trends in Tuberculosis, 2010 http://wwwcdc.gov/tb/publications/factsheets/statistics/TBTrends.htm, accessed 2/21/12.)

Tuberculosis is associated with poverty and substandard, crowded living conditions. The bacteria are released into the air when a person with active TB coughs or sneezes. Co-infection in persons with human immunodeficiency virus (HIV) infection is also a concern as the condition thrives in individuals with compromised immune systems.

Table 17: Annual TB Incidence by City and Year, 2005 - 2010

	2005	2006	2007	2008	2009	2010*
Bethel	0	0	0	0	1	1
Bridgewater	0	0	0	0	0	0
Brookfield	0	0	0	0	0	0
Danbury	6	6	11	4	4	7
New Fairfield	0	0	1	0	0	0
New Milford	0	0	1	0	0	0
Newtown	0	0	0	0	1	0
Redding	0	0	0	0	0	0
Ridgefield	0	0	0	0	0	0
Sherman	0	0	0	0	0	0
State	95	89	108	98	95	85

Sources: Connecticut Department of Public Health. http://www.ct.gov/dph/lib/dph/CityByYear2000_2009.pdf. accessed 4/3/2011 and CDC Reported Tuberculosis in the United States, 2010 http://www.cdc.gov/tb/statistics/reports/2010/table20.htm, accessed 12/20/12

* Local TB clinic data received from Maureen Singer, R.N., City of Danbury TB Clinic. Personal communication with Andrea Rynn 5/11/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tuberculosis, cont'd.

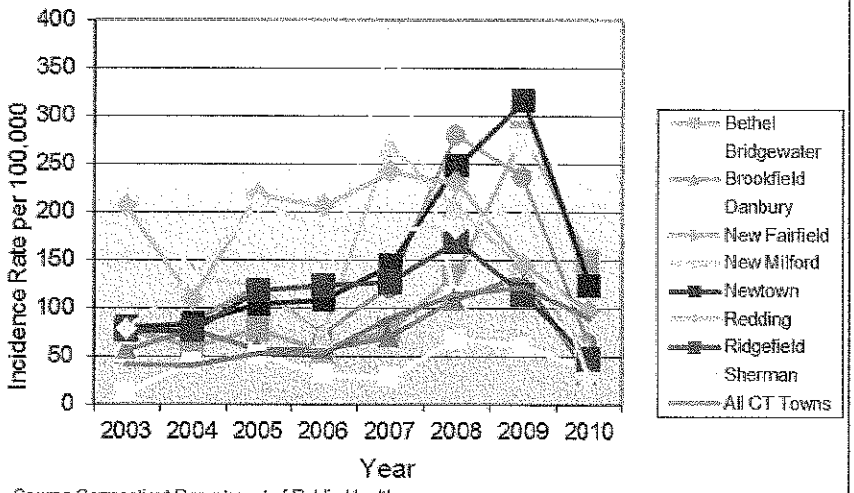
Findings: It appears that tuberculosis is not a major health issue in the HVR except in Danbury. "Danbury continues to have a higher incidence of tuberculosis than either the state as a whole or the nation at large. Most of the Danbury cases have occurred in persons born in Latin America or Asia who acquired a latent infection while resident in their home country which then reactivated some time after arrival in the U.S. Because there are large populations in Danbury from Brazil, Ecuador and Indochina at risk of reactivation TB as they age, the community is likely to continue to experience TB cases well into the future. This problem may well be augmented by travel and visitation to the home countries where the disease remains prevalent." (Source: Scott LeRoy, Director of Health, Danbury Health and Human Services Department, email communication received August 16, 2011).

Tick-Borne Illness

Our region has a higher rate of tick-borne illness than most other geographic areas in the nation. There are also extremely high rates reported in neighboring Hudson Valley New York counties. There are many varieties of tick-borne diseases but this report will focus on three: Lyme disease, Ehrlichiosis, and Babesiosis. The positive news is that effective precautions can significantly reduce the risk of contracting these illnesses.

According to CDC, Lyme disease is caused by the bacterium *Borrelia burgdorferi* and is transmitted to humans through the bite of infected blacklegged ticks. In Ehrlichiosis is also transmitted to humans by the bite of an infected tick. The lone star tick (Amblyomma americanum) is the primary vector of both *Ehrlichia chaffeensis* and *Ehrlichia ewingii* in the United States. Babesiosis is carried by blacklegged ticks infected with the *Babesia* parasite.

Figure 30: Lyme Disease Rates per 100,000 Population, 2003-2010



Source Connecticut Department of Public Health
http://www.ct.gov/dph/cwp/view.asp?a=3136&Q=399894&dphPNavCtr=|46973|#46999 Accessed 4/3/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tick-Borne Illness, cont'd.

Untreated Lyme disease can potentially result in extremely serious health consequences. Some people infected with Ehrlichiosis may have symptoms so mild that they never seek medical attention, and the body fights off the illness on its own. But untreated Ehrlichiosis with persistent symptoms can result in serious illness as well. Most patients recover from Babesiosis with few, if any, lasting effects.

The Housatonic Valley Council of Elected Officials (HVCEO) has endorsed the tick-borne disease prevention program called "BLAST" in all 10 HVCEO municipalities. The Ridgefield Health Department received a grant from the Connecticut Department of Public Health to create this unique health education program in 2008. BLAST stands for the five most important things families can do to stay safe from tick-borne illness (Bathe within two hours of outdoor activity, Look for ticks and rashes daily, Apply repellents to skin and clothing, Spray the yard perimeter for ticks, and Treat pets with veterinarian recommended products). The BLAST Program includes printed materials, age-appropriate power point presentations and health fair display materials in both English and Spanish. Trained community volunteers are available year round to staff community and corporate wellness events. Complete information about the program is available on the Town of Ridgefield website: www.ridgefieldct.org.

In addition, Western Connecticut State University is the setting for an annual Spring Lyme disease patient seminar and health fair coordinated by area task forces and Rotary Clubs. The event recognizes May as Lyme Awareness month and features practitioners and resources that may be helpful to this patient population. Lyme patients are also served by the Ridgefield Visiting Nurse Association's Lyme, Chronic Fatigue and Fibromyalgia Support Group. This free drop-in group, which is open to all area residents, meets at noon on the second Thursday of each month. Details can be found at www.ridgefieldvna.org under Community Wellness. A complete listing of local tick-borne disease related events, support services and resources can be found on the HVCEO Tick-Borne Illness Prevention Center website at www.hvceo.org/lymemain.php. (Source: Jennifer Reid, BLAST Program Coordinator, e-mail communication received 8/31/2011).

The Western Connecticut Health Network's Biomedical Research Institute currently operates the state's only Lyme Disease Registry. The purpose of the Registry is to create a comprehensive database of Lyme disease patients to support multidisciplinary research leading to a better understanding of: 1) the course of disease and how people are affected; 2) causes of persistent symptoms; and 3) improved diagnosis and treatment. The Registry is seeking persons ages 5 and older who have been diagnosed with Lyme by a health care provider. Participants are asked to answer questions about their symptoms and treatment and provide a blood sample. Participation is free, voluntary, and strictly confidential. Only one visit is required; all follow-up is conducted by mail or email. For more information or to participate, contact the Registry at 203-739-8383 or by mail: lymeregistry@danbosp.org.

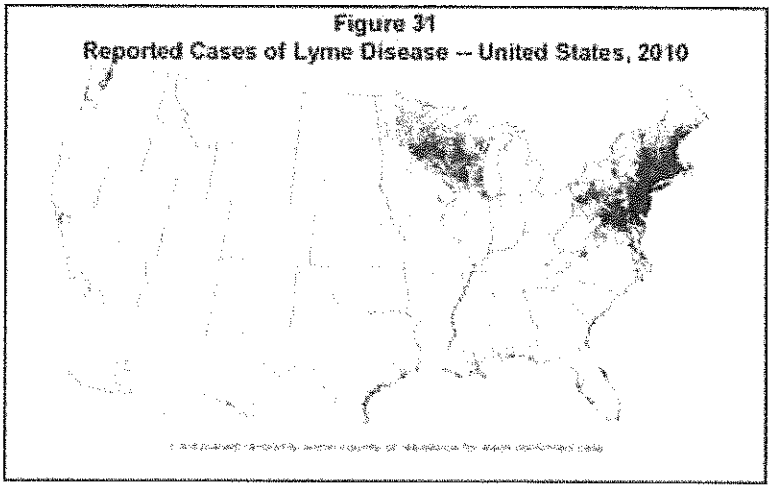
Findings: The data in Figure 30 show that Lyme disease is a prevalent health concern in the region; preventive health education initiatives are underway. Figure 31 graphically depicts the number of new Lyme disease cases reported across the country. It is evident that Lyme disease remains a priority health issue in our region.

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tick-Borne Illness, cont'd.

Figure 31
Reported Cases of Lyme Disease -- United States, 2010



Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs)

These conditions are preventable through education and safe sex practices. Injection drug use and risky sexual practices, including prostitution, are contributing factors in many HIV and STD cases. STD cases are on the rise nationally among high school students.

At a national level, the estimated number of HIV cases in 2009 as reported in 40 states with confidential name-based HIV infection reporting was 42,011 (rate of 17.4 per 100,000 population). This represents a slight increase from 2008 (42,005 cases). During the same year, the estimated number of cases of AIDS in the United States and dependent areas was 34,247 (rate of 11.2 per 100,000 population), a decrease from 2008 (34,755 cases). (Source: Centers for Disease Control and Prevention, HIV/AIDS Statistics and Surveillance, http://www.cdc.gov/hiv/topics/surveillance/index.htm accessed 8/13/2011). As shown in Table 18, Danbury has the largest number of residents living with HIV/AIDS in the region.

Table 18: HIV/AIDS Surveillance Program HIV and AIDS Cases Reported by City/Town of Residence 2009 and cumulative from 1980 through December 31, 2009*

	HIV/AIDS			
	Incidence[1] 2009	1980-2009	Living with 2009 [2]	Living with 2008 [2]
Bethel	1	29	21	20
Bridgewater	0	2	1	1
Brookfield	1	21	11	10
Danbury	9	407	215	224
New Fairfield	1	13	4	6
New Milford	0	54	24	29
Newtown	0	4	3	12
Redding	1	19	8	10
Ridgefield	0	22	13	13
Sherman	0	6	1	1
ALL CT Towns	538	19,473	10,574	10,860

*HIV and AIDS data are combined for 2009. The data were reported separately in previous years
[1]Current year data are new cases for the year.
[2]This number includes all cases from 1980 to current year still living.
Source: Connecticut Department of Public Health.
http://www.ct.gov/dph/lib/dph/aids_and_chronic/surveillance/city_and_county/ct_hivaids_town_currentyear_table_new.pdf, Accessed 4/3/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs), cont'd.

According to CDC, Chlamydia is the most commonly reported sexually transmitted disease in the United States with 1,244,180 cases in 2009 (409.2 per 100,000 people), increased 3% from 2008 and 19% from 2006. Gonorrhea is the second-most commonly reported STD with 301,174 cases in 2009 (99.1 cases per 100,000 people). Nationally, Gonorrhea rates declined 10% since 2008 and are at the lowest level since tracking began in 1941. Although the number of cases of primary and secondary syphilis is much lower (13,997 in 2009), the rate has been increasing. The national rate per 100,000 people is 4.6 for 2009, an increase of 5% from 2008 and 39% since 2006. (Source: Centers for Disease Control and Prevention, STD Surveillance, 2009 http://www.cdc.gov/std/stats09/default.htm accessed 8/13/2011).

Table 19 shows the cases of Chlamydia, Gonorrhea, and Syphilis as reported by the Connecticut STD Control Program for 2007 and 2009. The largest increase in the number of Chlamydia cases was reported in Danbury residents; the largest increase in Gonorrhea cases was reported in Bethel residents. Fortunately, there were no Syphilis cases reported in the region in 2009.

Table 19: Chlamydia, Gonorrhea, and Primary and Secondary Syphilis Cases by HVR Municipality and CT, 2007 and 2009

	2007				2009			
	Chlamydia cases	Gonorrhea cases	Syphilis cases	Total Cases	Chlamydia cases	Gonorrhea cases	Syphilis cases	Total Cases
Bethel	22	0	0	22	19	20	0	39
Bridgewater	0	0	0	0	0	0	0	0
Brookfield	10	1	0	11	8	1	0	9
Danbury	131	17	0	148	197	9	0	206
New Fairfield	10	0	1	11	11	2	0	13
New Milford	20	1	0	21	37	3	0	40
Newtown	6	3	1	10	17	1	0	20
Redding	4	0	0	4	6	0	0	6
Ridgefield	9	1	0	10	9	1	0	10
Sherman	0	0	0	0	3	3	0	6
State Total	11,512	2,332	39	13,883	12,136	2,554	65	14,755

Source: CT Department of Public Health. http://www.ct.gov/dph/lib/dph/infectious_diseases/std/std_city.pdf, Accessed 4/1/2011

Findings: Six of the 10 HVR municipalities have experienced an increase in the number of STD cases; Danbury has seen the largest increase in absolute numbers.

Diseases: Indicators and Findings, cont'd.

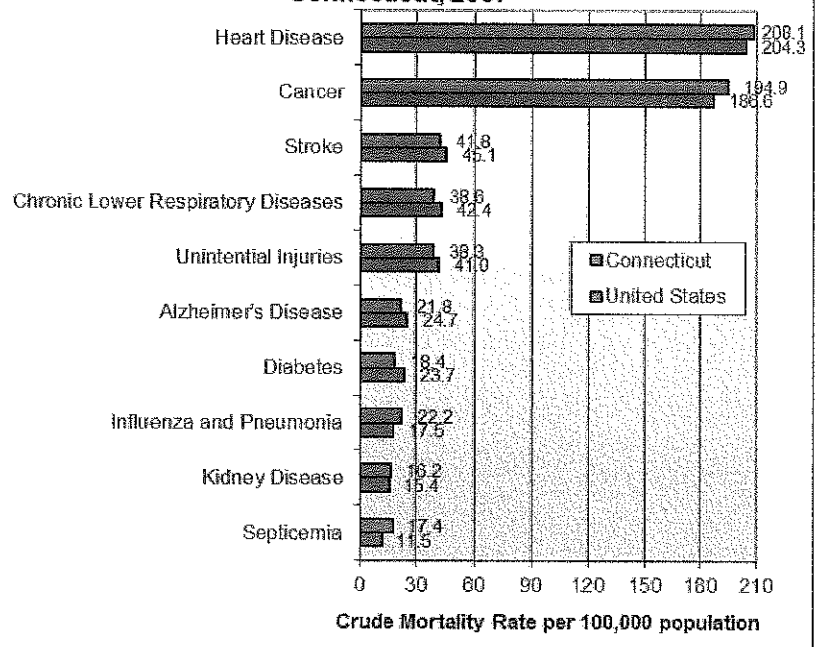
Leading Causes of Death and Mortality Rates

Examination of the leading causes of death and other mortality data is essential to assessing and monitoring the health of a community. This information is also critical to identify priority needs for programs and services to prevent or reduce premature death and disability from chronic diseases and injury.

Figure 32 presents the leading causes of death in the United States and Connecticut for 2007. Table 20 shows the leading causes of death in our community and Connecticut for 2005-2009.

Although the 10 causes of death are not in the same rank order for each community, the underlying causes of death are chronic conditions which are related to behavioral risk factors. Efforts should be focused on supporting health-promoting behaviors along with awareness education and skill-building. This is especially true of physical activity; healthy eating; avoiding tobacco use, alcohol abuse, and illicit drugs; managing stress; and other preventive lifestyle behaviors.

Figure 32: Leading Causes of Death United States and Connecticut, 2007



Source: Centers for Disease Control and Prevention, National Center for Health Statistics http://www.cdc.gov/nchs/data/dvs/LCWK9_2007.pdf, accessed 4/3/2011

Updated data from the National Center for Health Statistics for the 10 leading causes of death in CT residents reveal that the rank order (from first to last) in 2009 was the same as that shown in Figure 32 with the exception of kidney disease now ranked as the 9th leading cause and septicemia as the 10th leading cause. It is noteworthy that there are differences in the rank order of the leading causes of death by gender and race/ethnicity. For example, the leading cause of death for males of all races/ethnicities in CT is cancer and for females it is heart disease. For both White males and females, the leading cause of death in 2009 was heart disease, followed by cancer. For

Diseases: Indicators and Findings, cont'd.

Leading Causes of Death and Mortality Rates, cont'd.

Black/African American and Hispanic/Latinos residents, the leading cause of death was cancer for both genders, followed by heart disease. (Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ebappa.cdc.gov/cgi-bin/broker.exe, accessed 2/23/12.)

Table 20: Leading Causes of Death, 2005-2009 Average Crude Rate[1]

Community	Heart Disease	Cancer	Stroke	Chronic Lower Respiratory Diseases	Unintentional Injuries	Alzheimer's Disease	Diabetes	Influenza and Pneumonia	Kidney Disease	Septicemia	Suicide	Chronic Liver Disease and Cirrhosis
Bethel	169.2	158.3	28.2	45.6	29.3	9.8	13.0	17.4	9.8	14.1	7.6	4.3
Bridgewater	157.8	218.4	12.1	36.4	-	12.1	48.5	-	36.4	24.3	-	24.3
Brookfield	162.5	163.7	25.7	36.6	22.0	15.9	14.7	8.6	9.8	13.4	7.3	7.3
Danbury	166.7	154.0	24.6	32.3	26.4	13.0	16.8	12.5	9.1	14.5	8.6	7.6
New Fairfield	121.1	122.5	18.5	21.4	31.3	17.1	11.2	15.7	4.3	19.6	8.5	7.1
New Milford	235.6	156.8	28.8	37.3	30.9	28.1	11.3	19.0	8.4	16.2	7.7	10.5
Newtown	141.7	165.7	28.5	29.2	28.5	12.0	9.0	13.5	11.2	10.5	7.5	1.5
Redding	210.1	210.1	59.4	34.3	36.5	36.5	2.3	20.6	9.1	18.3	11.4	9.1
Ridgefield	134.7	135.5	29.3	23.4	20.9	14.2	10.9	12.5	10.9	9.2	5.0	2.5
Sherman	107.7	142.0	29.4	14.7	14.7	19.6	9.8	4.9	4.9	9.8	14.7	9.8
Connecticut	209.0	195.7	42.0	41.1	36.0	22.1	19.8	22.2	16.3	16.8	8.1	8.1

Source: Connecticut Department of Public Health Epidemiology Program, email communication 2/24/12
[2] Crude mortality rates were used for this table since the age-adjusted mortality rates were not available for all causes of death

It is important to note that Figure 32 and Table 20 reflect crude mortality rates, which have not been age-adjusted. Crude mortality rates are useful to assess the magnitude of the number of deaths in a community, however they do not account for differences in rates that are attributable to differences in the age composition of the resident population. For example, communities with a higher proportion of older residents, such as Bridgewater, would be expected to have higher mortality rates from chronic diseases, as the incidence and prevalence of these diseases increase with age. Age-adjusted mortality rates (AAMR) correct for differences in age distribution of communities, and therefore give an accurate representation of excess disease mortality. In 2008, CTDPH published two reports of age-adjusted town-state comparisons for the ten leading causes of death in CT residents for the time period 2002-2006. These reports can be accessed at www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/pdf/aamr_comparisons_2002_2006.pdf and www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/pdf/icod_2002-2006_aamr.pdf.

Statistically significant findings from 2002-2006 of relevance to HVR municipalities include:

- Bethel, Brookfield, New Milford, and Newtown had a *higher AAMR from all causes* for both genders combined compared with the state as a whole.
- Bethel and Newtown had a *higher AAMR for all causes for males* compared with males in the state as a whole.

Diseases: Indicators and Findings, cont'd.

Leading Causes of Death and Mortality Rates, cont'd.

- Bethel had a *higher AAMR for Major Cardiovascular Diseases and Diseases of the Heart for males* compared with males in the state as a whole.
- Danbury had a *higher AAMR for Coronary Heart Disease for both genders* combined compared with the state as a whole.
- Danbury had a *lower AAMR for Congestive Heart Failure for both genders* combined and for females compared with the state as a whole.
- New Milford had a *lower AAMR for Diseases of the Heart for both genders* combined compared with the state as a whole.

Updated age-adjusted mortality data provided by CTDPH for all causes of death by municipality for the five-year period 2005-2009 shows that the overall AAMR is *lower* than the state AAMR for the majority of HVR communities. The AAMR for all causes of death was lower than the state rate at statistically significant levels in Bethel, Bridgewater, Danbury, New Fairfield, Redding, and Ridgefield, and statistically higher than the state rate in New Milford.

Findings: When examining the leading causes of death in Connecticut and the U.S., data show HVR municipalities overall compare favorably, with some exceptions. Since 2000-2004, there has been a decline in the mortality rates for many the leading causes of death in the nation, state, and our region. However, the high prevalence of these conditions in the population warrants ongoing prevention efforts. Table 20 reflects crude death rates, which are statistically invalid for comparisons across communities. However, it is interesting to note that, based on crude mortality rates, Sherman, which has the second highest proportion of persons ages 50 and over in the region, had the lowest rates for heart disease, chronic lower respiratory diseases, unintentional injuries, and influenza/pneumonia. Data for 2005-2009 provided by CT DPH reflect a lower AAMR from all causes of death compared with the state in the majority of HVR municipalities.

Infant Mortality

Infant mortality is commonly used as an indicator of a community's health. The infant mortality rate typically varies from year to year in communities such as the HVR where there are a small number of infant deaths per year. Table 21 shows the number of infant deaths and rate of infant mortality in HVR communities from 2004 to 2006 and 2006 to 2008.

Diseases: Indicators and Findings, cont'd.

Infant Mortality, cont'd.

Table 21: Infant Mortality Rates in HVR Municipalities, 2004-2008

	2004-2006		2006-2008	
	Number	Rate	Number	Rate
Bethel	4	*	5	8.0
Bridgewater	0	0.0	0	0.0
Brookfield	1	*	1	*
Danbury	15	4.4	19	5.2
New Fairfield	2	*	2	*
New Milford	7	6.7	5	5.3
Newtown	0	0.0	0	0.0
Redding	0	0.0	0	0.0
Ridgefield	1	*	1	*
Sherman	2	*	0	0.0
Connecticut	717	5.7	753	6.2
United States (2006 & 2007)	28,527	6.7	29,138	6.8

Sources: Connecticut Association for Human Services Connecticut Kid Count http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
National KIDCOUNTS Data Center http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011
Rate is per 1,000 live births
* Rates are not calculated for cases of less than 5 events

Findings: In general, the infant mortality rate in Connecticut has increased but is still lower than the national average. With the small number of events in our communities, the rates vary considerably, with no consistent trend.

Suicide Mortality

Suicide can have a profound effect on a community. At times, especially in the suicide of a young person, an entire community suffers from feelings of guilt over what might have been done to prevent it. The sense of community is equally jarred when an adult commits suicide. A community's behavioral health resources should be fully engaged in the healing and recovery process and in ongoing prevention efforts.

Key findings from a special report issued by CT DPH and previously summarized in the *2009 Community Report Card* are provided for reference.

- Suicide was the second leading cause of injury death in Connecticut accounting for 18.1% of all injury-related deaths between 2000–2004, with 1,396 suicide deaths, for an average of 279 suicides a year.
- The cities and towns with the highest number of suicide deaths among residents were Hartford (60), New Haven (51), Bridgeport (45), Waterbury (40), Meriden (34), New Britain (34), Bristol (31), Stamford (29), East Hartford (28), Danbury (27), and Fairfield (25).
- Overall, males completed suicide at a rate of four times

Diseases: Indicators and Findings, cont'd.

Suicide Mortality, cont'd.

higher than females and up to 11 times higher among the 65–69 age group reaching a peak rate of 30.2 per 100,000 males 85 years or older. Females experienced their highest suicide death rate between 45–49 years.

- Suicide rates were roughly twice as high among non-Hispanic Whites (8.7 per 100,000 population) as compared to either Hispanics (4.6 per 100,000 population) or non-Hispanic Blacks (3.9 per 100,000 population).

Prevention of suicide in youth and young adults remains a key health priority in CT. As stated in a 2009 CT Department of Mental Health and Addiction Services Report, *Youth Suicide: A Public Health Problem in CT*, suicide was the second leading cause of death for ages 10-14 and the third among people aged 15 to 24; however, it ranks second for college students. The 2007 CT Youth Risk Behavior Survey found that 15.1% (U.S =16.9%) of students seriously considered attempting suicide during the past 12 months; 13.8 % (U.S.=13.0%) of students made a plan about how they would attempt suicide during the past 12 months; and 12.1 % (U.S.=8.4%; statistically significant difference) of students actually attempted suicide one or more times during the past 12 months. (Source: Youth Suicide: A Public Health Problem in CT, http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/YouthSuicideCT.pdf, assessed 2/23/12).

More recent mortality data from the National Center for Injury Prevention and Control indicate that in 2009, suicide was the second leading cause of death both in youth ages 15-19 (15 deaths; 16%) and in young adults ages 20-24 (27 deaths; 15.7%). (Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ehaapa.cdc.gov/cgi-bin/broker.exe, accessed 2/23/12.)

Older Adult Health: Survey and Focus Group Findings

As previously noted in the Introduction Section, a key objective of the 2012 Report Card was to provide more in-depth insight on the health and social needs of older adult residents in our region. The Report Card Steering Committee identified four broad topics to enable public health, hospitals, human service providers, and the general public to better assess how older adults in the region exemplify the vision statement "Seniors in our communities are healthy and thrive".

- *Housing.* This includes availability of housing options, skilled nursing, assisted living, and hospice facilities.
- *Support Services.* This includes services which promote access to health care and human services, such as public transportation, fuel assistance, meals on wheels, senior centers, etc.
- *Quality of Life.* This includes demographics, socioeconomic status, social supports, recreation, and spirituality.
- *Physical and Mental Health.* This includes risk factors, disease (morbidity) and death (mortality) rates.

Assessment of older adult health and social needs in the region was accomplished through three methods – health surveys administered to senior volunteers, focus groups with older adults conducted at area senior centers, and a focus group with providers of services to older adults in the region. Key focus group questions were developed by Mhora Lorentson, Ph.D., and Mary Bevan, M.P.H, of *The Center for Healthy Schools and Communities at EDUCATION CONNECTION*, in consultation with Steering Committee leadership. The consumer and provider focus group sessions were professionally facilitated by Dr. Lorentson.

Older Adult Health Surveys

The health survey design team at WCSU reviewed published senior health report cards to select indicators for an Older Adult Health Survey. As previously mentioned, these included the Naugatuck Valley 2007 *Senior Needs Assessment, Seniors in Canada 2006 Report Card* and *Improving Health Literary for Older Adults, 2009.*

After selection of relevant indicators, Senior Center and Social Services Directors from HVR municipalities reviewed both the topics and the indicators. Feedback confirmed that key needs of older adults were covered satisfactorily within the four topic areas and the indicators were then finalized.

During the spring of 2011, the Older Adult Health Survey was administered to senior volunteers in the region to gain insight on current health needs and the availability of local services to meet these needs. Dr. Lorentson completed the analysis of survey data. Survey questions targeted key indicators of older adult health-related needs in each topic area. Four surveys were developed and administered and included both long and short versions, with and without questions relating to dental health. All questions on the short survey

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Health Surveys, cont'd.

versions were included on the long versions.

Survey administration occurred through a comprehensive process in which 91 locations for survey distribution were identified across the region. Twenty of these identified sites provided permission to administer the survey and completed surveys were received from only 10 sites. A total of 123 surveys were received with the majority of these surveys being completed by participants at a regional volunteer recognition luncheon. Although this is not a representative sample of the older adult population in the HVR, as community volunteers, survey respondents are potentially more aware of available services and service gaps.

Key Findings

Overall, data suggest that survey respondents are experiencing a variety of successes, needs and challenges related to their existing housing, support services, quality of life and physical and mental health. It is noted that, due to the limited and relatively homogenous sample, data cannot be assumed to be representative of older adults in the region. However, data provide a good understanding of the experiences of the 123 respondents and can serve as a baseline from which to further explore and examine the health-related needs of our older adult population, design and administer more representative health surveys and, in conjunction with other data summarized in the Community Report Card for Western CT, to further develop strategies to identify and address the priority health needs of our community.

Housing

Data suggest that the majority of respondents live alone or with a spouse or partner. The majority of respondents own their home, pay no mortgage payments, perceive their financial resources to be sufficient to pay for housing and living expenses all or most of the time, and feel very safe in their communities. It is noted that, due to the small and relatively homogeneous sample, these results are skewed in the direction of highly active, non-minority older adults who are involved in their communities. It is of particular note that, even given this homogeneous sample, there was a subgroup of respondents who still pay a mortgage or rent and experience financial challenges most or some of the time. Additionally, of the sample, almost one-third expressed that they feel only somewhat safe in their communities.

Older Adult Health: Survey and Focus Group Findings, cont'd.

Key Findings, cont'd.

Support Services

The majority of respondents appeared to have a social support network in place to at least some extent. Overall, participants were most likely to report the availability of emotional support and less likely to express the availability of physical support in the sense of the presence of a person who could help them to do things they could not do for themselves. Individuals generally perceived their neighborhood to be a positive and friendly place to live. It is noted however, that even in the small sample expected to be healthier and more active than the majority of the community, there are generally eight to sixteen percent of individuals who do not perceive their neighborhoods to be a highly positive place to live.

The majority of respondents owned a car and drive themselves when necessary. Very few were dependent on others or on public transportation.

Quality of Life

As expected given the relatively small, homogeneous sample, survey results indicate that the majority of respondents are at least somewhat active in their communities with attendance at religious services being the most common activity reported. One-third of respondents attended religious services more than twice to six times per month. Respondents were less likely to have friends over to their home and more likely to attend clubs or organizational meetings or to volunteer.

Respondents were most likely to communicate using a cellular phone for voice applications or to use a computer for e-mail and communication and generally less likely to text for communication or to use computers to pay bills or manage money.

Even with the considerable bias of the sample toward healthier, active older adults in the community, respondents reported a range of physical and emotional health limitations with almost half expressing limitations in the area of moderate daily activities. Results indicate that respondents also experience challenges in the area of mental health with half or more of respondents expressing issues with anxiety and frequently not feeling happy.

Physical and Mental Health

When asked to complete a rating scale, the majority of respondents self-reported good to excellent mental and physical health and relatively healthy nutritional habits. However, it is noted that the majority of individuals also report not participating in any physical activity during the past month and 8% have only two meals a day on most days of the week. In addition, the majority of respondents consume less than the recommended number of servings of fruits and vegetables per day.

Chronic health conditions including diabetes, cancer, and angina were reported by 2 to 21% of respondents. Cancer was the chronic health condition most commonly faced by both respondents (21%) and their families (45%).

The majority of respondents stated that they understood their medications and were under the care of at least one health provider. Use of prescription medications was common (87% of respondents). A considerable proportion of respondents had never participated in recommended health screenings. Compliance was lowest for mammograms by women and for sigmoid/colonoscopy by both genders.

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups

Dr. Lorentson completed five focus group interviews with older adults and one focus group interview with providers of services to older adults in the region. Older adult focus group interviews were hosted by senior centers within the region. The focus group with providers of services to older adults was held at the Danbury City Hall. A total of 42 seniors participated in focus groups. Participants represented primarily the towns of Bethel, Brookfield, Danbury and New Milford with a few individuals attending from other area towns. The majority of respondents were women. Additionally, four providers of services to seniors participated in the provider focus group. These individuals worked in New Milford and Danbury and included representatives from a hospital, a visiting nurse association, a specialized care settings and an organization targeting the medical and non-medical needs of seniors.

Focus group interview questions were developed to identify key indicators within each topic area and were designed to assess current health needs, satisfaction with current health-related services and to identify recommendations for service improvement as appropriate.

Conceptual analysis of responses was used to analyze focus group interview results. Overall, the results of focus group interviews suggest a number of key themes.

Overall Perceptions

Participants are generally satisfied with the level of services provided for older adults in the ten town region. Most individuals "*love it*" and state that they "*get all kinds of help*". Participants expressed enthusiasm in a number of areas including the availability of senior centers and high quality healthcare. Participants describe available programs and services as providing motivation and support to keep moving forward.

Participants expressed satisfaction with the existence of SweetHART buses; opportunities for socialization provided by senior centers and area religious organizations; availability of a variety of high-quality medical services; support provided by area social services and hospitals; available living opportunities for low-income and high-income senior adults; and the interpersonal support provided to each other by senior adults. Respondents were particularly enthusiastic about the interest shown in the welfare of seniors as evidenced by the inclusion of focus groups and surveys to collect supplementary information related to Older Adult health needs as a component of the Community Report Card.

Participants expressed concerns related to the lack of transportation and limited availability of SweetHART buses; lack of sidewalks and places for seniors to walk; shortage of low-income and medium-income housing, in particular a lack of availability of housing on one floor; the need for opportunities for socialization and interpersonal interaction of homebound seniors; the need for increased availability of delivery services for food and pharmaceuticals; the need for dental services that accept Medicaid; the need for behavioral health services and support for seniors and their caregivers; the need for inexpensive in-home non-medical support for seniors; and the need for support for the "*very old*". All participants emphasized the importance of education for seniors to help them understand how to

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Overall Perceptions, cont'd.

take care of themselves medically and to increase their utilization of available services. All participants expressed interest in continuing to strengthen and expand senior center activities and the availability of services for older adults in the ten town region.

Housing and Living Environment

Respondents described the living situations of older adults as generally safe and comfortable with older adults described as living in condominiums or low-income/ medium-income housing or with family or friends. Housing was typically considered to be relatively safe and comfortable with adequate availability of low-income housing throughout the ten town region. Service providers however emphasized that the safety and security of individuals varies by income level. These individuals described some of the seniors they interacted with as living "*in extremely poor conditions*". A number of participants emphasized that the availability of low-income housing varies by town with shortages described as existing in some towns. A number of participants also described shortages of medium-income housing throughout the area.

Although generally satisfied with the overall living conditions in the region, participants expressed a number of concerns. Specifically, large gaps were identified in the availability of housing with only one floor, suitable for individuals with mobility concerns and in the availability of housing in which one senior can live with another senior to share costs and support personal safety. Participants stated that many seniors live alone and that living alone is often a risk itself for personal safety. Senior participants stated that a number of housing situations prohibit non-family members from living together.

Additionally, participants identified a number of safety issues for individuals living alone. Specifically, the high cost of "*safety buttons*" such as Life Alert was described as a barrier for many senior adults who were unable to purchase security systems. A number of individuals discussed the importance of "*senior-to-senior*" or other networks to just "*check in*" and make sure someone who is living alone is "*okay*".

Participants expressed significant concerns related to the isolation of individuals with medical issues living alone in any type of housing situation and emphasized that, in the current culture and work setting, many seniors do not live close to either family or friends. It was also emphasized that, when older adults do live in proximity to family, family members are often described as "*busy with their own lives*" and not easily available to address the needs of their senior relatives. Lastly, a number of participants expressed a need for support in cleaning and maintaining a household. Participants described situations in which isolation and medical limitations make it difficult for some seniors to clean their own homes and maintain a safe and sanitary living environment. These individuals described a service that used to be, but is no longer, available in which social service representatives went to senior households to help to clean and

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Housing and Living Environment, cont'd.

organize the house. This service was described as very important to seniors facing physical or emotional limitations that make it difficult to maintain a safe and sanitary household.

The majority of participants expressed that the financial impact of housing varies by individual. Participants generally described Connecticut as a very expensive state to live in for seniors. However, many of the towns in the region were described as providing a number of options for low-income seniors to support the cost of housing, including tax breaks and vouchers. Senior centers and social service agencies were identified as providing seniors with educational opportunities to learn about available financial assistance.

Quality of Life

Respondents identified a number of key indicators of quality of life for seniors including the need for socialization and communication on a consistent basis. Respondents were generally very satisfied with the number of opportunities available for socialization in the region and identified the senior centers as the hub for most social activities. Senior centers were described as critical to seniors to find support from their peers; participate in clubs and activities such as dancing, singing and yoga; to receive educational guidance related to issues of importance to seniors such as use of technology, financial planning and support services available, including tax services. In addition to senior centers, area religious and social service organizations were identified as sources of socialization and support for many seniors.

Challenges cited by participants include ongoing difficulties with transportation due to a lack of adequate availability of SweetHART buses, a lack of sidewalks or other venues seniors can use to walk to social events, a lack of opportunities to provide social activities for homebound seniors, and a lack of services to address the needs of "the oldest of the old." Additionally, the majority of participants described a lack of adequate funding for senior centers in recent years has resulted in decreased space for participants, decreased availability of "day trips" and decreased opportunities for a variety of activities.

Respondents described a wide variety of use of technology by seniors to support quality of life. Specifically, the majority of senior participants described themselves as using cell phones and computers for communication on a consistent basis. Approximately half of participants also used computers for games, to track finances, and to conduct Internet searches on topics of interest.

Participants described quality of life as dependent on the availability of support services to help older adults to cope with existing physical limitations. Participants described needs such as *"how to fix a light bulb"*, *"cook dinner"*, *"get groceries"*, *"clean the house"* and *"obtain medications"* as issues commonly faced by the senior population. This area was described for many as a *"tough"* area with the majority of participants being *"unsatisfied"* with support available in this area. A number of participants stated a belief that senior citizens often get *"taken advantage of"* when these needs have to be addressed. Seniors described a situation in which individuals with close and supportive family and neighbors were able to address many of these needs. However, for individuals

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Quality of Life, cont'd.

without close family, support in these areas was described as typically coming *"at a cost"* and requiring consistent efforts to find and identify trustworthy individuals to help.

Similarly, participants described a need for increased availability of support for emotional or mental health challenges faced by seniors. Senior participants emphasized a need for free or low-cost counseling services, increased support for seniors within the home setting, and support groups to provide emotional and interpersonal support.

Social Support

The majority of participants described social support as critical to the emotional and physical health of seniors. As one individual stated, *"We need laughter to keep moving forward...that is what we need."* Social support was generally described as being provided by family members who live in the area and the senior centers. Additionally, individuals residing in condominiums or other shared living situations often described a positive network of support within these communities.

As in other areas, transportation was described as a significantly limiting factor to obtaining social support. Some seniors stated that they still *"drove themselves"* or *"were picked up by other seniors"* to attend events. The need for increased availability of SweetHART buses, or similar door-to-door transportation services, was emphasized by participants throughout all focus groups. Participants described some availability of volunteer drivers for senior adults through local religious organizations.

Physical and Mental Health

All participants perceived the availability of high-quality medical care to be excellent within the area. However, large gaps in ability of individuals to access this care were identified. Specifically, participants emphasized that medical care for low-income individuals was generally highly supported through social services and high-income individuals could pay for care that was necessary. However, the middle-income population was consistently described as not having the ability to support the continuum of care required and, particularly, the long-term expense of home care when that became necessary. Additionally, access to dental care, behavioral healthcare and vision and hearing support were described as minimal due to lack of insurance coverage. Older adults from New Milford expressed concerns that the recent merger of Danbury and New Milford Hospitals might lead to a shortage of medical services in the New Milford area.

Individuals described challenges faced by older adults in practicing good health habits such as being physically active, eating nutritious meals, drinking plenty of water, participating in health screenings, not smoking and not drinking alcohol in excess. Seniors described a low degree of motivation for individuals living by themselves to cook nutritious meals or to *"get out and move."* Although all participants described a high availability of fitness centers and sports clubs with sliding fee scales or low-cost opportunities for seniors, transportation difficulties were described as making it challenging for seniors to use these services. Additionally, the physical layout of many of the ten

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Physical and Mental Health, cont'd.

municipalities in the region was described as having few sidewalks or walking paths and therefore creating a challenge for seniors to experience ongoing physical activities.

All participants described the ability to understand and have the energy to follow-up and practice medical recommendations as a challenge for seniors with stamina or cognitive issues. Participants expressed a need for ongoing education and follow-up support to assist seniors to follow medical recommendations and practice good health habits. This need was described as particularly acute for seniors with chronic health conditions such as asthma, high blood pressure, or heart disease as these individuals need to be especially diligent in practicing positive health habits.

Representative Focus Group Quotes

Older Adults

"Transportation is a big issue...many of us don't drive. There aren't enough SweetHART buses. And...for those with physical limitations, the buses only pick you up at the bottom of the driveway—you have to get there. Often there are hills, or slippery, it is tough."

"We have great healthcare resources out there—a lot of them and they are qualified. But, to use them you need Medicare plus supplemental—then you are fine."

"Senior centers are so important for seniors. Many senior volunteer services have often been cut back. It would be nice if the towns could do more—not depend so much on the senior centers."

"We have physical limitations...not at all satisfied with the support provided by communities to address these. A lot of people can't get out—there are no structures in place for friendly visits to the home, support for home-bound people. There are often no more neighborhoods so neighbors aren't there—have to go to the senior centers and that is often not possible."

"The gaps we face? We really need transportation, help for the "oldest of the old", and support for socialization needs—especially of home-bound adults. The senior centers are critical—we need a comfortable place to go."

"There is often not enough low or middle income housing—some towns have them but generally not enough. There are huge waiting lists. Especially, you need to have housing all on one floor—we need a lot more of that. And...many places don't let non-relatives live together, so you can't share expenses"

"Great housing options for the lower and high income brackets—very little middle income housing."

Older Adult Health: Survey and Focus Group Findings, cont'd.

Representative Focus Group Quotes, cont'd.

Health Care Providers

"How do older adults get support to meet their day-to-day needs? This is a huge portion of healthcare. Wealthy people can pay for it, there are a lot of options for low income people. Middle of the road people have nothing—they try to pull in family and friends to do this...a huge issue. There is very little support out there for caregivers either."

"The three major priorities we see to improve the health services for older adults are: 1) education—help them see and understand what they need to do to take care of themselves; 2) Transportation to get them out and where they need to go; and 3) Address the needs of middle-income older adults. They are hurting the most."

The complete Older Adult Health Survey and Focus Group Reports can be accessed at the United Way of Western CT website: http://www.uwwesternct.org.

Conclusions

Overall, survey and focus group data indicates that the region continues to be relatively successful at meeting a number of health and social needs of senior adults. The region was generally described as having high quality medical care, excellent housing options for low and high income seniors, and active and supportive senior centers. However, focus group data indicates that a number of gaps in service and opportunities for improvement also exist. Specifically, data suggests significant improvements are needed in the areas of health education for older adults, financial and social support for middle-income senior adults, and in the availability of more flexible housing and transportation options.

Recommendations for Future Data Collection

- Future older adult health surveys should be developed to be less complex and be validated prior to administration.
- Future data collection efforts should consider the use of a random sample for survey distribution or the use of targeted survey distribution directed toward key informants to increase the generalizability of findings. An individual trained in survey administration should be present to review surveys for completion and obvious errors prior to collection.
- It is highly recommended that future assessments include strategies to assess the needs of less active, less mobile, less affluent and minority senior adults who were not well-represented in the current survey and focus group information.
- Future provider focus groups should include broader representation of health and social service providers, both geographically and by area of specialty.

Conclusions and Recommendations

The leading health concerns in our community, as in the state and the nation, result from a number of interconnected factors, many of which can be controlled or modified. Harmful lifestyle behaviors such as smoking, overeating, poor nutrition, lack of physical activity, tobacco use, substance abuse, and unsafe sexual practices have major impacts on individual health. Lack of health insurance, limited English proficiency, and cultural factors present barriers to access and utilization of medical care and preventive health services. Income, employment status, educational attainment, housing, and transportation are social factors which impact health or access to care. Uncontrollable factors, including inherited health conditions or increased susceptibility to disease, also significantly influence health.

In spite of the favorable health status enjoyed by most HVR residents, health disparities exist and are concentrated in the uninsured and low income population groups. Families and individuals who live in poverty or are uninsured are more likely to have poor health status. Poverty underlies many of the social factors that contribute to poor health. Differences for many health indicators are also apparent by gender, race/ethnicity, age, and place of residence. This information should be used to determine subgroups in the population in need of further assessment, as well as to guide the development of programs and services to meet identified health needs. Expanded joint planning and coordination of programs and services among health partners in the community can reduce health disparities and improve the health of all area residents.

Effective strategies to improve community health involve active collaboration and commitment among providers, health agencies, educators, and community-based organizations and groups, and the public they serve. Developing a plan for health improvement in the community involves collective action and sharing of expertise and resources across agencies and organizations in both the public and private sectors.

With this in mind, the following key recommendations are proposed by the Community Report Card Steering Committee Leadership to guide future Community Report Card health assessment activities:

- *Broaden the CRC Steering Committee membership to assure active participation by community agencies providing services to and community groups most affected by health disparities in the region.*
- *Use a strategic health planning process to identify gaps in qualitative and quantitative data needed to determine priority health needs, and to begin to develop a comprehensive action plan for community health improvement.*
- *Collect more in-depth data, through surveys, focus groups, and key informant interviews, to better inform the determination of priority health needs and to better align community resources with these needs.*
- *Conduct a scan of available health-related data and assessments to refine the key health indicators for the region for inclusion in future editions of the Community Report Card.*

Applicant Exhibit 2

Community Report Card for Western Connecticut

Community Health Improvement Action Plan

Summary Report – January 2014

Prepared by: Mary Bevan, M.P.H. & Mhora Lorentson, Ph.D.
Center for Healthy Schools & Communities at EDUCATION CONNECTION

EDUCATION CONNECTION

Health Improvement Action Plan Development – The Process

Effective strategies to improve community health involve active collaboration and commitment among health providers, public and community health agencies, educators, worksites, community and faith-based organizations and groups, and the public they serve. Developing a plan for health improvement in the region involves collective action by and sharing of expertise and resources across agencies and organizations in both the public and private sectors. The process builds on best practices and effective programs and services underway in the community. Fortunately, there are many model programs and services in the ten-municipality Housatonic Valley Region (HVR)[1] that provided a strong foundation for action planning.

In response to the key findings and recommendations from the most recent Community Report Card for Western Connecticut[2] (CRC), the CRC Steering Committee, including leads from the City of Danbury Department of Health and Human Services, Western CT Health Network/Danbury Hospital-New Milford Hospital, United Way of Western Connecticut, New Milford Health Department, and the Regional YMCA of Western CT, convened two Community Health Conversations with key community stakeholders in October 2012. These initial Community Health Conversations were held in two locations (Danbury and New Milford, CT) to ensure accessibility by key stakeholders throughout the region. During the Conversations, the need for collective commitment and responsibility in the prioritization of health issues and development of an action plan for health improvement were emphasized. Attendees included a total of 52 representatives from hospitals; community health centers; school-based health centers; Visiting Nurse Associations/Services; municipal health, education, social service, senior centers and fire departments; non-profit organizations; and a legislator's office. Geographically, all 10 HVR municipalities were represented either directly or through regional agencies and organizations.

Prior to the conversations, Mary Bevan, M.P.H., and Mhora Lorentson, Ph.D., from *EDUCATION CONNECTION's Center for Healthy Schools & Communities* met with the Community Report Card Steering Committee to review the objectives and desired outcomes for these facilitated discussions. Dr. Lorentson led the overview of key findings from the Community Report Card for Western CT and, with the assistance of the CRC Steering Committee members, facilitated the workgroup discussions to prioritize health issues. Key findings were presented for each of the Report Card indicators, including: community population and demographic data, economic stability, education, health status, health and lifestyle behaviors and risk factors, chronic and communicable diseases, and older adult health survey and focus group findings. Additional data from the CT Association of Directors of Health's Health Equity Index related to social determinants of health and health outcomes and United Way of CT's Infoline 2-1-1 database of health-related programs and services was included.

The objectives of the Community Health Conversations were to: 1) obtain input and insight from a diverse group of stakeholders, 2) reach consensus on priority health issues in the region, 3) identify community assets and challenges related to the priority issues, and 4) begin the process of forming workgroups to identify action steps for improvement. Following the presentation of CRC findings, participants were asked the following two questions:

Based on what you have learned today, <u>and</u> your own experience, what community needs stand out for you?
What do you believe are the priority health issues in our community?

Participants in Community Health Conversations universally agreed that the Priority Health Issues (PHI) most representative of needs in the region were: 1) disparities in health care access and outcomes;[3] 2) prevention/reduction of most prevalent chronic diseases/health conditions (specifically obesity,

[1] *The ten municipalities in the HVR include: Bethel, Brookfield, Bridgewater, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield, and Sherman.*
[2] *The Community Report Card can be accessed at: http://www.danburyhospital.org/en/About-Us/Publications/Community-Report-Card.*
[3] *Ultimately, PHI workgroups determined that disparities in health care access and outcomes were cross-cutting issues, and this PHI was integrated into the other 4 Action Plans as a result.*

hypertension, and type II diabetes), by addressing underlying risk factors; 3) substance use/abuse and co-related mental health issues; 4) older adult health, housing and social support needs; and 5) improved awareness and utilization of existing health and social programs and services. Upon reaching consensus on the priority health issues to address, participants self-selected a workgroup to join based on their interests and expertise. Each workgroup focused on their selected PHI, and responded to the following questions:

- What assessment information presented today did you find most relevant and important to your PHI?
- What are the key community strengths or assets related to your health issue?
- What are the key needs or challenges to address?
- Develop at least three recommended actions the community should consider to address these needs/challenges over the next two years.

Each workgroup identified an individual to summarize results on printed worksheets and report out to the larger group. Additionally, one member of the CRC Steering Committee participated in each workgroup discussion and further documented key observations and discussion points. Worksheets and recorded data were provided to EDUCATION CONNECTION for summary and analysis.

Finally, after sharing the results of the PHI workgroups, the following questions were addressed by the entire group.

- In what ways did the CRC assessment information we reviewed today help to better define community health needs?
- What additional information would be helpful to developing recommendations and action steps for your PHI?
- How is each of our organizations already contributing and how can we collaborate and leverage our resources to move towards creating a healthier future together?

Overall, data obtained from the Community Health Conversations provided high quality information needed to begin the community health improvement action planning process in the region. A broad diversity of community stakeholders attended both sessions, conversations were dynamic, and stakeholders were actively engaged in the process and expressed commitment to working together in the future to address the identified priority health issues.

The overarching goal of health improvement action planning is to increase a community's cohesiveness, efficiency, and productivity in working together to positively affect health conditions and outcomes that are identified as priorities in the community. Creating change requires commitment, perseverance, shared leadership, and ongoing collaboration among diverse community partners who unite to form a community health improvement team. This collaborative team works to identify, implement, and evaluate programs, services, policies, systems, and practices to enhance each community's capacity to be a healthy environment in which to live, work, learn, and play.

An action plan outlines what should happen to achieve the vision for a healthy community. Desirable changes and proposed activities (action steps), timelines, and assignment of accountability provide a detailed road map for community teams to follow.

An action plan, while a significant investment of time and energy, is an effective way to ground health improvement teams with a common purpose. Developing an action plan is a critical first step toward success in achieving objectives. An action plan assures that:

- ☑ Details are not overlooked;
- ☑ Proposed action steps are feasible and/or realistic;

- ☑ Teams follow through with their commitments; and
- ☑ Measurable activities are documented and evaluated.

Each community in the HVR has unique strengths and challenges related to improving health conditions for its residents. Action planning provides the roadmap for the change process within the context of a community's priority health needs. During the planning process, community perspectives and ideas were first distilled into a common *vision and mission*. Next, the priority needs or issues were refined into *objectives with corresponding strategies and actions*.

Vision Statement: Healthy People Living in Healthy Communities

A partnership of diverse individuals who, through a commitment to creativity and innovation, collaborative leadership, cultural responsiveness, and the development of evidence-based solutions for priority health issues, strives to create a community of the healthiest people in Connecticut.

Mission Statement: Promote Overall Physical, Social, Emotional, and Mental Health

Through collaborative and sustained action and commitment to excellence, we strive to promote and maintain the health of our community residents through prevention, education, evidence-based interventions, and the assurance of access to quality health care.

Throughout 2013, the CRC Steering Committee and PHI workgroups continued to meet to further develop and refine the four PHI Health Improvement Action Plans. Technical consultation and workgroup facilitation were provided by *EDUCATION CONNECTION's Center for Healthy Schools & Communities*. In addition, the City of Danbury Health & Human Services Department recruited public health interns from Kaplan University, New York Medical College, Western CT State University, and Yale University to provide support to each PHI workgroup. Three additional workgroup action planning sessions were co-facilitated by Dr. Lorentson with the active participation of the CRC Steering Committee and PHI Workgroup Leads, including:

Community Health Improvement Team Leadership

Sally Herlihy, Andrea Rynn, Deborah Weymouth, Judy Becker, & Jean Huntington, *Western CT Health Network*
Scott LeRoy & LisaMichelle King-Riley, *City of Danbury Department of Health & Human Services*
Kim Morgan & Elizabeth Goehring, *United Way of Western CT*
Michael Crespan, *New Milford Department of Health*
Marie Miszewski & Maureen Farrell, *Regional YMCA of Western CT*
Melanie Bonjour, *CIFC Community Health Center of Greater Danbury*
Allison Fulton, *Housatonic Valley Coalition Against Substance Abuse*
Caroline LaFleur, *Danbury's Promise for Children Partnership*
Michael Gold, *Geron Nursing and Respite Care, Inc.*

Consistent with the Community Health Improvement Team's vision and mission, and informed by the Community Report Card and Community Health Conversation findings, the draft Community Health Improvement Action Plan for Western CT by PHI follows. It is important to note that Action Plans are dynamic documents and are influenced by emerging needs. With this in mind, the workgroups will continue to meet at least quarterly to expand upon, modify, and refine their PHI objectives, strategies, and action steps and to collectively evaluate progress towards achieving health improvement in the region.

Community Health Improvement Action Plan – The Results

Priority Health Issue (PHI) #1

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #1 - Prevention/ reduction of most prevalent chronic diseases and health conditions	• **To reduce the incidence and prevalence of obesity, diabetes, and hypertension for all individuals within our community.** • **To promote access to and utilization of related preventive health education, screenings, and diagnostic and treatment services for medically underserved groups within our community, including low SES and Latino or Hispanic groups.**	• By December 2015, stabilize or reduce the obesity prevalence rate in HVR adults from baseline county rates as reported in the 2013 County Health Rankings: 18% in Fairfield County (FC); 20% in Litchfield County (LC). • By December 2015, stabilize or reduce the diabetes prevalence rate in HVR adults from baseline county rates as reported by CDC: FC (7.1); LC (7.7). • By December 2015, stabilize or reduce the percentage of HVR adults reporting that they have hypertension (HTN). CT county baseline (2007-2009) BRFSS data compiled by DPH: 23.1% FC; 25.6% LC.	• Promote and strengthen a universal healthy lifestyle message by building on the 5,2,1,0 message across all sectors (Schools, Worksites, CBOs, FBOs, Healthcare, Health Depts. & Districts). • Collaborate with Coalition for Healthy Kids on 5,2,1,0 messaging with families. • Increase opportunities for residents to participate in no cost/low cost physical activity such as walking and biking. • Increase availability of healthy eating options across all age groups. • Collaborate with Regional YMCA for application to obtain Y Diabetes Prevention Program funding.	**0-6 Month Milestones:** • By February 2014, engage parish nurses and senior center directors to promote 5,2,1,0 messages and healthy food options at church and senior events. • By February 2014, create a unified "Know Your Numbers Campaign" screening tool based on sub-committee input to share with collaborating organizations. • By March 2014, identify 3-5 key organizations and worksites to implement the "5,2,1,0 Let's Go" Strategies. • By April 2014, include resources on stakeholder websites with existing recreational programs such as the CT Trails Day, Walkct.org, local walking trails, parks, schools and mall walking promotions. • By May 2014, launch Diabetes Awareness Campaign in the HVR. **6-12 Month Milestones:** • By July 2014, identify one site to pilot the Y Diabetes Prevention Program based on diabetes prevalence and	• Create opportunities for healthy cooking/recipe programs in local parishes and where families convene. • 5 key local employers in addition to the hospitals will adopt Worksite Wellness policies around healthy food options and increasing physical activity. • Collaborate on at least 1 annual physical activity event for each HVR municipality and include chronic disease prevention messaging. • Meet Y-USA goal for participants in the Y Diabetes Prevention Program (YDPP). • Expand YDPP to all towns in Y service area with tracking system.	*County level prevalence data:* BRFSS and County Health Rankings: www.countyhealthrankings.org CDC County Diabetes Reports: www.cdc.gov/diabetes/atlas/countydata/atlas.html Child Health Data State Obesity Reports: http://childhealthdata.org *Local level screening and prevalence data*: CHC Uniform Data System Patient Services Reports *Local level measures:* • # of parishes and senior centers engaged in 5,2,1,0 messaging • # of Healthy Kids Coalition families reached with 5,2,1,0 messaging • # of CBOs and worksites implementing 5,2,1,0 Let's Go Strategies • # of stakeholder websites listing recreational programs and # of hits • # of new options for physical activity created in community, school, and	**Parish Nurses** United Way Leads, Coalition for Healthy Kids **Worksite Wellness** United Way Leads with collaborating partners **Active Living** Each town takes lead but to include collaborating partners **Screening Tool** Health Department(s) Leads **Diabetes Awareness Pilot** YMCA Leads **Y Diabetes Prevention** YMCA leads with collaborating partners including WCHN DSME **"Know Your Numbers"** Health Department(s) Leads with collaborating partners

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
		• By December 2015, stabilize obesity rates in HVR children and adolescents from CT baseline prevalence rates as reported by Child Health Data.org of: Children 2 to 5 years - 15% Children 10-17 years - White: 24.7% Hispanic: 48.3% Black: 43.6%	• Identify funding sources for chronic disease prevention work in the community focused on awareness and screening.	availability of town locations. • By July 2014, increase opportunities for free "Know Your Numbers" screenings by incorporating into all existing and identified health education activities and adding opportunities in towns that need additional screenings. • By September 2014, Promote/Collaborate "Know your Numbers" Campaign with at least 2 local worksites. • By October 2014, develop a resource brochure for individuals identified in screening for secondary prevention programs including the WCHN Diabetes Self- Management Education Program (DSME), YMCA Diabetes Prevention Program, and local Community Health Centers.	• Track the number of residents in all HVR municipalities participating in Know Your Numbers Campaigns.	worksite locations • # of new opportunities for healthy eating created in community, school and worksite locations, including school and community gardens • Development of "Know Your Numbers" screening tool and # of sites implementing • # of worksite wellness policies developed and # adopted • # of sites and participants in YDPP	**Partner Sub-Committee** Resource guide for primary and secondary prevention health services

Action Step Progress:
YDDP grant awarded – start date 1/14.

Priority Health Issue (PHI) #2

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #2– Improve access to and utilization of quality prevention, counseling, and treatment services for substance use and abuse and co-related mental health issues	• To decrease the incidence and prevalence of substance use and abuse and co-related mental health issues for all individuals within our community, with an emphasis on adolescents and underserved individuals.	• Conduct ongoing advocacy in Western Connecticut to ensure accessibility to a continuum of high quality prevention, counseling, and treatment services. • By July 2014 collaborate with Regional Action Council, LPCs and other partners to create a prevention plan using SAMHSA's Strategic Prevention Framework (SPF).	• Map current assets and identify gaps in services and accessibility. • Communicate and engage key stakeholders to collaborate on system of care redesign. • Identify enhancement opportunities. • Increase awareness and provide education. • Promote efforts of local prevention councils (LPCs). • Increase involvement of youth in LPCs. • Conduct needs assessments as indicated. • Increase communication and awareness regarding existing programs. • Provide parent/adult education. • Engage local officials support and	6-12 Month Milestones: • By July 2014, increase awareness by key stakeholders of existing services, opportunities to improve, and additional resources needed. • By July 2014, map current services, programs, funders, and geopolitical relationships to identify gaps in services, support, and accessibility. • By July 2014, identify service enhancement opportunities by process and participation including providers, agencies and funders. • By July 2014, increase the number of youth and underserved groups engaged in local prevention councils by 20%. • By September 2014, provide education to providers including strategies for stigma reduction and engage providers in supporting regulation or legislation. • By October 2014, disseminate substance use/abuse prevention information to parents and guardians of students in all HVR K-12 public and private schools By November 2014, research legislative activities	• Continue provider education and awareness campaign to reduce stigma/ discrimination. • Advocate for appropriate insurance coverage/ reimbursement. • Collect and use assessment data to inform planning and leverage funding. • Plan and coordinate regional prevention conferences every two years with RAC staff. • Coordinate legislative advocacy activities through statewide/ regional prevention networks. • Establish a Youth Prevention Council. • A minimum of once every 2 years, administer student	• Asset map created • Advocacy Campaign created • # of stakeholder meetings • Summary document of System of Care Redesign produced • # of prevention planning meetings, attendance rates, and priorities identified • # and % of youth and members of underserved groups serving on local prevention councils, tracked over time • # and types of enhancement opportunities identified • 2-1-1 , DMHAS, and local provider data on service utilization with comparisons over time • CHC Uniform Data Reports on related ambulatory care services • CHIME ED visit and hospitalization data • # and types of provider educational sessions tracked • # and types of providers engaged in legislative advocacy tracked • # funding opportunities	**Stakeholder Meeting Coordination** WCHN Steering Committee Sponsor will assign lead to coordinate initial meetings with mental health specialists. Specific responsibilities will then be assigned. **Action Plan Coordination** HVCASA will coordinate all action plan steps in partnership with LPCs via existing roles and partnerships, i.e., HVCASA is the designated Suicide Prevention Coordinator for Region 5, a Drug Endangered Child Alliance Coordinator, attends statewide meetings of the CT Prevention Network, and serves on the DMHAS State Advisory Board. These partnerships

			advocacy. • Promote the use of SAMHSA's Strategic Prevention Framework in all communities via the Local Prevention Councils as designated by Local Officials.	to identify advocacy opportunities for next year. • By December, 2014, develop and administer student surveys in participating schools. • By December 2014, conduct at least 12 stakeholder focus groups. • By December 2014, conduct a total of two prevention planning meetings to identify priorities.	surveys in participating schools.	identified, # proposals submitted, amount of funding secured • Changes in policy, legislation and insurance coverage • Legislative breakfast held • Advocacy opportunities identified, summarized and appropriately distributed • # of student surveys designed, administered and analyzed; results disseminated in summary report with recommendations • Survey repeated every two years and results compared over time • # and type of schools where prevention education materials distributed and # students enrolled	will advance PHI #2 action steps as will the following local and regional networks: 12 LPC chairs (meet quarterly) Drug-Free Schools Committee (meets monthly throughout school year) Recovery Committee (meets quarterly) Youth Advisory Board/Teen Council (meets quarterly)
Action Step Progress:							

Priority Health Issue (PHI) #3

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #3 – Improved assessment and service planning to address older adult health, housing and social support needs	• **To improve the physical, emotional, and mental health of older adults within our community.** • **To increase the accessibility and availability of social supports for older adults within our community, with an emphasis on at-risk seniors.**	• Improve the physical, emotional, and mental health of older adults within our community. • Increase public awareness of changing demographics and its impact on our communities. • Increase access to and utilization of existing community support resources and housing options for the elderly.	• Identify, recruit, and convene a Task Force of providers from the HVR region. • Educate providers from the region on goals and strategies of the Health Improvement Action Plan for PHI#3. • Utilizing the results of the Community Report Card for Western CT (CRC) and Aging in Place (AIP) IRB-approved survey, disseminate best practices to the entire HVR. • Explore funding opportunities.	**<u>0-6 Month Milestones:</u>** • By March 2014, analyze Danbury-focused AIP survey results and align strategies, goals, and objectives with PHI#3 Action Plan. • By May 2014, recruit and convene providers and advocates for the Task Force including the following possible resources: law enforcement, faith-based and community organizations, older adult service providers, and physicians. • By June 2014, begin an audit of available resources for seniors in the region and complete gap analysis between results and the AIP survey and relevant CRC findings. **<u>6-12 Month Milestones:</u>** • By August 2014, compare the survey findings to the audit of services. • By November 2014, finalize plans to expand goals and objectives to region. • By December 2014, explore funding opportunities.	• Develop an online regional guide to services through local coordinators, and possibly in print, e.g., periodic newsletters etc. (2-1-1 included). • Assess the availability and utilization of services and measure changes as evidence for future funding opportunities. • Expand the scope of existing service providers as community needs indicate. • Continue to explore funding to communicate and educate both the elderly and their adult children.	• Representativeness of Task Force members • Consistency of meetings held, attendance rates, and action items generated and completed • Summary report of audit and gap analysis results produced and evidence of dissemination • Regional guide to services produced and evidence of dissemination • 3 year survey of key housing and social service providers developed; analysis of utilization data and service growth over time. Results summarized and disseminated • # of funding sources identified, proposals submitted, and funding secured	**<u>Task Force Recruitment</u>** Steering Committee PHI WCHN sponsor and co-lead will contact possible recruits for Task Force and schedule an initial meeting. **<u>AIP Coordination</u>** WCHN PHI co-lead will provide Danbury AIP survey results for analysis.

<u>Action Step Progress:</u>

Priority Health Issue (PHI) #4

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #4 – Improved awareness and utilization of existing health and social programs and services	• **To increase awareness and utilization of existing health and social service programs and services within the community with an emphasis on reaching vulnerable residents, including low-income, non-English speaking, and undocumented individuals and families.**	• Increase awareness around the Affordable Care Act (ACA) coverage provisions and access to health insurance. • Increase and promote Infoline 2-1-1 awareness. • Increase awareness of affordable health care services and medication programs such as prescription discount programs. • Develop a coordinated system for ongoing dissemination of key information on programs and services to health providers and agencies serving vulnerable populations.	• Collaborate with Access Health CT to inform and promote awareness (work with local Assisters to promote awareness and identify target populations covered by each site - identify vulnerable subgroups). • Work with United Way to identify target populations for outreach and to avoid overlap. • Identify effective methods to provide information to patients, physicians, pharmacists and the community. • Ensure information is widely available regarding options for generic drugs, FamilyWize Discount Cards,	**<u>0-6 Month Milestones:</u>** • By January 2014 and ongoing, promote awareness of the 5 Assistor Sites in Danbury. • By January 2014 and ongoing, broadly distribute information at community events about 2-1-1, Familywize, and affordable health service providers, using existing resources, such as the Directory of Services for Danbury Families. • By February 2014, create a link from community websites, including United Way and Danbury's Promise for Children Partnership websites, to connect consumers with information on signing up for insurance. • By March 2014, promote awareness of the need for providers to update 2-1-1 listings. • By May 2014, convene a meeting with Access Health CT representatives and assistor sites to obtain information regarding their publicity and coordination efforts.	• By 2015, explore holding a Danbury Community Health Fair. • By 2016, promote collaboration between local Public Health Directors and Public Schools to distribute information about public health initiatives (immunizations, etc.). • By 2015, co-develop a Health Ambassador Program with United Way to disseminate key information to local providers and agencies serving vulnerable populations. • By 2015, co-develop a 1-2 page fact sheet with PHI #3 leads containing key contact information for health and human services for older adults, i.e., 2-1-1; 3-1-1, Senior Center Call Centers.	• Access Health CT Assistor utilization and enrollment data • # of events attended • Survey developed and results recorded and summarized • Meeting held with Access Health CT, attendees and action items developed • Website links created and operational • # of providers in the region who have connected with 2-1-1 to update their listings • 2-1-1 utilization data • # of contacts with local media and # PSAs developed and aired, # feature articles • # and location of 2-1-1 presentations	**<u>Access Health CT, Assistor Site, and Discount Prescription Program Promotion</u>** Danbury's Promise for Children Partnership and United Way will promote awareness about the Assistor sites through their networks. Danbury's Promise for Children Partnership and United Way and other workgroup members will distribute print materials, and related information within the community, through community partnerships and other outreach efforts. Danbury's Promise for Children Partnership and United Way to provide links on websites. Workgroup members develop publicity plan to promote information through local media sources. Workgroup members to develop 1-2 page descriptions of health providers serving low-income persons and prescription discount programs. **<u>Provider Survey</u>** In collaboration with workgroup leads, PHI #4 Intern will develop survey of

			and other prescription discount programs, including those offered by retailers, etc. • Collaborate with the CRC Steering Committee to develop a Community Health Ambassador Program to systematically disseminate information on key programs and services to local health providers. • Collaborate with PHI#3 to develop a 1-2 page fact sheet for use by home care providers, etc. with key contact information on services for older adults (i.e., 2-1-1, 3-1-1, Senior Center Call Center).	• By May 2014 and ongoing, contact local media/e-newsletters about publicizing 2-1-1. • By June 2014, survey health providers and social service agency directors about their challenges in getting information to potential clients about their services. • By June 2014, create a 1-2 page description of health providers who provide care to vulnerable individuals and families (i.e., CHCs) and a 1-2 page description of most accessible prescription discount programs for distribution by nonprofits, other providers, and at community events. Create materials in multiple languages. **6-12 Month Milestones:** • By October 2014, explore the need to conduct additional public presentations about 2-1-1, the 2-1-1 Navigator, etc. Target underserved groups for presentations and offer presentations in multiple languages.		• # of Health Ambassadors recruited and trained • Older Adult Fact Sheet co-developed with PHI#3 leads; # printed and disseminated	health care and social service providers. **2-1-1 Promotion** United Way will promote awareness of 2-1-1 online verification process and timeline and others distribute through networks. Danbury's Promise for Children Partnership and United Way and other workgroup members will plan public presentations on 2-1-1 and the 2-1-1 Navigator. **Health Ambassador Program Development** United Way's Volunteer Center and Danbury's Promise for Children Partnership will collaborate to develop the program and recruit and train Health Ambassador volunteers. **Older Adult Fact Sheet** PHI #3 and PHI # 4 co-leads will co-develop Fact Sheet.
Action Step Progress:							

PUBLIC HEARING

APPLICANT

SIGN UP SHEET

February 19, 2014
4:00 p.m.

Applicant: Docket Number: 13-31859-CON
Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital
The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and Operation of it Under The Danbury Hospital's Current General Acute Care Hospital License

Name	Phone	Fax	Representing Organization/Self
Kathy DeMatteo	203-739-6543		WCHN
Andrea Rynn	203-739-7919		WCHN
Jen Zupcoe	203-739-7251		WCHN
Chris Ward	860-210-5373		NMH/WCHN

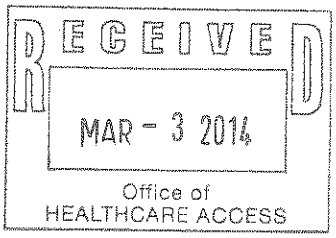
Name	**Phone**	**Fax**	**Representing Organization/Self**
Dr. John Murphy	203-739-7701		WCHN
Steven Rosenberg	203-739-7240		WCHN
Sally Herlihy	203-739-4903		WCHN
Deborah Weymouth	860-355-7200		WCHN

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



WESTERN CONNECTICUT HEALTH NETWORK,
THE DANBURY HOSPITAL AND NEW MILFORD HOSPITAL

THE TERMINATION OF NEW MILFORD HOSPITAL'S GENERAL ACUTE CARE HOSPITAL LICENSE WITH THE CONNECTICUT DEPARTMENT OF PUBLIC HEALTH AND OPERATION OF IT UNDER THE DANBURY HOSPITAL'S CURRENT GENERAL ACUTE CARE HOSPITAL LICENSE

DOCKET NO. 13-31859-CON

FEBRUARY 19, 2014

4:43 P.M.

388 DANBURY ROAD
NEW MILFORD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

HEARING RE: WESTERN CONNECTICUT HEALTH NETWORK
FEBRUARY 19, 2014

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Western Connecticut Health Network, The Danbury Hospital and New Milford Hospital, The Termination of New Milford Hospital's General Acute Care Hospital License with the Connecticut Department of Public Health and Operation of it under the Danbury Hospital's Current General Acute Care Hospital License, held at New Milford High School, 388 Danbury Road, New Milford, Connecticut, on February 19, 2014 at 4:43 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 13-31859-CON, is being held on February 19, 2014 to consider Western Connecticut Health Network, the Danbury Hospital and New Milford Hospital's application for the termination of New Milford Hospital's General Acute Care Hospital license with the Connecticut Department of Public Health and operation under the Danbury Hospital's

current General Acute Care Hospital license.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I've been appointed by Commissioner Jewel Mullen of the Department of Public Health to serve as the Hearing Officer for this matter.

The staff members assigned to assist me in this case are Kaila Riggott and Steven Lazarus, and the hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

Western Connecticut Health Network, the Danbury Hospital and New Milford Hospital have been designated as parties in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this case. All documents have been identified in the Table of the Record for

reference purposes. Mr. Lazarus?

MR. STEVEN LAZARUS: Good afternoon. Steven Lazarus, OHCA staff. We would like to enter into the record Exhibits A through J and, also, take administrative notice of Exhibit 1 and 2.

The Applicants were faxed over the information yesterday, but I do have a color copy of the Exhibit 2, if you would like. It's available for the Applicants.

HEARING OFFICER HANSTED: Any objections to the exhibits?

MR. TED TUCCI: No, Mr. Hearing Officer. No objection. Thank you.

HEARING OFFICER HANSTED: Thank you. At this time, I would ask all the individuals, who are going to testify on behalf of the Applicants, to please stand, raise your right hand and be sworn in.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: And, at this time, the Applicant may proceed.

MR. TUCCI: Thank you very much. Good afternoon, Hearing Officer Hansted, members of the OHCA staff. My name is Ted Tucci. I represent Western

Connecticut Health Network. It's our pleasure to be here before you this afternoon in connection with the pending Certificate of Need.

We're prepared to begin with our presentation, which we expect will be relatively brief. I now would like to introduce you to Dr. John Murphy, President and Chief Executive Officer of WCHN.

DR. JOHN MURPHY: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon, Doctor.

DR. MURPHY: As Ted said, my name is John Murphy. I'm the President and CEO of the network, and I also wanted to thank you for braving the weather and persevering and coming out here and making this convenient for us, in terms of having you here, and, so, thank you for that, and I also wanted to officially adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

DR. MURPHY: And I just thought I would have a conversation, since you have the pre-filed testimony, and give you my perspective on why we're doing this. I'll give you the high-level view, perhaps some of the clinical dimensions of this application, and then have Steve Rosenberg, our CFO, focus a little bit more on

the financial aspects of it.

But, fundamentally, the reason we've asked for this single license is largely about trying to address the need to get New Milford Hospital in compliance with ICD-10 by October 1st of this year.

As you may know, although not everybody does, ICD-10 stands for the International Classification of Diseases, so when you see a patient, you've got to assign a code, and ICD-10 has over 14,000 codes for different diseases and conditions, signs and symptoms, complaints, abnormal findings, etcetera, so it's a whole compendium of how you assess a patient.

CMS, Center for Medicare and Medicaid Services, established that, by October 1st, you had to use ICD-10, and it was going to replace the predecessor, which is ICD-9, which is not nearly as complex.

So if you don't have a billing system that uses ICD-10, you can't bill, and that's really -- we have to get New Milford's systems up to speed, so that, by October 1, it's in compliance with ICD-10.

We have a system in place at Danbury Hospitals, called Siemens(phonetic), which will be ready before October 1 to handle the ICD-10 requirements, so we were trying to figure out how do we get New Milford up to

speed in a way that we could do it efficiently, cost efficiently and expeditiously, and there were a number of options, and Steve will go through those, but, largely, it came down to there was one way to do it that was expensive, and there was another way that was redundant, and then there seemed to be an obvious third and best solution, which was to take the system that we had in Danbury and essentially export it and deploy it up at New Milford Hospital, but it would require us to do it under a single license, under a single tax ID, and that is really, in many respects, generating this request, and it seems to be the logical answer, and, again, Steve will walk you through the numbers, as to why that makes financial sense.

In addition to the ICD-10 requirements that this solution will provide, we also have to meet meaningful use requirements, also established by the Federal Government, and, if we do this and get up to speed with this system, as we've proposed it in a single license, we will be in compliance with meaningful use.

If we don't do it, we will begin to get the assessed financial penalties starting in 2015, because New Milford will not be in compliance with meaningful use.

So, in addition -- and there are some real financial savings by bringing together both institutions under a single license. There are a number of other cost efficiencies, independent of the IT systems, that we will enjoy as a result of this move, if, in fact, it's approved.

So I think there's a clear and compelling financial case to be made, as well as a technological need to have this solution, but I just wanted to speak for a few minutes about some of the clinical dimensions, that having a single IT platform across both hospitals brings benefit to the organization.

Right now, we have two completely separate systems, so if a patient is admitted to New Milford Hospital, his or her medical file is difficult to view, and, in fact, it exists in a silo, distinct from the medical file that exists at Danbury Hospital.

By going to a single license and having a single IT platform, we now have a shared medical record, so the patient's problem lists his or her allergies, the medications, the list of previous procedures and operations and laboratory data and imaging data. That is shared, because it's essentially in the same IT system. Not essentially. The same IT system, so it can be viewed

quite easily and quite readily, and we do think that you can take better care of patients if you know what's wrong with them, and you can know what's wrong with them if you can see the record real time, so we think there's a clear advantage to having a shared medical record.

But, beyond the shared medical record and being able to look at it across the two hospitals, there's also you can build in a single standard of care across the network, and, by that, I mean, if you're admitting patients with a stroke, or congestive heart failure, or sepsis, or whatever the clinical condition may be, we can establish and we have established clinical protocols, but it's hard to follow them if you're on two different systems.

For instance, New Milford right now they're paper-based. In Danbury, they are digitized, so you are prompted, as you're ordering a set of instructions for a patient with a stroke, remember to do this, remember to do this, and, on day two, you're prompted again about what the clinical standard is.

So the clinical protocols will be the same, and they'll exist in the same digital environment. The care pathways that the nurses will follow, in terms of when the patient needs to get up and ambulated, how to

do fall prevention, how to do name identification, all of that can be standardized.

So we think, in addition to the shared medical record, you can establish more easily a single clinical standard of care by having a single IT platform.

The other thing that results from having a single license is you have to have a single medical staff as a result of the Department of Public Health and Medicare.

Right now, we have two different medical staff structures. Each department has its own Chairman. Each section has its own chief. There are different medical executive committees. All of that would have to be consolidated, and we've been working on this for about a year now, where we have drafted a single set of bylaws that would exist across the entire network.

The benefit of that is, when you have a physician, who is applying for privileges on a medical staff, it's now one medical staff, so the tickets to get in the door are the same.

You have to have the same training, education, certifications, the same commitment to continuing medical education. In addition to the credentialing process, the peer review process is now the

same. You have the same body of individuals looking at the work, again, on the same shared medical record, so we can more easily be sure that there is adherence to our standards, so we feel that having a single medical staff will also improve the quality of care.

Lastly, as a result of consolidating the IT systems under a single license, we think it's important and will become increasingly important that, as we look to deliver value, we look at quality, but we also look at the costs associated with the care, is that we have to build a data analytics capability to look realistically at, so, tell me about the quality of care, and we would like to be able to look easily across the entire network, but, also, what was the cost at which that care was provided?

You have to build a data warehouse, and then you have to build analytic capabilities, even something called predictive analytic capabilities, where you could theoretically begin to identify patients, who are at risk of disease, and then find a way to preempt it.

It is very difficult to do that on disparate IT systems, so that's a fourth, and what I'll kind of tailor the remarks to just those four things; a

shared medical record, a single medical staff, a single standard of care, and the ability to do real time data analytics, or I think the clinical dimensions of why we think this is a good idea, because, ultimately, this is about for the network driving value, higher quality at reduced costs.

So our hope is that you will approve this application to establish a single license across the two hospitals. I'm happy to take any questions that you have after Steve is finished, and thanks for listening.

HEARING OFFICER HANSTED: Thank you, Doctor. Just before we move on, you had mentioned meaningful use requirements. Can you elaborate on that a bit and explain what that is?

DR. MURPHY: Yes. The Federal Government, under the High-Tech Act, has established that there are certain economic benefits to meeting these standards of meaningful use, and, essentially, it's the adoption of technology in ways that promote coordinated care.

The Federal Government is giving us economic rewards. We're getting a check from the Federal Government if we meet these standards, so there has to be, for instance, information that flows between doctors and the hospitals. You have to demonstrate that.

And now, as the criteria get more stringent, you also have to be able to share clinical information with the patients, but, ultimately, it's trying to provide more coordinated care that benefits our patients.

The criteria are well-established, and the Federal Government is paying millions of dollars to those institutions that meet those standards, but the standards are rigorous, and there are audited measures in place to be sure that all of the technology requirements are met.

Danbury has met those, both at stage one and stage two. New Milford has not. By 2015, if you don't -- so, at the beginning of this, there are rewards if you meet the criteria, but, by 2015, the game changes.

You begin to get penalized if you don't meet the criteria, so New Milford is not going to gain, New Milford Hospital is not going to get any federal dollars as a result of this, because that window will have closed by then, but it will avoid the penalties associated with not meeting the criteria by 2015.

HEARING OFFICER HANSTED: So if this application was approved, that would lead to New Milford Hospital essentially meeting these requirements?

DR. MURPHY: That's correct.

HEARING OFFICER HANSTED: Is this the only thing that's holding New Milford Hospital back from meeting those requirements?

DR. MURPHY: The system that is in place at New Milford Hospital now would have to be completely overhauled and upgraded if it were to meet meaningful use criteria, but that's a significant, again, investment, both in time and money.

If we do what we're proposing to do with a single license and have the same platform available at both hospitals, New Milford, within six months, will meet all meaningful use criteria, the same way that we do.

As I say, it won't enjoy any additional economic benefit from that, but it will avoid any penalties.

HEARING OFFICER HANSTED: Okay and when you referred to the system, you meant the computer system?

DR. MURPHY: Yes.

HEARING OFFICER HANSTED: Okay, thank you. Okay. Mr. Rosenberg?

MR. STEVEN ROSENBERG: You didn't leave a lot for me. Good afternoon, Hearing Officer Hansted and members of OHCA staff.

HEARING OFFICER HANSTED: Good afternoon.

MR. ROSENBERG: My name is Steven Rosenberg, and I hereby adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. ROSENBERG: Thank you for this opportunity. As you already heard, this application can merge under a single license in large part about fiscal responsibility and finding the most cost-effective and qualitative way of serving the residents of New Milford and the surrounding towns.

Simply put, a single license will enable our system to realize a minimum of $600,000 in operational savings each year going forward.

It also allows us to avoid expending another 3.2 million dollars in capital to replace the existing Medi-Tech system if we were to upgrade it.

So let me explain. New Milford is currently operating under an old version of Medi-Tech for its IT platform, which also includes the billing system.

In order to be ICD-10 compliant for billing this coming October, we have three options that we went through in our CON Application that we were faced with.

The first one was to upgrade Medi-Tech to

the current state at a cost of 3.2 million dollars, which would still leave us with two different IT platforms. You know, clearly, not ideal, in terms of cost and quality and all the benefits Dr. Murphy spoke about being on a single platform.

Our second option was to build out our existing Siemens Envision System used at Danbury to also accommodate New Milford under a separate license.

That carried a price tag of about 1.1 million dollars in capital expenditures, and, again, would still not allow us to save the duplicate cost by still running under two licenses, so there was $600,000 again in cost savings a year that we would not be able to enjoy.

Our third option was to build out Envision to accommodate New Milford under a single license at a one-time cost of $596,000, the lowest cost, and enable the savings of about $600,000 a year going forward, and, in our minds, that was clearly the best decision, in terms of financial responsibility and the quality issues you heard about.

So we began to pursue a single license as part of a considered process, and that decision goes back about a year, and I think we communicated our proposal

with OHCA along the way, and we've had discussions during that time.

We picked the most fiscally-responsible option, and we completed the work necessary to begin to accommodate New Milford under a single license.

System testing really needs to begin, you know, sometime in March, in order to insure that we're ready for October 1st.

As I stated in my pre-filed testimony, there's no intent to move beds as part of this request. The application does not ask for any adjustment to existing bed capacity or any change in services at the New Milford campus.

We ask that you would consider and approve our CON Application, because we believe it's the best way to address operational, financial, and clinical effectiveness.

Thank you for this opportunity.

HEARING OFFICER HANSTED: Thank you. And just one question before Steve and Kaila begin. And I don't know who would be the best to answer this question, but is there any benefit to the patient for these two hospitals to operate under two separate licenses?

MR. ROSENBERG: I do not see any. In

fact, on a number of occasions, we've run into issues, because if a patient ends up at the New Milford Emergency Department and later on gets transferred and admitted to Danbury Hospital, they end up with two separate bills.

They still end up with an Emergency Department visit and an inpatient hospital bill, where, under one license, it would actually be just one bill, and they would never be billed for the ED service.

HEARING OFFICER HANSTED: Okay. Dr. Murphy, do you have a comment on that from perhaps a clinical perspective?

DR. MURPHY: Well the clinical perspectives are clearly in favor of having this common view of the patient and the single standards, etcetera, as I mentioned.

I'm just trying to think of an advantage to having two separate systems, and I honestly can't think of how a patient would be advantaged by having separate systems, because it encourages siloed thinking and siloed viewing, so I don't think I can come up with one.

HEARING OFFICER HANSTED: Okay, thank you, Doctor. Kaila?

MR. LAZARUS: Steven Lazarus. I only have

a couple of questions. On page 52 and 53 of the completeness responses, the Applicants have stated that an overall specific long-term action for the implementation plan has not been identified at this time, and Western Connecticut Health Network will continue to evaluate the needs of the community served by New Milford Hospital and Danbury Hospital and provide those services at New Milford, as are identified as responsive to the needs of this community.

And, also, on page 56, I believe it was stated that we've not identified any need for the reduction at this time as part of the overall strategic planning, which include assessment of the distribution of inpatient services for the defined service area for both Danbury and New Milford service area.

Can the Applicants discuss any steps or any studies or assessments that are ongoing that are looking at that currently and, specifically, that need for in the New Milford service area?

DR. MURPHY: Well I can tell you that it is a continuous process of evaluation of are we effectively meeting the needs of the community in the most cost-efficient way, delivering high quality and delivering care that's accessible, but it is a highly-

dynamic environment, and, you know, change is really constant here, because the number of admissions are going down across the country, and we're not immune to that.

There's also a shift from more inpatient service to more outpatient service and even the observation status within the four walls of the hospital.

We've had a great focus on reducing readmissions, as has every other hospital in the state, and we're getting better at disease prevention, so I would say that it isn't really a static picture. We recognize that it's a dynamic picture.

Ultimately, it's conceivable to me that the present configuration of New Milford Hospital will change, but we think that we have worked very hard over the last three and a half years to try to tightly integrate the two hospitals into one seamless experience of care.

We will continue to do that, but we have not firmly concluded what the future is going to hold for New Milford Hospital. That process is active. The discussions are active, because the financial circumstances continue to change.

Over the last three years, hospitals in America have had a reduction in federal funding of 110

billion dollars. We've had a reduction in funding of half a billion dollars here in the state.

So as we try to confront those economic challenges and the shifting realities of the care needs of the patient population that we serve, we have to figure it out.

I don't think, though, that I have an answer for you today, because, certainly, the Board hasn't opined officially on what do we -- how will New Milford function five years from now? So there isn't a plan that has been finalized.

I can tell you, however, that the discussions continue not only with respect to the New Milford Hospital, but to Danbury Hospital. Are we providing services that are redundant on the inpatient side and on the outpatient side?

So it's really a highly-complex issue. It's one that certainly, if ever we were to consider terminating services at New Milford Hospital, we would only do that by strictly following any and all regulatory guidelines.

But I can't, in a finite sense, answer your question directly, except to say that it is an evolving discussion.

MR. LAZARUS: And just following up on that, I think, even in your testimony, you had mentioned that the process is among the highest priority for Western Connecticut, and is there a time frame that you envision for this to become a priority, as far as when it comes to looking at services and bed capacity and future changes?

DR. MURPHY: I would say this, that we have tried very hard to deal with the cost structure at New Milford Hospital. Over the past year, we've taken out seven million dollars, for instance, in non-salary expenses. We've had to lay off 55 people as a result of some of the budgetary pressures that we've confronted.

I think, truthfully, the low-hanging fruit is gone with respect to cost reduction. As you know, when we came here before you, this body, and talked about closing the Family Birth Center, we did it after a great deal of thought and fundamentally didn't believe primarily that we could continue to deliver high-quality care.

The economic issues were secondary. We just thought that that didn't make sense, and, as you know, we came before you and had that discussion, and we've subsequently closed the Family Birth Center.

I would say, as the economic pressures continue to mount, certainly I would say within the next year I think we are going to have to seriously address the question that you asked me and do it with, you know, potentially making some finite decisions and not just continuing to have the discussion, but actually make some decisions.

MR. LAZARUS: All right, thank you. And you may not be able to answer this question precisely, because of what you just said, but do you envision different hospital locations to have different roles, you know, more like centers of excellence and by location and need for the service areas?

MR. TUCCI: Mr. Lazarus, just by way of clarification, as between the two different campuses within the system?

MR. LAZARUS: Yes. Between the different campuses.

DR. MURPHY: I think that the question of, ultimately, there are some services that I think lend themselves to be centralized. The more complex services that require significant capital investments, for instance, and teams of individuals to, for instance, you know, resect a large ovarian cancer, or a difficult

hepatic malignancy, they need to be centralized. They can't be spread across the network.

What we want to try to do, I think, is to have, though, local access to that care, so the outpatient components can be delivered close to where the patient lives.

And if, for instance, it's a cancer patient, they can have radiation therapy close to home. They can have chemotherapy close to home, but the major surgical resection would be done not in a distributed fashion, but in a centralized fashion.

So I think, fundamentally, some of the difficult work that lies ahead is we have to right size the delivery system. I think that's a challenge for health care across the nation, but we have to continue to make access to it local, and we are going to have to, I think, and I don't want to use a word that sounds austere, but rationalize services.

We can't afford to do, you know, open heart surgery at three different places. Well you know that, as well as we do. I mean you make those decisions.

But I think we're going to have to be careful about how do you balance local access to efficient expertise, and I think that lends itself to a

balance, and those are the discussions that we have to have, because doctors want to have their patients have ready access to expertise.

So we think the outpatient part of that we can handle. I don't think we can duplicate all the inpatient services across the network, though.

MR. LAZARUS: Thank you. OHCA had submitted the Western Connecticut Health Assessment as Exhibit 2. Was there a separate Norwalk Hospital or Norwalk area health community --

DR. MURPHY: New Milford?

MR. LAZARUS: I'm sorry. New Milford. I'm saying Norwalk. New Milford community health assessment done?

MS. SALLY HERLIHY: I'll answer that.

COURT REPORTER: And your name, please?

MS. HERLIHY: Sally Herlihy. There is a community health needs assessment that was performed with Danbury and New Milford Hospital combined as part of the HVCEO, Housatonic Valley Council of Elected Officials Region, so it's 10 towns, and New Milford is one of those towns included in that community needs assessment.

MR. LAZARUS: Would OHCA be able to get a copy? Would you be able to provide us a copy of that as

a late file?

MS. HERLIHY: I can actually give it to you right now, if you'd like.

HEARING OFFICER HANSTED: Perfect.

MS. HERLIHY: So I can submit it. Okay.

MR. LAZARUS: Terrific.

MS. HERLIHY: Sure.

MR. LAZARUS: We'll label that at Applicant Exhibit 1. Thank you.

And I'll address a question to you, Sally, along the same topic. You talk about a couple of, two or three top priorities that were found for the New Milford service area in that?

MS. HERLIHY: I'm actually going to ask Deborah Weymouth to answer that question.

MR. LAZARUS: Sure. If you could please just identify your name and position?

MS. DEBORAH WEYMOUTH: Sure. Good afternoon. Deborah Weymouth. In terms of the report that you're referencing, the priorities that came out of that, is that the specific question?

MR. LAZARUS: Yes.

MS. WEYMOUTH: We actually looked at a number of things that were needed by our community. They

range from mental health, we looked at chronic disease prevention, specifically, with a focus on obesity.

We looked at the needs of our seniors in our community, and, as I know you know the demographics of where we are in the region of the state, that we have a number of aging individuals.

We also looked at a number of other ways that we can help and support these needs that we identified with other providers, so that we partnered with a number of other folks in our planning to bring about the services for our community, as was referenced several times, looking for the most cost-efficient way to do that.

I can give you a specific example of one thing that we do at New Milford that is very helpful to our community. We are very focused on food as an example of good quality care.

As you know, in the health care environment, as you are laying in a hospital bed, we've pretty much taken all your choices away, including what you can wear, what you eat, in terms of medicine, what you're imbibing, and when you can watch TV and when you can't, so your decisions are pretty much gone, other than a choice to have good quality food, and we, at New

Milford Hospital, have done that and continue to provide our seniors in our community with a branch of that food service. That's been very well-received.

We call that branch of our food service Senior Suppers, and we offer them every evening from 4:30 until 6:30. It's a five-dollar, three-course meal, and, for these seniors, we also offer education and socialization and, in some cases, entertainment.

So it directly speaks to a need that we had identified in our community, which is the caring for our seniors, who can be isolated in a rural community, and addressing their needs for good nutrition and support, both socially, spiritually and economically, in terms of the five-dollar meal, and we've come together to provide that plan, so that's just one example in our findings of a need in our community we identified and the way that we've addressed it and continue to address it today.

MR. LAZARUS: Well thank you for that example.

MR. TUCCI: Excuse me. Ms. Weymouth, can you just identify your position for the record?

MS. WEYMOUTH: Yes. I'm the Executive Director of New Milford Hospital and the Senior Vice

President.

MR. TUCCI: Thank you.

MR. LAZARUS: Is there an implementer plan, some sort of an implementer plan that was developed in response to the community health needs assessment?

MS. WEYMOUTH: Yes. We have a very detailed implementation plan, and we have a number of committees that came out of the planning effort.

I actually am on one, as well as the two women immediately to my right, and we have developed that. I know Sally was talking about that, in terms of earlier. Do you want to? I guess we can share it.

MR. LAZARUS: Yes, we would be happy to --

HEARING OFFICER HANSTED: I actually was going to ask.

MS. WEYMOUTH: Okay. There you go. And I think that you will be pleasantly surprised when you look through that, in terms of a level of detail and the action around that and the number of partners that we've included.

MR. LAZARUS: Thank you very much.

HEARING OFFICER HANSTED: And we'll mark that Applicant Exhibit 2, please.

MR. LAZARUS: I guess the last question

would be, as you move forward for the overall strategic planning part of this lengthy project, will Western Connecticut Health Network actually take their recommendations stuff from the community health needs assessment and include it as part of that planning endeavor?

DR. MURPHY: Yes. We don't want to make any significant decisions about the future of Milford Hospital and its portfolio of services without understanding what the community needs assessment says, as well as, you know, ongoing conversations with members of the community, including its Board of Directors, the Community Advisory Board, with whom we've broached this subject.

We've had several meetings with physicians in the community. Deborah and I have both met with a number of donors in the community, as well as some focus groups in the community, just to try to have the conversation about what does the community expect of the network, and at what point is fiscal responsibility going to demand that we reconfigure the portfolio, so those conversations are already taking place and certainly will continue to be had, but the decisions will be informed, and the strategic planning process will be informed.

And, as a matter of fact, these community needs assessments do flow to the same Board committee, the Planning Committee, that would ultimately make a recommendation or at least agree with a recommendation about what should the range of services be at New Milford at some point in the future.

MR. LAZARUS: Thank you. I think that's the last question I had.

HEARING OFFICER HANSTED: Kaila, do you have anything?

MS. KAILA RIGGOTT: No. I think you asked the question that I had, and I think you answered my other question. Thank you.

HEARING OFFICER HANSTED: Okay. I don't have any further questions. Just for the record, are there any members of the public here this evening that would like to give some public comment?

Okay. For the record, let it show that there are none, and, Attorney Tucci, would you like to give a closing statement?

MR. TUCCI: Yes, thank you.

HEARING OFFICER HANSTED: You're welcome.

MR. TUCCI: Hearing Officer Hansted and members of the OHCA staff, we appreciate the time and the

attention that you have given to Western Connecticut Health Network's Certificate of Need Application.

As I think you've heard very compellingly from both of our witnesses here today, this is not a request that has been lightly made of the Office of Health Care Access.

It is one component of an intended overall plan to continue to move Western Connecticut Health Network forward as a system.

You've heard, I think, important immediate benefits that will be garnered if this Certificate of Need is approved, in terms of both immediate positive financial impact on one of the constituent members of the system at New Milford Hospital, and perhaps, even more importantly, in terms of the positive quality of care benefits that will be promoted as a result of allowing the system to operate under a single license, in terms of clinical efficiency, integration of care, and the provision of that care in as seamless a fashion as possible.

So we would ask, respectfully, that you give favorable consideration to this application. As Dr. Murphy has indicated, it is but one part of a longer process.

It is, I think you've heard today, active and ongoing and will be continuing, and I'm sure, in due course, we'll be back before you to update you further and report on the progress that's being made to deliver quality health care in this part of the state.

HEARING OFFICER HANSTED: Thank you, Mr. Tucci.

MR. TUCCI: Thank you.

HEARING OFFICER HANSTED: Okay. At this point, it's, if I read that clock correctly, it's about 20 after 5:00. Is that accurate?

I just want to break until 6:30, just in case any other members of the public want to show up and give comment and they haven't had a chance to make it here yet.

I am not going to hold anyone. You're free to leave, with the exception of Attorney Tucci. Sorry. That's what happens as an attorney. I know that.

So we'll break until 6:30, and, at that time, we'll go back on the record. Thank you.

(Off the record)

HEARING OFFICER HANSTED: Let the record reflect that it is now 6:30 p.m., and there are no members of the public here to give public comment,

therefore, I will hereby adjourn this hearing. Thank you.

(Whereupon, the hearing adjourned at 6:30 p.m.)

HEARING RE: WESTERN CONNECTICUT HEALTH NETWORK
FEBRUARY 19, 2014

AGENDA

	PAGE
Convening of the Public Hearing	2
Applicant's Direct Testimony	5, 14
OHCA's Questions	12, 17
Closing Remarks	31
Public Hearing Adjourned	34

$596,000 [1] 16:17
$600,000 [3] 15:12 16:12 16:18
.Verbatim [1] 2:1
00 [1] 33:11
1 [4] 4:5 6:20 6:23 26:9
1.1 [1] 16:9
10 [1] 25:21
110 [1] 20:24
12 [1] 35:7
13-31859-CON [2] 1:11 2:19
14 [1] 35:6
14,000 [1] 6:9
17 [1] 35:7
19 [4] 1:12 2:11 2:19 35:2
19a-639 [1] 3:16
19a-639a [1] 3:3
1st [3] 6:5 6:14 17:8
2 [5] 4:5 4:8 25:9 29:23 35:5
20 [1] 33:11
2014 [4] 1:12 2:11 2:19 35:2
2015 [4] 7:22 13:12 13:14 13:20
262-4102 [3] 1:17 34:4 35:11
3.2 [2] 15:15 16:1
30 [6] 28:5 28:6 33:12 33:19 33:23 34:3
31 [1] 35:8
34 [1] 35:9
388 [2] 1:14 2:10
4 [3] 1:13 2:11 28:5
43 [2] 1:13 2:11
5 [2] 33:11 35:6
52 [1] 19:1
53 [1] 19:1
54 [1] 3:5
55 [1] 22:12
56 [1] 19:10
6 [5] 28:6 33:12 33:19 33:23 34:3
800 [3] 1:17 34:4 35:11
ability [1] 12:2
able [7] 9:7 11:13 13:2 16:13 23:9 25:23 25:24
abnormal [1] 6:11
access [8] 1:3 2:3 2:18 24:4 24:16 24:23 25:3 32:6
accessible [1] 19:24
accommodate [3] 16:8 16:16 17:5
accordance [1] 3:4
accurate [1] 33:11
Act [1] 12:16
action [2] 19:3 29:19
active [3] 20:20 20:21 33:1
Acute [6] 1:6 1:10 2:6 2:8 2:22 3:1
addition [4] 7:15 8:1 10:3 10:23
additional [1] 14:13
address [5] 6:4 17:16 23:3 26:10 28:17
addressed [1] 28:17
addressing [1] 28:12
adherence [1] 11:3
adjourn [1] 34:1
adjourned [2] 34:3 35:9
adjustment [1] 17:11
administrative [1] 4:5
admissions [1] 20:2
admitted [2] 8:14 18:3
admitting [1] 9:10
adopt [2] 5:16 15:3
adoption [1] 12:18
advantage [2] 9:5 18:16
advantaged [1] 18:18
Advisory [1] 30:13
afford [1] 24:19
afternoon [9] 2:17 4:2 4:23 5:2 5:8 5:9 14:23 15:1 26:19
again [6] 7:12 9:20 11:2 14:7 16:10 16:13
AGENDA [1] 35:3
aging [1] 27:6
agree [1] 31:4
ahead [1] 24:13
allergies [1] 8:20
allow [1] 16:11
allowing [1] 32:16
allows [1] 15:14
along [2] 17:1 26:11
ambulated [1] 9:24
America [1] 20:24
among [1] 22:3
analytic [2] 11:17 11:18
analytics [2] 11:11 12:3
answer [7] 7:12 17:21 21:8 21:22 23:9 25:15 26:15
answered [1] 31:12
appearing [1] 3:22
Applicant [3] 4:21 26:9 29:23
Applicant's [1] 35:6
Applicants [5] 4:6 4:9 4:16 19:2 19:16
application [10] 2:21 5:23 12:8 13:22 15:6 15:22 17:11 17:15 32:2 32:22
applying [1] 10:18
appointed [1] 3:8
appreciate [1] 31:24
approve [2] 12:7 17:14
approved [3] 8:6 13:22 32:12
area [5] 19:14 19:15 19:19 25:10 26:13
areas [1] 23:13
aspects [1] 6:1
assess [1] 6:12
assessed [1] 7:22
assessment [8] 19:13 25:8 25:14 25:18 25:22 29:5 30:5 30:10
assessments [2] 19:17 31:2
assign [1] 6:9
assigned [1] 3:11
assist [1] 3:11
associated [2] 11:10 13:20
attention [1] 32:1
attorney [3] 31:19 33:17 33:18
audited [1] 13:9
austere [1] 24:18
available [2] 4:8 14:10
avoid [3] 13:19 14:14 15:14
away [1] 27:20
balance [2] 24:23 25:1
become [2] 11:8 22:5
bed [3] 17:12 22:6 27:19
beds [1] 17:10
began [1] 16:22
begin [7] 5:4 7:21 11:19 13:15 17:4 17:6 17:20
beginning [1] 13:13
behalf [1] 4:16
benefit [4] 8:12 10:17 14:14 17:22
benefits [5] 12:17 13:4 16:4 32:11 32:16
best [4] 7:6 16:19 17:15 17:21
better [2] 9:2 20:9
between [3] 12:23 23:15 23:17
beyond [1] 9:6
bill [3] 6:18 18:6 18:7
billed [1] 18:8
billing [3] 6:17 15:19 15:21
billion [2] 21:1 21:2
bills [1] 18:4
Birth [2] 22:17 22:24
bit [2] 5:24 12:14
Board [4] 21:8 30:12 30:13 31:2
body [2] 11:1 22:16
branch [2] 28:2 28:4
braving [1] 5:13
break [2] 33:12 33:19
brief [1] 5:5
bring [1] 27:10
bringing [1] 8:2
brings [1] 8:12
broached [1] 30:13
budgetary [1] 22:13
build [6] 9:8 11:11 11:16 11:17 16:6 16:15
bylaws [1] 10:15
campus [1] 17:13
campuses [2] 23:15 23:18
cancer [2] 23:24 24:7
capabilities [2] 11:17 11:18
capability [1] 11:11
capacity [2] 17:12 22:6
capital [3] 15:15 16:10 23:22
care [33] 1:3 1:7 1:10 2:3 2:6 2:9 2:18 2:22 3:1 9:2 9:8 9:23 10:5 11:5 11:10 11:12 11:15 12:2 12:19 13:4 19:24 20:17 21:4 22:20 24:4 24:15 27:17 27:18 32:6 32:15 32:18 32:19 33:5
careful [1] 24:23
caring [1] 28:10
carried [1] 16:9
case [5] 3:4 3:12 3:23 8:8 33:13
cases [1] 28:8
Center [3] 6:13 22:17 22:24
centers [1] 23:12
centralized [3] 23:21 24:1 24:11
CEO [1] 5:12
certain [1] 12:17
certainly [4] 21:8 21:18 23:2 30:22
Certificate [3] 5:3 32:2 32:11
certifications [1] 10:22
CFO [1] 5:24
Chairman [1] 10:11
challenge [1] 24:14
challenges [1] 21:4
chance [1] 33:14
change [4] 17:12 20:1 20:14 20:22
changes [2] 13:14 22:7
Chapter [1] 3:5
check [1] 12:21
chemotherapy [1] 24:9
chief [2] 5:7 10:12
choice [1] 27:24
choices [1] 27:20
chronic [1] 27:1
circumstances [1] 20:22
clarification [1] 23:15
Classification [1] 6:7
clear [2] 8:7 9:4
clearly [3] 16:3 16:19 18:13
clinical [13] 5:23 8:10 9:11 9:12 9:20 9:21 10:5 12:3 13:2 17:16 18:11 18:12 32:18
clock [1] 33:10
close [3] 24:5 24:8 24:9
closed [2] 13:19 22:24
closing [3] 22:17 31:20 35:8
CMS [1] 6:13
code [1] 6:9
codes [1] 6:9
color [1] 4:7
combined [1] 25:19
coming [2] 5:14 15:21
comment [4] 18:10 31:17 33:14 33:24
Commissioner [1] 3:8
commitment [1] 10:22

committee [2] 31:2 31:3
committees [2] 10:13 29:8
common [1] 18:13
communicated [1] 16:24
community [25] 19:6 19:9 19:22 25:10 25:13 25:18 25:22 26:24 27:4 27:11 27:16 28:2 28:10 28:11 28:16 29:5 30:4 30:10 30:12 30:13 30:16 30:17 30:18 30:19 31:1
compelling [1] 8:7
compellingly [1] 32:3
compendium [1] 6:12
complaints [1] 6:11
completed [1] 17:4
completely [2] 8:13 14:5
completeness [1] 19:2
complex [2] 6:16 23:21
compliance [4] 6:5 6:20 7:20 7:23
compliant [1] 15:20
component [1] 32:7
components [1] 24:5
computer [1] 14:17
CON [2] 15:22 17:15
conceivable [1] 20:12
concerning [1] 3:15
concluded [1] 20:19
condition [1] 9:11
conditions [1] 6:10
conducted [1] 3:4
configuration [1] 20:13
confront [1] 21:3
confronted [1] 22:13
congestive [1] 9:10
Connecticut [22] 1:1 1:4 1:8 1:15 2:2 2:4 2:7 2:10 2:20 2:23 3:3 3:5 3:17 3:18 5:1 19:5 22:4 25:8 30:3 32:1 32:8 35:1
connection [1] 5:2
consider [4] 2:20 3:14 17:14 21:18
consideration [1] 32:22
considered [1] 16:23
consolidated [1] 10:14
consolidating [1] 11:6
constant [1] 20:2
constituent [1] 32:13
contested [1] 3:4
continue [11] 19:5 20:18 20:22 21:13 22:19 23:2 24:15 28:1 28:17 30:23 32:8
continuing [3] 10:23 23:6 33:2
continuous [1] 19:21
convenient [1] 5:15
Convening [1] 35:5
conversation [2] 5:20 30:19
conversations [2] 30:11 30:22
coordinated [2] 12:19 13:4
copy [3] 4:7 25:24 25:24
correct [1] 13:24
correctly [1] 33:10
cost [11] 7:1 8:3 11:14 16:1 16:3 16:11 16:13 16:17 16:17 22:9 22:15
cost-effective [1] 15:8
cost-efficient [2] 19:23 27:12
costs [2] 11:10 12:6
Council [1] 25:20
country [1] 20:3
couple [2] 19:1 26:11
course [1] 33:3
COURT [1] 25:16
credentialing [1] 10:24
criteria [7] 13:1 13:6 13:14 13:16 13:20 14:7 14:12
CT [3] 1:17 34:4 35:11
current [4] 1:10 2:8 3:1 16:1
Danbury [20] 1:5 1:9 1:14 2:4 2:8 2:10 2:20 2:24 3:19 6:21 7:8 8:17 9:16 13:11 16:7 18:4 19:7 19:15 21:14 25:19
data [5] 8:22 8:22 11:11 11:16 12:2
deal [2] 22:9 22:18
Deborah [4] 26:15 26:18 26:19 30:16
decision [3] 3:14 16:19 16:23
decisions [6] 23:5 23:7 24:21 27:23 30:8 30:23
defined [1] 19:14
deliver [3] 11:9 22:19 33:4
delivered [1] 24:5
delivering [2] 19:23 19:24
delivery [1] 24:14
demand [1] 30:21
demographics [1] 27:4
demonstrate [1] 12:24
department [10] 1:2 1:8 2:2 2:7 2:23 3:8 10:8 10:11 18:3 18:6
deploy [1] 7:8
designated [1] 3:20
detail [1] 29:18
detailed [1] 29:7
developed [2] 29:4 29:10
different [10] 6:10 9:14 10:10 10:12 16:2 23:11 23:11 23:15 23:17 24:20
difficult [4] 8:15 11:22 23:24 24:13
digital [1] 9:22
digitized [1] 9:16
dimensions [3] 5:23 8:10 12:3
Direct [1] 35:6
directly [2] 21:23 28:9
Director [1] 28:24
Directors [1] 30:12
discuss [1] 19:16
discussion [3] 21:24 22:23 23:6
discussions [4] 17:1 20:21 21:13 25:1
disease [3] 11:20 20:9 27:1
diseases [2] 6:8 6:10
disparate [1] 11:23
distinct [1] 8:16
distributed [1] 24:10
distribution [1] 19:13
Docket [2] 1:11 2:18
Doctor [3] 5:10 12:12 18:23
doctors [2] 12:23 25:2
documents [2] 3:22 3:23
dollars [8] 13:7 13:18 15:15 16:1 16:10 21:1 21:2 22:11
done [3] 24:10 25:14 28:1
donors [1] 30:17
door [1] 10:20
down [2] 7:4 20:3
Dr [17] 5:6 5:8 5:11 5:19 12:15 13:24 14:4 14:19 16:4 18:9 18:12 19:20 22:8 23:19 25:11 30:7 32:22
drafted [1] 10:15
driving [1] 12:5
due [1] 33:2
duly [1] 4:18
duplicate [2] 16:11 25:5
during [1] 17:1
dynamic [2] 20:1 20:11
easily [4] 9:1 10:4 11:3 11:13
eat [1] 27:21
economic [6] 12:17 12:21 14:14 21:3 22:21 23:1
economically [1] 28:13
ED [1] 18:8
education [3] 10:22 10:23 28:7
effectively [1] 19:22
effectiveness [1] 17:17
efficiencies [1] 8:4
efficiency [1] 32:18
efficient [1] 24:24
efficiently [2] 7:1 7:2
effort [1] 29:8
elaborate [1] 12:13
Elected [1] 25:20
Emergency [2] 18:2 18:5
enable [2] 15:11 16:17
encourages [1] 18:19
end [2] 18:4 18:5
endeavor [1] 30:6
ends [1] 18:2
enjoy [3] 8:5 14:13 16:14
enter [1] 4:3
entertainment [1] 28:8
entire [2] 10:16 11:14
environment [3] 9:22 20:1 27:19
envision [4] 16:7 16:15 22:5 23:10
essentially [5] 7:8 8:23 8:24 12:18 13:23
establish [3] 9:12 10:4 12:8
established [4] 6:14 7:17 9:12 12:16
etcetera [2] 6:11 18:14
evaluate [1] 19:6
evaluation [1] 19:21
evening [2] 28:5 31:16
everybody [1] 6:6
evolving [1] 21:24
example [4] 27:14 27:16 28:15 28:20
excellence [1] 23:12
except [1] 21:23
exception [1] 33:17
Excuse [1] 28:21
executive [3] 5:7 10:13 28:23
Exhibit [5] 4:5 4:8 25:9 26:9 29:23
exhibits [2] 4:4 4:11
exist [2] 9:22 10:16
existing [3] 15:16 16:7 17:12
exists [2] 8:16 8:17
expect [2] 5:5 30:19
expeditiously [1] 7:2
expending [1] 15:14
expenditures [1] 16:10
expenses [1] 22:12
expensive [1] 7:5
experience [1] 20:16
expertise [2] 24:24 25:3
explain [2] 12:14 15:17
export [1] 7:8
faced [1] 15:22
fact [4] 8:5 8:16 18:1 31:1
failure [1] 9:11
fall [1] 10:1
Family [2] 22:17 22:24
far [1] 22:5
fashion [3] 24:11 24:11 32:19
favor [1] 18:13
favorable [1] 32:22
faxed [1] 4:6
February [4] 1:12 2:10 2:19 35:2
federal [7] 7:18 12:15 12:20 12:21 13:7 13:17 20:24
few [1] 8:10

figure [2] 6:24 21:6
file [3] 8:15 8:17 26:1
finalized [1] 21:11
financial [9] 6:1 7:14 7:22 8:2 8:8 16:20 17:16 20:21 32:13
finding [1] 15:8
findings [3] 3:15 6:11 28:16
finished [1] 12:10
finite [2] 21:22 23:5
firmly [1] 20:19
first [1] 15:24
fiscal [2] 15:7 30:20
fiscally-responsible [1] 17:3
five [1] 21:10
five-dollar [2] 28:6 28:14
flow [1] 31:2
flows [1] 12:23
focus [4] 5:24 20:7 27:2 30:17
focused [1] 27:16
folks [1] 27:10
follow [2] 9:13 9:23
following [2] 21:20 22:1
food [4] 27:16 27:24 28:2 28:4
forth [1] 3:16
forward [4] 15:13 16:18 30:1 32:9
found [1] 26:12
four [2] 11:24 20:6
fourth [1] 11:23
frame [1] 22:4
free [1] 33:17
fruit [1] 22:14
function [1] 21:10
fundamentally [3] 6:2 22:18 24:12
funding [2] 20:24 21:1
future [4] 20:19 22:6 30:8 31:6
gain [1] 13:16
game [1] 13:14
garnered [1] 32:11
General [9] 1:6 1:10 2:6 2:8 2:22 3:1 3:3 3:5 3:17
generating [1] 7:11
given [1] 32:1
giving [1] 12:20
goes [1] 16:23
gone [2] 22:15 27:23
good [12] 2:16 4:2 4:22 5:8 5:9 12:4 14:23 15:1 26:18 27:17 27:24 28:12
Government [5] 7:18 12:15 12:20 12:22 13:7
great [2] 20:7 22:17
groups [1] 30:18
guess [2] 29:12 29:24
guidelines [2] 3:16 21:21
half [2] 20:15 21:2
HAMDEN [3] 1:17 34:4 35:11
hand [1] 4:17
handle [2] 6:23 25:5
Hansted [29] 2:16 3:7 4:10 4:14 4:20 4:23 5:9 5:18 12:11 13:21 14:1 14:16 14:20 14:23 15:1 15:4 17:19 18:9 18:22 26:4 29:14 29:22 31:9 31:14 31:22 31:23 33:6 33:9 33:22
happy [2] 12:9 29:13
hard [3] 9:13 20:14 22:9
health [31] 1:2 1:3 1:4 1:8 2:3 2:3 2:4 2:7 2:18 2:20 2:24 3:9 3:18 5:1 10:8 19:5 24:15 25:8 25:10 25:13 25:18 27:1 27:18 29:5 30:3 30:4 32:2 32:6 32:8 33:5 35:1
heard [5] 15:6 16:21 32:3 32:10 33:1
hearing [39] 2:1 2:16 2:17 3:2 3:9 3:13 4:10 4:12 4:14 4:20 4:23 5:9 5:18 12:11 13:21 14:1 14:16 14:20 14:23 15:1 15:4 17:19 18:9 18:22 26:4 29:14 29:22 31:9 31:14 31:22 31:23 33:6 33:9 33:22 34:1 34:3 35:1 35:5 35:9
heart [2] 9:10 24:20
held [3] 2:9 2:19 3:2
help [1] 27:8
helpful [1] 27:15
hepatic [1] 24:1
hereby [2] 15:3 34:1
Herlihy [7] 25:15 25:17 25:17 26:2 26:5 26:7 26:14
high [2] 2:9 19:23
high-level [1] 5:22
high-quality [1] 22:19
High-Tech [1] 12:16
higher [1] 12:5
highest [1] 22:3
highly [1] 19:24
highly-complex [1] 21:17
hold [2] 20:19 33:16
holding [1] 14:2
home [2] 24:8 24:9
honestly [1] 18:17
hope [1] 12:7
hospital [41] 1:5 1:5 1:7 1:10 2:4 2:5 2:6 2:9 2:21 2:23 3:1 3:19 3:19 6:4 7:9 8:15 8:17 13:17 13:23 14:2 14:5 18:4 18:6 19:7 19:7 20:6 20:8 20:13 20:20 21:14 21:14 21:19 22:10 23:11 25:9 25:19 27:19 28:1 28:24 30:9 32:14
Hospital's [7] 1:6 1:10 2:6 2:8 2:21 2:22 2:24
hospitals [9] 6:22 8:11 9:7 12:9 12:24 14:11 17:23 20:16 20:23
Housatonic [1] 25:20
HVCEO [1] 25:20
ICD-10 [9] 6:5 6:7 6:9 6:15 6:18 6:20 6:23 7:15 15:20
ICD-9 [1] 6:16
ID [1] 7:10
idea [1] 12:4
ideal [1] 16:3
identification [1] 10:1
identified [8] 2:18 3:24 19:4 19:8 19:11 27:9 28:10 28:16
identify [3] 11:19 26:17 28:22
imaging [1] 8:22
imbibing [1] 27:22
immediate [2] 32:10 32:12
immediately [1] 29:10
immune [1] 20:3
impact [1] 32:13
implementation [2] 19:4 29:7
implementer [2] 29:3 29:4
important [3] 11:8 11:8 32:10
importantly [1] 32:15
improve [1] 11:5
include [2] 19:13 30:5
included [2] 25:22 29:20
includes [1] 15:19
including [2] 27:20 30:12
increasingly [1] 11:8
independent [1] 8:4
indicated [1] 32:23
individuals [4] 4:15 11:1 23:23 27:6
information [3] 4:7 12:23 13:3
informed [2] 30:23 30:24
inpatient [5] 18:6 19:14 20:4 21:15 25:6
instance [6] 9:15 12:23 22:11 23:23 23:23 24:7
institutions [2] 8:2 13:8
instructions [1] 9:18
insure [1] 17:7
integrate [1] 20:16
integration [1] 32:18
intended [1] 32:7
intent [1] 17:10
International [1] 6:7
introduce [1] 5:6
investment [1] 14:7
investments [1] 23:22
isolated [1] 28:11
issue [1] 21:17
issues [3] 16:20 18:1 22:21
itself [1] 24:24
J [1] 4:4
Jewel [1] 3:8
John [3] 5:6 5:8 5:11
Kaila [5] 3:12 17:20 18:23 31:9 31:11
Kevin [2] 2:16 3:7
kind [1] 11:24
label [1] 26:8
laboratory [1] 8:22
large [2] 15:7 23:24
largely [2] 6:3 7:3
last [4] 20:15 20:23 29:24 31:8
Lastly [1] 11:6
late [1] 26:1
lay [1] 22:12
laying [1] 27:19
Lazarus [23] 3:12 4:1 4:2 4:3 18:24 18:24 22:1 23:8 23:14 23:17 25:7 25:12 25:23 26:6 26:8 26:16 26:22 28:19 29:3 29:13 29:21 29:24 31:7
lead [1] 13:22
least [1] 31:4
leave [3] 14:22 16:2 33:17
lend [1] 23:20
lends [1] 24:24
lengthy [1] 30:2
level [1] 29:18
license [23] 1:7 1:10 2:6 2:9 2:23 3:1 6:3 7:10 7:20 8:3 8:18 10:7 11:7 12:8 14:10 15:7 15:11 16:8 16:16 16:22 17:5 18:7 32:17
licenses [2] 16:12 17:23
lies [1] 24:13
lightly [1] 32:5
list [1] 8:21
listening [1] 12:10
lists [1] 8:20
lives [1] 24:6
local [3] 24:4 24:16 24:23
location [1] 23:12
locations [1] 23:11
logical [1] 7:12
long-term [1] 19:3
longer [1] 32:23
look [7] 9:7 11:9 11:9 11:10 11:11 11:13 29:17
looked [4] 26:23 27:1 27:3 27:7
looking [4] 11:1 19:18 22:6 27:12
low-hanging [1] 22:14
lowest [1] 16:17
major [1] 24:9
makes [1] 7:13

malignancy [1] 24:1
March [1] 17:7
mark [1] 29:22
matter [3] 2:3 3:10 31:1
may [4] 4:21 6:6 9:12 23:9
meal [2] 28:6 28:14
mean [2] 9:9 24:21
meaningful [7] 7:17 7:20 7:24 12:13 12:18 14:6 14:12
meant [1] 14:17
measures [1] 13:9
Medi-Tech [3] 15:16 15:18 15:24
Medicaid [1] 6:13
medical [16] 8:15 8:17 8:19 9:5 9:6 10:4 10:7 10:10 10:13 10:18 10:19 10:23 11:2 11:4 12:1 12:1
Medicare [2] 6:13 10:9
medications [1] 8:21
medicine [1] 27:21
meet [7] 7:16 12:22 13:8 13:14 13:16 14:6 14:11
meeting [5] 12:17 13:20 13:23 14:3 19:22
meetings [1] 30:15
members [9] 3:11 4:23 14:24 30:11 31:16 31:24 32:13 33:13 33:24
mental [1] 27:1
mentioned [3] 12:12 18:15 22:2
merge [1] 15:7
met [3] 13:10 13:11 30:16
Milford [52] 1:5 1:6 1:15 2:5 2:5 2:9 2:10 2:21 2:22 3:19 6:4 6:24 7:9 7:23 8:14 9:15 13:12 13:16 13:17 13:22 14:2 14:5 14:11 15:9 15:17 16:8 16:16 17:5 17:13 18:2 19:6 19:8 19:15 19:19 20:13 20:20 21:10 21:14 21:19 22:10 25:11 25:12 25:13 25:19 25:21 26:12 27:15 28:1 28:24 30:8 31:5 32:14
Milford's [1] 6:19
million [4] 15:15 16:1 16:10 22:11
millions [1] 13:7
minds [1] 16:19
minimum [1] 15:12
minutes [1] 8:10
money [1] 14:8
months [1] 14:11
most [4] 15:8 17:3 19:23 27:12
mount [1] 23:2
move [5] 8:5 12:12 17:10 30:1 32:8
Ms [13] 25:15 25:17 26:2 26:5 26:7 26:14 26:18 26:23 28:21 28:23 29:6 29:16 31:11
Mullen [1] 3:8
Murphy [18] 5:6 5:8 5:11 5:12 5:19 12:15 13:24 14:4 14:19 16:4 18:10 18:12 19:20 22:8 23:19 25:11 30:7 32:23
name [7] 3:7 4:24 5:11 10:1 15:2 25:16 26:17
nation [1] 24:15
nearly [1] 6:16
necessary [1] 17:4
need [11] 5:3 6:4 8:9 19:11 19:18 23:13 24:1 28:9 28:16 32:2 32:12
needed [1] 26:24
needs [15] 9:24 17:6 19:6 19:9 19:22 21:4 25:18 25:22 27:3 27:8 28:12 29:5 30:4 30:10 31:2
network [17] 1:4 2:4 2:20 3:18 5:1 5:12 9:9 10:16 11:14 12:5 19:5 24:2 25:6 30:3 30:20 32:9 35:1
Network's [1] 32:2
never [1] 18:8
New [52] 1:5 1:6 1:15 2:5 2:5 2:9 2:10 2:21 2:22 3:19 6:4 6:19 6:24 7:8 7:23 8:14 9:15 13:12 13:16 13:17 13:22 14:2 14:5 14:11 15:9 15:17 16:8 16:16 17:5 17:13 17:17 18:2 19:6 19:8 19:15 19:19 20:13 20:20 21:9 21:13 21:19 22:10 25:11 25:12 25:13 25:19 25:21 26:12 27:15 27:24 28:24 31:5 32:14
next [1] 23:2
non-salary [1] 22:11
none [1] 31:19
Norwalk [3] 25:9 25:10 25:13
notice [1] 4:5
now [13] 5:6 8:13 8:19 9:15 10:10 10:15 10:19 10:24 13:1 14:5 21:10 26:3 33:23
number [11] 7:2 8:3 18:1 20:2 26:24 27:6 27:7 27:10 29:7 29:19 30:17
numbers [1] 7:13
nurses [1] 9:23
nutrition [1] 28:12
obesity [1] 27:2
objection [1] 4:13
objections [1] 4:10
observation [1] 20:6
obvious [1] 7:6
occasions [1] 18:1
October [6] 6:5 6:14 6:20 6:23 15:21 17:8
off [2] 22:12 33:21
offer [2] 28:5 28:7
Office [4] 1:3 2:3 2:18 32:5
Officer [31] 2:16 3:9 4:10 4:12 4:14 4:20 4:23 5:7 5:9 5:18 12:11 13:21 14:1 14:16 14:20 14:23 15:1 15:4 17:19 18:9 18:22 26:4 29:14 29:22 31:9 31:14 31:22 31:23 33:6 33:9 33:22
officially [2] 5:16 21:9
Officials [1] 25:20
OHCA [8] 3:14 4:3 4:23 14:24 17:1 25:7 25:23 31:24
OHCA's [2] 3:23 35:7
old [1] 15:18
one [17] 7:4 10:19 13:11 15:24 17:20 18:7 18:7 18:21 20:16 21:18 25:21 27:14 28:15 29:9 32:7 32:13 32:23
one-time [1] 16:17
ongoing [3] 19:17 30:11 33:2
open [1] 24:19
operate [2] 17:23 32:17
operating [1] 15:18
operation [3] 1:9 2:7 2:24
operational [2] 15:13 17:16
operations [1] 8:22
opined [1] 21:9
opportunity [2] 15:6 17:18
option [3] 16:6 16:15 17:4
options [2] 7:3 15:21
order [2] 15:20 17:7
ordering [1] 9:17
organization [1] 8:12
outpatient [4] 20:5 21:16 24:5 25:4
ovarian [1] 23:24
overall [4] 19:3 19:12 30:1 32:7
overhauled [1] 14:6
own [2] 10:11 10:12
p.m [4] 1:13 2:11 33:23 34:4
page [3] 19:1 19:10 35:4
paper-based [1] 9:16
part [10] 15:7 16:23 17:10 19:12 25:4 25:19 30:2 30:5 32:23 33:5
parties [2] 3:20 4:18
partnered [1] 27:9
partners [1] 29:19
past [1] 22:10
pathways [1] 9:23
patient [12] 6:8 6:12 8:14 9:18 9:24 17:22 18:2 18:14 18:18 21:5 24:6 24:8
patient's [1] 8:20
patients [6] 9:2 9:10 11:19 13:3 13:5 25:2
paying [1] 13:7
peer [1] 10:24
penalized [1] 13:15
penalties [3] 7:22 13:19 14:15
pending [1] 5:2
people [1] 22:12
Perfect [1] 26:4
performed [1] 25:18
perhaps [3] 5:22 18:10 32:14
persevering [1] 5:14
perspective [2] 5:21 18:11
perspectives [1] 18:13
phonetic [1] 6:22
physician [1] 10:18
physicians [1] 30:15
picked [1] 17:3
picture [2] 20:10 20:11
place [4] 6:21 13:9 14:4 30:22
places [1] 24:20
plan [7] 19:4 21:11 28:15 29:4 29:4 29:7 32:8
planning [7] 19:13 27:10 29:8 30:2 30:5 30:24 31:3
platform [6] 8:11 8:19 10:5 14:10 15:19 16:5
platforms [1] 16:2
pleasantly [1] 29:17
pleasure [1] 5:1
point [3] 30:20 31:6 33:10
population [1] 21:5
portfolio [2] 30:9 30:21
position [2] 26:17 28:22
positive [2] 32:12 32:15
possible [1] 32:20
Post [4] 1:16 3:13 34:4 35:10
potentially [1] 23:5
pre-filed [4] 5:17 5:20 15:3 17:9
precisely [1] 23:9
predecessor [1] 6:15
predictive [1] 11:18
preempt [1] 11:20
prepared [1] 5:4
present [1] 20:13
presentation [1] 5:5
President [3] 5:7 5:12 29:1
pressures [2] 22:13 23:1
pretty [2] 27:20 27:23
prevention [3] 10:1 20:9 27:2
previous [1] 8:21
price [1] 16:9
primarily [1] 22:19
principles [1] 3:15
priorities [2] 26:12 26:20
priority [2] 22:3 22:5
privileges [1] 10:18
problem [1] 8:20
procedures [1] 8:21
proceed [1] 4:21
proceeding [1] 3:20

proceedings [1] 2:1
process [8] 10:24 10:24 16:23 19:21 20:20 22:3 30:24 32:24
progress [1] 33:4
project [1] 30:2
promote [1] 12:19
promoted [1] 32:16
prompted [2] 9:17 9:20
proposal [1] 16:24
proposed [1] 7:19
proposing [1] 14:9
protocols [2] 9:13 9:21
provide [6] 7:16 13:4 19:7 25:24 28:1 28:15
provided [1] 11:15
providers [1] 27:9
providing [1] 21:15
provision [1] 32:19
provisions [1] 3:5
public [16] 1:2 1:8 2:2 2:7 2:17 2:24 3:2 3:9 10:8 31:16 31:17 33:13 33:24 33:24 35:5 35:9
purposes [1] 4:1
pursuant [1] 3:2
pursue [1] 16:22
put [1] 15:11
qualitative [1] 15:9
quality [11] 11:5 11:9 11:12 12:5 16:4 16:20 19:23 27:17 27:24 32:15 33:5
questions [4] 12:9 19:1 31:15 35:7
quite [2] 9:1 9:1
radiation [1] 24:8
raise [1] 4:17
range [2] 27:1 31:5
rationalize [1] 24:18
RE [1] 35:1
read [2] 3:21 33:10
readily [1] 9:1
readmissions [1] 20:8
ready [3] 6:22 17:8 25:3
real [3] 8:1 9:4 12:2
realistically [1] 11:12
realities [1] 21:4
realize [1] 15:12
really [6] 6:18 7:11 17:6 20:1 20:10 21:17
reason [1] 6:2
recognize [1] 20:11
recommendation [2] 31:4 31:4
recommendations [1] 30:4
reconfigure [1] 30:21
record [17] 3:22 3:23 3:24 4:4 8:19 9:4 9:5 9:6 10:4 11:2 12:1 28:22 31:15 31:18 33:20 33:21 33:22
recorded [1] 3:13
reduced [1] 12:6
reducing [1] 20:7
reduction [4] 19:12 20:24 21:1 22:15
redundant [2] 7:5 21:15
reference [1] 4:1
referenced [1] 27:11
referencing [1] 26:20
referred [1] 14:17
reflect [1] 33:23
region [2] 25:21 27:5
regulatory [1] 21:20
relatively [1] 5:5
remarks [2] 11:24 35:8
remember [2] 9:18 9:19
replace [2] 6:15 15:15
report [2] 26:19 33:4
REPORTER [1] 25:16
Reporting [4] 1:16 3:13 34:4 35:10
represent [1] 4:24
request [3] 7:11 17:10 32:5
require [2] 7:9 23:22
requirements [7] 6:23 7:15 7:17 12:13 13:10 13:23 14:3
resect [1] 23:24
resection [1] 24:10
residents [1] 15:9
respect [2] 21:13 22:15
respectfully [1] 32:21
respects [1] 7:11
response [1] 29:5
responses [1] 19:2
responsibility [3] 15:8 16:20 30:20
responsive [1] 19:8
result [6] 8:5 10:8 11:6 13:18 22:12 32:16
results [1] 10:6
review [1] 10:24
rewards [2] 12:21 13:13
Riggott [2] 3:12 31:11
right [8] 4:17 8:13 9:15 10:10 23:8 24:13 26:3 29:10
rigorous [1] 13:9
risk [1] 11:20
Road [2] 1:14 2:10
roles [1] 23:11
Rosenberg [7] 5:24 14:21 14:22 15:2 15:3 15:5 17:24
run [1] 18:1
running [1] 16:12
rural [1] 28:11
Sally [4] 25:15 25:17 26:10 29:11
save [1] 16:11
savings [4] 8:2 15:13 16:13 16:18
says [1] 30:10
School [1] 2:9
seamless [2] 20:16 32:19
second [1] 16:6
secondary [1] 22:21
section [3] 3:3 3:16 10:12
see [3] 6:8 9:4 17:24
Senior [2] 28:5 28:24
seniors [4] 27:3 28:2 28:7 28:11
sense [3] 7:14 21:22 22:22
separate [7] 8:13 16:8 17:23 18:4 18:17 18:19 25:9
sepsis [1] 9:11
seriously [1] 23:3
serve [2] 3:9 21:5
served [1] 19:6
service [13] 1:16 18:8 19:14 19:15 19:19 20:5 20:5 23:13 26:13 28:3 28:4 34:4 35:10
services [15] 3:13 6:14 17:12 19:7 19:14 21:15 21:19 22:6 23:20 23:21 24:18 25:6 27:11 30:9 31:5
serving [1] 15:9
set [3] 3:16 9:17 10:15
seven [1] 22:11
several [2] 27:12 30:15
share [2] 13:2 29:12
shared [7] 8:19 8:23 9:5 9:6 10:3 11:2 12:1
shift [1] 20:4
shifting [1] 21:4
show [2] 31:18 33:13
side [2] 21:16 21:16
Siemens [2] 6:22 16:7
significant [3] 14:7 23:22 30:8
signs [1] 6:10
silo [1] 8:16
siloed [2] 18:19 18:20
Simply [1] 15:11
single [28] 6:3 7:10 7:10 7:19 8:3 8:11 8:18 8:19 9:8 10:4 10:5 10:7 10:7 10:15 11:4 11:7 12:1 12:1 12:8 14:10 15:7 15:11 16:5 16:16 16:22 17:5 18:14 32:17
six [1] 14:11
size [1] 24:13
socialization [1] 28:8
socially [1] 28:13
solution [3] 7:7 7:16 8:9
sometime [1] 17:7
sorry [2] 25:12 33:18
sort [1] 29:4
sounds [1] 24:17
speak [1] 8:9
speaks [1] 28:9
specific [3] 19:3 26:21 27:14
specifically [2] 19:18 27:2
speed [3] 6:19 7:1 7:19
spiritually [1] 28:13
spoke [1] 16:4
spread [1] 24:2
staff [12] 3:11 3:21 4:3 4:24 10:7 10:11 10:19 10:19 11:4 12:1 14:24 31:24
stage [2] 13:11 13:12
stand [1] 4:16
standard [4] 9:8 9:20 10:5 12:2
standardized [1] 10:2
standards [6] 11:4 12:17 12:22 13:8 13:8 18:14
stands [1] 6:7
starting [1] 7:22
state [7] 1:1 2:2 16:1 20:8 21:2 27:5 33:5
statement [1] 31:20
static [1] 20:10
status [1] 20:6
Statutes [3] 3:3 3:6 3:17
steps [1] 19:16
Steve [5] 5:24 7:3 7:12 12:10 17:20
Steven [6] 3:12 4:2 4:3 14:22 15:2 18:24
still [4] 16:2 16:11 16:12 18:5
strategic [3] 19:12 30:1 30:24
strictly [1] 21:20
stringent [1] 13:2
stroke [2] 9:10 9:18
structure [1] 22:9
structures [1] 10:11
studies [1] 19:17
stuff [1] 30:4
subject [1] 30:14
submit [1] 26:5
submitted [1] 25:8
subsequently [1] 22:24
Suppers [1] 28:5
support [2] 27:8 28:13
surgery [1] 24:20
surgical [1] 24:10
surprised [1] 29:17
surrounding [1] 15:10
sworn [2] 4:17 4:18
symptoms [1] 6:10
system [19] 6:17 6:21 7:7 7:19 8:23 8:24 14:4 14:17 14:18 15:12 15:16 15:19 16:7 17:6 23:16 24:14 32:9 32:14 32:17
systems [8] 6:19 8:4 8:14 9:14 11:7 11:23 18:17 18:19
Table [2] 3:23 3:24
tag [1] 16:9
tailor [1] 11:24
taking [1] 30:22
tax [1] 7:10
teams [1] 23:23
technological [1] 8:8
technology [2] 12:19 13:10

Ted [3] 4:12 4:24 5:11
terminating [1] 21:19
termination [3] 1:6 2:5 2:22
terms [12] 5:15 9:23 16:3 16:20 26:19 27:21 28:14 29:11 29:18 32:12 32:15 32:17
Terrific [1] 26:6
testify [1] 4:16
testimony [6] 5:17 5:21 15:3 17:9 22:2 35:6
testing [1] 17:6
thank [26] 4:13 4:14 4:22 5:13 5:16 5:18 12:11 14:20 15:4 15:5 17:18 17:19 18:22 23:8 25:7 26:9 28:19 29:2 29:21 31:7 31:13 31:21 33:6 33:8 33:20 34:1
thanks [1] 12:10
themselves [1] 23:21
theoretically [1] 11:19
therapy [1] 24:8
therefore [1] 34:1
thinking [1] 18:19
third [2] 7:6 16:15
thought [3] 5:19 22:18 22:22
three [5] 15:21 20:15 20:23 24:20 26:12
three-course [1] 28:6
through [5] 4:4 7:3 7:13 15:22 29:18
tickets [1] 10:19
tightly [1] 20:15
times [1] 27:12
today [4] 21:8 28:18 32:4 33:1
together [2] 8:2 28:14
top [1] 26:12
topic [1] 26:11
towns [3] 15:10 25:21 25:22
training [1] 10:21
transferred [1] 18:3
tried [1] 22:9
truthfully [1] 22:14
try [4] 20:15 21:3 24:3 30:18
trying [4] 6:3 6:24 13:4 18:16
Tucci [12] 4:12 4:22 4:24 23:14 28:21 29:2 31:19 31:21 31:23 33:7 33:8 33:17
TV [1] 27:22
two [17] 8:13 9:7 9:13 9:19 10:10 12:8 13:12 16:2 16:12 17:22 17:23 18:4 18:17 20:16 23:15 26:11 29:9
ultimately [5] 12:4 13:3 20:12 23:20 31:3
under [17] 1:9 2:8 2:24 7:9 7:10 8:3 11:7 12:16 15:7 15:18 16:8 16:12 16:16 17:5 17:23 18:7 32:17
up [11] 6:19 6:24 7:8 7:18 9:24 18:2 18:4 18:5 18:20 22:1 33:13
update [1] 33:3
upgrade [2] 15:16 15:24
upgraded [1] 14:6
used [1] 16:7
uses [1] 6:18
Valley [1] 25:20
value [2] 11:9 12:5
version [1] 15:18
Vice [1] 28:24
view [3] 5:22 8:15 18:14
viewed [1] 8:24
viewing [1] 18:20
visit [1] 18:6
walk [1] 7:13
walls [1] 20:6
warehouse [1] 11:16
watch [1] 27:22
ways [2] 12:19 27:7
WCHN [1] 5:7
wear [1] 27:21
weather [1] 5:13
welcome [1] 31:22
well-established [1] 13:6
well-received [1] 28:3
Western [12] 1:4 2:4 2:20 3:18 4:24 19:5 22:4 25:8 30:2 32:1 32:8 35:1
Weymouth [8] 26:15 26:18 26:19 26:23 28:21 28:23 29:6 29:16
whole [1] 6:11
window [1] 13:18
within [4] 14:11 20:6 23:2 23:16
without [1] 30:9
witnesses [1] 32:4
women [1] 29:10
word [1] 24:17
worked [1] 20:14
written [1] 3:15
wrong [2] 9:2 9:3
year [8] 6:5 10:15 15:13 16:13 16:18 16:24 22:10 23:3
years [3] 20:15 20:23 21:10
yesterday [1] 4:7
yet [1] 33:15

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 27th day of February, 2014.

Paul Landman
President

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, May 15, 2014 2:27 PM
To: Greer, Leslie
Subject: FW: Question about Financials for Docket # 13-31859-CON

Please add to the record.

Thank you!

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Herlihy, Sally [mailto:Sally.Herlihy@wchn.org]
Sent: Thursday, May 15, 2014 1:04 PM
To: Lazarus, Steven
Cc: Zupcoe, Jen; Rosenberg, Steven
Subject: Question about Financials for Docket # 13-31859-CON

Hi Steven,
In response to your call earlier today about Financial Attachment I, please see the response below. Feel free to reach out to Jen directly if you have questions or would like to discuss further.
Sally

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

From: Zupcoe, Jen
Sent: Thursday, May 15, 2014 12:44 PM
To: Herlihy, Sally
Cc: Rosenberg, Steven; Zupcoe, Jen
Subject: NM CON

HI Sally,
In response to OHCA's question:

DH Attachment 1 shows Operating Margin With CON as follows: FY14 $30M, FY15 $22M, FY16 $20M.
This is a result of the following:

- DH's Operating Margin without CON shows a year over year decline due to expense increases resulting from inflation and incremental depreciation/interest associated with the New Tower outpacing revenue increases.
- DH's Operating Margin with CON shows a continued downward trend however it has been adjusted to include New Milford Hospital's anticipated losses adjusted for savings/efficiencies moving to a Single License as outlined below.

Reference: Financial Assumptions table provided in initial filing:

	Year 1	Year 2	Year 3
NMH Without Project Operating Income	**($5,578)**	**($6,328)**	**($6,813)**
Savngs Projected with Project:			
Salaries & Fringe Benefits	**350**	**350**	**350**
Contracted Services	**175**	**175**	**175**
Other Operating Expense			
Software Expense	**154**	**158**	**162**
Membership Dues	**26**	**26**	**26**
JCAHO	**10**	**10**	**10**
Depreciation	**513**	**513**	**513**
Tot. Savings	**1,228**	**1,232**	**1,236**
Operating Income WITH PROJECT	**(4,349)**	**(5,096)**	**(5,577)**

Jennifer Zupcoe
Vice President, Financial Operations and Decision Support
Western Connecticut Health Network

Voice:(203) 739-7251
Fax: (203) 739-1543
Email: Jen.Zupcoe@wchn.org

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

This transmittal is intended for a particular addressee(s). If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, copying or distribution or dissemination is strictly prohibited. If you suspect that you have received this transmittal in error, please notify Western Connecticut Health Network immediately by email reply to the sender, and delete the transmittal and any attachments.

READER BEWARE: Internet e-mail is inherently insecure and occasionally unreliable. Please contact the sender if you wish to arrange for secure communication or to verify the contents of this message.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

June 10, 2014

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Agreed Settlement Office of Health Care Access Docket Number: 13-31859-CON
New Milford Hospital, Danbury Hospital and Western Connecticut Health Network, Inc	**Termination of New Milford Hospital's License and the Acquisition of New Milford Hospital's Licensed Beds by Danbury Hospital**

To:

Sally Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

Dear Ms. Herlihy:

This letter will serve as notice of the approved Certificate of Need Application in the above-referenced matter. On June 10, 2014, the Agreed Settlement, attached hereto, was adopted and issued as an Order by the Department of Public Health, Office of Health Care Access.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:swl

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants: **New Milford Hospital, Danbury Hospital and Western Connecticut Health Network, Inc. 24 Hospital Avenue, Danbury, CT 06810**

Docket Number: **13-31859-CON**

Project Title: **Termination of New Milford Hospital's License and the Acquisition of New Milford Hospital's Licensed Beds by Danbury Hospital**

Project Description: New Milford Hospital, Danbury Hospital and Western Connecticut Health Network, Inc. ("WCHN") are proposing the termination of New Milford Hospital's Acute Care General Hospital License and the acquisition of New Milford Hospital's 85 acute care beds by Danbury Hospital.

Procedural History: New Milford Hospital, Danbury Hospital and WCHN (herein referred to as "Applicants") published notice of their intent to file a CON application in *The News Times* (Danbury) on July 4, 5 and 6, 2013. On August 15, 2013, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from the Applicants for the above-referenced project. On December 20, 2013, OHCA deemed the application complete.

On January 16, 2014, the Applicants were notified of the date, time, and place of the public hearing. On January 17, 2014, a notice to the public announcing the hearing was published in *The News Times*. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on February 19, 2014; rescheduled from February 5, 2014, due to inclement weather.

Commissioner Jewel Mullen designated Attorney Kevin Hansted as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes) and Conn. Gen. Stat. § 19a-639a. The public hearing record was closed on February 20, 2014. Deputy Commissioner Davis considered the entire record in this matter.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.*, 605 F.Supp. 816 (Md. Tenn. 1985).

Findings of Fact and Conclusions of Law

1. WCHN is the parent corporation of Danbury Hospital and New Milford Hospital. Ex. A, p. 7.

2. New Milford Hospital is an 85-bed acute care hospital located at 21 Elm Street, New Milford, Connecticut. Ex. A, p. 7.

3. Danbury Hospital is a 371-bed (345 general and 26 bassinets) acute care hospital located at 24 Hospital Avenue, Danbury, Connecticut. Ex. A, p. 7.

4. In 2010 New Milford Hospital and Danbury Hospital became wholly-owned subsidiaries of WCHN. The governing instruments of New Milford Hospital and Danbury Hospital were revised so that both corporations have the same governance with the same sole member and the same directors. WCHN also has the same reserved powers/voting rights as both New Milford Hospital and Danbury Hospital. Ex. A, p. 7.

5. The 2010 affiliation established a regional health care delivery system. Since then, New Milford Hospital and Danbury Hospital have integrated operations in an effort to create consistent quality and cost-effective healthcare delivery. Ex. A, p. 8.

6. This proposal involves further consolidation of the operations of Danbury Hospital and New Milford Hospital, which share a unified mission to promote the health of people in the communities they serve in a cost effective manner. Ex. A, p. 8.

7. The Applicants propose to consolidate Danbury Hospital and New Milford Hospital into one license; Danbury Hospital's general hospital license ("license"). Ex. A, p. 7.

8. There will be no change in governance or control of the Applicants as part of this proposal. Ex. A, p. 7.

9. Operating under a single license will provide cost reductions while improving the quality of care provided to patients through clinical, financial and operational integration. Ex. A, p. 9.

10. Section 19-13-D3 of the Regulations of Connecticut State Agencies requires each licensed hospital to have its own medical staff, with its own set of bylaws and medical staff leadership. Ex. A, p. 16; Ex. C, p. 63.

11. With a single license, there would be a single set of bylaws that wholly govern the medical staff, thereby creating a single standard of expectations of providers, a single standard of care for all clinical conditions, and a formal and consistent peer review process, resulting in centralized oversight of the quality and safety of care across WCHN's hospital network. Ex. A, p. 16; Ex. C, p. 63.

12. WCHN has developed a matrix organizational structure across service lines, ensuring provision of a single standard of care for patients, supported by ongoing alignment of policies and procedures and practices at Danbury Hospital and New Milford Hospital. Ex. A, p. 8.

13. WCHN and its affiliated hospitals have aligned and simplified their collective policies and procedures in an effort to support the single standard of care concept. As a direct result, care and service practices have been standardized, variation has been reduced and training has been streamlined. Ex. A, p. 16.

14. Under a single license, the medical staff will have greater opportunity to coordinate care across the network consistently, efficiently and under one standard. The proposed consolidation will create one unified medical staff with the same policies, procedures and clinical pathways/order sets. Ex. A, p. 16, Ex. C, p. 52.

15. With separate licenses, New Milford Hospital and Danbury Hospital patients have separate medical records and patient account numbers. Ex. C, p. 52 and Ex. I, Prefiled Testimony of Steven Rosenberg, Senior Vice President and Chief Financial Officer of WCHN, pp. 1-2.

16. A shared medical record spanning both the Danbury Hospital and New Milford Hospital campuses will enhance quality and safety by eliminating the inefficiencies of duplicative efforts; increasing coordination of care with all clinicians working off the same admissions information; creating more efficient quality assurance and peer review through seamless access to shared information; and increasing the ability to perform quality analytics by using a single database. Ex. A, p. 17.

17. The implementation of a single electronic health record spanning both campuses will further enhance the quality and safety of health care delivery by improving communications across sites of care, including physician offices, emergency services, ambulatory centers and the inpatient environment. Ex. C, p. 52.

18. A single license will also allow WCHN, through a single IT platform, to examine quality and costs of care, as well as utilize predictive analytics to identify Danbury Hospital or New Milford Hospital patients who are at risk for disease and develop preemptive interventions. Ex. I, Pre-filed Testimony of John M. Murphy, M.D., President and CEO of WCHN, p. 3 and Ex. L, Testimony of Dr. Murphy, p. 11.

19. The Applicants' proposal will allow New Milford Hospital to be in compliance with federal ICD-10 coding requirements.[1] Ex. A, p. 7.

[1] ICD-9 codes used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 codes. ICD-9 codes use 3 to 5 digits while the new ICD-10 codes use 3 to 7 digits. ICD-9 codes produce limited data and are inconsistent with current medical practice. Source: www.cms.gov/Medicare/Coding/ICD10/

20. In order to be ICD-10 compliant, WCHN explored three options, with respect to its billing systems:
    a. Upgrading New Milford Hospital's Medi-Tech system at a cost of $3.2 million, with two separate platforms;
    b. Building out Danbury Hospital's Siemens Invision system to accommodate New Milford Hospital under a separate license at a cost of $1.1 million, with two duplicate platforms; or
    c. Building out Danbury Hospital's Siemens Invision system at a one-time cost of $596,000 to accommodate New Milford Hospital under a single license.
    Ex. L, Testimony of Mr. Rosenberg, pp. 15-16.

21. Danbury Hospital's Siemens patient accounting system can only function as a "single entity" system, and cannot accommodate multiple medical record numbers for a patient or process claims or accounts receivable for multiple tax identification number ("TINs").[2] Consequently, moving forward with consolidation of the IT systems under two licenses would require a complete duplication of the Invision system to accommodate the different TINs required for billing and managing accounts. Ex. C, p. 52 and Ex. I, Prefiled Testimony of Mr. Rosenberg, pp. 1-2.

22. Building out Danbury Hospital's Siemens Invision system and accommodating New Milford Hospital under a separate license would take approximately one year to develop and test. Ex. L, Testimony of Mr. Rosenberg, p. 16.

23. The most cost-effective solution to ensure New Milford Hospital's compliance with ICD-10 is to integrate New Milford Hospital's system with Danbury Hospital's and bill as a single entity. Ex. A, p. 8, Ex. C, p. 59.

24. By consolidating the two hospitals under a single license with a single IT platform, WCHN will avoid as much as $3.2 million in costs and realize operational savings of a minimum of $600,000 annually, including savings associated with a reduction in redundant platforms, maintenance costs, licensing and IT staff productivity. Ex. A, p. 8, Ex. C, p. 57, Ex. L, Testimony of Mr. Rosenberg, p. 15.

25. The Applicants' proposal will put New Milford Hospital in compliance with federal health care reform Meaningful Use ("MU") requirements[3] and avoid financial penalties, through the adoption of technology in ways that promote coordinated care. Currently, Danbury Hospital has met the MU requirement and New Milford Hospital has not. Ex. L, Testimony of Dr. Murphy, pp. 7, 12-13.

26. Shifting to a single license will accelerate pricing alignment, which will provide consistency across WCHN, whereupon a charge for a specific procedure will be the same regardless of location. Ex. C, p. 65 and Ex. D, p. 75.

27. There is no capital expenditure associated with this proposal. Ex. C, p. 63 and Ex. A, p. 18.

---

[2] Each hospital has a unique tax identification number ("TIN"). Payers use these numbers to process and pay claims.
[3] Meaningful Use is the adoption of technology to promote coordinated care. Ex. L, Testimony of Dr. Murphy, p.12.

28. After the proposal is implemented, all New Milford Hospital revenues and expenses will be shifted to Danbury Hospital's financial accounting system, resulting in the following financial projections.

Table 1: New Milford Hospital Financial Projections Incremental to the Proposal

Description	FY 2014	FY 2015	FY 2016
Incremental Operating Revenue	$(72,137,000)	$(73,799,000)	$(76,759,000)
Incremental Operating Expenses	$(77,715,000)	$(80,127,000)	$(82,573,000)
Revenue in Excess of Expenses	**$5,578,000**	**$6,328,000**	**$6,813,000**

Assumption: All New Milford Hospital revenues and expenses will shift to Danbury Hospital's financial statements.
Ex. A, pp. 47&48.

29. The following table illustrates Danbury Hospital's projected gain from operations for the first three years following implementation of the proposal:

Table 2: Danbury Hospital Financial Projections with the Proposal

Description	FY 2014	FY 2015	FY 2016
Revenue from Operations	$601,411,000	$613,573,000	$629,022,000
Operating Expenses	$585,194,000	$605,669,000	$623,140,000
Gain from Operations	**$30,699,000**	**$22,240,000**	**$20,075,000**

Assumptions: Danbury Hospital's operating margin without CON shows a year over year decline due to expense increases resulting from inflation and incremental depreciation/interest associated with the construction of a new tower outpacing revenue increases. Danbury Hospital's operating margin with CON shows a continued downward trend. However it has been adjusted to include New Milford Hospital's anticipated losses adjusted for savings/efficiencies moving to a single license.
Ex. A, p. 46.

30. New Milford Hospital projects the following savings, based on a single license:

Table 3: New Milford Hospital Projected Savings with the Proposal

Description	FY 2014	FY 2015	FY 2016
Salaries & Fringe Benefits	$350,000	$350,000	$350,000
Contracted Services	$175,000	$175,000	$175,000
Software Expense	$154,000	$158,000	$162,000
Membership Dues	$26,000	$26,000	$26,000
JCAHO	$10,000	$10,000	$10,000
Depreciation*	$513,000	$513,000	$513,000
Total Savings	**$1,228,000**	**$1,232,000**	**$1,236,000**

*A method of allocating the cost of a tangible asset over its useful life.
The depreciation savings identified above are comprised of the following capital costs depreciated over 5 years. Moving to a single IT platform avoids extensive capital investment as well as ongoing annual maintenance savings.

Cost to upgrade Medi-Tech, savings:	$(3,161,000)
Incremental cost to move to one IT platform:	$(597,000)
Net Savings:	$2,564,000
Depreciation expense over 5 years:	$513,000

Ex. A, p. 48.

31. Patient days at New Milford Hospital dropped from 11,757 in FY 2008 to 8,566 in FY 2012 (-27%).

Table 4: Acute Care Patient Days: FYs 2008 - 2012

						Year-to-Year Change (%)				
Hospital	**FY 08**	**FY 09**	**FY 10**	**FY 11**	**FY 12**	**08/09**	**09/10**	**10/11**	**11/12**	**08/12**
New Milford	11,757	9,858	9,346	9,378	8,566	-16%	-5%	0%	-9%	-27%
Danbury	87,317	92,474	95,142	96,560	91,875	6%	3%	1%	-5%	5%

OHCA Exhibit 1: Appendices I through V from the DPH 2013 Health Care Utilization in Connecticut Report

32. The occupancy rate for available beds at New Milford Hospital was 25% in FY 2012, compared to 68% at Danbury Hospital.

Table 5: Available Bed Occupancy Rates: FY 2012

	Fiscal Year 2012			
Hospital	**Licensed Beds**	**Available Beds**	**Staffed Beds**	**Available Bed Occupancy Rate**
New Milford	95	95	27	25%
Danbury	371	371	265	68%

OHCA Exhibit 1: Appendices I through V from the DPH 2013 Health Care Utilization in Connecticut Report

33. The distribution of inpatient services across a larger geographic area, the unknown impact of health care reform and bringing online the new bed tower at Danbury Hospital will ultimately determine the overall number of licensed beds required for WCHN and the allocation of these licensed beds at each facility. Ex. I, Prefiled Testimony of Mr. Rosenberg, p. 3.

34. The Applicants' proposal does not involve the addition, replacement or termination of any health care functions or services at Danbury Hospital or New Milford Hospital, or the movement of beds between New Milford Hospital and Danbury Hospital. Ex. A, p. 7.

35. As shown in Tables 6, 7 and 8, no change in the patient population mix is projected for Danbury Hospital, New Milford Hospital or WCHN, as a result of the proposal:

Table 6: Danbury Hospital's Patient Population Mix

	Current	Projected		
	FY 2013	**FY 2014**	**FY 2015**	**FY 2016**
Medicare*	45.5%	45.5%	45.5%	45.5%
Medicaid*	17.7%	17.7%	17.7%	17.7%
CHAMPUS &TriCare	0.2%	0.2%	0.2%	0.2%
Total Government	**63.4%**	**63.4%**	**63.4%**	**63.4%**
Commercial Insurers*	35.5%	35.5%	35.5%	35.5%
Uninsured	0.7%	0.7%	0.7%	0.7%

Workers Compensation	0.4%	0.4%	0.4%	0.4%
Total Non-Government	**36.6%**	**36.6%**	**36.6%**	**36.6%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

Note: * Includes managed care activity.
Exhibit C, p. 64.

Table 7: New Milford Hospital's Patient Population Mix

	Current	Projected		
	FY 2013	**FY 2014**	**FY 2015**	**FY 2016**
Medicare*	57.9%	57.9%	57.9%	57.9%
Medicaid*	10.3%	10.3%	10.3%	10.3%
CHAMPUS &TriCare	0.1%	0.1%	0.1%	0.1%
Total Government	**68.3%**	**68.3%**	**68.3%**	**68.3%**
Commercial Insurers*	27.8%	27.8%	27.8%	27.8%
Uninsured	3.1%	3.1%	3.1%	3.1%
Workers Compensation	0.9%	0.9%	0.9%	0.9%
Total Non-Government	**31.7%**	**31.7%**	**31.7%**	**31.7%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

Note: * Includes managed care activity.
Exhibit C, p. 64.

Table 8: WCHN's Patient Population Mix

	Current	Projected		
	FY 2013	**FY 2014**	**FY 2015**	**FY 2016**
Medicare*	46.7%	46.7%	46.7%	46.7%
Medicaid*	17.0%	17.0%	17.0%	17.0%
CHAMPUS &TriCare	0.2%	0.2%	0.2%	0.2%
Total Government	**63.8%**	**63.8%**	**63.8%**	**63.8%**
Commercial Insurers*	34.8%	34.8%	34.8%	34.8%
Uninsured	0.9%	0.9%	0.9%	0.9%
Workers Compensation	0.4%	0.4%	0.4%	0.4%
Total Non-Government	**36.2%**	**36.2%**	**36.2%**	**36.2%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

Note: * Includes managed care activity.
Exhibit C, p. 64.

36. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any policies and standards not yet adopted as regulations by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

37. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

38. The Applicants have established that there is a clear public need for their proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

39. The Applicants have satisfactorily demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

40. The Applicants have satisfactorily demonstrated that access will be maintained and demonstrated an improvement in quality and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5))

41. The Applicants have shown that there would be no change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

42. The Applicants have satisfactorily identified the population to be served by the proposal, and have satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

43. The historical utilization of health care facilities and services in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

44. The Applicants have satisfactorily demonstrated that the proposal would not result in an unnecessary duplication of existing health care facilities or services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

Discussion

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. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790 (2008).*

WCHN is the parent corporation of Danbury Hospital and New Milford Hospital. *FF1.* The current licensed bed complement for New Milford Hospital and Danbury Hospital is 85 and 371, respectively. *FF2-3.* In 2010 New Milford Hospital and Danbury Hospital became wholly-owned subsidiaries of WCHN. The governing instruments of New Milford Hospital and Danbury Hospital were revised so that both corporations have the same governance with the same sole member and the same directors. *FF4.* The purpose of the affiliation was to establish a regional health system. *FF5.* The Applicants are now proposing to terminate New Milford Hospital's license and consolidate operations and beds under Danbury Hospital's license. *F7.* As a result, New Milford Hospital will become a campus of Danbury Hospital.

The move to a single license will allow for more formal synergies between New Milford Hospital and Danbury Hospital, as the medical staff can be combined under one license, thus eliminating the need to have separate bylaws and medical staff leadership. *FF10.* A single set of bylaws governing the entire WCHN medical staff will create a single standard of expectations of providers, a single standard of care for all clinical conditions and a formal and consistent peer review process, through centralized oversight of quality and safety across WCHN. *FF11.* This will provide an opportunity to coordinate one standard of care across the WCHN network consistently and efficiently with a unified medical staff utilizing the same policies, procedures and clinical pathways. *FF13, 14.* A shared medical record spanning both campuses will contribute to enhanced quality and safety by eliminating the inefficiencies of duplicative efforts and improving communication across sites of care. *FF16, 17.* It will also allow for the use of predictive analytics to improve the quality of patient care by identifying patients across the WCHN network that are at risk for disease and developing preemptive interventions. *FF18.*

Since 2010, WCHN has focused its efforts on determining the appropriate mix of services for each hospital and each patient population. The process of evaluating services has been a continuing effort driven by community needs, demographics, patient convenience, and technology. *Ex. C, pp. 52-53.* The Applicants' objective is to deliver what is needed as efficiently and as effectively as possible. WCHN considered which services would be best provided at the local level, the travel patterns of patients for various health services and the needs and preferences of the populations served. *Ex. C, p. 53.* An important aspect of this proposal is that it will not result in any termination or change in location of any health care functions or services provided to the patients, or any change in the patient population mix for New Milford Hospital, Danbury Hospital or WCHN. *FF31, 32.* Therefore, the Applicants have ensured that access to services will be maintained for all patient populations currently being served.

One of the overarching goals of the Statewide Healthcare Facilities and Services Plan is the use of healthcare facility resources in an efficient, cost-effective manner while maintaining the

highest quality healthcare services being provided to the patient. The Applicants' proposal not only provides for the streamlining of resources over the WCHN network, it also demonstrates an improvement in the quality of healthcare services provided to the patient. Therefore, the Applicants have demonstrated a clear public need for their proposal.

Operating under a single license will enable New Milford Hospital to achieve savings through economies of scale (e.g., software expenses, membership fees, accreditation, etc.). New Milford Hospital will not incur operating expenses as a result of the proposal. Instead, it is projecting savings of $1.2 million annually from FY2014-2016. *FF29, 30.* Once consolidation occurs, New Milford Hospital's revenues and expenses will shift to Danbury Hospital's financial accounting system. *FF28.* Even with this shift, Danbury Hospital is projecting gains from operations for FY2014-2016. *FF30.* Although Danbury Hospital's projected gains are less than those actually realized in previous years, it is still projecting substantial revenues. Therefore, the Applicants have satisfactorily demonstrated that their proposal is financially feasible.

In order for New Milford Hospital to become compliant with federal ICD-10 billing requirements, WCHN explored several options: upgrading New Milford Hospital's billing system for $3.2 million (with two separate IT platforms); building out Danbury Hospital's billing system for $1.1 million (with two duplicate IT platforms); or building out Danbury Hospital's billing system to accommodate New Milford Hospital utilizing the same IT platform for both hospitals under a single license. *FF20.* Consolidating New Milford Hospital and Danbury Hospital into a single license will avoid the incurrence of costs to build a redundant IT platform and represents the most cost-effective and efficient solution for bringing New Milford Hospital into compliance with the forthcoming ICD-10 coding requirements. *FF23.* The single IT platform will also enable New Milford Hospital to meet federal Meaningful Use requirements and avoid associated financial penalties. *FF25.* By consolidating the two hospitals under a single license and IT platform, WCHN will avoid as much as $3.2 million in costs and realize operational savings of approximately $600,000 annually. *FF24.* Shifting to a single license will also accelerate pricing alignment, providing for consistency in charges across both hospital campuses. *FF26.*

The Applicants' proposal will result in integrated clinical, financial and operational efficiencies which will create a coordinated standard of care across the WCHN network of hospitals. Moreover, the implementation of a shared medical record will facilitate the use of predictive analytics in an effort to improve patient health. This proposal, which represents the most cost effective option of complying with federal ICD-10 billing and Meaningful Use requirements, will also improve the financial strength of the health care system in the region and enable WCHN to avoid increased costs associated with building and maintaining two duplicative IT platforms. By eliminating redundant efforts and creating consistency and standardization across hospitals, the quality of care will be improved and costs savings will be achieved.

The distribution of inpatient services across a larger geographic area, the unknown impact of health care reform and the results of bringing the new Danbury Hospital bed tower online will impact the overall number of licensed beds required for WCHN and the allocation of these licensed beds at each facility. FF33. OHCA is concerned with New Milford Hospital's low occupancy rate (25% of available beds) and its ability to maintain the current level of acute care

services in the region. FF32 In order to ensure that access to quality healthcare is maintained, OHCA requires that the Applicants take certain actions as identified in the attached Order.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA"), Western Connecticut Health Network, Inc. ("WCHN"), New Milford Hospital Inc. and Danbury Hospital, herein collectively referred to as the "Applicants," hereby stipulate and agree to the terms of settlement with respect to the Applicants' request for the termination of New Milford Hospital's license and the acquisition of New Milford Hospital's services and licensed beds by Danbury Hospital:

1. The Applicants' request for a CON to consolidate the operations of Danbury Hospital and New Milford Hospital under a single general hospital license, with no associated capital expenditure, is hereby approved. Danbury Hospital shall be the surviving corporation after the consolidation and will hold the single hospital license.

2. Within ten (10) calendar days of the closing of the transaction, Danbury Hospital shall report to OHCA the date of such transaction and shall provide OHCA with copies of all associated documents, including any and all attachments or exhibits thereto.

3. Simultaneous to or upon surrender of New Milford Hospital's license, Danbury Hospital's hospital license shall be authorized to increase its licensed bed capacity from the present 371 beds (including 26 bassinets) to 456 beds (including 26 bassinets). Danbury Hospital shall file with OHCA a copy of the revised license to reflect this increased bed capacity within ten (10) calendar days of the issuance of the revised license.

4. Within thirty (30) calendar days of integration of the IT systems and reimbursement processes, the Applicants shall report to OHCA in writing the date the IT systems and reimbursement processes were fully integrated between the New Milford and Danbury campuses.

5. On an annual basis for a period of three (3) years, WCHN shall file with OHCA a copy of a report or study performed by or on behalf of WCHN and/or its affiliates, utilizing predictive analytics to identify patients in the service area of Danbury Hospital and New Milford Hospital who are at risk for disease. Such filings are due within thirty (30) calendar days of the end of each of the three (3) calendar years, commencing on January 30, 2015. Included within these annual filings shall be the following:

    a. An initial plan, as well as annually updated plans, as applicable, to identify WCHN's efforts and initiatives to address the identified needs of at-risk patients in the service area of Danbury Hospital and New Milford Hospital, and

    b. Any cost savings realized by WCHN for the prior calendar year specifically related to efforts and initiatives identified utilizing predictive analytics, and identifying the factors or assumptions which entered into the calculation of the identified cost savings.

6. For the first three (3) years of the combined license, within thirty (30) calendar days of completion of any formal written assessment(s) prepared by or on behalf of, and approved by, the WCHN Board regarding the distribution of inpatient or outpatient services (as such terms are defined for purposes of CON authorization pursuant to Section 19a-638, C.G.S.) between the two campuses, WCHN shall provide OHCA with a copy of any such written assessment(s) and a high-level summary description of any action plan developed by WCHN responding to any recommendations made in the assessment(s). WCHN shall also include with any such submission a description of how such action plan is consistent with the Community Health Needs Assessments for the areas served. Any strategic action plan shall be considered by OHCA as a trade secret and therefore exempt from disclosure pursuant to Section 1-210, C.G.S.

7. WCHN shall request a CON Determination pursuant to Section 19a-638(c), C.G.S. prior to any planned relocation of any inpatient or outpatient service (as such terms are defined for purposes of CON authorization pursuant to Section 19a-638, C.G.S.) from one campus (New Milford or Danbury) to the other whereby such service will no longer be offered at the original campus site. In addition, WCHN shall comply with Section 19a-638, C.G.S. in connection with any termination of an inpatient or outpatient service (as such terms are defined for purposes of CON authorization pursuant to Section 19a-638, C.G.S.) currently offered at and by New Milford Hospital or Danbury Hospital.

8. Danbury Hospital shall notify OHCA within thirty (30) days of any planned reduction (other than temporary reductions for repairs, maintenance, fluctuations in volume, scheduling and other similar conditions) by more than 50% of the current capacity as of the date of this Order at either campus of an inpatient or outpatient service for which Section 19a-638, C.G.S. would require CON authorization if such service was terminated.

9. Danbury Hospital shall submit to OHCA, no later than October 31, 2015, a detailed and comprehensive document showing a three-year plan ("the plan") to integrate the patient care and non-patient care operations of both hospitals. At a minimum, the submission shall address the planned location of services and and their associated beds, anticipated cost savings, staffing and quality improvements, and any merger-related revenue enhancements. Subsequent to the submission of the plan, Danbury Hospital shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the Order, semi-annual periods are October 1 – March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are November 30, 2015, May 31, 2016, November 30, 2016, May 31, 2017 and November 30, 2017. Danbury Hospital shall submit the following on a semi-annual basis:

    a. Danbury Hospital shall provide OHCA with narrative updates on the progress of the implementation of the plan.

    b. Danbury Hospital shall report cost saving totals of the merger for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and

Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. Danbury Hospital will also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. Danbury Hospital shall file a completed Balance Sheet and Statement of Operations for the consolidated Danbury Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

d. Danbury Hospital shall file a completed Hospital Operating Expenses by Expense Category and Department for the consolidated Danbury Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

10. OHCA and the Applicants agree that this Agreed Settlement represents a final agreement between OHCA and the Applicants with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes that may have been raised by the Applicants with regard to Docket Number: 13-31859-CON.

11. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 at the Applicants' expense if the Applicants fail to comply with its terms.

12. This Agreed Settlement shall inure to the benefit of and be binding upon the Office of Health Care Access and the Applicants, and their successors and assigns.

Signed by John M. Murphy, M.D., Chief Executive Officer
(Print name) (Title)

6/9/14
Date

Duly Authorized for
New Milford Hospital, Inc.

Signed by John M. Murphy, M.D., Chief Executive Officer
(Print name) (Title)

6/9/14
Date

Duly Authorized for
Danbury Hospital

Signed by John M. Murphy, M.D., President & CEO
(Print name) (Title)

6/9/14
Date

Duly Authorized for
Western Connecticut Health Network, Inc.

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on June 10, 2014.

Lisa A. Davis, MBA, BS, RN
Deputy Commissioner