

STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Orlando Regional Healthcare System, Inc./CON#9614
175 Salem Court
Tallahassee, Florida 32301

Authorized Representative: Paul McCall
(850) 222-7110, ext.103

2. Service District/County

District 7 (Orange County)

B. PUBLIC HEARING

No public hearing was requested or held regarding the proposed project. The applicant submitted fifty-nine letters of support. Twenty-seven letters of support were submitted by physicians, 21 by patients and their families, and 11 by members of the community, including the Orlando Regional Healthcare Foundation Board, the Orlando Mayor, the Orlando Chief of Police, an Orlando City Commissioner, the Orange County Chairman, the Center for Drug-Free Living, the Dr. P. Phillips Foundation, Sustainable Orlando, Give Kids the World, KernsAble Enterprises, and Darden Restaurants (two). Arnold Palmer wrote a letter in support of the project and Florida Hospital sent an email in support. The physicians indicate that the applicant provides high quality care and due to the large population growth in the area, especially for women of reproductive age, and increasing number of deliveries, additional beds are needed to avoid admission delays and other concerns. Several physician letters further state that additional beds would increase access for the uninsured. Also, these letters refer to the high occupancy in the NICU and the fact that the applicant is a Regional Perinatal Intensive Care Center (RPICC). The support letters from patients and their families reference their favorable personal experiences with the facility, the excellent care received, and the need for additional capacity due to area population growth. The other letters emphasize the hospital's large birth volume and high NICU occupancy, as well as the benefits Arnold Palmer Hospital brings to the community.

C. PROJECT SUMMARY

The applicant operates Arnold Palmer Hospital (APH), a 281-bed Class II specialty hospital with 203 acute care, 34 Level II NICU, and 44 Level III NICU beds, located in Orange County. The applicant proposes to add 34 Level II Neonatal Intensive Care Unit (NICU) beds in District 7 at that hospital.

According to the applicant's *Certificate of Need Predicated on Conditions* page, upon approval of this project, the applicant will relinquish Certificate of Need (CON) Number 9441, an approved CON issued October 8, 2001, for the addition of five Level II NICU beds.

The applicant operates other hospitals in District 7, including Lucerne Medical Center and Orlando Regional Medical Center (ORMC). ORMC is a 517-bed Class I acute care hospital, which is also located in Orange County. ORMC is a Medicaid Disproportionate Share Hospital.

The proposed project cost is estimated to be \$1,611,244. The applicant states that the project is contingent upon approval of its companion application, CON Application #9615, for additional acute care beds. The applicant is proposing, under CON #9615, to add 116 acute care beds to Arnold Palmer Hospital. Architectural schedules submitted with this proposal reflect the entire costs of what the applicant characterizes and the "NICU Center", which presumably include both this proposal and renovation costs associated with the relocation of its existing NICU beds. Although Schedule 9 indicates that the "NICU Center" involves 52,189 GSF of new construction and \$11,581,783 in construction costs, this project is presented as only involving equipment costs of \$1,562,844. The applicant has indicated in Schedule 1 that no construction or building costs are involved in this project to add 34 Level II NICU beds. Therefore, while Schedule 9 presents construction costs, these costs are apparently not associated with this proposal. Total costs for CON #9615, which proposes to add 116 acute care beds at APH, are estimated at \$129,887,939 and involve construction costs of \$77,211,889 and 341,374 GSF of new construction.

D. REVIEW PROCEDURE

The evaluation process is structured by the certificate of need review criteria found in Section 408.035, Florida Statutes. These criteria form the basis for the goals of the review process. The goals represent desirable outcomes to be attained by successful applicants who demonstrate an overall compliance with the criteria. Analysis of an applicant's capability to undertake the proposed project successfully is conducted by assessing the responses provided in the application, and independent information gathered by the reviewer.

Applications are analyzed to identify strengths and weaknesses in each proposal. If more than one application is submitted for the same type of project in the same district (subdistrict), applications are comparatively reviewed to determine which applicant best meets the review criteria.

Section 59C-1.010(2)(b), Florida Administrative Code, allows no application amendment information subsequent to the application being deemed complete. The burden of proof to entitlement of a certificate rests with the applicant. As such, the applicant is responsible for the representations in the application. This is attested to as part of the application in the certification of the applicant.

As part of the fact-finding, the consultant, Richard Patterson, analyzed the application in its entirety with consultation from the Financial Analyst, John Williamson, who evaluated the financial data, and the Architect, Joel Hill, who evaluated the architectural and the schematic drawings.

E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

The following indicate the level of conformity of the proposed project(s) with the criteria and application content requirements found in Florida Statutes, sections 408.035, and 408.037; applicable rules of the State of Florida, Chapters 59C-1 and 59C-2, Florida Administrative Code; and Local Health Plans.

1. Fixed Need Pool

- a. Does the project proposed respond to need as published by a fixed need pool? Ch. 59C-1.008 and Ch. 59C-1.042, Florida Administrative Code.**

In Volume 28, Number 30, dated July 26, 2002, on pages 3318-3319 of the Florida Administrative Weekly, a fixed need pool of zero beds was published for neonatal intensive care Level II beds in District 7 for the January 2005 planning horizon.

As of July 26, 2002, District 7 had 93 licensed Level II NICU beds and five approved Level II NICU beds (CON #9441). The Level II NICU beds in District 7 experienced an occupancy rate of 79.14 percent during the period January through December 2001. The applicant is applying outside of the fixed need pool and indicates it is applying under special (not normal) circumstances.

- b. Regardless of whether bed need is shown under the need formula, the establishment of new Level II neonatal intensive care unit beds within a district shall not normally be approved unless the average occupancy rate for Level II beds in the district equals or exceeds 80 percent for the most recent 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the fixed need pool. Ch. 59C-1.042(3)(d), Florida Administrative Code.**

As stated above, the 93 Level II NICU beds in District 7 experienced an occupancy rate of 79.14 percent for the most recent reporting period.

- c. Special Circumstances for the Approval of Additional Neonatal Intensive Care Unit Beds at Existing Providers, Ch. 59C-1.042(3)(g), Florida Administrative Code - Need for additional Level II neonatal intensive care beds at hospitals with Level II neonatal intensive care services seeking additional Level II beds is demonstrated in the absence of need shown under the formula specified in paragraph (3)(c) of this rule if the occupancy rate for their Level II beds exceeded an average of 90 percent as computed by the agency for the same time period specified in subparagraph (3)(e)(2).**

Although the published need in the district is for zero Level II NICU beds, the applicant is requesting 34 beds. The applicant intends to relinquish CON #9441 upon approval of this project, therefore, approval of the proposed project will add 29 beds to the Level II NICU licensed and approved bed inventory in District 7. The occupancy rate for Arnold Palmer Hospital's Level II NICU beds for the 12 months ending December 31, 2001, was 131.50 percent. The applicant meets the "special circumstances" defined in Rule. The applicant contends that the need

for 34 additional Level II NICU beds is based on historic utilization patterns, anticipated population growth, birth trends, age-specific fertility rates, and current operating conditions at APH.

The applicant discusses that although the six existing Level II NICU providers had a combined calendar year 2001 occupancy below 80 percent (79.14 percent), APH provided over twice as many patient days of service as any other program in the district and accounted for 61 percent of all Level II NICU days.

District 7 Level II NICU Occupancy January-December 2001

| Hospital | Level II Beds | Level II Patient Days | Occupancy |
|---------------------------------|----------------------|------------------------------|------------------|
| Holmes Regional Medical Center | 10 | 810 | 22.19% |
| Florida Hospital-Orlando | 28 | 7,103 | 69.50% |
| Arnold Palmer Hospital | 34 | 16,319 | 131.50% |
| Winter Park Memorial Hospital | 5 | 605 | 33.15% |
| Osceola Regional Medical Center | 6 | 950 | 43.38% |
| Wuesthoff Memorial Hospital | 10 | 1,078 | 29.53% |
| Total | 93 | 26,865 | 79.14% |

Source: Florida Hospital Bed and Service Utilization by District, July 2002 Batching Cycle

The applicant notes that the two programs in Brevard County, Holmes Regional and Wuesthoff Memorial, are operating below 30 percent occupancy; however, the proposed project would not adversely affect their performance because APH does not draw a large number of patients from Brevard County. Seventy-nine percent of the high acuity neonates from Brevard County received care from one of the two neonatal services providers located in Brevard County, while only 10 percent received care at APH (and one percent at Florida Hospital); therefore, the market for NICU services among Brevard County residents functions independently from the other three counties in District 7. The applicant indicates that the low NICU occupancy rates at Holmes Regional and Wuesthoff Memorial are a function of a limited need for services among Brevard County residents rather than outflow to other programs, and thus additional Level II NICU bed capacity at APH will not adversely impact the two existing programs in Brevard County.

The applicant also describes the current operating conditions at APH's NICU. The occupancy levels of the Level II and Level III NICU beds were combined to reflect the fact that to a large extent, the beds are used interchangeably due to infant acuity levels, and level of care assignments may change without physical movement of the neonate from one unit to the other. The applicant explains that this care model assures an optimal level of staffing while preserving continuity of care, operational efficiency, and parental convenience. The following table shows that the NICU (Levels II and III) at APH has been operating at approximately 90 percent or higher for the last three years.

APH NICU Utilization Trends By Calendar Year

| Year | Patient Days | | | Percent Occupancy | | |
|------|--------------|----------|--------|-------------------|----------|--------|
| | NICU II | NICU III | Total | NICU II | NICU III | Total |
| 1997 | 13,498 | 9,702 | 23,200 | 137.31% | 52.05% | 81.49% |
| 1998 | 14,096 | 9,554 | 23,650 | 113.59% | 59.54% | 83.07% |
| 1999 | 16,064 | 10,238 | 26,302 | 129.44% | 63.75% | 92.38% |
| 2000 | 15,972 | 9,628 | 25,600 | 128.35% | 59.79% | 89.67% |
| 2001 | 16,319 | 9,443 | 25,762 | 131.50% | 58.80% | 90.49% |

Source: *Florida Hospital Bed and Service Utilization by District*

The applicant further states that at 90+ percent *average* occupancy in the NICU, many times there are no available NICU beds, and many high-risk antepartum patients are turned away.

The applicant provided a comparison between the growth in birth volumes and growth in Level II NICU volumes at APH over the last five years, which indicates that from 1997 to 1999, NICU capacity was able to keep pace with the growing volume of births, but after 1999, birth volumes continued to grow while NICU volumes stagnated due to capacity limitations. Moreover, according to the applicant, during the last four months, APH has had to deny admission to 53 high-risk obstetric transfers due to a lack of bed availability. The applicant states that APH's inability to accept many high-risk transfers has caused a decline in its Level III NICU market share. The applicant concludes that approval of the proposed project in conjunction with the project proposed in companion CON Application #9615 will assure adequate capacity to meet current and future community needs for both Level II and Level III NICU services, eliminate the need to redirect high-risk transfers, and prevent a further erosion of APH's Level III NICU services market share.

The applicant's primary service area (PSA) for NICU services is comprised of Orange, Seminole, and Osceola Counties, representing 81 percent of APH's high acuity neonatal discharges in 2001. Fourteen percent were from Lake, Brevard, Polk, and Volusia Counties, and the remaining five percent from other areas. Table 4 of the application displays the number and percentage of APH's high acuity neonatal discharges by county for 2001 and Table 5 of the application contains the 2001 District 7 NICU providers' market shares of high acuity neonatal discharges by county of residence.

With respect to birth trends, the applicant supplied the resident live births and change from 1998-2001 in Table 6 of the application.

Resident Live Births, by County: District 7 1998-2001

| Year | Brevard | Orange | Osceola | Seminole | District | PSA |
|------|---------|--------|---------|----------|----------|--------|
| 1998 | 4,811 | 12,914 | 2,253 | 4,247 | 24,225 | 19,414 |
| 1999 | 4,741 | 13,176 | 2,355 | 4,445 | 24,717 | 19,976 |
| 2000 | 5,014 | 14,070 | 2,615 | 4,583 | 26,282 | 21,268 |
| 2001 | 4,789 | 14,242 | 2,704 | 4,510 | 26,245 | 21,456 |

Source: *Florida Vital Statistics (some figures vary slightly from the applicant's Table 6).*

Change in Resident Live Births, by County: District 7 1998-2001

| | Brevard | Orange | Osceola | Seminole | District | PSA |
|---------|----------------|---------------|----------------|-----------------|-----------------|------------|
| Number | (23) | 1,328 | 451 | 263 | 2,020 | 2,042 |
| Percent | -0.5% | 10.3% | 20.0% | 6.2% | 8.3% | 10.5% |

Source: Florida Vital Statistics (some figures vary slightly from the applicant's Table 6).

In comparison to the increase in the number of District 7 live births for 1998-2001 of 8.3 percent, the increase in total NICU days of care was 7.9 percent for the same period. The applicant also analyzed the growth in female population age 15-44 by county for District 7 in Table 7 of the application.

**Female Population Age 15-44, by County: District 7
July 1998-July 2001**

| Year | Brevard | Orange | Osceola | Seminole | District | PSA |
|-------------|----------------|---------------|----------------|-----------------|-----------------|------------|
| 1998 | 87,785 | 203,095 | 34,935 | 79,696 | 405,511 | 317,726 |
| 1999 | 88,305 | 208,581 | 37,333 | 80,945 | 415,164 | 326,859 |
| 2000 | 89,082 | 216,768 | 38,793 | 82,333 | 426,976 | 337,894 |
| 2001 | 89,911 | 221,953 | 39,743 | 84,265 | 435,872 | 345,961 |

Source: AHCA Population Estimates (2000 and 2001 figures vary slightly from the applicant's Table 7).

**Change in Female Population Age 15-44, by County: District 7
July 1998-July 2001**

| | Brevard | Orange | Osceola | Seminole | District | PSA |
|---------|----------------|---------------|----------------|-----------------|-----------------|------------|
| Number | 2,126 | 18,858 | 4,808 | 4,569 | 30,361 | 28,235 |
| Percent | 2.4% | 9.3% | 13.8% | 5.7% | 7.5% | 8.9% |

Source: AHCA Population Estimates (some figures vary slightly from the applicant's Table 7).

The applicant states that growth in the population of fertile women lagged behind growth in the number of live births signaling an increase in fertility rates for both the district and the PSA; however, for Brevard County, the population of women age 15 to 44 grew while births declined, resulting in a decline in that area's fertility rate.

The applicant also evaluated the demographic changes in the population of District 7 over a 10-year period. Population projections show that, overall, the District 7 female population age 15 to 44 is expected to increase by 12.2 percent; the age 15 to 34 component is expected to grow by 23 percent whereas the age 35 to 44 component is expected to decline by 5.3 percent, from 2000 to 2010. The applicant explains that this is due to the last of the baby-boom generation aging out of their childbearing years while their children are just now entering into their prime childbearing years. The applicant notes that the largest number of fertile women as well as the greatest percentage growth in fertile women is expected in Orange County and the smallest is in Brevard County. For the applicant's PSA, the number of younger childbearing women (age 15 to 34) is expected to increase by 22.1 percent, while the number of older childbearing women is expected to be unchanged over the ten-year period. The applicant concludes that the rapid growth in the female

population age 15 to 34 over the next eight years coupled with flat or declining growth in the age 35 to 44 component will produce an increase in the overall fertility rate. For the PSA, the applicant projected live births in Table 11 of the application based on the age-specific fertility rates calculated in Table 10 of the application, which indicates the impact of the demographic shift toward a higher mix of younger women in the childbearing population, resulting in a steadily increasing overall fertility rate. The applicant states that the overall fertility rate will increase from 62.0 in 1999-2001 to 64.4 by 2010 and 65.6 by 2015. Tables 12, 13, and 14 of the application contain the forecasts of Level II NICU, Level III NICU, and total NICU utilization using the methodology contained in Ch. 59C-1.042(3)(c), Florida Administrative Code. Annual utilization in the expanded Level II NICU is projected to be 70.8 percent in the first year of operation (January 2006), increasing to 76.0 percent by year five, and by year 10, 82.4 percent. It is noted that one component of the at-risk female population, the age 35-44 female population, is expected to decrease. The applicant does not discuss the younger at-risk female population growth or decline. Age co-hort breakdowns in data presented by the applicant include the age 15-34 group and the age 35-44 group.

As discussed earlier, the applicant interchangeably utilizes its Level II and Level III NICU beds and expects this practice to continue. Utilization forecasts are presented for both, with Level II beds continuing to be more highly utilized than Level III. The following chart is a composite of projections provided by the applicant:

Projected NICU Utilization Arnold Palmer Hospital

| Year | Patient Days | | | Occupancy | | | | | |
|------------------|-----------------|------------------|-----------------|---------------|-----------------|---------------|------------------|---------------|-----------------|
| | <i>Level II</i> | <i>Level III</i> | <i>Combined</i> | <i># Beds</i> | <i>Level II</i> | <i># Beds</i> | <i>Level III</i> | <i># Beds</i> | <i>Combined</i> |
| Base Year (2001) | 16,319 | 9,443 | 25,762 | 34 | 131.5% | 44 | 58.8% | 78 | 90.5% |
| Year 2 (2007) | 17,859 | 10,162 | 27,724 | 68 | 70.8% | 44 | 67.8% | 112 | 67.8% |

Source: CON 9614, page 23

The applicant's five-year projections (Year 2, 2007), anticipate a 9.4 percent increase in Level II patient days. This is consistent with historic data presented above. However, as noted above, the applicant has not clearly demonstrated that it can expect this continued percentage of increase in neonate births. The applicant has demonstrated that some percentage increase can be expected and that the five approved, not yet implemented, beds will most likely be inadequate to meet future need at the hospital for Level II NICU services.

2. Local Health Plan Preferences

Is need for the project supported by the applicable district plan? ss. 408.035(1) and 408.037(1), Florida Statutes, and Ch. 59C-1.030(2)(c), Florida Administrative Code.

The District 7 Local Health Council has not specified any preferences for neonatal intensive care beds.

3. Agency Rule Criteria

Please indicate how each applicable preference for the type of service proposed is met. Ch. 59C-1.042, Florida Administrative Code.

- a. Ch. 59C-1.042(3)(i), Florida Administrative Code - Regional Perinatal Intensive Care Centers and Step-Down Neonatal Special Care Units. Hospitals which are under contract with the Children's Medical Services Program for the provision of regional perinatal intensive care (RPICC) center or step-down neonatal special care unit care will be given priority over other applicants to expand or establish new neonatal intensive care services when a need is indicated for additional Level II or Level III neonatal intensive care unit beds.**

There is no competing application for Level II NICU beds in District 7 in this review cycle. The applicant notes that APH has been the designated RPICC provider for District 7 since 1974, the additional Level II NICU beds sought in this application will help the hospital to continue to serve all of the neonates seeking Level II NICU services at this facility, including the large numbers of infants who are CMS or County Public Health Unit clients, Medicaid-sponsored, or indigent, and the addition of these beds will reduce the potential for having to transfer babies and families to other facilities, or re-direct high-risk antepartum patients, whenever the demand for Level II services exceeds APH's current Level II licensed bed capacity.

- b. **Ch. 59C-1.042(3)(j), Florida Administrative Code – Conversion of Under-utilized Acute Care Beds.** New Level II or Level III neonatal intensive care unit beds shall normally be approved only if the applicant converts a number of acute care beds as defined in Rule 59C-1.038, excluding specialty beds, which is equal to the number of Level II or Level III beds proposed, unless the applicant can reasonably project an occupancy rate of 75 percent for the applicable planning horizon, based on historical utilization patterns, for all acute care beds, excluding specialty beds. If the conversion of the number of acute care beds which equals the number of proposed Level II or Level III beds would result in an acute care occupancy exceeding 75 percent for the applicable planning horizon, the applicant shall only be required to convert the number of beds necessary to achieve a projected 75 percent occupancy for the applicable planning horizon, excluding specialty beds.

The applicant states that APH is a specialty hospital, and therefore, this provision is not applicable to the review of the proposed project. However, APH has 203 licensed acute care beds. The applicant is not proposing to convert underutilized acute care beds in this application and the applicant did not discuss this criterion to demonstrate that occupancy would be at 75 percent. However, as noted earlier, the applicant has filed a companion application (CON No. 9615) to add 116 acute care beds through the delicensure of 116 acute care beds at Lucerne Medical Center. Refer to the need for additional acute care beds at APH discussed in CON #9616.

- c. **Ch. 59C-1.042(3)(k), Florida Administrative Code - Services to Medically Indigent and Medicaid Patients.** In a comparative review, preference shall be given to hospitals which propose to provide neonatal intensive care services to Children’s Medical Services patients, Medicaid patients, and non-Children’s Medical Services patients who are defined as charity care patients according to the Health Care Board, Florida Hospital Uniform Reporting System Manual, Chapter III, Section 3223. The applicant shall estimate, based on its historical patient data by type of payer, the percentage of neonatal intensive care services patient days that will be allocated to:

- (1) Charity care patient;
- (2) Medicaid patients;
- (3) Private pay patients, including self-pay; and
- (4) Regional Perinatal Intensive Care Center Program and Step Down Neonatal Special Care Unit patients.

The applicant is not proposing a payer condition for the proposed project. However, APH is the designated RPICC provider for

District 7 and historically provided and projects to continue to provide approximately 55 percent of Level II and Level III NICU patient days to Medicaid and charity care patients. The applicant expects that the NICU program will provide approximately 49 percent of its patient days to Medicaid-sponsored patients (including CMS patients) and approximately five percent to Medicaid HMO patients. The applicant also projects 0.5 percent of patient days to self-pay/uninsured/indigent neonates, due to the fact that nearly all patients who would otherwise fall into these categories qualify for Medicaid reimbursement. According to the applicant, historically, about 60 percent of the patients reported as Medicaid patients by the facility's NICU program are in fact CMS/RPICC clients.

Please refer to E.4.i. below for further discussion.

d. Ch. 59C-1.042(4), Florida Administrative Code - Level II and Level III Service Continuity. To help assure the continuity of services provided to neonatal intensive care services patients:

- (1) Hospitals may be approved for Level II neonatal intensive care services without providing Level III services. In a comparative review, preference for the approval of Level II beds shall be given to hospitals, which have both Level II neonatal intensive care unit beds and Level III neonatal intensive care unit beds.**

The applicant provides Level II and Level III NICU services.

- (2) Applicants proposing to provide Level II or Level III neonatal intensive care services shall ensure developmental follow-up on patients after discharge to monitor the outcome of care and assure necessary referrals to community resources.**

The applicant states that neonates requiring intervention services related to developmental problems may first receive these services in-house from APH's rehabilitative therapy staff, which includes physical, occupational, and speech therapists, and from the NICU's developmentalist, Linda Baghdoian-Lowman. Families of infants who have been identified as being at risk for developmental disabilities receive education and counseling regarding early intervention services, continued evaluation, and follow-up services within the community. The applicant explained that each newborn is discharged via physician order, with their scheduled appointments and written instructions regarding repeat metabolic screenings, which better ensures continued screening and appropriate follow-up, and enhances the management, referral, and follow-up of these cases within the local service community.

Many of these children may be referred to area Children's Medical Services providers, such as the Howard Phillips Center for Children and Families, which is affiliated with the applicant, for ongoing developmental disabilities intervention services to ensure the best possible support for these fragile children and their families.

e. Ch. 59C-1.042(5), Florida Administrative Code - Minimum Unit Size.

The applicant currently exceeds the minimum unit size for each level of service.

f. Ch. 59C-1.042(6) - Minimum Birth Volume Requirement. Hospitals applying for Level II neonatal intensive care services shall not normally be approved unless the hospital has a minimum service volume of 1,000 live births for the most recent 12-month period ending six months prior to the beginning date of the quarter of the publication of the fixed bed need pool. Specialty children's hospitals are exempt from these requirements.

The hospital exceeds the minimum service volume of 1,000 live births for the most recent 12-month period.

g. Ch. 59C-1.042(7) - Geographic Access. Level II and Level III neonatal intensive care services shall be available within two hours ground travel time under normal traffic conditions for 90 percent of the population in the service district.

Currently Level II and Level III NICU services are available and accessible within the two hours ground time to 90 percent of the residents of District 7.

h. Ch. 59C-1.042(8) - Quality of Care Standards.

(1) Physician Staffing: Level II neonatal intensive care services shall be directed by a neonatologist or a group of neonatologists who are on active staff of the hospital with unlimited privileges and provide 24-hour coverage, and who are either board-certified or board eligible in neonatal-perinatal medicine.

The applicant states that there is a group of nine neonatologists, eight of whom are board-certified in neonatal-perinatal medicine, with the ninth physician board-eligible in this specialty, on active staff of the hospital with full privileges and providing 24-hour coverage for patients in the NICU. A curriculum vita for each of the physicians is included in the application (several pages are missing from one of the curricula vitae).

- (2) **Nursing Staffing: The nursing staff in Level II and Level III neonatal intensive care units shall be under the supervision of a head nurse with experience and training in neonatal intensive care nursing. The head nurse shall be a registered professional nurse. At least one-half of the nursing personnel assigned to each work shift in Level II and Level III neonatal intensive care units must be registered nurses.**

According to the applicant, Louise Kaigle, R.N., B.S.N., M.S.N., has been the nursing operations manager of the NICU program since 1989 and has over 20 years of professional nursing experience, principally in neonatal intensive care nursing and NICU administration. The applicant also states that 90 percent of the professional nurses assigned to the NICU are RNs. Schedule 6A of the application indicates that all of the proposed additional nursing staff for the project (14.2 FTE) are registered nurses.

- (3) **Special Skills of Nursing Staff: Nurses in Level II and Level III neonatal intensive care units shall be trained to administer cardio-respiratory monitoring, assist in ventilation, administer I.V. fluids, provide pre-operative and post operative care of newborns requiring surgery, manage neonates being transported, and provide emergency treatment of conditions such as apnea, seizures, and respiratory distress.**

The applicant states that all of the RNs who work in APH's NICU program are certified in neonatal resuscitation program and are trained to assist in the foregoing requirements and that initial training for any new or additional nurses assigned to the NICU and ongoing in-service training/education for experienced NICU nursing staff are designed to review and enhance skills maintenance, and to expand staff members' knowledge in these and other areas necessary for the continued delivery of high quality Level II and Level III NICU services.

- (4) **Respiratory Therapy Technician Staffing: At least one certified respiratory care practitioner therapist with expertise in the care of neonates shall be available in the hospitals with Level II or Level III neonatal intensive care services at all times. There shall be at least one respiratory therapist technician for every four infants receiving assisted ventilation.**

The applicant states that respiratory therapy (RT) staffing and certification levels at APH are in compliance with this criterion, with adequate RT personnel currently available to support the

program. The applicant also states that the additional required staffing is reflected on Schedule 6A of the application. However, Schedule 6A does not identify any RTs, although there is an "Other" line in the Ancillary category on the schedule (an additional 12 FTE), which may be RTs.

- (5) **Blood Gases Determination and Ancillary Service Requirements: Blood gas determination shall be available and accessible on a 24-hour basis in all hospitals with Level II or Level III neonatal intensive care services. Hospitals providing Level II or Level III neonatal intensive care services shall provide on-site, on a 24-hour basis, x-ray, obstetric ultrasound, and clinical laboratory services. Anesthesia shall be available on an on-call basis within 30 minutes. Clinical laboratory services shall have the capability to perform microstudies.**

The applicant states that the hospital has blood gas equipment located within the NICU in order to provide prompt and efficient micro sampling of blood gases for these neonates 24 hours per day. The proposed project includes relocation of three of the four current blood gas stations, and additional new ones budgeted. The applicant anticipates that there will be one blood gas monitoring station for each patient pod. The applicant also provides on site x-ray, obstetric ultrasound, and clinical laboratory services with the ability to perform microstudies, 24 hours, seven days a week. In addition, an anesthesiologist is on standby in-house on a 24-hour basis to support the NICU.

- (6) **Nutritional Services: Each hospital with Level II or Level III neonatal intensive care services shall have a dietician or nutritionist to provide information on patient dietary needs while in the hospital and to provide the patient's family instruction or counseling regarding the appropriate nutritional and dietary needs of the patient after discharge.**

The applicant states that a registered dietitian and designated dietary staff members with special expertise in the nutritional needs of neonates are available at APH to work with the NICU's neonatologists, nursing, and social work staff as well as each family to provide dietary planning and nutrition counseling on both an inpatient and outpatient basis. In addition, all mothers and infants are screened for Healthy Start eligibility and many mothers already receiving WIC coupons are referred as needed for additional assistance.

- (7) **Social Services: Each hospital with Level II or Level III neonatal intensive care services shall make available the services of the hospital's social service department to patients' families which shall include, but not be limited to, family counseling and referral to appropriate agencies for services. Children potentially eligible for the Medicaid, Children's Medical Services, or Developmental Services Programs shall be referred to the appropriate eligibility worker for eligibility determination.**

The applicant indicates that it has five social workers (family specialists) familiar with neonatal developmental needs and the resources and needs of NICU families assigned to the NICU. The family specialists consult with family members to ascertain the family's ability to cope and provide the social and emotional support necessary for their newborn's healthy development, make daily rounds in the unit to ensure that these needs are being met, and to discuss potential social service needs and referrals for each patient with other members of the team, helping to ensure that appropriate arrangements are made in preparation for discharge, matching the needs of the neonate and family with appropriate community resources.

Schedule 6A of the application indicates an additional 1.9 FTE for social workers.

- (8) **Developmental Disabilities Intervention Services: Each hospital that provides Level II or Level III neonatal intensive care services shall provide in-hospital intervention services for infants identified as being at high risk for developmental disabilities to include developmental assessment, intervention, and parental support and education.**

The applicant states that it provides in-hospital intervention services for infants identified as being high risk for developmental disabilities by the unit's full-time developmentalist, Linda Lowman, who works with staff to develop a program of intervention and referral for each at-risk infant. In-hospital interventions for infants identified as potentially at risk for developmental disabilities may include medical consultation and therapies, family support, and caregiver education.

- (9) Discharge Planning: Each hospital that provides Level II or Level III neonatal intensive care services shall have an interdisciplinary staff responsible for discharge planning. Each hospital shall designate a person responsible for discharge planning.**

According to the applicant, one of the RNs assigned to the NICU has the designated responsibility for coordinating discharge planning for each neonate, with interdisciplinary support from other team members, as appropriate, to ensure that an optimal discharge plan is developed and implemented. The resulting discharge plan addresses the infant's medical and social support needs following discharge in terms of rehabilitative therapies (PT, OT, and/or speech therapies), breastfeeding, family support and counseling, and referral to community resources as needed.

- i. Ch. 59C-1.042(9) - Level II Neonatal Intensive Care Unit Standards: The following standards shall apply to Level II neonatal intensive care services:**

- (1) Nurse to Neonate Staffing Ratio. Hospitals shall have a nurse to neonate ratio of at least 1:4 in Level II neonatal intensive care units at all times. At least 50 percent of the nurses shall be registered nurses.**

The applicant states that staffing currently meets or exceeds the minimum requirement of one nurse to every four neonates in the Level II NICU and will continue to be met following implementation of the proposed project. The applicant also states that over 90 percent of the professional nurses assigned to the NICU are RNs and that this percentage will increase slightly upon implementation of the proposed project because all nurses expected to be added in association with this project will be RNs. Schedule 6A of the application indicates that all of the proposed additional nursing staff for the project (14.2 FTE) are RNs.

- (2) Requirements for Level II NICU Patient Stations. Each patient station in a Level II NICU shall have, at a minimum:**
- a. Fifty square feet per infant;**
 - b. Two wall mounted suction outlets preferably equipped with a unit alarm to signal loss of vacuum;**
 - c. Eight electrical outlets;**
 - d. Two oxygen outlets and an equal number of compressed air outlets and adequate provisions for mixing these gases;**
 - e. An incubator or radiant warmer;**

- f. One heated humidifier and oxyhood;**
- g. One respiration or heart rate monitor;**
- h. One resuscitation bag and mask;**
- i. One infusion pump;**
- j. At least one oxygen analyzer for every three beds;**
- k. At least one non-invasive blood pressure monitoring device for every three beds;**
- l. At least one portable suction device; and**
- m. Not less than one ventilator for every three beds.**

The applicant indicates that it currently meets or exceeds all of the requirements above and will continue to meet or exceed these requirements following implementation of the proposed project. Refer to the architectural review below in Section E.4.h.

(3) Equipment Required to be Available to Each Level II NICU on demand:

- a. An EKG machine with print-out capacity;**
- b. Transcutaneous oxygen monitoring equipment; and**
- c. Availability to continuous blood pressure measurement.**

The applicant indicates it currently has all of the required equipment above available.

j. Ch. 59C-1.042(11) - Emergency Transportation Services: Each hospital providing Level II neonatal intensive care services or Level III neonatal intensive care services shall have or participate in an emergency 24-hour patient transportation system.

- (1) Provision of Emergency Transportation. Hospitals providing Level II or Level III neonatal intensive care services must operate a 24-hour emergency transportation system directly, or contract for this service, or participate through a written financial or non-financial agreement with a provider of emergency transportation services.**
- (2) Requirements for Emergency Transportation System. Emergency transportation systems, as defined in paragraph (11)(a), shall conform to section 64E-2.006, Florida Administrative Code.**

The applicant states that it maintains a NICU transport team and two specially equipped ambulances, which perform the neonatal transports to the APH NICU, as well as transports of an infant back to a local referral hospital. Designated transport team members, consisting of at least one neonatal RN and RT qualified

for transport duty, are available within 30 minutes or less on a 24-hour basis to perform transport services. The applicant also states that all of the transportation services provided and utilized by APH conform to Rule 64E-2.006 (formerly Rule 10D-66.52).

- k. **Ch. 59C-1.042(12) - Transfer Agreements: A hospital providing only Level II neonatal intensive care services shall provide documentation of a transfer agreement with a facility providing Level III neonatal intensive care services in the same or nearest service district for patients in need of Level III services. Facilities providing Level III neonatal intensive care services shall not unreasonably withhold consent to transfer agreements which provide for transfers based upon availability of service in the Level III facility, and which will be applied uniformly to all patients requiring transfer to Level III, as defined in subparagraph (2)(e)2. An applicant for Level II or Level III neonatal intensive care services shall include, as part of the application, a written protocol governing the transfer of neonatal intensive care services patients to other inpatient facilities.**

See response to 3.j. above. A copy of the applicant's transfer policies and procedures is included in the application.

- l. **Ch. 59C-1.042(13) - Data Reporting Requirements: All hospitals with Level II or Level III neonatal intensive care services shall provide the agency or its designee with patient utilization and fiscal reports which contain data relating to patient utilization of Level II and Level III neonatal intensive care services.**

The applicant states that it will continue to provide all data required by the agency in this section of the Rule.

4. **Statutory Review Criteria**

- a. **Is need for the project evidenced by the availability, efficiency, quality of care, accessibility, and extent of utilization of existing health care facilities and health services in the applicant's service area? ss. 408.035(2) and 408.035(7), Florida Statutes.**

The applicant states that need for the proposed project is demonstrated by its occupancy having exceeded 90 percent for the most recent reporting period (January-December 2001), pursuant to Ch. 59C-1.042(3)(g), Florida Administrative Code. As stated above, the applicant meets the special circumstances defined in that Rule. The Level II NICU utilization for the last five years at Arnold Palmer Hospital is as follows:

APH Level II NICU Occupancy 1997-2001

| Calendar Year | Occupancy |
|----------------------|------------------|
| 1997 | 137.31% |
| 1998 | 113.59% |
| 1999 | 129.44% |
| 2000 | 128.35% |
| 2001 | 131.50% |

Source: Florida Hospital Bed and Service Utilization by District

The applicant states that need for its proposal is also supported by this statutory review criterion. The table below represents the period January through December 2001 utilization data for each Level II NICU provider in the district:

District 7 Level II NICU Occupancy January-December 2001

| Hospital | Level II Beds | Level II Patient Days | Occupancy |
|---------------------------------|----------------------|------------------------------|------------------|
| Holmes Regional Medical Center | 10 | 810 | 22.19% |
| Florida Hospital-Orlando | 28 | 7,103 | 69.50% |
| Arnold Palmer Hospital | 34 | 16,319 | 131.50% |
| Winter Park Memorial Hospital | 5 | 605 | 33.15% |
| Osceola Regional Medical Center | 6 | 950 | 43.38% |
| Wuesthoff Memorial Hospital | 10 | 1,078 | 29.53% |
| Total | 93 | 26,865 | 79.14% |

Source: Florida Hospital Bed and Service Utilization by District

The applicant notes that the two District 7 providers who offer both Level II NICU and Level III NICU services (APH and Florida Hospital) are well utilized. The four other district Level II NICU programs are much smaller and experience much lower rates of utilization. The two Brevard County programs (Holmes Regional and Wuesthoff Memorial) are below 30 percent occupancy. As stated in Section E.1.c., above, there is very little patient flow from Brevard County to APH and therefore, availability and accessibility to those programs is limited for the APH patient base. The Level II NICU program at Osceola Regional (six beds) was implemented in October 1999 and Winter Park Memorial has the smallest program in the district (five beds). The applicant states that the smaller Level II NICU programs do not represent reasonable treatment alternatives for most of the high-risk obstetrical patients or infants being treated at APH due to the range of services available at APH as well as APH's position as the RPICC for District 7. The applicant also contends that the utilization at the two larger programs, particularly at APH, results in an average district-wide occupancy rate almost at the desired district average occupancy standard of 80 percent (79.14 percent).

According to the applicant, APH is generally regarded as the premier NICU provider in District 7, with the largest NICU bed capacity, the largest number and percentage of NICU patient days, and the highest volume of live births in the district, and is also noted for its capability and success in providing advanced neonatal procedures and treatments, including general surgery, cardiac surgery, and neurosurgery, and is the only facility in District 7 providing Extracorporeal Membrane

Oxygenation (ECMO) and Nitric Oxide therapy. As stated above, APH is the state designated RPICC Program provider of obstetric and neonatal services for District 7 and a high proportion of the neonates cared for by APH are Medicaid, indigent, and CMS or County Public Health Unit clients and other high-risk cases. It is noted that Florida Hospital, owned by Adventist Health System/Sunbelt, Inc. (Adventist) submitted a letter of support for this project. Adventist also owns Winter Park Hospital, another provider of Level II NICU services in District 7.

Regarding the possible improvement of the quality of care currently being provided in the district. The somewhat innovative construction of the proposed extension to the physical plant offers a better working environment for staff and has the potential to offer a more healing environment for patients. This project is linked to CON #9615 in which the applicant proposes to move 116 beds from it Lucerne facility to construct an extension to APH. The new extension will be constructed of a glass curtain wall system with shading devices to deflect the heat gain from the sun and make a more energy efficient building. Through the use of light and color, the applicant states it will create an environment that will “aid the healing process”. A review of the literature suggests that a well-designed hospital can aid patients in recovering both their health and spirits through the use of natural sunlight, flexible spaces and a streamlined approach to patient care. The applicant indicates that studies show compact circular layouts decrease the time that healthcare professionals spend getting from patient to patient and this makes the building and its patient care more efficient and therefore less costly. The Agency’s architectural review of the project indicates that the applicant has proposed such a configuration, but goes on to say that circular or curved building are more expensive to build. It appears that while some efficiency will be gained, including energy efficiencies and efficiencies in the delivery of patient care, they will not be gained without a price. Overall, however studies conducted in Australia, England and the United States indicate that this type of innovative construction, which results in high performance hospital buildings, not only creates a better working environment for staff, but also can improve patient well-being¹.

¹ Lawson, Brian, *The Architectural Review*, March, 2002; Langdon, Mark, CII Construction Industry Institute Australia, 5th Annual Conference “Innovation in Construction – High Performance Buildings” <http://www.ciaa.qut.com/conference/LANGDON,%20Mark.doc> ; Better Public Buildings website: <http://www.betterpublicbuildings.gov.uk/care.htm>, Prime Minister’s Award, Norfolk and Norwich University Hospital.

- b. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability of providing quality care? ss. 408.035(3), Florida Statutes.**

The applicant is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A copy of the JCAHO accreditation for 1999-2002 is included in the application. The application also includes copies of the applicant's Performance Improvement Plan 2002-2004 and Utilization Management Plan 2002 to establish, guide, monitor, and constantly improve the quality of care delivered at the applicant's facilities.

The NICU at APH is one of 11 CMS-designated regional perinatal intensive care centers in Florida. The unit provides specialized care including state-of-the-art respiratory management such as high frequency ventilation, use of Nitric Oxide, and ECMO. The applicant indicates that the NICU staff is comprised of extensively trained nurses, therapists, family specialists, and board-certified neonatologists. The transport team and specially-designed newborn ambulances, as well as helicopter transport when necessary, provide stabilization and transport for the critically ill babies born in community hospitals. A site visit to the NICU at APH was conducted on April 12, 2002, by CMS Neonatal Consultant John S. Curran, M.D. A letter dated April 25, 2002 from Dr. Curran regarding the visit was submitted in the application. Dr. Curran states:

The program fully meets standards and provides exemplary patient care. The low birth weight mortality is exceptionally low over a 12-year review. The ECLS results are likewise impressive and aggressive implementation of a nitric oxide protocol for PPHN has been implemented.

The applicant also states that the existing NICU program at APH complies with the standards endorsed by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the State of Florida, and the unit's planned relocation will result in few changes to the clinical or operational aspects of the existing program. The applicant also described the benefits of the new unit design, which is evaluated in Section E.4.h. below.

According to AHCA data, the applicant had 30 confirmed complaints (12 without deficiency), during the last three years. The confirmed complaints concerned patient care (three), medical records (three), medicine problem (two), EMTALA/emergency access (two), failure to report incident (two), patient rights (two), and one each involving medical services, infection control, equipment in disrepair, and death.

- c. **Is the applicant proposing special health care services for its service area that are not reasonably and economically accessible in adjacent service areas? ss. 408.035(4), Florida Statutes.**

The proposed project does not involve special health care services that are not reasonably or economically accessible in adjacent districts. APH does serve a relatively small proportion of patients from beyond District 7 and expects this historic patient flow pattern to continue in the future.

- d. **Is this project to be located in a research or teaching hospital? Will the program affect the clinical needs of health professional training programs in the service area? ss. 408.035(5), Florida Statutes.**

Although Arnold Palmer Hospital is included on the license of Orlando Regional Medical Center, a statutory teaching hospital, APH is not so designated. The applicant has 153 physician residents in its eight Accreditation Committee for Graduate Medical Education-accredited residency programs. Two of those programs, obstetrics/gynecology and pediatrics, conduct the bulk of their activities at APH. The applicant lists the extensive institutional affiliations with medical schools for education, training, and research, and describes the residency, training/internship, clinical support, and research opportunities, including those in the NICU, which benefit service delivery at the facility and advance the field of health care, improving quality and clinical outcomes, reducing cost, or providing other benefits.

- e. **What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? ss. 408.035(6), Florida Statutes.**

The audited financial statements for the periods ending September 30, 2001 and 2000 were analyzed for the purpose of evaluating the applicant's ability to provide the capital and operational funding necessary to implement the project. The following is a list of accounts and ratios used in the analysis:

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| | <u>09/30/2001</u> | <u>09/30/2000</u> |
|---|-------------------|-------------------|
| Current Assets | \$ 332,116,000 | \$ 297,230,000 |
| Cash and Current Investment | \$ 139,445,000 | \$ 103,924,000 |
| Assets Restricted for Capital Projects | \$ 110,621,000 | \$ 101,383,000 |
| Total Assets | \$ 1,105,929,000 | \$ 1,066,612,000 |
| Current Liabilities | \$ 127,933,000 | \$ 124,100,000 |
| Total Liabilities | \$ 690,639,000 | \$ 666,795,000 |
| Net Assets | \$ 415,290,000 | \$ 399,817,000 |
| Total Revenues | \$ 896,546,000 | \$ 815,762,000 |
| Interest Expense | \$ 28,722,000 | \$ 29,621,000 |
| Excess of Revenues over Expenses | \$ 30,149,000 | \$ 24,804,000 |
| Cash Flow from Operations | \$ 92,538,000 | \$ 95,275,000 |
| Working Capital | \$ 204,183,000 | \$ 173,130,000 |
| Current Ratio (CA/CL) | 2.6 | 2.4 |
| Cash Flow to Current Liabilities (CFO/CL) | 0.7 | 0.8 |
| Long-Term Debt to Net Assets (TL-CL/NA) | 1.4 | 1.4 |
| Times Interest Earned (NPO+Int/Int) | 2.0 | 1.8 |
| Net Assets to Total Assets (TE/TA) | 37.6% | 37.5% |
| Total Margin (ER/TR) | 3.4% | 3.0% |
| Return on Assets (ER/TA) | 2.7% | 2.3% |
| Operating Cash Flow to Assets (CFO/TA) | 8.4% | 8.9% |

Short-term position:

The applicant's current ratio of 2.6 indicates current assets are more than twice that of short-term liabilities, a good position. The working capital (current assets less current liabilities) of \$204.2 million is a large amount. The ratio of cash flow to current liabilities of 0.7 is good. The applicant has a strong short-term position.

Long-term position:

The long-term debt to equity of 1.4 is only fair, indicating a significant amount of debt when compared to total equity. The ratio of cash flow to assets of 8.4 percent is considered good for Florida hospitals. The most recent year had an excess of revenues over expenses of \$30.1 million, which resulted in a margin of 3.4 percent, a satisfactory level. Net assets of \$415.3 million with the ratio of net assets to total assets 37.6 percent results in a strong position. Although the indicators are somewhat mixed, the significant amount of total equity and good earnings and cash flows overshadows the others resulting in a good long-term position.

Capital requirements:

Schedule 2 indicates the applicant has capital projects totaling \$366.4 million. Schedule 2 did not include maturities of long-term debt. The financial statements showed \$54.1 million through 2005 for a total funded need of \$420.5 million.

Available capital:

Schedule 2 indicates funding will come from \$47.2 million in hand, \$148.5 million in cash flows, \$149.3 million assured but not in-hand and \$21.5 million currently being sought. If cash flows from operations of \$92.5 million in 2001 continue through 2005 a total of \$370.2 million would be generated from operations. The financial statements showed \$139.4 million in cash on hand. The applicant provided a letter from MorganStanley expressing confidence that Orlando Regional would have no difficulty financing its capital need with a bond issue.

Conclusion:

The applicant has the financial resources to fund this project. Funding for all capital projects should be available as needed.

f. What is the immediate and long-term financial feasibility of the proposal? ss. 408.035(8), Florida Statutes.

A comparison of the applicant's estimates to the control group values provides for an objective evaluation of financial feasibility, (the likelihood that the services can be provided under the parameters and conditions contained in Schedules 7 and 8), and efficiency, (the degree of economies achievable through the skill and management of the applicant). In general, projections that approximate the median are the most desirable, and balance the opposing forces of feasibility and efficiency. In other words, as estimates approach the highest in the group, it is more likely that the project is feasible, because fewer economies must be realized to achieve the desired outcome. Conversely, as estimates approach the lowest in the group, it is less likely that the project is feasible, because a much higher level of economies must be realized to achieve the desired outcome. These relationships hold true for a constant intensity of service through the relevant range of outcomes. As these relationships go beyond the relevant range of outcomes, revenues and expenses may, either go beyond what the market will tolerate, or may decrease to levels where activities are no longer sustainable.

Comparative data were derived from hospitals in peer groups that reported data in 2000; the applicant will be compared to the hospitals in peer group 8. Per diem rates are projected to increase by an average of 3.4 percent per year. Inflation adjustments were based on the most current Florida Hospital Input Price Index.

Net revenue per adjusted patient day (NRAPD) of \$1,713 in year one and \$1,763 in year two is just above the control group highest values of \$1,686 in year one and \$1,736 in year two. With net revenues falling above the highest, the facility is expected to consume more health care resources in proportion to the services provided than any other provider in the group. (See Comparative Table). The 2000 actual NRAPD for this hospital was \$1,406, which was between the median and the highest in that year.

Projected cost per adjusted patient day of \$1,726 in year one and \$1,785 in year two is between the control group lowest and median values \$1,522 and \$1,740 in year one and \$1,568 and \$1,792 in year two. Compared to the control group these costs are efficient. (See Comparative Table).

The year two operating profit for the hospital of -\$12.67 million computes to an operating margin per adjusted patient day of -\$22 which is between the control group median and highest of -\$77 and \$66. The computed operating margin ratio is -1.3 percent.

This hospital's total revenues include a large amount of non-operating revenues, resulting in an overall profit for the applicant. While this project will not generate an operating surplus in the first two years, the project is likely to be financially viable in the long-term.

g. Will the proposed project foster competition to promote quality and cost-effectiveness? ss. 408.035(9), Florida Statutes.

The applicant forecasts managed care levels of 42.8 percent, which is between the median and highest level of the control group of 30.5 and 43.5 percent. This level, if realized, is less than levels reported in 2001 of 43.3 percent and will have only a marginal positive impact on competition to promote quality assurance and cost-effectiveness.

The proposed NICU II project was compared to all other hospitals in the state with approved NICU II programs. Schedule 7, total gross revenue for the NICU II only is projected to be \$9,017,856 for year two. With 2,431 patient days anticipated the gross revenue (gross charges) per patient day computes to \$3,710. This amount is between the statewide median and highest values for all NICU providers with level II beds \$2,093 and \$4,035. The project should have a positive impact on competition to promote quality assurance and cost-effectiveness.

NICU beds to the hospital, but those beds will be relinquished if this application is approved.

It was stated for CON #9615 that the shape of the building is cost-effective. Without any precedent to verify this, it is not possible to say whether this premise is correct or not. The concrete and glass curtain wall structural/skin system proposed is probably the most efficient method to use for a circular configuration, suggesting that the entire shape issue has been considered by the design professionals and their client, the hospital.

For this CON, the layout for the Level II NICU spaces brings up several questions that are not clearly addressed in the narrative or on the plans. Chapter 59A-3 of the Florida Administrative Code, and comparable wording in the Florida Building Code, have specific requirements for all NICU levels. This is particularly true for support spaces such as clean and soiled rooms of various types, staff lounges and locker areas, toilets and similar ancillary functions. Some of these spaces are required per suite, some per nursery, some per unit, etc. It cannot be determined exactly which or if any of the circular pods are intended to be part of a larger suite and therefore whether the required support spaces have been provided in sufficient number and with adequate adjacency. Some examples are:

- Clean Utility Rooms, at the hospital's discretion, may be replaced by storage areas and clean work surfaces in the nursery. This appears to have been done in several circular pods.
- Chapter 59A-3 and the FBC require "a scrub and gown area at each entrance to the unit. This area shall be equipped with a minimum of two scrub sinks and gowning supply and disposal facilities." There are two groups of what appear to be scrub sinks adjacent to what may be main nurse stations. The applicant/design professional needs to indicate in more detail, which units or groups of units are to be considered together to be a suite.

The codes referenced above are quite specific as to the requirements for these ancillary spaces, but the plans need to utilize the same space nomenclature as the codes so that the AHCA reviewers can determine if the required spaces have actually been provided. A clear definition and labeling of the spaces to correspond with the wording of the codes would clarify matters.

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The conceptual shape of this new building is quite unusual. It consists of several circular elements connected to other circular forms. NICU pods on all levels are circular with a nurse station at the hub surrounded by isolette/bassinets spaces on the perimeter. The circular shape of the nursing units decreases to some extent the amount of space that is usually needed for corridors in a more rectangular layout.

The applicant indicates that studies show the compact circular layouts decrease the time that healthcare professionals spend in getting from patient to patient and this will make the building and its patient care more efficient and therefore less costly. However, this saving of time and space does not always come without a price. Generally, circular or curved buildings are more expensive to build.

The design of the new building is quite striking and the shapes and materials have been well integrated into the plan. If built as proposed, the building will make quite an interesting and dramatic architectural statement.

The shape of many of the building's components gives rise to some concern about way-finding. Hospitals are notoriously difficult to navigate intuitively, but this also applies to other large buildings with big footprints as opposed to smaller and taller buildings such as office towers.

Another by-product of the building's form is that some spaces have rather strange shapes which could be somewhat disorienting. Built-in furniture and millwork will be more expensive than they would be in a rectangular building.

Lists of codes are included in several places in the application and they are up to date for the latter part of 2002. The application goes into more than usual detail about the materials to be used in the construction and into equal detail regarding the interior spatial organization of each floor.

Construction scheduling and building cost data are part of CON #9615. Cost information shown at the end of this review has no funds listed for building construction since the construction of the new facility is included in CON #9615. The application includes copies of the site plan and all floor plans of the new building that were submitted with CON #9615.

- i. Does the applicant have a history of providing health services to Medicaid patients and the medically indigent? Does the applicant propose to provide health services to Medicaid patients and the medically indigent? ss. 408.035(11), Florida Statutes.**

Although the applicant is not proposing any payer condition for the proposed project, APH is the designated RPICC provider for District 7 and historically provided and projects to continue to provide approximately 55 percent of Level II and Level III NICU patient days to Medicaid and charity care patients. The applicant expects that the NICU program will provide approximately 49 percent of its patient days to Medicaid-sponsored patients (including CMS patients) and approximately five percent to Medicaid HMO patients. The applicant also projects 0.5 percent of patient days to self-pay/uninsured/indigent neonates, due to the fact that nearly all patients who would otherwise fall into these categories qualify for Medicaid reimbursement. According to the applicant, historically, about 60 percent of the patients reported as Medicaid patients by the facility’s NICU program are in fact CMS/RPICC clients.

The following table provides an indication of the applicant’s commitment to charity and Medicaid, with comparison to the district, based on Fiscal Year (FY) 2000 Actual Data prepared by AHCA:

**Medicaid and Charity Care of the Applicant
Compared to the District for Fiscal Year 2000**

| Applicant | FY 00 Conventional Medicaid Days | FY 00 Gross Charity Percentage of Charges |
|--------------------|---|--|
| Orlando Regional* | 14.2% | 3.5% |
| District 7 Average | 9.4% | 2.5% |

Source: FY 2000 Actual Data/AHCA

*APH is listed on the license of Orlando Regional Medical Center and the system reports Medicaid and charity days as a whole to the Agency

As reflected in the table, the applicant’s provision of Medicaid and charity care is greater than the district average. The applicant operates a designated Medicaid Disproportionate Share Hospital.

F. SUMMARY

The applicant proposes to add 34 Level II NICU beds to the existing NICU at Arnold Palmer Hospital, located in Orange County. Arnold Palmer Hospital is a 281-bed specialty hospital with 203 acute care, 34 Level II NICU, and 44 Level III NICU beds. The applicant agrees to relinquish CON No. 9441, an approved CON for the addition of five Level II NICU beds at Arnold Palmer Hospital, upon approval of this project.

The proposed project cost is estimated to be \$1,611,244. There are no construction costs involved with the project. The only reviewable costs the applicant anticipates incurring other than those associated with developing the CON are equipment costs of \$1,562,844.

Need/Access:

A fixed need pool of zero was published for additional Level II NICU beds in District 7. The applicant is applying outside of the fixed need pool and indicates it is applying under special (not normal) circumstances for the approval of additional NICU beds at existing providers. Occupancy in the applicant's Level II NICU has exceeded 100 percent since 1997. Although the applicant has an approved CON to add five Level II beds, it demonstrated that this number of approved beds is inadequate to meet future demand for Level II NICU services at Arnold Palmer Hospital.

Quality of Care:

The applicant is JCAHO accredited and a quality care provider.

Medicaid/Indigent Care:

Although the applicant is not proposing any Medicaid or indigent care condition for the proposed project, APH is the designated RPICC provider for District 7 and historically provided and projects to continue to provide approximately 55 percent of Level II and Level III NICU patient days to Medicaid (including Medicaid HMO) and charity care patients.

Financial/ Cost:

The short-term position of the applicant is strong and the applicant has a good long-term position. The applicant has the financial resources to fund this project and funding for all capital projects should be available as needed.

The project will have only a marginal positive impact on competition to promote quality assurance and cost-effectiveness.

Architectural:

The layout for the Level II NICU spaces brings up several questions that are not clearly addressed in the narrative or on the plans. It cannot be determined exactly which or if any of the circular pods are intended to be part of a larger suite and therefore whether the required support spaces have been provided in sufficient number and with adequate adjacency. The plans should utilize the same space nomenclature as the codes so that the AHCA reviewers can determine if the required spaces have actually been provided. A clear definition and labeling of the spaces to correspond with the wording of the codes would clarify matters.

Construction scheduling and building cost data are part of CON #9615. Cost information for this review has no funds listed for building construction since the construction of the new facility is included in CON #9615. The application includes copies of the site plan and all floor plans of the new building that were submitted with CON #9615.

G. RECOMMENDATION

Approve CON #9614 to add 34 Level III neonatal intensive care beds to Arnold Palmer Hospital. Project costs total \$1,611,244 and involves no construction costs.

CONDITION: Upon issuance of CON #9614 and CON #9615, previously issued CON #9441 will be relinquished.

AUTHORIZATION FOR AGENCY ACTION

Authorized representatives of the Agency for Health Care Administration adopted the recommendation contained herein and released the State Agency Action Report.

DATE: _____

Karen Rivera
Health Services and Facilities Consultant Supervisor
Certificate of Need

Jeffrey N. Gregg
Chief, Bureau of Health Facility Regulation