Checklist

☒ A completed CON Main Form, including an affidavit signed and notarized by the appropriate individuals. CON forms can be found at OHCA Forms.

☒ A completed Supplemental Form specific to the proposal type (see next page to determine which Supplemental Form to include in the application).

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

☒ Attached is evidence demonstrating that public notice has been published for 3 consecutive days in a newspaper that covers the location of the proposal. Use the following link to help determine the appropriate publication: Connecticut newspapers. **The application must be submitted no sooner than 20 days, but no later than 90 days from the last day of the newspaper notice.**

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HEALTHCARE ACCESS

The following information **must** be included in the public notice:

- A statement that the applicant is applying for a certificate of need pursuant to section § 19a-638 of the Connecticut General Statutes;
- A description of the scope and nature of the project;
- The street address where the project is to be located; and
- The total capital expenditure for the project.

(Please fax (860-418-7053) or email (OHCA@ct.gov) a courtesy copy of the newspaper order confirmation to OHCA at the time of publication.)

☒ A completed Financial Worksheet specific to the application type.

☒ All confidential or personally identifiable information (e.g., Social Security number) has been redacted.

☒ Submission includes one USB flash drive containing:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the application) and MS Excel (the Financial Worksheet).

Note: OHCA hereby waives requirement to file any paper copies.

☒ All submissions should be emailed to **OHCA@ct.gov**.

For OHCA Use Only:

Docket No.: 17-32165 **Check No.:** 296351

OHCA Verified by: SP **Date:** 5/2/17

Checklist

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☒ A completed Supplemental Form specific to the proposal type (see next page to determine which Supplemental Form to include in the application).

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

☒ Attached is evidence demonstrating that public notice has been published for 3 consecutive days in a newspaper that covers the location of the proposal. Use the following link to help determine the appropriate publication: Connecticut newspapers. **The application must be submitted no sooner than 20 days, but no later than 90 days from the last day of the newspaper notice.**

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For OHCA Use Only:

Docket No.: _____ **Check No.:** _____

OHCA Verified by: _____ **Date:** _____

Proposal Information

Select the appropriate proposal type from the dropdown below. If unsure which item to select, please call the OHCA main number (860-418-7001) for assistance.

Proposal Type	Termination of inpatient or outpatient services offered by a hospital
Brief Description	Transition of certain services from St. Vincent's Medical Center to Southwest Community Health Center
Proposal Address	St. Vincent's Family Health Center, 762 Lindley Street, Bridgeport, CT 06606
Capital Expenditure	$ 0.00

Is this Application the result of a Determination indicating a CON application must be filed?

☒ No

☐ Yes, Docket Number: Click here to enter text.

Applicant(s) Information

	Applicant One	**Applicant Two*** (if applicable)
Applicant: Name & Address	St. Vincent's Medical Center 2800 Main Street Bridgeport, CT 06606	
Parent Corporation: Name & Address (if applicable)	Ascension Health 4600 Edmundson Road St. Louis, MO 63134	
Contact Person: Name, Title, Address	Kurt Bassett Director of Strategic Planning 2800 Main Street Bridgeport, CT 06606	
Company	St. Vincent's Medical Center	
Email Address	Kurt.bassett@stvincents.org	
Phone	(203) 576-6264	

Fax Number	(203) 576-5345	
Tax Status (check one box)	☐ For Profit ☒ Not-for-Profit	☐ For Profit ☐ Not-for-Profit

**For more than two Applicants, attach a separate sheet with the above information*

FOR OFFICE USE ONLY	
Docket #:	Staff Assigned :
Date Received:	

Executive Summary

The Application by St. Vincent's Medical Center ("SVMC" or the "Applicant") is for the purpose of addressing a community need for enhanced primary care and specialty care services for medically underserved and underinsured individuals in the Bridgeport community and its surrounding towns ("Bridgeport"). The target populations for this proposal are: (i) historically underserved and underinsured patients currently receiving health care services from SVMC's Family Health Center ("FHC"); and (ii) medically uninsured and underserved individuals who are currently without a primary care provider and who look to hospital emergency departments for their limited and intermittent health care ("Target Population").

SVMC has been providing outpatient health care services at the FHC located at 762 Lindley Street ("Lindley Street Location") since 1996, and such services have been provided in accordance with SVMC's charitable mission, which includes serving the health care needs of all individuals regardless of ability to pay. Currently, the FHC serves two general categories of patients: (i) patients enrolled in Medicaid; and (ii) patients who have no insurance and are considered "self-pay". It is a widely known fact that Medicaid reimbursement in Connecticut is inadequate to cover rising healthcare costs. In the instant case, despite being efficiently run, reimbursement provided by Medicaid covers less than half of the costs associated with each FHC patient visit. Patients that do not have Medicaid or any other insurance are considered to be self-pay and to the extent possible, pay on a sliding scale basis. Most uninsured patients either pay nothing or a de minimis amount. Given the inadequacy of Medicaid reimbursement, cost-shifting to offset the losses associated with the uninsured patients is not an option. By way of example, if you have 100 patients and only 50% of the patients pay for services and the payment for those 50 patients represents 50% of the provider's cost, the provider ends up being reimbursed for 25% of its costs associated with caring for those 100 patients. It is a financial model that is not sustainable.

Moreover, many of these same patients also require referrals to specialty-care providers. The FHC provides some specialty services at the Lindley Street Location, but currently it does not have the resources to meet more of the needs of its FHC patients at this location given the substantial losses it incurs in connection with providing mostly uncompensated primary care services to FHC patients. To further complicate matters, it is typically very difficult to get these patients referred to other specialists in the community since many private practice physicians limit the number of uninsured and/or Medicaid patients in their practice due to the fact that the Medicaid reimbursement is considerably lower than commercial insurance. Hence, FHC patients very often do not get the specialty service appointments they need until a problem becomes acute and leads to an emergency department visit, resulting in much higher costs to the State's health care system.

Southwest Community Health Center, Inc. ("SWCHC") is a federally qualified health care center that is also located in Bridgeport, providing primary care, along with behavioral health and dental health services to the community's most vulnerable individuals and families, including but not limited to, homeless, veterans, residents of public housing and other marginalized individuals. SWCHC is a community-based and patient-directed health center focused on providing culturally competent, high-quality primary care services, as well as supportive services, such as health education, and the facilitation of transportation to promote access to care. More specifically, SWCHC provides patient-centered and integrated care that is responsive to the unique needs of the Target Population.

In addition to receiving a higher level of reimbursement from Medicaid than that received by the FHC, SWCHC also receives grant funding from the U.S. Health Resources & Services Administration ("HRSA") to improve the health of underserved and vulnerable populations, 340B pricing discounts for pharmaceutical products, free vaccines for uninsured and underinsured children and medical malpractice coverage under the Federal Torts Claims Act. SWCHC also receives assistance in the recruitment and retention of primary care providers though the National Health Services Corps. Therefore, SWCHC is uniquely qualified to care for the Target Population currently being cared for by the FHC and it can do so in a manner that will allow it to: (i) handle larger volumes without extensive financial loss; (ii) provide outpatient behavioral health and dental health services; and (iii) allow SVMC to devote its resources to providing more specialty services to these same patients in collaboration with the enhanced primary care services to be provided by SWCHC.

While the Application represents a request to have SVMC terminate services at the Lindley Street Location, it is more accurately described as a transition of primary care services from SVMC to SWCHC, along with SVMC making a greater commitment to providing specialty services at the same Lindley Street Location. The Applicant believes that it is preferable to have these patients be seen in the same location that they receive their primary care services because it is a familiar environment for the patient and thus, more conducive to ensuring follow up and care coordination. Most importantly, this proposal allows for greater patient access, service sustainability, enhanced patient satisfaction, improved health care outcomes and a reduction in health care costs for the State health care system.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. **Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits to the public and for each Applicant, separately. Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.**

   Founded in 1903 by the Daughters of Charity, SVMC is licensed to operate a 397-bed general hospital located in Bridgeport, Connecticut and a 76-bed specialty psychiatric hospital located in Westport, Connecticut. In addition to its inpatient facilities, SVMC operates the FHC located at 762 Lindley Street in Bridgeport, Connecticut and its subsidiary, St. Vincent's Multispecialty Group, Inc., operates approximately 30 ambulatory care sites and urgent care clinics.

   The FHC was established to provide primary care services to the Target Population, which includes individuals who are low income, handicapped, homeless or frail[1]. Specifically, the FHC provides approximately 18,000 primary care patient visits and 4,000 specialty care visits annually to adults and children from the Bridgeport area. The FHC also provides a limited number of specialty clinics at the Lindley Street Location for its FHC patients. Currently, the FHC has extremely long wait times for specialty care visits (e.g., cardiology, endocrinology and neurology have wait times that exceed 3 months, gastroenterology has wait times that exceed 4 months and ophthalmology has wait times that exceed 6 months).

   SVMC believes that access to a baseline level of high-quality, safe and effective health care services for the medically disadvantaged and underserved Target Population must be preserved in Bridgeport. Nonetheless, because most of the FHC patients are either medically uninsured or underinsured (as described in the Executive Summary herein), the FHC's reimbursement is severely inadequate to cover the costs associated with the provision of these primary care health services, resulting in significant financial losses for SVMC. As a result of these losses, SVMC has fewer resources to provide specialty services to this same Target Population. As a responsible health care institution, these losses necessitate SVMC to find a viable and sustainable solution to address the need for these services.

[1] At-risk or vulnerable populations include the elderly; residents with incomes below 200% of the federal poverty level; residents in urban core areas, defined as towns with the highest poverty and most dense population; racial or ethnic minorities such as Black non-Hispanics, Hispanics, American Indians, Asians and other non-White groups; residents of rural areas; persons who do not have insurance; homeless populations; non-English speakers; lesbian, gay, bisexual and transgender (LGBT) residents and immigrants. See, 2015 Supplement of the Statewide Health Care Facilities and Services Plan at page 57.

SWCHC is a licensed Federally Qualified Health Center ("FQHC") that provides comprehensive primary care services as well as supportive enabling services (e.g., education, translation and facilitation of transportation) to individuals residing in Bridgeport. Specifically, SWCHC operates its main site at 46 Albion Street in Bridgeport, and four additional Bridgeport sites at: 1046 Fairfield Avenue, 510 Clinton Avenue, 968 Fairfield Avenue and 743 South Avenue.

The proposal involves the transition of responsibility for the provision of primary health care services from SVMC's FHC to SWCHC at the same Lindley Street Location. Once transitioned to SWCHC, the site of care will not change and is depicted on the map attached hereto as Exhibit A. The Primary Service Area ("PSA") for the FHC includes the service area attached hereto as Exhibit B and also will not change.

By transitioning responsibility for the provision of primary care services at the FHC to SWCHC, SVMC will be able to more efficiently allocate resources to address the unmet specialty care needs of patients served at the Lindley Street Location with the goal that wait times for specialty services will be reduced and access to specialty care will be expanded. If this proposal is approved by OHCA, SVMC will provide the enhanced specialty services listed in Exhibit C attached hereto at the Lindley Street Location. In essence, this proposal allows two providers to collaborate for the purpose of more effectively allocating resources to serve and address the needs of the Target Population. The primary goals of this proposal are: (i) to facilitate enhanced access to both primary care (by expanding primary care services to include behavioral health and dental health services) and specialty care (by SVMC offering more specialty services); (ii) the reduction in the incidence of unnecessary or avoidable emergency department visits, hospitalizations and inpatient readmissions; and (iii) improved health outcomes for the Target Population.

Currently, the Target Population is burdened with a variety of social determinants, such as poverty, low income, low health literacy levels, joblessness and adverse environmental factors that contribute to its high rate of chronic and disabling health conditions. These social challenges often prevent or interfere with individuals accessing health care or achieving their intended health care goals. SWCHC is culturally competent, consumer-driven and skilled at working with this Target Population. Accordingly, the Applicant believes that SWCHC will offer an enhanced primary care experience for this Target Population.[2]

SVMC is the current lessee of the Lindley Street Location and the proposal contemplates that SWCHC would sublease a majority of the space for the Lindley Street Location from SVMC. More specifically, SWCHC would occupy the main level where it would provide its primary care services and would share the lower level with SVMC, where SVMC would provide specialty-care services. See floor plan attached hereto as Exhibit D. In addition, to the extent that SVMC can offer office equipment and assets and SWCHC desires such office equipment and assets,

[2] SWCHC currently serves this neighborhood as a provider at a School Based Health Center and at a number of homeless shelters.

SVMC shall transfer such to SWCHC for its use at the Lindley Street Location. Certain employees of SVMC currently working at the Lindley Street Location will be offered employment by SWCHC for those that satisfy SWCHC's credentialing and employment requirements.

It is expected that the transitions described herein will begin upon OHCA's approval or shortly thereafter and will be done in a manner that is as seamless as possible for the patient (e.g., to the extent feasible, Lindley Street Location patients can meet their SWCHC provider through an introduction by their SVMC provider). The Applicant and SWCHC are prepared to pace the transition so that there are no interruptions in service and that the transition will be completed no later than 12 months from OHCA's approval. The Applicant would provide notice to the FHC patients explaining the transition along with other follow-up communications encouraging patients to remain patients at the Lindley Street Location.

SVMC has provided its obstetrics and gynecology services at the Lindley Street Location through a professional services agreement with a group of private physicians on its medical staff who specialize in obstetrics and gynecology, and SWCHC will also enter into a professional services agreement with the same group of physicians so there will be no change in the Lindley Street Location's obstetrics and gynecology providers. Under the proposal, the Applicant will enter into a five (5) year Community Benefit and Support Agreement with SWCHC to provide financial support to cover SWCHC's transition and other "ramp up" expenses at the Lindley Street Location.[3]

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

In 2014, when it became very clear that State and Federal reimbursement for the services performed by the FHC would continue to decline in future years, SVMC began reviewing alternative models for sustaining primary care services for the Target Population. The idea of a hospital partnering with an FQHC was identified as a strong option given that this model had been proven to work and has been successfully implemented both in Connecticut and other states throughout the country. Most recently, the American Hospital Association created a task force (composed of 29 hospital CEOs, state hospital association representatives and health system leaders) to study and recommend strategies for hospitals ensuring access to healthcare services in vulnerable communities. One of those strategies includes clinical collaborations between hospitals and FQHCs. See Exhibit E attached hereto. SVMC knows from SWCHC's reputation and its own experience[4] that SWCHC is uniquely qualified to provide primary care services to the patients

[3] SWCHC would enter into a teaching physician agreement and a residency training agreement with SVMC so that its internal medicine residents can continue to train and provide services to patients at the Lindley Street Location.
[4] SVMC and SWCHC have a strong history of positive clinical collaborations in the area of behavioral health and mobile mammography services as discussed in greater detail herein.

served by the Lindley Street Location.

SVMC and SWCHC began to pursue more detailed discussions in the fall of 2015. Over the course of the next 12 months, the Applicant and SWCHC met regularly to:

- Discuss other FQHCs and hospitals that have made similar successful transitions in Connecticut;
- Perform financial modeling to allow SVMC to reallocate expenditures for primary care to specialty care for this Target Population;
- Discuss SVMC's and SWCHC's ongoing commitment to continuing the rotation of the SVMC internal medicine residents through the Lindley Street Location;
- Discuss shared quality programs that would be in place to ensure that the care provided to the Target Population was comprehensive and of high-quality;
- Develop financial models to support the effort of SWCHC to transition as the provider of primary care services at the Lindley Street Location; and
- Review the Lindley Street Location physical plant, and discuss other matters to ensure a successful transition.

Beginning in January of 2016, internal committees were formed by the parties and representatives from both SVMC and SWCHC were assigned tasks to review data, finances and operations for the proposal. The Applicant and SWCHC entered into a non-disclosure agreement as of February 4, 2016. During the fall of 2016, a letter of intent was developed for the purpose of moving forward with the proposal.

Throughout the planning, it has been the objective of both the Applicant and SWCHC to sustain and enhance the integration of primary care, behavioral health and dental health, as well as secondary and tertiary care for this Target Population.

3. Provide the following information:

a. utilizing OHCA Table 1, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

Please see Table 1.

b. identify in OHCA Table 2 the service area towns (i.e., use only official town names) and explain the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

Please see Table 2. Please note that under this proposal the service area towns will remain unchanged.

4. **List the health care facility license(s) that will be needed to implement the proposal;**

   SVMC:
   CT DPH License # 0057

   SWCHC:
   CT DPH License # 0688 Outpatient Clinic
   CT DPH License # 0563 Psychiatric Outpatient Clinic for Adults
   CT DPH License # 0466 Facility for the Care or Treatment of Substance Abusive or Dependent Persons

5. **Submit the following information as attachments to the application:**

   a. **a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);**

      See SVMC license attached hereto as Exhibit F.

   b. **a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;**

      See CVs for key SWCHC personnel attached hereto as Exhibit G.

   c. **copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;**

      See relevant articles attached hereto as Exhibit H. These articles were provided because they support the fact that FQHCs are an excellent option in the community for the provision of efficient and culturally competent primary care services.

   d. **letters of support for the proposal;**

      See letters of support attached hereto as Exhibit I.

   e. **the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.**

      N/A

   f. **copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed**

version is not available, provide a draft with an estimated date by which the final agreement will be available.

See Letter of Intent attached hereto as Exhibit J.

Public Need and Access to Care

§ *"Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))*

6. **Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.**

There is an undeniable public need for continued and enhanced access to primary care and specialty care for the Target Population in Bridgeport. This specific proposal is based upon the need to allocate and expand limited resources in the most judicious and efficient way in order to maintain and expand access to primary care and specialty care health services for the Target Population. This proposal also provides an opportunity for the parties to collaborate in ways that will better ensure that a majority of the health care needs of this Target Population are being met in a cost-effective manner and without duplication of effort. Moreover, inadequate State and Federal reimbursement makes this proposal a necessity that requires community providers to collaborate to find ways to most effectively meet the needs of this Target Population.

§ *"The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn.Gen.Stat. § 19a-639(a)(2))*

7. **Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.**

The City of Bridgeport is Connecticut's largest city and one of its most impoverished urban centers. In fact, Bridgeport has been identified in the *2015 Supplement of The Statewide Health Care Facilities and Services Plan* as a city with the lowest income, highest poverty and highest population density (also known as an "Urban Core"). See, *2015 Supplement of The Statewide Health Care Facilities and Services Plan* at page 52. Individuals with lower socioeconomic status typically do not have access to coordinated care and thus, there is a higher rate of avoidable emergency department use, hospitalizations and readmissions. See, *The Statewide Health Care Facilities and Services Plan* at page 64. *The Statewide Health Care Facilities and Services Plan* focuses on increasing access to and improving the health outcomes of vulnerable and at-risk populations. It is the objective of the Applicant and SWCHC to ultimately improve the health care outcomes for this Target

Population while avoiding duplication of resources.[5] See, *The Statewide Health Care Facilities and Services Plan* at pages 64, 91 and 97. Through carefully planned strategic collaborations, the Applicant along with SWCHC, will provide more access for those in need and hopefully, improve health outcomes for the Target Population. See, *The Statewide Health Care Facilities and Services Plan* at page 79.

> *§ "Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))*

8. With respect to the proposal, provide evidence and documentation to support clear public need:

a. identify the target patient population to be served;

The Target Population in Bridgeport is the medically uninsured and underinsured. Bridgeport's current poverty rate is 23.6% compared to the average for the State of Connecticut, which is 10.5% according to Connecticut Economic Resource Center 2016 town profile. The same profile shows an unemployment rate in Bridgeport of 10.2% compared to 6.6% for the State of Connecticut. There is a clear need for primary care services in Bridgeport, as evidenced by the more than 18,000 primary care visits and 4,000 specialty care visits annually made by adults and children to the FHC. In addition, there is a clear need for more specialty clinics for this Target Population given the long wait times for these patients to see a specialist.

b. discuss if and how the target patient population is currently being served;

The Target Population is currently being served by the FHC. The FHC operates Monday through Friday 8:30 a.m. – 4:30 p.m. SVMC serves all patients regardless of their ability to pay for services. *The Statewide Health Facilities and Service Plan* has identified Bridgeport as an area with a population that has many social determinant factors that puts the Target Population at risk for unmet healthcare needs, poor healthcare outcomes, and unnecessary utilization of hospital emergency department services.

c. document the need for the equipment and/or service in the community;

The FHC currently delivers approximately 18,000 primary care visits and

[5] "Unmet need is defined as when individuals of a distinct socio-demographic group, such as the uninsured or people with low income, forego or delay accessing needed available health care services because the associated costs are unaffordable. The Institute of Medicine (IOM) has identified lack of insurance as a significant driver of health disparities." See, *The Statewide Health Care Facilities and Services Plan* at page 74. "These definitions of unmet health need aim to take into account the complexity of factors that have an adverse impact on health status as a result of limited or disproportionate access to care. Whichever definition is used, unmet need has to be quantified to determine the appropriate intervention(s) or policy change(s). The expected result is a more integrated health care delivery system in which resources are allocated efficiently based on agreed priorities to improve health status and eliminate inequalities." See, *The Statewide Health Care Facilities and Services Plan* at page 53.

approximately 4,000 specialty care visits on an annual basis. Individuals in need of specialty care services at the FHC currently have extremely long wait times due to limited resources. Currently, wait times for cardiology, endocrinology and neurology are over 3 months, gastroenterology patients wait over 4 months for an appointment and the wait times for ophthalmology appointments can be up to 6 months. This proposal would allow SWCHC to provide primary care services so that SVMC can reallocate resources to provide more specialty services. In addition, the added services of behavioral health will be an important enhancement to the primary care clinic that SWCHC will operate at the Lindley Street Location. Currently, the FHC does not provide behavioral health services at the Lindley Street Location. Upon OHCA's approval, qualified behavioral health clinicians will be embedded in the SWCHC Lindley Street Location, which will allow for better coordination of behavioral health services between SWCHC and SVMC for the Target Population. In addition, patients at the Lindley Street Location will have access to SWCHC's dental health clinic located at one of SWCHC's other facilities.

d. explain why the location of the facility or service was chosen;

FHC has been operating at the Lindley Street Location since 1996. It is a location that is populated with many individuals living in poverty. It is also in close proximity (within two blocks) to the SVMC hospital location. Utilizing the current site, SWCHC will deliver primary care (including obstetrics and gynecology) and behavioral health services, and SVMC will provide its enhanced specialty services at the same site, resulting in enhanced and more coordinated services for the Target Population.

e. provide incidence, prevalence or other demographic data that demonstrates community need;

Please see response to 8a herein. According to the 2011 American Community Survey, the Bridgeport region has the widest gap between rich and poor of all 516 metropolitan and micropolitan areas included in the survey. As evidenced by the 18,000 primary care visits and 4,000 specialty care visits to the FHC every year, the demand and need for primary care services at the Lindley Street Location in Bridgeport is well substantiated. *The Statewide Health Facilities and Service Plan* identifies Bridgeport as an Urban Core center which by definition is an area with many social determinants that makes access to healthcare services for the Target Population more difficult.

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

The focus of this proposal is specifically about serving a Target Population that is medically underserved and uninsured. SVMC's community outreach programs and partnerships are designed to enhance public health and quality of life in

Bridgeport and improve access to health services for members of the community regardless of ability to pay. Bridgeport has a significantly higher percentage of Black or African Americans and Latinos than any other city in the State of Connecticut. According to the 2011 American Community Survey, Bridgeport has the widest gap between rich and poor of all 516 metropolitan and micropolitan areas included in the survey. As evidenced by the 18,000 annual primary care visits to the FHC, the need for access to primary care services in Bridgeport is substantial. The collaboration between SVMC and SWCHC will facilitate enhanced access to both primary and specialty care and reduce the incidence of unnecessary or avoidable emergency department visits, hospitalizations and inpatient readmissions.

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

In March of 2014, it became clear to SVMC that due to inadequate Medicaid reimbursement and the escalating costs associated with providing services at the FHC, the financial sustainability of the FHC was uncertain. In fact, SVMC considered closing the FHC for periods of time, (e.g., one day a week), in order to reduce FHC's financial losses. Instead, the proposal outlined in this Application was developed to allow SVMC to reallocate its resources to provide more specialty care clinics at the Lindley Street Location with the goal of reducing wait times and providing more timely access to needed specialty services.

h. explain how access to care will be affected; and

The proposal will improve accessibility and cost-effectiveness of health care services in Bridgeport by enhancing the provision of primary care, including behavioral health and dental health services, and enhancing access to timelier specialty care services. The goal of the collaboration between SVMC and SWCHC is to improve the health of the Target Population while avoiding unnecessary medical expenses.

i. discuss any alternative proposals that were considered.

In March of 2014, due to inadequate Medicaid reimbursement and escalating operational costs, the FHC was identified as not being financially sustainable. Reimbursement for the services performed by SVMC was projected to decline in future fiscal years due to (i) continued reductions in Medicaid reimbursement; and (ii) escalating operational costs despite efficient operations. Given the benefits that SWCHC offers as a FQHC and the positive working history between SVMC and SWCHC, it was determined that a collaboration with SWCHC would be a strong option for continuing to provide enhanced primary care services while expanding access to specialty care for this Target Population.

§ "Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn.Gen.Stat. § 19a-639(a)(5))

9. Describe how the proposal will:

a. improve the quality of health care in the region;

The proposal will improve quality, accessibility and cost-effectiveness of health care delivery in Bridgeport by providing enhanced primary care and specialty services for the Target Population.

It is anticipated that specialty care services to be provided by SVMC will include the following specialty services:

- Endocrinology
- Infectious Disease
- Gastroenterology
- Cardiology
- Podiatry
- General Surgery
- Ophthalmology
- Neurology
- Orthopedics
- Nephrology
- Rheumatology
- Pulmonology
- Nutritional Counseling

See Exhibit C attached hereto.

Moreover, integrating primary health care is vital to addressing the healthcare needs of individuals with mental health and substance use disorders. Mental and physical health problems have been found to be intricately connected. The behavioral healthcare and primary care currently provided in Bridgeport is typically fragmented, often leading to uncoordinated care for patients. Pursuant to this proposal, SWCHC will introduce behavioral healthcare services at the Lindley Street Location, and allow for enhanced collaborative care between the Applicant's and SWCHC's behavioral health and primary care teams to develop an integrated treatment plan that can address and coordinate both medical and behavioral health needs of the Target Population. Embedding behavioral health clinicians at the Lindley Street Location will enable mental health issues to be

identified and addressed in a more coordinated manner. Patients will be seamlessly referred to the most appropriate service depending on their behavioral health needs. This proposed collaboration of enhanced integration of behavioral health and primary care services will facilitate more consultations and a more holistic treatment approach to members of the Target Population needing behavioral health care. Both providers will continue to offer intensive outpatient, outpatient and medication management; however, the collaboration will not only allow for better care coordination with medical needs, but also will allow for enhanced access for patients to the distinct patient services offered by SVMC and SWCHC. For example, SVMC offers an intensive outpatient program for persons of Latino descent. The clinical services are provided by bilingual clinicians and are focused not only on the clinical needs of patients but also the cultural and ethnic diversity of this population. Additionally, SVMC's intensive outpatient programs provide patient-centered care for persons with severe and chronic mental illness and those who are dually diagnosed, while SWCHC's intensive outpatient programs are focused on individuals with significant substance use disorders.

b. improve accessibility of health care in the region; and

Please see the sections above.

c. improve the cost effectiveness of health care delivery in the region.

Please see the sections above. As stated earlier herein, SWCHC receives a higher level of reimbursement and support from both the State and Federal governments. SVMC is losing millions of dollars currently in providing primary care services at the FHC that could be more cost-effectively allocated to provide needed specialty care services.

10. How will the Applicant(s) ensure that future health care services provided will adhere to the National Standards on culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area? (More details on CLAS standards can be found at http://minorityhealth.hhs.gov/).

Upon approval from OHCA, the Applicant will transition responsibility for the provision of primary care services at the Lindley Street Location to SWCHC. SWCHC is culturally competent and experienced in advancing health equity and eliminating health disparities. This proposal is specifically focused on enhancing access to services along with enhancing the collaboration and coordination of care for the Target Population. SWCHC has a community-driven board focused on providing comprehensive, preventative primary care services, as well as supportive enabling services (e.g., education, translation and facilitation of transportation, etc.) to individuals.

11. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

Currently, SVMC does not utilize an electronic health record at the Lindley Street Location. If this Application is approved, SWCHC will install NextGen, its electronic health record. Communication between clinicians will be improved with the use of this electronic health record, and will allow for greater coordination of care. In addition, electronic health records make it easier for clinicians to follow up with patients and track health outcomes. The SWCHC electronic health record will be available to SVMC's clinicians to ensure that patients who are seen by SWCHC clinicians and who follow up with SVMC specialty care clinicians will have access to SWCHC's electronic health record so that care is coordinated. In addition, SVMC and SWCHC will form an operating committee to monitor access, patient outcomes, and efficiency issues, and establish a quality committee for monitoring the quality and safety of services provided at the Lindley Street Location.

12. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

This proposal is entirely focused on the medically underserved and underinsured, including Medicaid patients. No patient will be refused care because of their inability to pay. In addition and as discussed herein, Medicaid recipients will have enhanced access to behavioral health, dental health and specialty care services.

13. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

See Applicant's Charity Care Policy attached hereto as Exhibit K.

14. If charity care policies will be changed as a result of the proposal, list all changes and describe how the new policies will affect patients.

There will be no change for SVMC. SWCHC has a sliding scale payment policy based upon financial need and consistent with federal guidelines for FQHCs.

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

15. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

This proposal will not reduce access to Medicaid recipients, rather this proposal will enhance access for Medicaid patients.

§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))

16. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

Those patients that do not have insurance will be expected to pay for services on a sliding scale basis based upon their financial resources, with some patients paying nothing at all.

Financial Information

§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;" (Conn.Gen.Stat. § 19a-639(a)(4))

17. Provide the Applicant's fiscal year: start date (mm/dd) and end date (mm/dd).

07/01 through 06/30

18. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

The proposal will have a positive impact on the State's health care system in that it will reduce unnecessary emergency department visits, admissions and readmissions

by addressing the health needs of the Target Population and providing enhanced primary and specialty care services.

19. **Provide an estimate of the capital expenditure/costs for the proposal using OHCA Table 3.**

There are no capital expenditures for this proposal.

20. **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.**

There are no capital expenditures, and there is no financing. SVMC will enter into a Community Benefit and Support Agreement with SWCHC over a five-year period wherein SVMC will subsidize the transition and "ramp up" costs of SWCHC.

21. **Include as an attachment:**

a. **audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, statement of cash flow, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;**

See Exhibit L attached hereto.

b. **completed Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale), available at OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." Note: the actual results reported in the Financial Worksheet must match the audited financial statements previously submitted or referenced. In addition, please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the financial projections, utilization and payer mix tables (OHCA Tables 4, 6 and 7).**

See Exhibit L attached hereto.

22. **Complete OHCA Table 4 utilizing the information reported in the attached Financial Worksheet.**

Please see Table 4.

23. Fully identify and explain all assumptions used in the projections reported in the Financial Worksheet. In providing these detailed assumptions, please include the following:

a. **Identify general assumptions for projected amounts that are estimated to be the same, both with or without this proposed project (i.e., project-neutral increases or decreases that occur between years). Explain significant variances (+/- 25% variances) that occur between years for the project neutral changes;**

Despite its proposal to discontinue primary care services, SVMC's financial losses will not be completely offset because of its commitment to subsidize SWCHC's transition costs for five years and to reallocate its expenses to enhance specialty services at the Lindley Street Location.

b. **Identify specific assumptions for all projected amounts that are estimated to change as a result of implementation of the proposed project (i.e., project-specific increases or decreases). Address projected changes in revenue, payer mix, expense categories and FTEs. In addition, connect any service, volume (utilization) or payer mix changes described elsewhere in the CON application narrative or tables with these financial assumptions;**

There is a slight decrease in revenue expected in that SVMC will no longer be providing primary care services. There is an expected increase in volume associated with more specialty clinics, but not to the extent that it would offset primary care decreases. There is a reduction in salaries and benefits based on SVMC not providing primary care. Again the increase to specialty care does not offset the reduction in primary care staffing. The reduction in FTE's is based upon the reduction in staff that will no longer be providing primary care. There is an increase in expenses related to ramp up and transition expenses to be paid to SWCHC as discussed above. There is no expected change in payer mix as the population being served will not change.

c. **If the Applicant does not project any specific increases or decreases with the project in the Financial Worksheet, please explain why.**

N/A

24. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal. Provide an estimate of the timeframe needed to achieve incremental operational gains.

SVMC will continue to experience financial losses with respect to providing specialty services to the Target Population. However, projected losses will decrease slightly upon the five-year Community Benefit and Support Agreement expiration.

Utilization

§ "The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn.Gen.Stat. § 19a-639(a)(6))

25. Complete OHCA Table 5 and OHCA Table 6 for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Note: for OHCA Table 6, if the first year of the proposal is only a partial year, provide the partial year and then provide projections for the first three complete FYs. In addition, please make sure that the fiscal years reported on OHCA Table 6 are the same fiscal years reported for the financial projections and payer mix tables (OHCA Tables 4 and 7).

Please see Tables 5 and 6.

26. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

Table 5 - FY17 volumes are based upon six (6) months actual and six (6) months projected. Table 6 projections are based on specialty care services and indicate an increase in volume due to the increase in specialty service hours and types. There are no projections made for the Applicant for primary care and pediatric services in that those services will no longer be provided by the Applicant.

27. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using OHCA Table 7 and provide all assumptions. Note: payer mix should be calculated from patient volumes, not patient revenues. Also, current year should be the most recently completed fiscal year.

Please see Table 7.

§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))

28. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health and Connecticut State Data Center) and document the source.

As previously stated, Bridgeport is identified as an "Urban Core" area in *The Statewide Health Facilities and Service Plan* and as such, is a city with very high poverty, unemployment, and crime rates. This type of population is typically identified as being at risk and vulnerable for chronic diseases and having unmet health care needs.

29. Using OHCA Table 8, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as the number of persons, visits, scans or other unit appropriate for the information being reported.

Please see Table 8.

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))

30. Using OHCA Table 9, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

Please see Table 9.

31. Will this proposal shift volume away from existing providers in the area? If not, explain in detail why the proposal will have no impact on existing provider volumes.

Pursuant to this proposal, responsibility for the provision of primary care services (which includes obstetrics and gynecology services) will be transitioned to SWCHC. Because limited specialty services are currently being provided by SVMC and this transition will help to alleviate long wait times for specialty services, there will be no

negative impact on existing specialty providers.

32. If applicable, describe what effect the proposal will have on existing physician referral patterns in the service area.

Currently, patients are referred to specialty care based on need and availability. Currently there are extremely long wait times for specialty care at the FHC as previously described herein. The goal of the proposal will be to increase access to specialty services for the Target Population.

SVMC will reallocate resources to enhance and expand specialty care for patients served by the SWCHC clinic site. Referrals for specialty services will be made by SWCHC to SVMC specialty providers providing services at the Lindley Street Location. If other providers in the community are willing to provide specialty services, referrals will be made to such providers.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))*

33. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

The Applicant and SWCHC will have access to the patient's EHR and will be on site at the Lindley Street Location. In addition, the Applicant and SWCHC will form an operating committee and a quality committee to ensure optimal coordination of services and quality of care.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn.Gen.Stat. § 19a-639(a)(11))*

34. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

The proposal will enhance the diversity of providers by adding the SWCHC providers along with adding more specialty care providers. Patients will be able to continue with the same obstetrics and gynecology providers, as SWCHC will be contracting with the same group currently contracted by FHC.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
SVMC FHC Primary Care Clinic	762 Lindley St., Bridgeport	Medically uninsured and underinsured	8:30 a.m.-4:30p.m. M-F	Termination

[back to question]

TABLE 2
SERVICE AREA TOWNS

Town*	Reason for Inclusion
Bridgeport Stratford Shelton Fairfield Easton Trumbull Monroe	These towns are considered to be towns in the Applicant's primary service area and are expected to be the same towns serviced by SWCHC at the Lindley Street Location.

*List official town name only - village or place names are not acceptable.

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical, Imaging) Land/Building Purchase* Construction/Renovation** Other (specify)	
Total Capital Expenditure (TCE)	
Lease (Medical, Non-medical, Imaging)***	
Total Lease Cost (TLC)	
Total Project Cost (TCE+TLC)	**$0**

There are no capital expenditures associated with this proposal.

*If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

**If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

***If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

[back to question]

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2018*	FY 2019*	FY 2020*
Revenue from Operations	$(350,000)	$(700,000)	$0
Total Operating Expenses	$(540,000)	$(1,944,000)	$(1,944,000)
Gain/Loss from Operations	$190,000	$1,244,000	$1,944,000

*Fill in years using those reported in the Financial Worksheet attached.

Note: please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the financial projections, utilization and payer mix tables (OHCA Tables 4, 6 and 7).

Please note that the bracketed amounts represent reductions in expenses for the Applicant.
[back to question]

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2014***	FY 2015***	FY 2016***	FY 2017***
Adult Primary Care	6,954	9,331	11,502	11,674
Pediatric Care	5,982	6,252	6,254	6,158
Specialty Care Clinic	4,104	4,281	4,493	4,146
Total	17,040	19,864	22,249	21,978

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

**Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.

***Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2018**	FY 2019**	FY 2020**
Adult Primary Care	0	0	0
Pediatric Care	0	0	0
Specialty Care Clinic	5,225	6,400	6,850
Total	5,225	6,400	6,850

*Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

**If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

Note: please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the financial projections, utilization and payer mix tables (OHCA Tables 4, 6 and 7).

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2017**		Projected					
			FY 2018**		FY 2019**		FY 2020**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	2,198	10%	523	10%	640	10%	685	10%
Medicaid*	14,066	64%	3,344	64%	4,096	64%	4,384	64%
CHAMPUS & TriCare	0	0%	0	0%	0	0%	0	0%
Total Government	**16,264**	**74%**	**3,876**	**4,736**	**4,736**	**74%**	**5,069**	**74%**
Commercial Insurers	440	2%	95	2%	128	2%	137	2%
Uninsured	5,274	24%	1,254	24%	1,536	24%	1,644	24%
Workers Compensation	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**5,714**	**26%**	**1,349**	**26%**	**1,664**	**26%**	**1,781**	**26%**
Total Payer Mix	**21,978**	**100%**	**5,225**	**100%**	**6,400**	**100%**	**6,850**	**100%**

*Includes managed care activity.

Fill in years. Current year should be the most recently **completed fiscal year. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

Note: please make sure that the fiscal years reported on the Financial Worksheet are the same fiscal years reported for the financial projections, utilization and payer mix tables (OHCA Tables 4, 6 and 7).

This Table 7 represents volumes at the FHC only and discharges should be considered visits.

[back to question]

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2016**
Bridgeport	18,459
Stratford	1,139
Fairfield	805
Trumbull	516
Shelton	363
Monroe	154
All Others	813

*List inpatient/outpatient/ED volumes separately, if applicable

Fill in most recently **completed fiscal year.

[back to question]

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
SWCHC	Bridgeport	NPI (1699703 686)	SWCHC 968 Fairfield Avenue Bridgeport, CT 06605	Monday & Wednesday 8:30 a.m.-8:00 p.m., Tuesday, Thursday, and Friday 8:30 a.m. - 4 :30 p.m., Saturday 9:00 a.m. - 1:00 p.m.	45,629*
SWCHC	Bridgeport	NPI (1699703 686)	SWCHC 46 Albion Street Bridgeport, CT 06605	Monday - Friday 8:30 a.m. - 4:30 p.m., Tuesday and Thursday 5:00 p.m. - 8:00 p.m., Saturday 9:00 a.m. - 1:00 p.m.	44,730*
SWCHC	Bridgeport	NPI (1699703 686)	510 Clinton Avenue Bridgeport, CT 06605	Monday - Friday 8:30 a.m.-4:30 p.m.	5,356*
SWCHC	Bridgeport	NPI (1699703 686)	Marina Village 743 South Avenue Bridgeport, CT 06604	Monday - Friday 8:30 a.m. - 4:30 p.m.	9,169*
SWCHC**	Bridgeport	NPI (1699703 686)	1046 Fairfield Avenue	Monday - Friday 8:30 a.m. - 4:30 p.m., Monday, Wednesday and Thursday 5:00 p.m. - 9:00 p.m.	15,121*
Optimus	Not Available	Not Available	Optimus 982 East Main St. Bridgeport CT	Monday, Wednesday, Thursday, Friday 8:00 a.m. - 5:00 p.m. Tuesday 8:00 a.m. - 7:00 p.m. Saturday 9:00 a.m. - 1:00 p.m. Sunday 11:00 a.m. - 3:00 p.m.	Not Available
Optimus	Not Available	Not Available	Optimus 471 Barnum Ave. Bridgeport, CT	Monday & Tuesday 8:00 a.m.- 7:30 p.m. Wednesday, Thursday, & Friday 8:00 a.m.- 5:00 p.m.	Not Available

*SWCHC visits from 4/1/16 through 3/31/17
**SWCHC also provides services at four homeless shelters and at operates seven school-based clinics.

*Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

Connecticut Department of Public Health

Supplemental CON Application Form
Termination of a Service
Conn. Gen. Stat. § 19a-638(a)(5),(7),(8),(15)

Applicant: St. Vincent's Medical Center

Project Name: Family Health Center Transition

05-02-2017 00029

TABLE A
PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Facility Name	Facility ID*	Facility Address	Total Capacity	Available Capacity	Utilization FY16**	Utilization Current CFY17***
Southwest Community Health Center, Inc.	Medicare NPI # 1699703686	46 Albion St. Bridgeport, CT 06605	183,000	At Lindley St. 25,000	130,000	155,000

* Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

** Fill in year and identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate.

*** 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.

a. 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.

This Proposal does not displace any Lindley Street Location patients. The attached Letter of Intent (please see Exhibit J) reflects that while SVMC will no longer be providing primary care services at the Lindley Street Location, SVMC will enhance the provision of needed specialty services for the Target Population. SWCHC will assume the full role as provider of primary care services at the Lindley Street Location.

b. Identify any special populations that utilize the service(s) and explain how these populations will maintain access to the service following termination at the specific location; also, specifically address how the termination of this service will affect access to care for Medicaid recipients and indigent persons.

Please see description of Target Population as described in the Main Application.

c. Describe how clients will be notified about the termination and transfer to other providers.

Clients will be sent letters from SVMC notifying them of the proposed transition of their primary care services to SWCHC.

d. For DMHAS-funded programs only, attach 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.

1. Affidavit

Applicant: **St. Vincent's Medical Center**

Project Title: **Family Health Center Transition**

I, Vincent Caponi, CEO, of St. Vincent's Medical Center being duly sworn, depose and state that St. Vincent's Medical Center complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Vincent C. Caponi
Signature

APRIL 27, 2017
Date

Subscribed and sworn to before me on 4/27/17

Dolores Miele

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2021

5613959v1

2. Affidavit

Applicant: **St. Vincent's Medical Center**

Project Title: **Family Health Center Transition**

I, Vincent Caponi, CEO, of St. Vincent's Medical Center being duly sworn, depose and state that St. Vincent's Medical Center complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Vincent C. Caponi — Signature

APRIL 27, 2017 — Date

Subscribed and sworn to before me on 4/27/17

Dolores Miele

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2021

5613959v1

SHIPMAN & GOODWIN LLP
COUNSELORS AT LAW

One Constitution Plaza
Hartford, Connecticut 06103-1919

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51-57/119 CT

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296351

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Date	Amount
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TWO SIGNATURES REQUIRED OVER $20,000.00

By

⑈0000296351⑈ ⑆011900571⑆ 009443134922⑈

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296351

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04/28/2017

Invoice #	Inv. Date	G/L Acct	Client	Matter	Narrative	Amount	Inv. Total
)42817.500.00	4/28/2017				Filing Fee		
)42817.500.00	Apr 28/17		55883	01	VENDOR: Treasurer, State of Connecticut; INVOICE#: 042817.500.00; DATE: 4/28/2017 - Filing Fee	500.00	500.00
					Invoice Totals:	$500.00	$500.00

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AFFIDAVIT OF PUBLICATION

STATE OF CONNECTICUT
COUNTY OF FAIRFIELD

Public Notice St. Vincent's Medical Center and Southwest Community Health Center, Inc.

PUBLIC NOTICE St. Vincent's Medical Center and Southwest Community Health Center, Inc. (the "Applicants") intend to file a joint Certificate of Need application under Section 19a-638 of the Connecticut General Statutes to request approval for the termination of the services provided by St. Vincent's Medical Center at its Family Health Center located at 762 Lindley Street, Bridgeport, CT 06066 and a contemporaneous assumption of the complete operation of the Family Health Center and the provision of the same services at the same location by Southwest Community Health Center.

I, _____
Being duly sworn, depose and say that I am a Representative in the employ of HEARST CONNECTICUT MEDIA GROUP, Publisher of the Connecticut Post, that a LEGAL NOTICE as stated below was published in the Connecticut Post.

Subscribed and sworn to before me on this 24th Day of April, A.D. 2017.

Sharon R Boroskey
Notary Public

My commission expires on

SHARON R BOROSKEY
Notary Public, State of Connecticut
My Commission Expires Oct 31, 2021

PO Number

Ad Caption
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BRIDGEPORT near Merritt Prkwy 1 BR & studios. Nice neighborhood. Gated parking & heat included in rent 203-212-1910 Mon-Fri, 1-5 pm. www.lynn apartmentsct.com

BRIDGEPORT BLACK ROCK Studios, 1 & 2BR apts. $815-$1395 203-520-6372 See photos: HubRealty.com local.ctpost.com /160713/

Bridgeport Modern Brick Buildings Heat, Hot water, wall to wall carpet, appliances, parking & laundry. 1Brs-St.V's Hospital & Black Rock area. 1BRs-Waldbaum Area. (203) 767-5573 or (203) 371-5339 nusiterealty-ct.com

MILFORD BRIEMONT LODGE New remod. rooms. Incld. kit, cable, wi-fi, utils. & prkg. Downtown Mfld. Weekly. 203-801-5413

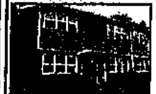
★ MILFORD LUXURY GARDEN APTS ★Great Winter Special★ 1.5 Months Free Rent on 1 BR Units ★Spacious★ Some include Heat, Hot water, Cooking gas, c/ac, off-street parking, on bus route. Beautifully landscaped. Very quiet and safe. 1&2BR apts. Some have a 21ft. patio. 24/hr. service. Come see! Ask for BR or Sandy 203-877-9065 Special for new residents only

MILFORD BEACH WINTER SPECIALS!! FALLING RENT PRICES!! $99 SECURITY DEPOSIT!!! HEAT, HOT WATER AND COOKING GAS INCLUDED 1 & 2 Bedrooms Open 7 days a week 203-878-7810 www.windsorNY.com

NORTH END 3BDRM 2BA, $1100m, 1 mo & sec, refs 203-895-5808

Call Us! ORANGE - Prindle Terrace NEWER UNITS! 2BR $1,550/month 1BR $1,150/month Adult Comm. 62 YEAR+. All one level. Fully appl'd w/ W&D. Ouellette Realty •203-984-8851•

★★★



SEYMOUR 2BR in Quiet Neighborhood, Freshly Painted, New Carpet, Off Street Parking, Stove, Fridge, D/W, Coin-op Laundry & Storage basement, $950, 1 Year lease/sec. No Pets! 203.888.6440

SHELTON 1BR apt, refrige, range/ micro., W/D, AC, deck, yard, osp. No pets/smk. Tenant pays utils. Lease+Sec. $820/m, 203-382-7840

RENT ME SHELTON 5 ROOM APT 2 br, 1st fl, Clean, HW flrs, gas heat, off street pkg. $1,200 /mo Pepe Realty 203-929-6775

SHELTON- 2 Apts. remdld, appls, 2 br. 2nd flr $950/ $1125 + utils, sec + ref, no pets/smkg, 203-924-9266.

SHELTON 2BR Appl. & WD-hup. reduced to $850 (203) 249-0986

SHELTON, Priv room ent+ba., female, Util.incl. No pets $800 203-924-0148

RENT ME SHELTON 5 RM APT 5 room 2 bedroom, 2nd floor with stove, refrig, washer, dryer. HW floors, gas heat. off st prkg. $1200/mo Pepe Realty 203-929-6775

STRATFORD 1bedroom apt. Ideal location. No pets. Call for details. Richelieu Apts., 203-378-8587

STRATFORD 2BR apt. 3rd flr. newly renov! WD, osp, nice yard. Gas h/Hw, c/ac. 2m. sec. No pets/smk. Avl. Now. $1075 Joe 203.520.1556

STRATFORD - Paradise Green, 2rm studio, 2nd fl, EIK, full bath, no pets/ no smkg, $875+sec 203-470-3638

TRUMBULL 2 APTS: 2bdrm $1300 3bdrm $1400. osp, apls, trumbull schl district, 203-767-3506

WESTON Convenient loc. 3BR, 2.5bth, Kitchen/LR/DR/office, Large yard. $3300. Call 203-434-0082

HOUSES FOR RENT

RENT ME SHELTON WHITE HILLS AREA 2BR RANCH 1BTH , Appliances and W/D Oil and Elec heat, wood floors. $1,650 /mo. Pepe Realty 203-929-6775

RENT ME STRATFORD 2006 3BR RANCH 2BTH. No Pets, No smoking, Appl incl W/D. Gas Heat, CA $1700/mo. Pepe Realty 203-929-6775

HOUSES / APARTMENTS TO SHARE

BPT NORTH END Furnished Lrg BR w/cust closets. W/D, shr hse & pool with others. Storage avail. $775+sec. Includes ut lk/cbl/inter. Call 203.400.0812

CONDOS FOR RENT

MILFORD FOXWOOD 1Br Lr Dr EIK AC, Deck, Pool/Tennis, HT+HW Incl. No pets/smk. $1250 (203) 926-1450

RENT ME Shelton - Birmingham Condo 4th floor, loft style, 2 BR, Heat incl in rent. $1475/mo Pepe Realty • 203-929-6775

OFFICE SPACE

DANBURY AFFORDABLE OFFICE SPACE Various 500, 1200, 6000SF. Bright, spacious, high ceilings. On-site pkg. all utilities. Call for pricing, 203-797-8255 www.nolanrealestate.org

OFFICE SPACE

GREENWICH - Greenwich Ave. Furnished suites, w/reception, conference room & lounge area. 203-861-3343. EDG, Inc. EST. 1974

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WESTPORT - Post Road singles, 1500, 3000, 4000, 6500 sf Office spaces 203-226-6969 Leiferproperties.com

WESTPORT: GORGEOUS! Office suites: Singles 500, 1,500, 2,100, 3300 up to 12,500sf Either dwntwn or nr RR. Hwd flrs, Hi-speed internet, fireplaces, kitchenettes, skylights, etc. Flex terms. 203-226-6969. Leiferproperties.com

FARMS AND LANDS FOR SALE

12.92 ACRES - SHELTON Borders C2 zone. City water/sewer Available. Call 203-306-9540

BOAT SLIPS

LOOK 40 FT BOAT SLIP FOR SALE OR LEASE BY OWNER Located at Full Service Marina, The River Club Palmer Point, Greenwich CT. Owner- 914-391-1474 or howardkaye@earthlink.net

VEHICLES FOR SALE

1961 CHEVROLET Impala. Red. 4-dr Sedan. Turbo 350 Trans, 327 engine. Excellent condition. $14,000 OBO. (203)268-6486

1995 E320 MERCEDES WAGON very clean, no rust, runs good. $2900 Dave 203-987-2550

2012 - LINCOLN NAVIGATOR, 61k miles, well maintained, fully loaded, garaged, VGC. $27K, 203-417-8193.

BMW X5 '12 100K mi. Gray w/ Leather. 1 Owner. Great Condition. Well Maintained. NAV System. Trailer Seats 7; Hitch. $18,000 Please Call: 203-554-0003.

DODGE RAM 3500 '96, Cummings diesel, dual wheels, 4x4, 12 ft dump body, new cab, new paint, new intr, no rust, 115K miles, $14,000. news transmission. 5 yr 100K mile warranty 203-848-8541

DONATE YOUR CAR TRUCK OR SUV TO the SPCA and receive the maximum tax deduction and quick, free pick up. Call 203-445-9978

HONDA PILOT '04 EXL Well Maint. SUV. 1 Owner, Leather Seats, 3rd Row Seating. 146K mi, Reliable, Runs Well, $4000. Call: 203-273-9062.

HUNDAI XG 350L '02. $1600 obo with snow tires Call 203-417-6718

FOR SALE

HYUNDAI ELANTRA GTL '06 Sedan, 120k miles, silver. Good condition. Includes bike rack. $3,50 0.00 • (914) 396-6520

LINCOLN NAVIGATOR '99. Fully loaded, 197k miles, new tires, good condition. $2850. 203-858-1317

MINI COOPER '12. 61k miles, white extr, blk leather intr, auto, sun roof, waranty, new tires, great condi $10,000 obo Call 201-410-0439

TOYOTA TACOMA 99 4X4 TRD PKG Xtra Cab SR5 V6 $2250 Call me: 860-285-8326

VEHICLES WANTED

1-203-243-3800 $$$ AUTOS & TRUCKS wanted for junk. Cash Paid.

VEHICLES WANTED

CASH FOR CARS RUNNING OR NOT NO TITLE- NO PROBLEM $100-$1500. 24 HOUR PICK UP 203-997-9810

CLASSIC CARS WANTED Pre '73 Jags, Healeys, Chevys, Porsche, Benz, Fords, Cadillacs, Ferraris, & others. Basket cases - running or not. Call 203-889-6856

DONATE YOUR CAR to the SPCA and receive the maximum tax deduction and quick. free pick up. Call 203-445-9978

JUNK VEHICLES WANTED w/ Titles or Registration. We pay for them! (203)449-6310

WTB/Wanted Old cars, convertibles and motorcycles. If crusty, rusty, broken, and dusty, all the better. Thank you, Dan: 512-632-7724.

What should I do when the power comes back on?

Throw out unsafe food.

American Red Cross

For more information on disaster & emergency preparedness, visit RedCross.org

PUBLIC NOTICES

LEGAL NOTICE

Connecticut Superior Court J. D. of Fairfield at Bridgeport

Return Date: 03/28/17

RE: Tide Harbor Towers Condominium Association B, Inc. Vs: Gary W. Firmender, Et Al

Notice To: Gary W. Firmender

Upon the Complaint of the Plaintiff (s) in the above entitled action, praying for reasons therein set forth, for the foreclosure & foreclosure of common charges on the property known as 1460 Elm Street, #128B, Stratford, Connecticut at the condominium known as TIDE HARBOR TOWERS CONDOMINIUM ASSOCIATION B, INC., in Stratford, Connecticut,

and possession of said premises, returnable before the above name Court to be held at Bridgeport on 3/28/2017, and upon a motion in said action for an order of notice, it appearing to and being found by the subscribing authority that the Defendant whose name and address is unknown is absent from this State – the residence of the Defendant is unknown to the Plaintiff, and that notice of the institution of this action most likely to come to his attention is that hereinafter ordered: It is Ordered, that notice of the institution of said action be given the said Defendant by some proper officer or other person causing a true and attested copy of this order and notice to be published in the CONNECTICUT POST, a newspaper printed in Bridgeport, Connecticut, Fairfield County two times consecutively – once a week for 2 successive weeks, commencing on or before 2/27/2017, and that return of such service be made to the above-named Court.

Superior Court Judge: Alfred Jennings Date Signed: 01/30/17

A True Copy Attest N. E. Nikola State Marshal/Fairfield County

PUBLIC NOTICES

LEGAL NOTICE

Pursuant to Conn. Gen. Stat. §§16-19, 16-19b and 16-244c(c), the Public Utilities Regulatory Authority will conduct an administrative proceeding at its offices, Ten Franklin Square, New Britain, Connecticut, on Thursday, February 23, 2017, at 9:30 a.m., concerning Docket Nos. 17-01-01 & 17-01-02 – Administrative Proceeding to Review The Connecticut Light and Power Company's and The United Illuminating Company's Standard Service and Supplier of Last Resort Service 2017 Procurement Results and Rates. For information and the Notice of Administrative Proceeding filed with the Secretary of State's Office, contact: PUBLIC UTILITIES REGULATORY AUTHORITY, JEFFREY R. GAUDIOSI, ESQ., EXECUTIVE SECRETARY.

Public Notice St. Vincent's Medical Center and Southwest Community Health Center, Inc.

PUBLIC NOTICE St. Vincent's Medical Center and Southwest Community Health Center, Inc. (the "Applicants") intend to file a joint Certificate of Need application under Section 19a-638 of the Connecticut General Statutes to request approval for the termination of the services provided by St. Vincent's Medical Center at its Family Health Center located at 782 Lindley Street, Bridgeport, CT 06606 and a contemporaneous assumption of the complete operation of the Family Health Center and the provision of the same services at the same location by Southwest Community Health Center.

PUBLIC NOTICES

City of Bridgeport Inland Wetland and Watercourse Agency Monday, February 27, 2017 6:00pm

The Inland / Wetland Commission of the City of Bridgeport will convene for an application review on February 27, 2017 in the Common Council Chambers, 45 Lyon Terrace, Bridgeport, relative to the following proposal:

(17-01) – Application review - submitted by the General Electric Company regarding the soil remediation project located at 1285 Boston Avenue.

Should you have any questions concerning this ad, call (203) 576-7217, Zoning Department, Room 210, 45 Lyon Terrace, Bridgeport, Connecticut 06604.

Melville T. Riley, Jr., Chairman

SHELTON PLANNING AND ZONING COMMISSION NOTICE OF PUBLIC HEARING WEDNESDAY, FEBRUARY 22, 2017 AT 7:00 P.M.

The Shelton Planning and Zoning Commission of the City of Shelton, Connecticut hereby gives notice of a public hearing to be held on Wednesday, February 22, 2017 at 7:00 P.M. in the Shelton City Hall, Auditorium, 54 Hill Street to consider the following:

2017 Final Draft Update to the 2006 Plan of Conservation and Development; Dated January 19, 2017:
was prepared in accordance with Section 8-23 of the Connecticut General Statutes consisting of: Executive Summary, Section 1: Introduction and Overview, Section 2: Vision Statement, Section 3: Conditions and Trends, Section 4: Updated Plan Strategies, Section 5: Future Land Use Plan, Section 6: and Implementation Section 7.

Said 2017 Final Draft POCD Update was prepared by the POCD Update Subcommittee submitted to and finalized by the Shelton Planning and Zoning Commission. Copies are available for review in the City/Town Clerk's Office, Planning and Zoning Office, Plumb Memorial and Huntington Branch Libraries and the city's website at cityofshelton.org. At said hearing all persons will have the right to be heard and written communications will be received.

Dated at Shelton, Connecticut this 9th day of February, 2017
Shelton Planning and Zoning Commission
Ruth Parkins, Chairman
Virginia Harger, Secretary

CITY OF BRIDGEPORT PLANNING & ZONING COMMISSION PUBLIC HEARING NOTICE Monday, February 27, 2017 at 6:45pm

A public hearing of the Planning & Zoning Commission of the City of Bridgeport, CT will be held in the City Hall Common Council Chambers, 45 Lyon Terrace, Bridgeport, relative to the following:

D-1 (16-58) Text Amendment – Petition of Three Corners, LLC – Seeking to amend the liquor regulations of Sec. 12-10a, 12-10b and 12-10e and eliminate Sec. 12-10c and 12-10d and have all future liquor applicants seek special permits and site plan reviews, rather than variances in all retail zones.

D-2 (16-59) 1044 Brooklawn Ave. – Petition of Three Corners, LLC – Seeking a special permit and a site plan review to permit the establishment of package store use and the issuance of a package store liquor permit in the existing retail building in an OR zone.

(17-08) 887 Reservoir Ave – Petition of Bridgeport Auto Sales, LLC – Seeking to grant under Sec. 14-54 of the CT General Statutes an Amended Certificate of Location for an existing used car dealership license under new ownership in an R-A zone.

(17-09) 1 Lincoln Boulevard – Petition of T-Mobile Northeast, LLC – Seeking a site plan review to permit the construction of three (3) telecommunication equipment sheds and the installation of antennas on the existing 100' light stanchion on the Central High School campus in an R-B zone.

The applications for all the above described matters are on file in the Zoning Department, Room 210, 45 Lyon Terrace and may be inspected during business hours between 9am-5pm Monday thru Friday. This notice is also posted in the City Clerk's Office.

CITY OF BRIDGEPORT
PLANNING & ZONING COMMISSION
Mel T. Riley – Acting Chairperson

City of Shelton Board of Zoning Appeals 54 Hill Street, Shelton, Connecticut

LEGAL NOTICE –CITY OF SHELTON

TO WHOM IT MAY CONCERN:
The following having applied to the Shelton Board of Zoning Appeals for certificate of approval, public hearing on such applications will be held on Tuesday, February 21, 2017 at 7:30 p.m., in the hearing room of the Municipal Building, 54 Hill Street, Shelton, CT:
1.#0217-01 9 Cedarwood Lane, Wayne Hodson of 9 Cedarwood Lane, Shelton, for the following 3 variances in order to construct a one -story, 30' x 35' x 26' detached garage: 1) Section 24, Schedule B, Line 8 to reduce the minimum setback from the right side property line from 30 feet to 25 feet; 2) Section 24.12.1 to increase the total floor area from 750 sq. ft. to 1,050 sq. ft.; 3) Section 24.12.3 to increase the maximum height from 20 feet to 26 feet, in an R-1 zone.
2. #0117-01 405 Long Hill Avenue, Jack and Josephine A. Galde of 405 Long Hill Avenue, Shelton, (c/o Atty. Dominic Thomas, 315 Main Street, Derby), for a variance to Article 24, Section 24.9.4 to create driveway access through an R-1 residential zone to an IA-2 industrial/ commercial building zone. *(CONTINUED FROM JANUARY MEETING)*
3. #0117-02 854 -856 Howe Avenue, Pramod Kandel of 856 Howe Avenue, Shelton, for variances to Section 24, Schedule B, Lines 9 and 10 to reduce the minimum setback from the left side property line from 12 feet to 7 feet and to reduce the minimum setback from the residence district boundary from 40 feet to 30 feet in order to construct a 2-story, 13' x 16' rear addition in an CB-2 zone.
(CARRIED FROM JANUARY MEETING)

NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the Town of Monroe will conduct a public hearing by the Town Council on February 27, 2017, at 7:30 p.m. at the Town Hall, 7 Fan Hill Rd, Monroe, CT 06468 to discuss the Fiscal Year 2017 Community Development Block Grant program and to solicit citizen input.

Maximum award limits: $700,000 for Public Facilities; $700,000 for Public Housing Modernization of 25 units or less, or $800,000 for 25 units and over; $800,000 for Infrastructure; $400,000 for Housing Rehabilitation Program for single towns, $500,000 for two-town consortium, and $600,000 for three or more Towns; $25,000 for Planning Only Grants; $500,000 for Economic Development Activities, and $500,000 for Urgent Need.

Major activity categories are: Acquisition, Housing Rehabilitation, Public Housing Modernization, Community Facilities, Public Services, and Economic Development. Projects funded with CDBG allocations must carry out at least one of three National Objectives: benefit to low- and moderate-income persons, elimination of slums and blight, or meeting urgent community development needs.

The purpose of the public hearing is to obtain citizen's views on the Town's community development and housing needs and review and discuss specific project activities in the areas of housing, economic development or community facilities which could be part of the Town's Application for funding.

Also, the public hearing will be to give citizens an opportunity to make their comments known on the program and for approval of the Program Income Reuse Plan. If you are unable to attend the public hearing, you may direct written comments to the Town of Monroe, First Selectman Stephen J. Vavrek, 7 Fan Hill Rd, Monroe, CT 06468 or you may telephone Stephen J. Vavrek at 203-452-2821. In addition, information may be obtained at the above address between the hours of 8:30 a.m. and 4:30 p.m. on M-Th and 8:30 a.m. and 1:30 p.m. on Fridays.

The Community Development/Housing Department on behalf of the Town of Monroe anticipates applying for the maximum grant amount of $400,000 under the housing rehabilitation category. In addition, the Town will create a revolving loan fund with program income (principal and interest) generated from the grant for a housing rehabilitation loan program.

The Town of Monroe promotes fair housing and makes all programs available to low- and moderate-income households regardless of age, race, color, religion, sex, national origin, familial status, disability, sexual orientation, marital status, lawful source of income, or gender identity or expression.

If you are unable to attend the public hearing, you may direct written comments to the First Selectman Stephen J. Vavrek, 7 Fan Hill Rd, Monroe, CT 06468 or you may telephone Stephen J. Vavrek at 203-452-2821 . In addition, information may be obtained at the above address between the hours of 8:30 a.m. and 4:30 p.m. Monday through Thursday and 8:30 a.m. and 1:30 p.m. on Fridays. The hearing will also review and discuss the Town's prior Small Cities projects including any currently open or underway.

"All are encouraged to attend. The hearing is accessible to the handicapped. Any disabled persons requiring special assistance or non-English speaking persons should contact First Selectman Stephen J. Vavrek, ADA Coordinator, at 203-452-2821 at least five days prior to the hearing."

Equal Opportunity/Affirmative Action

APARTMENTS FOR RENT

Bridgeport
Modern Brick Buildings
Heat, Hot water, wall to wall carpet, appliances, parking & laundry.
1Brs-St.V's Hospital & Black Rock area.
1BRs-Waldbaum Area.
(203) 767-5573 or (203) 371-5339
nusiterealty-ct.com

DANBURY Apts. Bright Studios $600-$700, 1BR, $800-$1000. OSP, LAUNDRY. Security Req'd. NO PETS. Applications avail. 203-797-8255 nolanrealestate.org

DERBY - 2 BR apt., 1st fl. Close to hospital & Rt.8. No smk+pets. 1m sec. Formal LR/DR. $1100/mo. Avail 3/1. (203)545-5367

DERBY REMODL'D, 3BR, 1st flr, 6rm, no pets/no smkg, sec/crd ck. $1300. 203-470-3838

MILFORD BRISMONT LODGE New remod. rooms, incld. kit, cable, wi-fi, utils. & prkg. Downtown Mlfd. Weekly. 203-804-5413

★

MILFORD
LUXURY GARDEN APTS
★Great Winter Special★
1.5 Months Free Rent on 1 BR Units
★Spacious★
Some include Heat, Hot water, Cooking gas, c/ac, off-street parking, on bus route. Beautifully landscaped. Very quiet and safe. 1&2BR apts. Some have a 21ft. patio. 24/hr. service. Come see! Ask for Bill or Sandy 203-877-9066
Special for new residents only

MILFORD BEACH
WINTER SPECIALS!!
FALLING RENT PRICES!!
$99 SECURITY DEPOSIT!!
HEAT, HOT WATER AND COOKING GAS INCLUDED
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NORTH END 3BDRM 2BA, $1100m, 1 mo & sec, refs 203-895-5806

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NEWER UNITS!
2BR $1,550/month
1BR $1,150/month
Adult Comm. 62 YEARs+. All one level. Fully appl'd w/ W&D.
Ouellette Realty
•203-954-5651•

★★★

SEYMOUR 2BR in Quiet Neighborhood, Freshly Painted, New Carpet, Off Street Parking, Stove, Fridge, D/W, Coin-op Laundry & Storage basement, $950, 1 Year lease/sec, No Pets! 203.888.6440

SHELTON 1BR apt, refrige, range/micro., W/D, AC, deck, yard, osp. No pets/smk. Tenant pays utils. Lease+Sec. $920/m, 203-362-7840

RENT ME
SHELTON 5 RM APT
5 room 2 bedroom, 2nd floor with stove, refrig, washer, dryer. HW floors, gas heat. off st prkg. $1200/mo
Pepe Realty 203-929-6775

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SHELTON 5 ROOM APT
2 br, 1st fl, Clean, HW firs, gas heat, off street pkg.
$1,200 /mo
Pepe Realty 203-929-6775

SHELTON- 2 Apts, remdld, appls, 2 br. 2nd fl $850/ $1125 + utils, sec + ref, no pets/smkg. 203-924-8288.

SHELTON 2BR Appl. & WD-hup. reduced to $850 (203) 249-0988

STRATFORD 1bedroom apt. Ideal location. No pets. Call for details, Richelieu Apts., 203-378-8687

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SHELTON WHITE HILLS AREA
3BR RANCH
1BTH . Appliances and W/D Oil and Elec heat, wood floors.
$1,650 /mo.
Pepe Realty 203-929-6775

RENT ME
STRATFORD 2006 3BR RANCH
2BTH. No Pets, No smoking. Appl incl W/D. Gas Heat, CA $1700/mo.
Pepe Realty 203-929-6775

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BPT NORTH END
Furnished Lrg BR w/cust closets, W/D, shr hse & pool with others. Storage avail. $775+sec. Includes utils/cbl/inter. Call 203.400.0812

CONDOS FOR RENT

MILFORD FOXWOOD 1Br Lr Dr EIK AC, Deck, Pool/Tennis. HT+HW incl. No pets/smk. $1250 (203) 926-1450

RENT ME
Shelton - Birmingham Condo
4th floor, loft style, 2 BR, Heat incl in rent.
$1475/mo
Pepe Realty • 203-929-6775

OFFICE SPACE

DANBURY
AFFORDABLE OFFICE SPACE
Various 500, 1300, 6000SF. Bright, spacious, high ceilings. On-site pkg, all utilities.
Call for pricing, 203-797-8255
www.nolanrealestate.org

GREENWICH - Greenwich Ave. Furnished suites, w/reception, conference room & lounge area. 203-661-3343, EOG, Inc. EST. 1974

☆★☆

PROBATE NOTICES

State of Connecticut

Court of Probate, District of New Haven Regional Children's Probate Court

NOTICE TO Nicole Ende

whose last known residence was in the town of Milford, CT.

Pursuant to an order of Hon. Beverly K. Streit-Kefalas, Judge, a hearing will be held at New Haven Regional Children's Probate Court, 873 State Street, New Haven, CT 06511-3923 on March 13, 2017 at 1:00 PM on an application for Temporary Custody Pending Removal of Guardian concerning a certain minor child born on December 13, 2006. The Court's decision will affect your interest, if any, as in said application on file more fully appears.

RIGHT TO COUNSEL: If the above-named person wishes to have an attorney, but is unable to pay for one, the Court will provide an attorney upon proof of inability to pay. Any such request should be made immediately by contacting the court office where the hearing is to be held.

By Order of the Court

Karen M. Parzych,
Deputy Chief Clerk

OFFICE SPACE

WESTPORT - Post Road singles, 1500, 3000, 4000, 8500 sf Office spaces 203-226-6969
Lefferproperties.com

WESTPORT: GORGEOUS!
Office suites: Singles 500, 1,500, 2,100, 3300 up to 12,500sf
Either dwntwn or nr RR. Hwd flrs, Hi-speed internet, fireplaces, kitchenettes, skylights, etc. Flex terms.
203-226-6969.
Lefferproperties.com

Place a Memoriam to remember a loved one. Call 203-330-6306. obituaries@hearstmediact.com

PUBLIC NOTICES

PUBLIC NOTICE
WSHU Public Radio, Sacred Heart University, will hold an open meeting of its Community Advisory Board at its administrative offices at 101 Oakview Drive, Trumbull, CT on Wednesday, March 1st, 4:00 pm. Information about the Community Advisory Board is available at www.wshu.org. A meeting agenda will be posted on the WSHU website by February 22nd.

HOUSES FOR SALE

BRIDGEPORT - NEW LISTING 5BR W/IN-LAW Brooklawn Area Colonial, Updated. 3.5 BTH, 2 Car gar. $289,900
Trojanowski Realty 203-865-3166

FARMS AND LANDS FOR SALE

12.92 ACRES - SHELTON Borders C2 zone. City water/sewer Available. Call 203-305-8540

BUY, BUY BUY!

PUBLIC NOTICES

NOTICE OF APPLICATION FOR DEMOLITION PERMIT:

In accordance with Chapter 5 Article I Section 5-5 of the Trumbull Municipal Code, notice is herby given that the Town of Trumbull Building Department has received a demolition permit application to demolish a structure located within the Town. Merry Go Round Properties LLC, the property owner of a dilapidated 1186 square foot single family residential house constructed in 1936 and a 1916 square foot 2 car garage/barn built in 1960 located at 151 Strobel Rd. in Trumbull, CT has filed for an application for a demolition permit. A determination of historic, architectural or cultural significance of stated structures will be made by the Demolition Review Committee within 30 days of the date the application was filed.

Trumbull Building Official

PUBLIC NOTICES

NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the Town of Trumbull will conduct a public hearing on Monday, March 6, 2017 at 6:00 p.m. in the Town Council Chambers, located at 5866 Main Street, Trumbull, CT to discuss its 2017 Small Cities Program Application and to solicit citizen input.

Maximum award limits are $700,000 for Public Facilities, $700,000 for Public Housing Modernization of 25 units or less, or $800,000 for 26 units and over; $500,000 for Infrastructure; $400,000 for Housing Rehabilitation Program for single towns, $500,000 for two-town consortium, and $800,000 for three or more Towns; $25,000 for Planning Only Grants; $500,000 for Economic Development Activities, and $500,000 for Urgent Need.

Major activity categories are: Acquisition, Housing Rehabilitation, Public Housing Modernization, Community Facilities, Public Services, and Economic Development. Projects funded with CDBG allocations must meet at least one of three National Objectives: 1) benefit to low and moderate income persons, 2) elimination of slums and blight, or 3) meeting urgent community development needs. Only one (1) project Application may be submitted to DOH.

The Town is proposing to submit an Application under the Public Housing Modernization category for Stern Village Phase II Energy Improvements. The Town of Trumbull anticipates applying for up to the maximum grant amount of $800,000.

The purpose of the public hearing is to obtain citizens' views on the Town's community development and housing needs and review and discuss specific project activities in the areas of housing, economic development or community facilities which could be a part of the Town's Application for funding. The hearing will also review and discuss the Town's prior Small Cities projects including any currently open or underway.

The public hearing will give citizens an opportunity to make their comments known on the program and review and discussion of the Program Income Reuse Plan. If you are unable to attend the public hearing, you may direct written comments to the Town of Trumbull, Office of the First Selectman, 5866 Main Street, Trumbull CT, 06611 or you may telephone Mr. Rob Librandi, Town of Trumbull Land Use Planner at 203-452-5047. In addition, information may be obtained at the above address between the hours of 9:00 am and 4:30 pm weekdays.

The Town of Trumbull promotes fair housing and makes all programs available to low- and moderate-income families, and will not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, color, religion, sex, national origin, familial status, disability, sexual orientation, marital status, lawful source of income, or gender identity or expression.

"All are encouraged to attend. The hearing is accessible to the handicapped. Any disabled persons requiring special assistance or non-English speaking persons should contact Mary Ann Meier, ADA Coordinator at 203-452-5040 at least five days prior to the hearing."

The Town of Trumbull is an Equal Opportunity/Affirmative Action Employer

Public Notice for Suspension of "Spring Freshet" Minimum Stream Flow Standards

Pursuant to section 26-141a-4(b) of the Regulations of Connecticut State Agencies (RCSA), the Commissioner of Energy and Environmental Protection ("the Commissioner") hereby suspends the minimum stream flow standards imposed under section 26-141a-8(b) RCSA, commonly known as the "spring freshet" release standard, for the period of February 15, 2017 to March 15, 2017.

The Commissioner received a petition from the South Central Regional Water Authority requesting this variance. This petition includes reference to the abnormally low precipitation received over the past two years creating below average water levels in their public water supply reservoirs. Further, these conditions are present state-wide, causing the Connecticut Interagency Drought Work Group to declare a Drought Advisory in Windham and New London Counties, and a heightened stage of Drought Watch in the remainder of state, pursuant to the Connecticut Drought Preparedness and Response Plan.

This suspension shall apply statewide to any dam or other structure which impounds, or diverts waters located on those watercourses which are listed in an annual publication by the Commissioner of stocked watercourses as excepted in section 26-141a-3(b) RCSA. The latest annual publication of stocked watercourses can be found at http://www.ct.gov/deep/lib/deep/fishing/general_information/fishdistributionreport.pdf

Note that this suspension does not apply to those minimum stream flow release requirements imposed under section 26-141a-8(a) RCSA commonly known as the "daily release" standards. Operators of impoundments or diversions shall continue to comply with the daily release requirements imposed under section 26-141 a-8(a) RCSA.

Questions regarding this action may be directed to Doug Hoskins, Department of Energy and Environmental Protection, 79 Elm Street, Hartford, CT 06106 | 860-424-4192 | douglas.hoskins@ct.gov.

Michael Sullivan
Deputy Commissioner

PUBLIC NOTICES

LEGAL NOTICE – PUBLIC HEARING

The State Board of Education will conduct a public hearing on the application for the renewal of a charter for The Bridge Academy located in Bridgeport. The public hearing will be held on February 23, 2017 beginning at 6:00 p.m. and concluding on or before 8:00 p.m. at Bullard-Havens Technical High School in Building A Large Tier Lecture Hall, at 500 Palisade Ave. in Bridgeport. Anyone interested in commenting on the application for the renewal of a charter for The Bridge Academy is welcome. All organizations and individuals offering comments are encouraged to provide a written copy of their remarks.

Public Notice St. Vincent's Medical Center and Southwest Community Health Center, Inc.

PUBLIC NOTICE St. Vincent's Medical Center and Southwest Community Health Center, Inc. (the "Applicants") intend to file a joint Certificate of Need application under Section 19a-638 of the Connecticut General Statutes to request approval for the termination of the services provided by St. Vincent's Medical Center at its Family Health Center located at 762 Lindley Street, Bridgeport, CT 06606 and a contemporaneous assumption of the complete operation of the Family Health Center and the provision of the same services at the same location by Southwest Community Health Center.

CITY OF SHELTON
SHELTON PLANNING AND ZONING COMMISSION
LEGAL NOTICE

The regular and special meetings of the Shelton Planning and Zoning Commission held on February 14, 2017, Shelton City Hall, 54 Hill Street, Shelton, CT the following actions were taken:

1. Rescheduled public hearing to 3/22/17 to conduct the public hearing for the 2017 Update to the 2006 Plan of Conservation and Development.
2. Added to the agenda Applications for Certificate of Zoning Compliance 0993, 0992, 0884, 0981, 0795, 0970, 0844, 0792, 1003 and 0956.
3. Added to the agenda Appl. #17-04.
4. Approved Appl.'s for Cert. of Zoning Compliance 0973, 0993, 0992, 0984, 0981,0795, 0970, 0844 and 0792.
5. Tabled action on Appl.'s for Cert. of Zoning Compliance 1003,0856 and 0956.
6. Accepted extension of the decision period for Appl. #16-8, Shelter Ridge.
7. Accepted and scheduled public on3/17/17 for Appl. #17-04, Modification of Statement of Uses and Standards for PDD #70, The Market Shopping Center.

Ruth Parkins, Chairman
Virginia Harger, Secretary

PUBLIC NOTICE

Notice of sale or other disposition pursuant to Connecticut State Statues Section 42-108 to 42-168. Notice is herby given that "PSORANGECO" will sell at PUBLIC AUCTION the personal property in the units to satisfy unpaid storage rentals of delinquent accounts. Sales to be paid in cash only at the time of sales. Contents to be removed off the premises the same day. Tenants may claim their merchandise up to the time of sales by paying their just debts and vacate.

Public Storage, Inc: 77 Mill Plain Road #83, Danbury, CT 06811
Sale to be held on February 21st 2017 at 9:30 AM
Unit 1080 Monique Authelat: Boxes, Furniture, Tools
Unit 1086 Tiffany Ford: Boxes, Furniture, Tools
Unit 1137 Paul Paske: Boxes, Furniture, Tools
Unit 1158 Tanya Gibson: Boxes, Furniture, Tools
Unit 2261 Mayra Gallego: Boxes, Furniture, Tools
Unit B1065 John Costello: Boxes, Furniture, Tools
Unit B3166 Alam Mohammed: Boxes, Furniture, Tools
Unit C1011 David Youngberg: tires

Public Storage, Inc: 38 Hoyt Street, Norwalk, CT 06851
Sale to be held on February 21st 2017 at 9:30 AM
Unit 1042 susan Burrows: Boxes, Furniture, Tools
Unit 1048 Ali Medet: Boxes, Furniture, Tools
Unit 2112 Sandra Johnson: Boxes, Furniture, Tools
Unit 2160 Riverside Management Group: Boxes, Furniture, Tools
Unit 3350 Chris Maki: Boxes, Furniture, Tools
Unit 4408 Amber Jean-Louis: Boxes, Furniture, Tools

Public Storage, Inc,1296 Kings Hwy Cutoff, Fairfield, CT 06824
Sale to be held on February 21st 2017 at 9:30 AM
Unit B337 Frank Robliotto: Boxes, Furniture, Tools
Unit B369 Maria Roche: Boxes, Furniture, Tools
Unit C623 KEITH SCHAUWECKER: Boxes, Furniture, Tools
Unit O003 Tri State Restoration: Boxes, Furniture, Tools
Unit O006 Hodges Leon: Boxes, Furniture, Tools

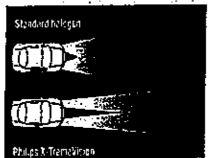
Public Storage, Inc, 299 Wordin Ave, Bridgeport, CT 06605
Sale to be held on February 21st 2017 at 9:30 AM
Unit 1041 Lateefah Emery: Boxes, Furniture, Tools
Unit 1052 Amber Valentine: Boxes, Furniture, Tools
Unit 1092 Angel Gonzalez: Boxes, Furniture, Tools
Unit 1101 Laila Howell: Boxes, Furniture, Tools
Unit 1147 Guy Pettiford: Boxes, Furniture, Tools
Unit 1148 Beverley Lloyd: Boxes, Furniture, Tools
Unit 1177 Shawn Spencer: Boxes, Furniture, Tools
Unit 2218 Tiffany Roberson: Boxes, Furniture, Tools
Unit 2318 Nanette Mosely: Boxes, Furniture, Tools
Unit 2330 Kayla Ortiz: Boxes, Furniture, Tools
Unit 3360 James White: Boxes, Furniture, Tools
Unit 3400 Natasha Moore: Boxes, Furniture, Tools
Unit 3428 James Mack: Boxes, Furniture, Tools
Unit 3437 Asia Williams: Boxes, Furniture, Tools
Unit 3450 Paris Forney: Boxes, Furniture, Tools
Unit 4498 Pamella Lassiter: Boxes, Furniture, Tools
Unit 4541 Briana Day: Boxes, Furniture, Tools
Unit 4584 Jocelyn Frye: Boxes, Furniture, Tools
Unit 4586 Timothy Lyles: Boxes, Furniture, Tools
Unit C844 Diana Harris: Boxes, Furniture, Tools
Unit C662 Michael Pickering: Boxes, Furniture, Tools
Unit E705 Annette Void: Boxes, Furniture, Tools
Unit E712 Karissa Bradley: Boxes, Furniture, Tools

Public Storage, Inc: 168 Bull Hill Lane, West Haven, CT 06516
Sale to be held on February 21st 2017 at 9:30 AM
Unit 1002 Belinda Hawkins: Boxes, Furniture, Tools
Unit 1039 Rukaiyah Rasul-Byrd: Boxes, Furniture, Tools
Unit 1104 Liana Silva: Boxes, Furniture, Tools
Unit 2152 Vanessa Parker: Boxes, Furniture, Tools
Unit 3068 Ingrid Carlo: Boxes, Furniture, Tools
Unit 3084 Millicent White: Boxes, Furniture, Tools
Unit 3124 Marcus Williams: Boxes, Furniture, Tools
Unit 548 Gladimir Calderon: Boxes, Furniture, Tools
Unit 554 Michael Briscoe: Boxes, Furniture, Tools

Public Storage, Inc: 125 Railroad Ave, West Haven, CT 06516
Sale to be held on February 21st 2017 at 9:30 AM
Unit B012 Michael Ramos: Boxes, Furniture, Tools
Unit B020 Wayne Simmons: Boxes, Furniture, Tools
Unit C024 Wilson Cruz: Boxes, Furniture, Tools
Unit C037 Renny Ghani-Eaton: Boxes, Furniture, Tools
Unit G031 April Hines: Boxes, Furniture, Tools
Unit G041 Jeanne Moccia: Boxes, Furniture, Tools

Public Storage, Inc: 6 Summit Place, Branford, CT 06405
Sale to be held on February 21st 2017 at 9:30 AM
Unit A043 William Brunson: Boxes, Furniture, Tools
Unit B016 Steve Salvati: Boxes, Furniture, Tools
Unit D008 Dana Chadwick: Boxes, Furniture, Tools
Unit D021 Donna Fenn: Boxes, Furniture, Tools
Unit E024 Frederick Ross Jr: Boxes, Furniture, Tools
Unit E098 Sandy Campbell: Boxes, Furniture, Tools
Unit E100 Jason Palmer: Boxes, Furniture, Tools

How drivers can enhance nighttime visibility



Philips Upgrade Headlight Bulbs can put up to 100 percent more light on the road than standard halogen bulbs.

(MS) - Many drivers are considerably less comfortable driving at night than during the day. Even though roads tend to be less congested when the sun goes down, reduced visibility at night can compromise the safety of drivers and their passengers.

Statistics indicate that drivers' fears of driving at night are not unwarranted.

According to the National Safety Council*, traffic death rates are three times greater at night than during the day, and the anxiety many drivers feel when behind the wheel at night no doubt contributes to nighttime driving fatalities.

But drivers who take steps to enhance their nighttime visibility may feel more comfortable driving at night, making the roads safer for themselves, their passengers and their fellow motorists.

· Turn your headlights on earlier. Daytime running lights can make it easier for drivers to be seen during the day, but they are not designed for nighttime driving. If you find yourself struggling to see as evening transitions into nighttime, turn your headlights on earlier or use your car's automatic switch setting if it has one.

· Prioritize headlight maintenance. Headlight maintenance is often overlooked, but properly maintained headlights can go a long way toward improving driver visibility at night. Check your headlight bulbs. If they are more than three years old or dimming, it would be a good idea to replace them to ensure the best performance. Headlamp clouding is also an issue. Plastic headlamp lenses, which are common on most vehicles, grow hazed and yellowed over time from the effects of sunlight, ozone, road pollution, and wash chemicals. While many motorists accept this as inevitable wear and tear, clouding reduces headlight output and compromises nighttime visibility. Designed to restore plastic lenses in less than 30 minutes, the Philips Headlight Restoration Kit quickly and effectively combats clouding on headlights as well as taillights, turn signals and reflective lens covers, improving driver visibility while also making cars more visible to other drivers. In addition, the Philips Headlight Restoration Kit employs a protective UV coating that produces longer lens clarity while preventing future clouding for up to two years.

· Take steps to fight fatigue. The National Highway Traffic Safety Administration estimates that driver fatigue contributes to 100,000 reported traffic accidents each year. Drowsiness is a concern for any motorist driving at night for long periods of time, as heavy eyes can make drivers less alert and less likely to see fellow motorists, pedestrians or animals. When driving at night for long periods of time, take periodic breaks so you can get out of the car and revive yourself with a quick walk and some fresh air. In addition, avoid smoking while driving, as the NSC notes that the nicotine and carbon monoxide from tobacco smoke can further compromise nighttime vision.

· Upgrade your headlights. According to a recent study from the automotive club AAA, the halogen headlights found in more than 80 percent of vehicles on the road today fail to safely illuminate unlit roadways, even when vehicles are moving at speeds as low as 40 miles per hour. The solution for this problem is simple: Put more light on the road. There is new bulb technology available to help you do just that. Philips Upgrade Headlight Bulbs can deliver up to 100 percent more light on the road than standard halogen bulbs. They also create a better beam pattern for the drive, greatly improving nighttime visibility.

More information is available at www.philips.com/automotive.

APARTMENTS FOR RENT

PLEASANTVIEW APARTMENTS

& ART GALLERY: 500+ Originals on permanent display

(State of the Art Green Technology Bldg)

★☆★

A beautiful place to live. Affordable!

Two bedrooms & two full baths! $1150+

★☆★

Visit: www.PleasantViewBridgeport.com

★☆★

Call Resident Agent Norman, 203-916-2796 or 203-372-0828

CONDOS FOR RENT

RENT ME

Shelton - Birmingham Condo 4th floor, loft style, 2 BR. Heat incl in rent. $1475/mo

Pepe Realty • 203-929-6775

OFFICE SPACE

DANBURY AFFORDABLE OFFICE SPACE Various 500, 1200, 6000SF. Bright, spacious, high ceilings. On-site mgt, all utilities. Call for pricing. 203-797-8355 www.solanorealestate.org

GREENWICH - Greenwich Ave. Furnished suites, w/reception, conference room & lounge area. 203-661-3343, EOG, Inc. Est. 1974

★★★

WESTPORT - Post Road singles, 1500, 3000, 4000, 6500 sf Office spaces 203-226-6969 Lefferproperties.com

WESTPORT GORGEOUS! Office suites: Singles 500, 1,500, 2,100, 3300 up to 12,500sf Either dwntwn or nr RR. Hwd firs, Hi-speed internet, fireplaces, kitchenettes, skylights, etc. Flex terms. 203-226-6969.

Lefferproperties.com

HOUSES FOR SALE

BRIDGEPORT - NEW LISTING 6BR W/W-LAW Brooklawn Area Colonial, Updated, 3.5 BTH, 2 Car gar. $269,900 Trojanowski Realty 203-496-3186

FARMS AND LANDS FOR SALE

12.92 ACRES - SHELTON Borden C2 zone. City water/sewer Available. Call 203-926-9540

BOAT SLIPS

LOOK

40 FT BOAT SLIP FOR SALE OR LEASE BY OWNER

Located at Fall Service Marina, The River Club Palmer Point, Greenwich CT. Owner- 914-391-1474 or howardkaye@earthlink.net

VEHICLES FOR SALE

1991 CHEVROLET Impala. Red. 4-dr Sedan, Turbo 350 Trans. 327 engine. Excellent condition. $14,000 OBO. (203)268-5606

1995 E320 MERCEDES WAGON very clean, no rust, runs good. $2000 Dave 203-967-2860

2012 LINCOLN NAVIGATOR, 61k miles, well maintained, fully loaded, garaged, VGC. $27K, 203-417-6193.

DODGE RAM 3500 '05. Cummings diesel, dual wheels, 4x4, 12 ft dump body, new cab, new paint, new int/ext, no rust, 175K miles, $14,000. news transmission. 5 yr 100K mile warranty 203-569-8541

DONATE YOUR CAR TRUCK OR SUV TO the SPCA and receive the maximum tax deduction and quick, free pick up. Call 203-445-9978

HUNDAI XG 350L '02. $1500 obo with snow tires Call 203-417-6719

VEHICLES FOR SALE

FOR SALE

HYUNDAI ELANTRA GTL '06 Sedan, 129k miles, silver. Good condition. Includes bike rack. $3,50 0.00 • (914) 388-8620

MINI COOPER '12. 51k miles, white ext/, blk leather int/, auto, sun roof, warranty, new tires, great cond! $10,000 obo Call 201-410-0438

*** MOTIVATED SELLER *** 914-314-5525 and ask for Anthony FOR SALE 2011 Jeep Grand Cherokee 4x4 Jeep Estimated worth is $17,600; Asking Price of $15,750 Received Highest Quality Rating from Top Car Superiors (Report Available Upon Request)

TOYOTA TACOMA 99 4X4 TRD PKG Xtra Cab SR5 V6 $2250 Call me: 860-265-8328

PUBLIC NOTICES

TOWN OF TRUMBULL PWD REQUEST FOR QUALIFICATIONS AND PROPOSAL ON CALL WELDING SERVICES

Due Date: MARCH 7, 2017

Sealed bids will be received at the Town Hall, Trumbull, CT, on the date indicated above at 2:00PM for the following:

BID	DESCRIPTION
#220	ON CALL WELDING SERVICES

Bid documents are available from the Purchasing Department website www.trumbull.ct.gov. Also on the State Contracting portal http://das.ct.gov/cta.aspx. The Town of Trumbull reserves the right to accept or reject any or all responses if it is deemed to be in the best interest of the Town.

Kevin Bevs
Purchasing Agent

PUBLIC NOTICES

NOTICE OF PUBLIC HEARING

ORDINANCE COMMITTEE — February 27, 2017

PURSUANT TO THE DIRECTION OF COUNCIL MEMBER PHILIP YOUNG, CHAIRMAN, THE ORDINANCE COMMITTEE OF THE STRATFORD TOWN COUNCIL WILL CONDUCT A PUBLIC HEARING ON MONDAY, FEBRUARY 27, 2017 IN COUNCIL CHAMBERS OF STRATFORD TOWN HALL, 2725 MAIN STREET, STRATFORD, CT AT 7:00 p.m.

TO HEAR TESTIMONY IN CONNECTION WITH THE FOLLOWING:

PROPOSED ORDINANCE FOR THE NEW YOUTH CAMPGROUND AT SHORT BEACH (#17-01)

Public Notice St. Vincent's Medical Center and Southwest Community Health Center, Inc.

PUBLIC NOTICE St. Vincent's Medical Center and Southwest Community Health Center, Inc. (the "Applicants") intend to file a Joint Certificate of Need application under Section 19a-638 of the Connecticut General Statutes to request approval for the termination of the services provided by St. Vincent's Medical Center at its Family Health Center located at 782 Lindley Street, Bridgeport, CT 06606 and a contemporaneous assumption of the complete operation of the Family Health Center and the provision of the same services at the same location by Southwest Community Health Center.

LEGAL NOTICE
FORECLOSURE AUCTION SALE:

Docket No.: FBT-CV-15-6056280 S
Case Name: HSBC Bank USA v. Soares, Kinley A/K/A Soares, Kinley L., et. al
Property Address: Foreclosure of 182 Sedgwick Avenue, Stratford, CT
Property Type: Residential Property
Date of Sale: February 25, 2017 @ 12 Noon
Committee Name: Victoria J. Koch
Committee Tel. Number: 203-259-6363
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

NOTICE

THE ZONING BOARD OF APPEALS OF THE TOWN OF TRUMBULL WILL CONDUCT A PUBLIC HEARING IN THE COUNCIL CHAMBERS OF THE TRUMBULL TOWN HALL, 5866 Main Street, Trumbull, CT on Wednesday, March 1, 2017 at 7:30 p.m., on the following applications:

Stawomir Karpinski – 232 Lake Avenue – Appeal of Building Department Official to decline to reinstate stopwork order at 226 Lake Avenue.

17-05) Paul Sullivan – 48 Bonita Avenue – Variance of Art. III, Sec. 7 to install an above ground pool, 5' from rear lot line, 22.4' from E/S lot line.

17-06) 50 Corporate Drive, LLC c/o R. D. Scinto, Inc. – 50 Corporate Drive – Variance of Art. II, Sec. 4.2, Par. 5, subparagraph d. to install a generator, 21.9' from the front lot line.

17-07) Lisa Kalisiewicz – 601 Church Hill Rd. – Variance of Art. I, Sec. 4.3.1 and Art. III, Sec. 1 to remove existing deck & stairs, replace with extension of family room on W/S of house, 7.0' from lot line. Build deck (28'4" x 10'6") on back of house 46.6' from rear lot line, and a one car garage on lower level under new addition.

17-08) BCZ Homes LLC – 37 Louis Street – Variance of Art. I, Sec 4.3.1 and Art. III, Sec. 1 to incorporate pre-existing front porch as livable area within the existing footprint.

17-09) Long Hill Fire District c/o Agent Chris Russo, Esq. – 5404 Main St. and 20 & 24 Wilmot Ave. – To construct a 17,278 sq. ft. firehouse in Res. A Zone w/parking & site improvements for volunteer fire dept. 1) Variance of Sec. 1.3.7.2 to increase the permitted signage area from 8 sq. ft. to 25.97 sq. ft. to relocate an existing sign and place "Long Hill Fire District" lettering onto the proposed Building. 2) Variance of Article III, Sec. 2.5 to reduce the minimum required side yard setback from 40' to 20' within the first 100' from the front lot line and further reduce the minimum required side yard setback from 50' to 20' from that point to the rear lot line; 3) Variance of Article II, Section 1.3.5 and Article III, Section I to increase the permitted maximum building height from 40' to 43'4"; 4) Variance of Article II, Section 1.3.5 and Article III, Section 1 to reduce the minimum required rear yard setback from 50' to 28.7'; 5) Variance of Article II, Section 1.3.5 and Article III, Section 1 to increase the maximum permitted floor area ratio 25% to 61%; 6) Variance of Article IV, Section 1.3.5 and Article III, Section 4.6.2 to reduce the minimum landscape area requirement in a Residence A Zone from 50% to 41.2%; 7) Variance of Article IV, Section 1.3.5 and Article III, Section 4.6.4 to reduce the minimum front landscaped area requirement in a Residence A Zone from 25' to 15'; and 8) Variance of Article IV, Section 1.3.5 and Article III, Section 4.6.5 to reduce the minimum perimeter buffer requirement in a Residence A Zone from 20' to 2' in one location and 5' in another location.

Dated at Trumbull, CT this 18th Day of February, 2017
By Gail Andreyka, Clerk

VEHICLES WANTED

1-203-243-3800

$ $ $

AUTOS & TRUCKS wanted for junk. Cash Paid.

CASH FOR CARS RUNNING OR NOT

NO TITLE- NO PROBLEM $100-$1000. 24 HOUR PICK UP 203-997-9810

CLASSIC CARS WANTED Pre '75 Jags, Healeys, Chevys, Porsche, Benz, Fords, Cadillacs, Ferraris, & others. Basket cases - running or not. Call 203-889-5855

DONATE YOUR CAR to the SPCA and receive the maximum tax deduction and quick, free pick up. Call 203-445-9978

JUNK VEHICLES WANTED w/ Titles or Registration. We pay for them! (203)449-5310

WYB/Wanted Old cars, convertibles and motorcycles. If crusty, rusty, broken, and dusty, all the better. Thank you, Dan: 512-632-7724.

PUBLIC NOTICES

PUBLIC AUCTION – FORECLOSURE SALE

DOCKET NO: FBT-CV-15-6056392-S
CASE NAME: Citi Bank, N.A. v. Pierce, Nugh Lee, et al
PROPERTY ADDRESS: 69 Trumbull Avenue, Bridgeport, CT
PROPERTY TYPE: Residential / Single-family Dwelling
DATE OF SALE: February 25, 2017 at noon
See Foreclosure Sales at www.jud.ct.gov for more detailed information
Timothy Kaiser, Committee
1136 Broadbridge Avenue
Stratford, CT 06615
Tel. (203) 375-3221 / Fax: (203) 377-0597

PUBLIC AUCTION FORECLOSURE SALE

Docket No: CV-15-6064638
Case name: WELLS FARGO BANK, NA v. Zumstag, Barbara aka Zumstag, Barbara, L., the Widow, Heir and/or Creditors of the Estate of, et al
Property Address: 90 Cartright Street, Unit 8K, Bridgeport, CT 06604
Property Type: Residential
Date of Sale: MARCH 4, 2017 at 12:00 PM
See Foreclosure Sales at www.jud.ct.gov for more detailed information
Albert T. Sirarra, Committee
ph: 203-292-9782
fax: 203-492-3484

PUBLIC AUCTION- FORECLOSURE SALE

Docket No. FBT-CV15-6063685-S
Case Name: Citi Bank NA v. Odwale, Marie R, Widowen Heirs and or Creditors Et Al
Property Address: 789 Sylvan Avenue, unit 14, Bridgeport CT
Property Type: Residential
Date of Sale: March 4, 2017
Committee Name: David S. LaFollette
Telephone: 203-254-1387
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

FORECLOSURE NOTICE

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket Number: FBT-CV-16-6065588-S
Case Name: SELENE FINANCE LP V. BROWN, RASHID
Property address: 295 Adams Street, Bridgeport, CT
Type of Property: Residential
Date of Sale: February 25, 2017
Committee name: Frances D. Hodges
Phone: (203) 336-0585
See Foreclosure Sales at www.jud.ct.gov for more detailed information

NOTICE OF PUBLIC AUCTION FORECLOSURE SALE:

Docket No.: FBT-CV 15-6048315-S
Case Name: People's United Bank, National Association v. Hans K. Isler, et al
Property Address: 239 Jackson Avenue, Fairfield, Connecticut
Property Type: Residential Property
Date of Sale: Saturday, February 25, 2017 at 12:00 noon.
Committee Name: Claire DeVidas, Esq.
Committee Phone Number: 203-254-2340
See Foreclosure Sales at www.jud.ct.gov for more detailed information

PUBLIC NOTICES

Foreclosure Sale

Residential
275 Harlem Avenue, Bridgeport, CT
Benchmark v. Damiani
Docket Number: FBT CV 15 6059554
Sale Date: March 4, 2017
Inspection: 10:00 a.m.
Sale Time: 12:00 p.m.
Deposit: $10,500
Property sold subject to court approval
For any questions contact Committee:
Daniel H. Kryzanski, Esq.
30 Ferry Blvd. #2
Stratford, CT 06615
Phone: 203-380-1364

LEGAL NOTICE
FORECLOSURE AUCTION SALE

DOCKET #: FBT-CV16-6056561-S
CASE NAME: LIVE WELL FINANCIAL, INC. VS. MARY ELIZABETH MCMAHON A/K/A MARY E. MCMAHON, ET AL.
Property Address: 281 BARN HILL ROAD, MONROE, CT 06468
Property Type: RESIDENTIAL
SALE DATE: FEBRUARY 25, 2017 @ 12 NOON ON THE PREMISES
Committee Name /TEL: JONATHAN S. KOSOVA,
COMMITTEE . 203-366-5530
See Foreclosure Sales @ www.jud.ct.gov for more

NOTICE

PZC
SPECIAL MEETING
TUESDAY, February 21, 2017

The Planning and Zoning Commission will hold a Special Meeting on Tuesday, February 21, 2017 at 7:00 p.m. in the Council Chambers of the Trumbull Town Hall.

Agenda: Incentive Housing Zone Study Community Presentation by Milone and MacBroom

Please contact the Planning and Zoning Department if you have any questions about the above item.
Dated at Trumbull, CT this 18th day of February 2017.
By: Lynn Dmsbee, Clerk

FORECLOSURE NOTICE

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket No.: FBT CV 16 6057584 S
Case Name: Citi Bank NA v. Walter H. Edwards, et al
Property Address: 106 Hollister Ave, Bridgeport, CT
Property Type: Residential
Date of Sale: Saturday, March 4, 2017
Committee Name: Charles J. Willinger, Jr.
Committee Tel. Number: 203-288-3939
See Foreclosure Sales at www.jud.ct.gov for more detailed information.

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket No. CV 06 6026108 S
Case Name: Wells Fargo Bank, NA v Robert Rankear, et al
Property Address: 119 Farmington Avenue, Fairfield, CT
Property Type: Residential
Date of Sale: February 25, 2017
Committee Name: Thomas V Battaglia, Jr., Esq.
Committee Phone Number: 203-375-9386
See Foreclosure Sales at www.jud.ct.gov for more detailed information

LEGAL NOTICE
FORECLOSURE AUCTION SALE

Docket No.: FBT-CV-08-5014056-S
Case Name: AURORA LOAN SERVICES, LLC (FEDERAL NATIONAL MORTGAGE ASSOCIATION, SUBSTITUTED PLAINTIFF vs. CEOMATTY RAMROOP, ET AL
Property Address: 54 Marcy Road, Bridgeport, CT
Property Type: Residential
Date of Sale: Saturday, February 25, 2017 at 12:00 p.m.
Committee Name: George W. Derbyshire Esq.
Committee Phone #: 203-452-7691
See Foreclosure Sales at www.jud.ct.gov

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Docket No.: FBT CV 15 6051781 S
Case Name: Benchmark Municipal Tax Services, LTD v. Louis Silvestre, et al
Property Address: 34 Willow Street, Bridgeport, CT
Property Type: Commercial
Date of Sale: Saturday, February 25, 2017
Committee Name: Tracey L. Costello-Norris
Committee Tel. Number: 203-380-3939
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Docket No. FBT-CV-14-6046519-S
Case Name: City Tax Liens 6, LLC v. Black Diamond Group, LLC, Et Al
Property Address: 1739 Stratford Avenue, Bridgeport, CT 06607
Property Type: Commercial/ Residential
Date of Sale: March 4, 2017
Committee Name: Andrew S. Liskov
Committee Phone: 203-916-7177
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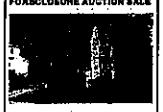

Docket No: FBT-CV16-6058144S
Case Name: Nationstar Mortgage LLC v. Sabina Baldini, et. al.
Property Address: 92 Harmony Street, Bridgeport, CT
Property Type: Residential-Single Family
Date of Sale: Saturday, February 25, 2017 @ 12 Noon
Committee Name: A. Scott Fels
Committee Phone Number: 203-366-0503
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Docket No. FBT-CV-16-6054993-S
Case Name: Federal National Mortgage Association v. Mandeville, Jr Charles, Et Al
Property Address: 15-17 Beacon View Drive, Fairfield, CT
Property Type: Residential
Date of Sale: March 4, 2017
Committee Name: Stanton H. Lesser, Esq.
Committee Phone Number: (203) 536-1611

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Docket No. FBT-CV-16-6054366-S

Case Name: Titan Capital ID, LLC v Wanda D. Rikes, Et Al
Property Address: 13 Hudson St., Unit R-3, Bridgeport, CT
Property Type: Residential
Date of Sale: Saturday, February 25, 2017
Committee Name: Roger C. Agatston
Committee Phone Number: (203)459-8600

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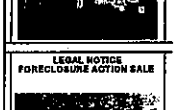

Case Captiani Connecticut Housing Finance Authority vs. Wells, Dennis, et al.
DOCKET NO: FBT-CV-15-6058663-S
PROPERTY ADDRESS: 196 Sylvan Avenue, Bridgeport, CT
PROPERTY TYPE: RESIDENTIAL PROPERTY
DATE OF SALE: February 25, 2017 at 12:00 Noon on the premises
COMMITTEE: Patricia A. Starkey
COMMITTEE TELEPHONE: (203) 380-6656
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DOCKET NO. FBTCV 16-6058288S
JPMorgan Chase Bank, NA vs. Daniels, Audrey, et al
2850 Broadbridge Avenue, Stratford, CT
Date of sale: 2/4/17
Residential Property
Committee: Ernest C. LaFollette, Esq.
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EXHIBIT A

LOCATION OF
FAMILY HEALTH CENTER

St. Vincent's Medical Center
Family Health Center – 762 Lindley St. Bridgeport CT 06606

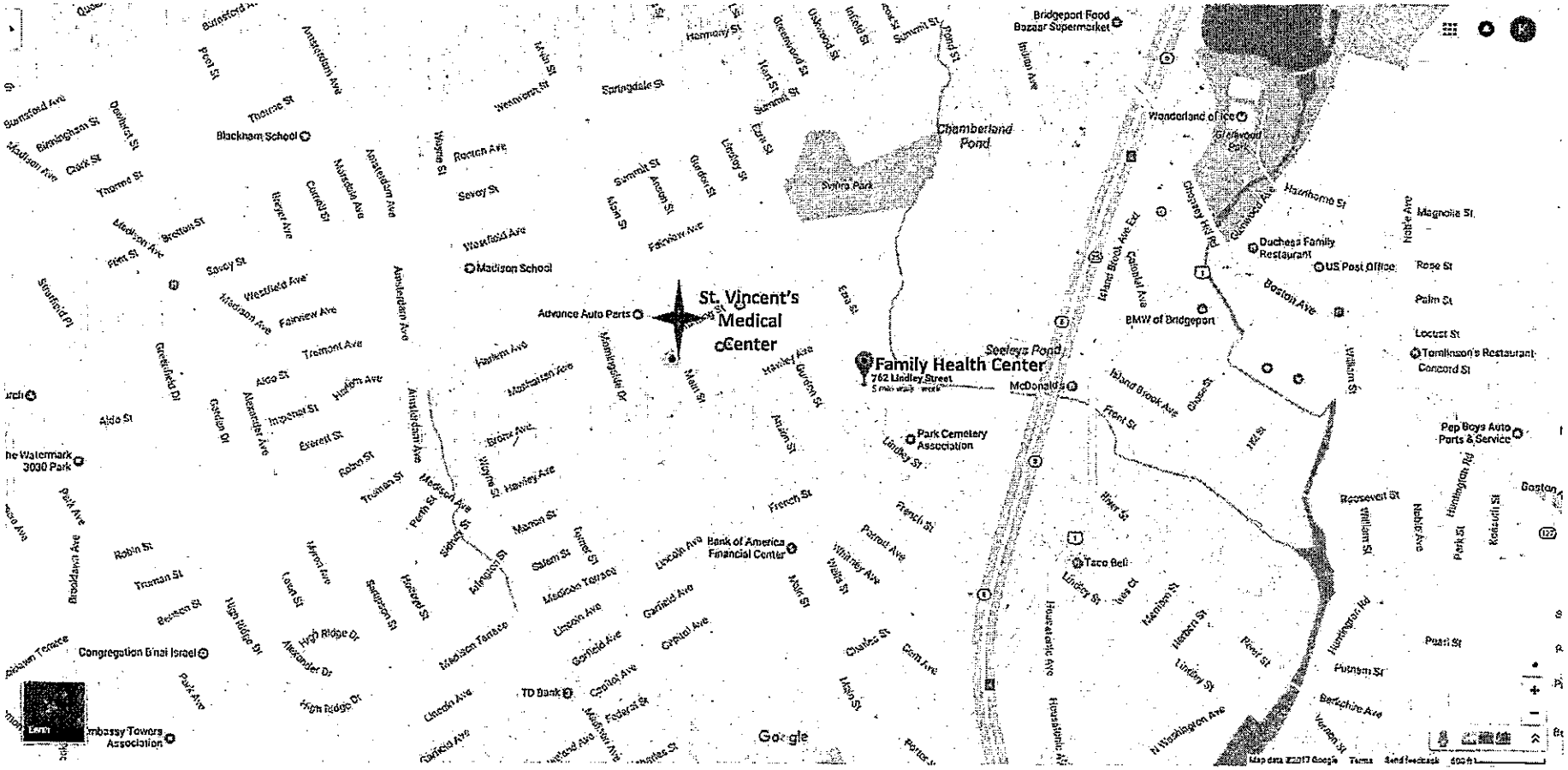
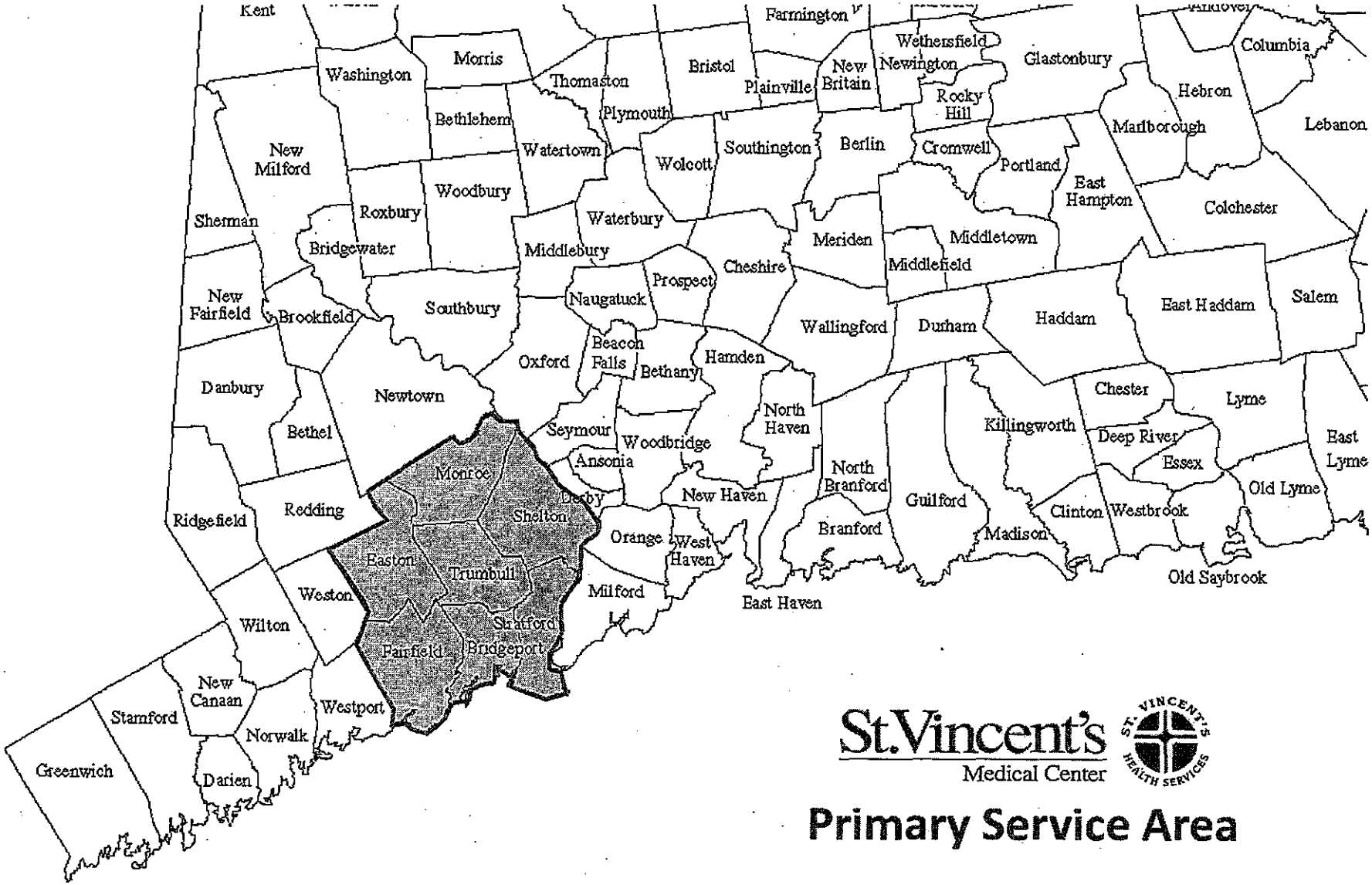


EXHIBIT B

FAMILY HEALTH CENTER

SERVICE AREA

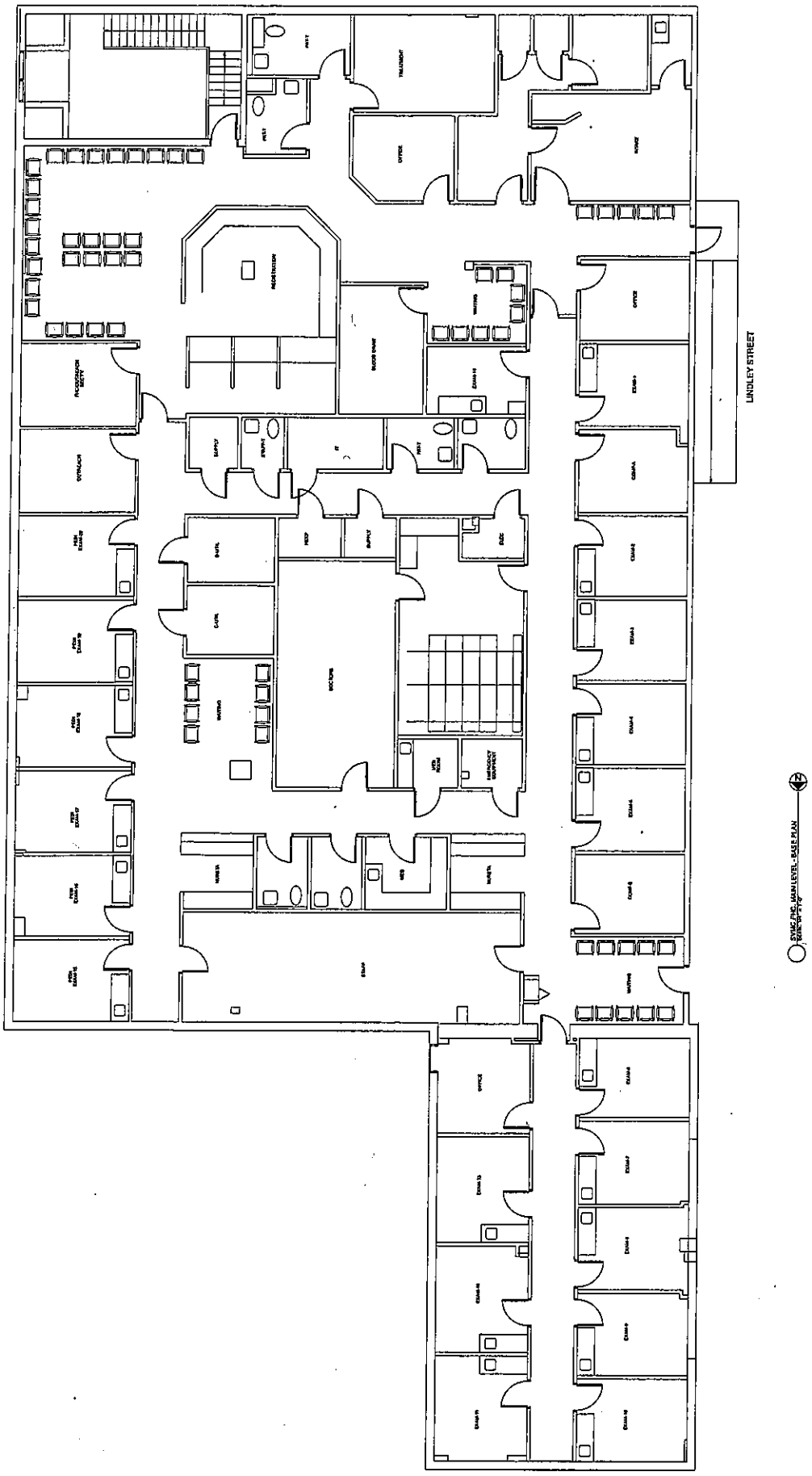


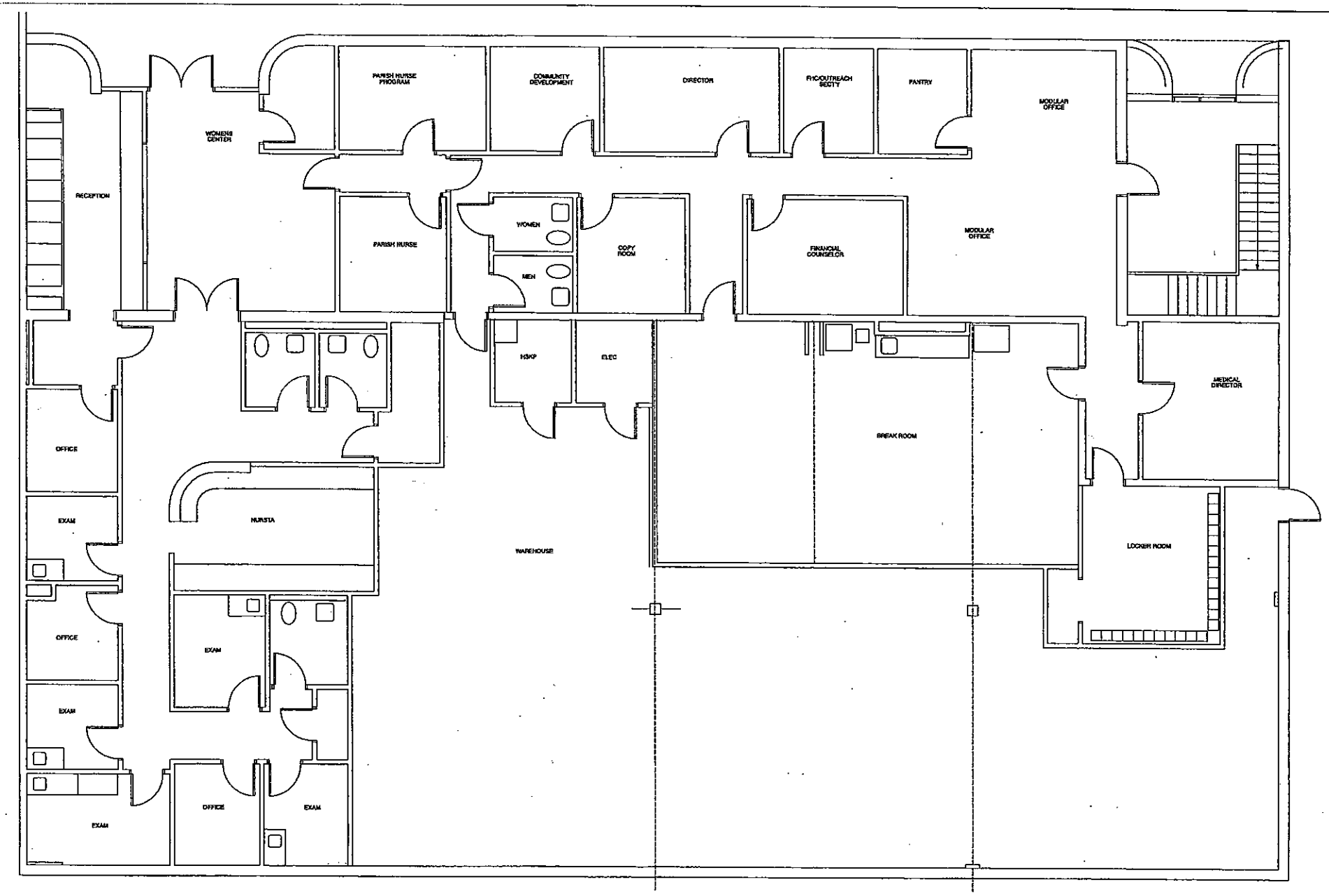
St.Vincent's Medical Center

Primary Service Area

EXHIBIT C

LIST OF
ENHANCED SPECIALTY SERVICES
TO BE PROVIDED
BY APPLICANT


LINDLEY STREET



SVMC.FHC. LOWER LEVEL - BASE PLAN
Scale: 1/4" = 1'-0"

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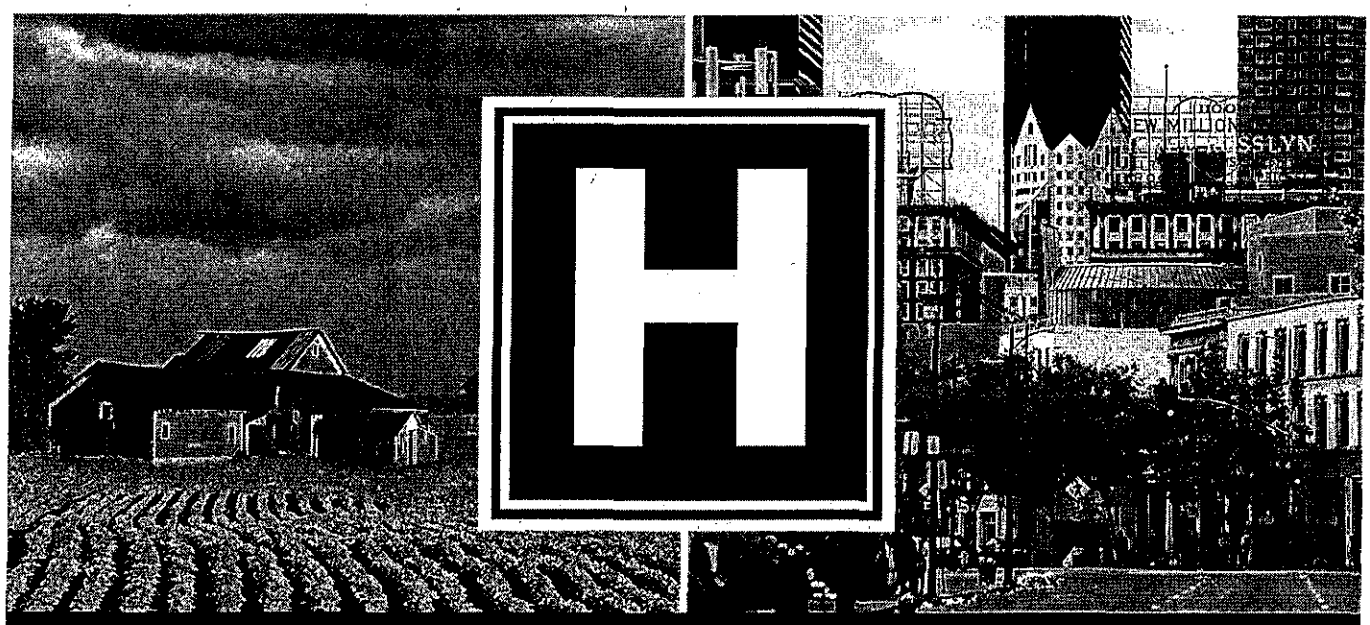
EXHIBIT E

AHA ARTICLE



Task Force on Ensuring Access in Vulnerable Communities

Millions of Americans living in vulnerable rural and urban communities depend upon their hospital as an important, and often only, source of care. However, these communities and their hospitals face many challenges. As the hospital field engages in its most significant transformation to date, some communities may be at risk for losing access to health care services. It will be necessary for payers and health care providers to work together to develop strategies that support the preservation of health care services for all Americans.

Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, created a task force to address these challenges and examine ways in which hospitals can help ensure access to health care services in vulnerable communities. The task force considered a number of integrated, comprehensive strategies to reform health care delivery and payment. Their report sets forth a menu of options from which communities may select based on their unique needs, support structures and preferences. The ultimate goal is to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential services they should strive to maintain locally, and the delivery system options that will allow them to do so. While the task force's focus was on vulnerable communities, these strategies may have broader applicability for all communities as hospitals redefine how they provide better, more integrated care.

November 29, 2016

American Hospital Association

Characteristics and Parameters of Vulnerable Communities

The task force defined a vulnerable community as a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions. While the reasons a population may be deemed vulnerable vary widely, the task force found there is no formulaic, defined set of factors that can determine whether or not a community is vulnerable. However, they created a list of characteristics and parameters, of which one or more may be necessary and sufficient to identify a vulnerable rural or urban community.

Characteristics and Parameters of Vulnerable Rural Communities

- Declining population, inability to attract new businesses and business closures
- Aging population

Characteristics and Parameters of Vulnerable Communities

- Lack of access to primary care services
- Poor economy, high unemployment rates and limited economic resources
- High rates of uninsurance or underinsurance
- Cultural differences
- Low education or health literacy levels
- Environmental challenges

Characteristics and Parameters of Vulnerable Urban Communities

- Lack of access to basic "life needs," such as food, shelter and clothing
- High disease burden

Essential Health Care Services

The range of health care services needed and the ability of individuals to obtain access to health care services varies widely in each community. The task force determined, however, that access to a baseline of high-quality, safe and effective services must be preserved. Table 1 below highlights the essential health care services identified by the task force and illustrates those which may be maintained or enhanced by each emerging strategy.

Table 1

Emerging Strategy	Primary care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
	Essential Health Care Service								
Addressing the Social Determinants of Health					X				X
Global Budget Payments	X	X	X	X	X	X	X		X
Inpatient/Outpatient Transformation Strategy	X	X	X	X		X			X
Emergency Medical Center	X		X		X	X			X
Urgent Care Center	X					X			X
Virtual Care Strategies	X	X	X						X
Frontier Health System	X	X	X	X	X	X	X		X
Rural Hospital-Health Clinic Strategy	X	X	X	X		X		X	X
Indian Health Services Strategies	X	X	X	X	X	X	X		X

Emerging Strategies to Ensure Access to Health Care Service

Addressing the Social Determinants of Health

Social challenges often prevent individuals from accessing health care or achieving health goals. This strategy includes screening patients to identify unmet social needs; providing navigation services to assist patients in accessing community services; and encouraging alignment between clinical and community services to ensure they are available and responsive to patient needs.

Global Budgets

Global budgets provide a fixed amount of reimbursement for a specified population over a designated period of time. They may be designed in a way that allows each provider to create a unique plan to meet mandated budgets, thereby allowing vulnerable communities autonomy and flexibility to create solutions that work best for them.

Inpatient/Outpatient Transformation Strategy

This strategy involves a hospital reducing inpatient capacity to a level that closely reflects the needs of the community. The hospital would then enhance the outpatient and primary care services they offer.

Emergency Medical Center (EMC)

The EMC allows existing facilities to meet a community's need for emergency and outpatient services, without having to provide inpatient acute care services. EMCs provide emergency services (24 hours a day, 365 days a year) and transportation services. They also would provide outpatient services and post-acute care services, depending on a community's needs.

Urgent Care Center (UCC)

UCCs allow existing facilities to maintain an access point for urgent medical conditions that can be treated on an outpatient basis. They are able to assist patients with an illness or injury that does not appear to be life-threatening, but requires care within 24 hours.

Virtual Care Strategies

Virtual care strategies may be used to maintain or supplement access to health care services. These strategies could offer benefits such as immediate, 24/7 access to physicians and other health care providers, the ability to perform high-tech monitoring and less expensive and more convenient care options for patients.

Frontier Health System

This strategy addresses challenges faced by frontier communities, including extreme geographic isolation and low population density. It provides a framework for coordinated health care as individuals move through primary and specialized segments of the medical system.

Rural Hospital-Health Clinic Strategy

This strategy allows for integration between rural hospitals and various types of health centers in their communities (e.g., Federally Qualified Health Centers and Rural Health Clinics). These partnerships also could facilitate integration of primary, behavioral and oral health and allow for economies of scale between both organizations.

Indian Health Services (IHS) Strategies

This strategy includes development of partnerships between IHS and non-IHS health care providers aimed at increasing access to health care services for Native American and Alaska Native Tribes and improving the quality of care available and promoting care coordination.

To learn more about these strategies and explore case examples, please see the full report at *www.aha.org/ensuringaccess*.

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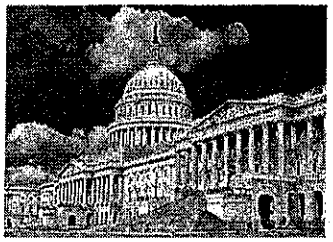
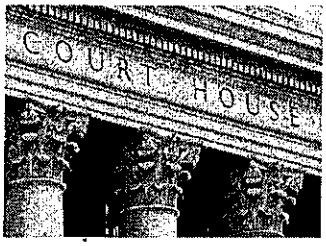
Barriers to Implementation

The task force identified four types of barriers that could impede transitioning to or implementing these emerging strategies:



Federal Barriers

Many federal policies serve as barriers to successful implementation of these strategies. These include, but are not limited to, fraud and abuse laws and Medicare payment rules.



State Barriers

State laws also present barriers to implementation of these strategies. For example, issues related to clinician licensure across state lines must be addressed for broad implementation of virtual care strategies.

Community Barriers

At the community level, the ability to attract or retain health care providers will remain a challenge, regardless of which of these strategies are selected. Community input, buy-in and acceptance will be critical for success as hospitals transition to these new strategies.

Provider Barriers

Transitioning to these new strategies also may be challenging. For example, it may take longer or require significant investments of time, effort and finances for providers to implement these strategies.

Advocacy Agenda and Assistance Strategy

Successful implementation of these emerging strategies by vulnerable communities is dependent on numerous public policy changes. The task force recommends that AHA develop an advocacy strategy to facilitate adoption of these emerging strategies. This includes advocating for:

- Creation of new Medicare payment methodologies and transitional payments, as appropriate, that would allow for successful implementation of the strategies identified above;
- Creation of new and expansion of existing federal demonstration projects;
- Modification of existing Medicare Conditions of Participation to allow for the formation of the strategies identified above, where necessary;
- Modification of laws that prevent integration of health care providers and the provision of health services;
- Modification of the existing Medicare payment rules that stymie health care providers' ability to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals; and
- Expansion of Medicare coverage and payment for telehealth.

Even with public policy changes, vulnerable communities and the hospitals that serve them may not have the resources they need to successfully adopt these emerging strategies. AHA will explore providing operational tools and resources to assist our member hospitals and health systems, including toolkits, data analyses, information on grant opportunities, and convening learning networks for information and idea sharing.

To learn more about the work of the AHA Task Force on Ensuring Access in Vulnerable Communities, please visit *www.aha.org/ensuringaccess*.

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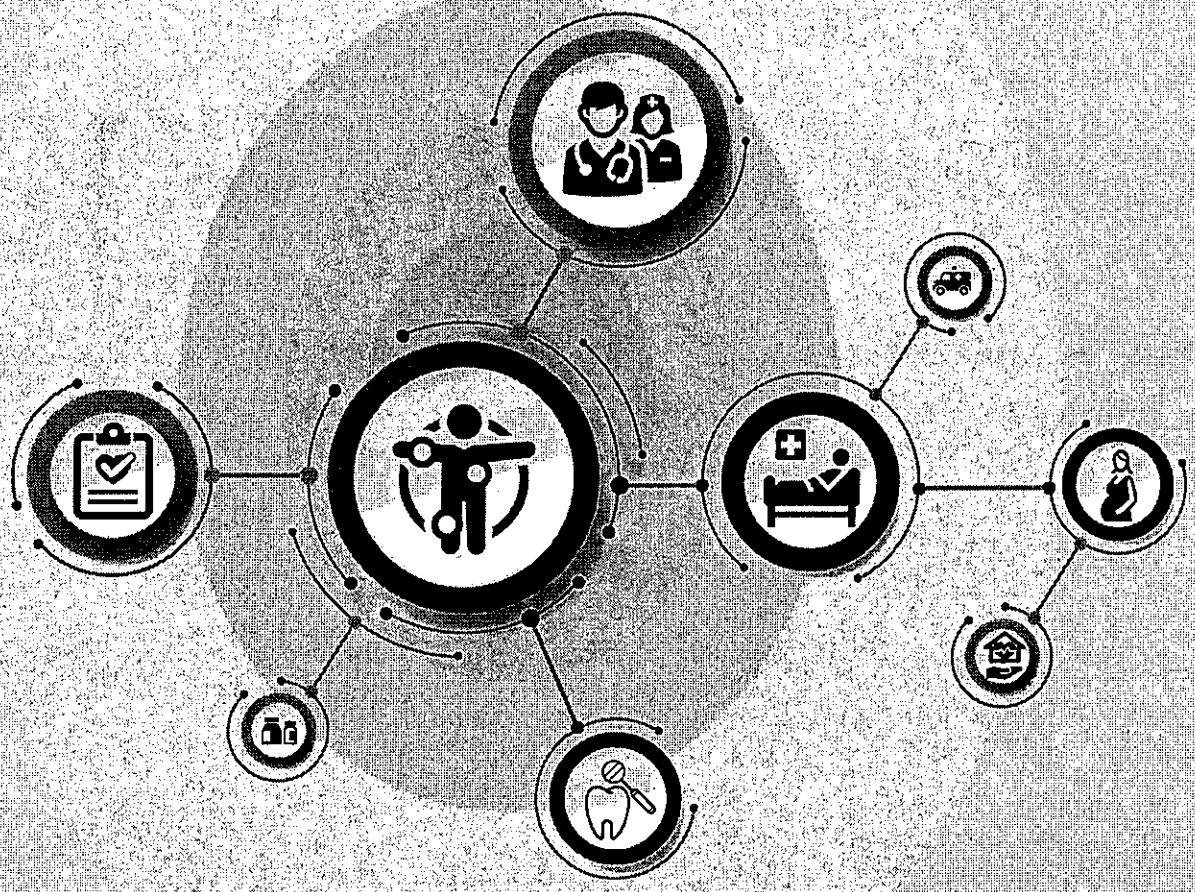
Task Force on Ensuring Access in Vulnerable Communities

November 29, 2016



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Executive Summary

Millions of Americans living in vulnerable rural and inner city communities depend upon their hospital as an important, and often only, source of care.

However, these communities and their hospitals face many challenges. As the hospital field engages in its most significant transformation to date, many are fighting to survive – potentially leaving their communities at risk for losing access to health care services. The loss of such a critical health care access point could be devastating to the individuals living in these vulnerable communities, and the concern for them is only growing as significant pressures on the health care sector continue.

Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, approved the creation of this 29-member task force to address these challenges and examine ways in which hospitals can help ensure access to health care services in vulnerable rural and urban communities. We were charged with confirming the characteristics and parameters of vulnerable rural and urban communities; identifying emerging strategies for health care services in rural and urban areas; and identifying federal policies and issues that serve as barriers to implementation of the recommended emerging strategies.

In taking on this charge, we determined it was critical to also identify those essential health care services we believed should be maintained for individuals living in vulnerable rural and urban communities. We acknowledge that the range of health care services needed and the ability of individuals to obtain access to health care services varies widely across communities. However, we believe that access to a baseline level of high-quality, safe and effective services must be protected and preserved. Some of these include primary care services, psychiatric and substance use treatment services and transportation.

In developing this report, we also examined the characteristics and parameters of vulnerable rural and urban communities. We determined that the reasons a population may be deemed vulnerable vary widely and there is no formulaic, defined set of factors that can determine whether or not a community is vulnerable. We also found that while there were unique characteristics and parameters for rural and urban communities, many of these characteristics and parameters were the same. As a result, we created a list of characteristics and parameters of which one or more may be necessary and sufficient to identify a vulnerable community. For example, lack of access to primary care services; poor economy, high unemployment rates and limited economic resources; cultural differences; and low education or health literacy levels.

We then considered integrated, comprehensive strategies to reform health care delivery and payment in vulnerable communities that would allow them to choose different options based on their needs, support structures and preferences. Our ultimate goal was to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential health care services they should strive to maintain locally, as well as with the delivery system options that will allow

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them to do so. We identified nine emerging strategies that we believe can accomplish this. These include strategies that address the social determinants of health, adopt new and innovative virtual care technologies, build upon existing delivery models (these include inpatient-outpatient transformation, urgent care centers, integration between rural hospitals and health centers and strategies to address Indian Health Services) or allow for the creation of new delivery models (such as global budget payments, emergency medical center and a frontier health system). While our focus was on vulnerable communities, these strategies may have broader applicability and may serve as a roadmap for all communities as hospitals begin to redefine how they provide better, more integrated and more efficient care.

Finally, we examined federal policies that serve as a barrier to implementation of these strategies. We determined that the ability to successfully adopt many of the strategies is dependent on numerous federal policy changes. The options we set forth also will require a certain level of transformation and redefinition on the part of the hospital as well as collaboration between hospitals and a diverse group of community stakeholders.

Introduction

The millions of Americans living in vulnerable rural and inner city communities depend upon their hospital as an important, and often only, source of care. The nation's nearly 2,000 rural community hospitals and more than 2,000 urban community hospitals frequently serve as the anchor for their area's health-related services, often providing prevention and wellness services, community outreach and employment opportunities. Many serve as cornerstones within their communities, working to advance population health and well-being, as well as serving as economic engines.

However, these communities and their hospitals face many challenges. Rural hospitals often struggle with their remote location, limited workforce and constrained resources. Inner-city urban hospitals strive to achieve financial stability while pursuing their charitable mission. As the hospital field engages in its most significant transformation to date, many of these hospitals are fighting to survive – potentially leaving their communities at risk for losing access to local health care services. The loss of such a critical health care access point could be devastating to the individuals living in these vulnerable communities, and the concern for them is only growing as significant pressures on the health care sector continue.

As communities grapple with the challenge of maintaining access to health care services, it will be necessary for payers and health care providers to work together to develop alternative payment and delivery strategies that support the preservation of health care services for Americans living in vulnerable communities. Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, approved the creation of this 29-member task force to address these challenges and examine ways in which hospitals can help

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ensure access to health care services in vulnerable rural and urban communities. They charged us with the following:

- **Confirming the characteristics and parameters of vulnerable rural and urban communities** by analyzing hospital financial and operational data and other information from qualitative sources, where possible;
- **Identifying emerging strategies, delivery models and payment models** for health care services in rural and urban areas; and
- **Identifying policies and issues at the federal level that impede, or could create, an appropriate climate for transitioning** to a different payment model or model of care delivery, as well as identifying policies that should be maintained.

In taking on this charge, we determined it was critical to identify those essential health care services we believed should be maintained for individuals living in vulnerable rural and urban communities. In this report, we acknowledge that the range of health care services needed and the ability of individuals to obtain access to health care services varies widely across communities. We do, however, believe that access to a baseline level of high-quality, safe and effective services must be protected and preserved.

The AHA Board also made clear, and we wholeheartedly concur, that while the current special payment programs that attempt to account for the unique circumstances of vulnerable communities have their place, what is now needed are integrated, comprehensive strategies to reform health care delivery and payment within which vulnerable communities can make individual choices based on their needs, support structures and preferences. Therefore, in this report, we aim to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential health care services they should strive to maintain locally, as well as with the delivery system options that will allow them to do so.

The options we set forth will require a certain level of transformation on the part of the hospital. They will require them to begin defining the "H" by focusing on quality and population health management, and on providing more integrated, efficient and better coordinated care. In addition, they will require hospitals to continue evaluating how to provide patients with the right care, at the right time in the right setting. Improving the value of care will involve increased stewardship of resources and innovative ways to transform care for changing communities. In some cases, a hospital will need to redefine the services it offers or the facilities in which it offers those services in order to ensure essential health care services are available to individuals in that community.

We fully recognize and acknowledge that the choice to transform in such a manner is not easily made; however, pursuing such a path is certainly preferable to the only option that many of these communities have at the present time – hospital closure. As a hospital field, we must face these challenges by keeping the goal of ensuring access to health care in mind.

It is also more important than ever that hospitals build and maintain strong linkages with a diverse group of community stakeholders to ensure the needs of the community are supported in the future. Collaboration through community health needs assessments and other strategic endeavors will be vital as a foundation for planning and aligning health priorities. In addition, hospitals and stakeholders will need to work together to identify obstacles that exist to achieve good health, unite around shared goals and work collaboratively to implement changes that promote a healthier community, and do so while developing a sustainable business model.

Our report and recommendations are presented below.

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Characteristics and Parameters of Vulnerable Communities

As a starting point for framing this issue, we defined a vulnerable community as a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions. We then worked to identify the characteristics and parameters that would identify such vulnerable rural and urban communities. In doing so, we relied upon our personal experiences, as well as an analysis of financial data and other information from qualitative sources related to vulnerable rural and urban communities.

We found that the reasons a population may be deemed vulnerable vary widely and there is no formulaic, defined set of factors that can determine whether or not a community is vulnerable. Therefore, we created the following list of characteristics and parameters (listed in no particular order), of which one or more may be necessary and sufficient to identify a vulnerable community.

- **Lack of access to primary care services.** High-quality primary care involves health care providers offering a range of medical care (preventive, diagnostic, palliative, therapeutic, behavioral, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated.[1] A meaningful and sustained relationship between patients and their primary care health care providers can lead to greater patient trust in the provider, good patient-provider communication, and the increased likelihood that patients will receive, and comply with, appropriate care.[2]

  Unfortunately, access to primary care services is unavailable for many Americans. Today, nearly 20 percent of Americans live in areas with an insufficient number of primary care physicians. These health professional shortage areas for primary care face clear recruitment and retention issues and have less than one physician for every 3,500 residents.[3] They also tend to be in remote rural towns and inner-city urban areas. Lack of access makes it difficult for millions of Americans to get preventive health care services, leaving them and their communities susceptible to fragmented, episodic care and poorer health outcomes.

- **Poor economy, high unemployment rates and limited economic resources.** The presence of a poor economy typically leads to high levels of unemployment and a limited amount of economic resources. These factors are linked to poor health outcomes. For example, poverty may result in individuals purchasing processed food instead of fresh produce, which over time could lead to hypertension, obesity and diabetes. This also may affect individuals' mental health and result in other health conditions, such as high blood pressure, high cholesterol, diabetes and obesity.[4]

  Rural and inner city areas more often show the effects of a poor economy. For example, overall, rural areas have seen moderate growth in employment, but certain areas face losses in jobs (including much of the South, Appalachia, Northwest and the Mountain West).[5] Likewise, while urban areas of the United States have generally seen moderate employment growth over the last several years, inner cities have a higher rate of unemployment (14 percent) than the national average (9 percent).[6] Therefore, while not all rural or inner-city urban areas face

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high levels of unemployment, those that do may be most vulnerable.

- **High rates of uninsurance or underinsurance.** High rates of uninsurance or underinsurance negatively impact health care delivery and access to quality care. Individuals without insurance coverage often go without needed medical care, including preventive services, and are at a higher risk for preventable hospitalizations and missed diagnoses.[7] In addition, when the rate of uninsurance is high, health care providers may restrict the provision of certain services or shorten hours.[8] As a result, even those with insurance are less likely to have a regular source of care, likely to report delaying or forgoing care, and less satisfied with the care that they receive.

- **Cultural differences.** Cultural differences, including ethnic heritage, nationality of family origin, religion, and the beliefs and practices that make up a patient's value system can pose challenges. For example, even when quality care is available, individuals that come from different cultural backgrounds may have difficulty trusting providers in a way that facilitates the acquisition of necessary care. Or, populations facing language barriers may have difficulty understanding the services offered by a health care provider. These individuals may not be able to accurately describe symptoms or read and understand items, such as discharge instructions. In addition, cultural differences cause concepts such as health, illness, suffering and care to mean different things to different people. Immigration status also can impact health – patients that are not in the United States legally may not seek care due to a fear of possible repercussions. A lack of culturally competent care can contribute to poor patient outcomes, including racial and ethnic disparities in care, reduced patient compliance and increased health disparities, regardless of the health care services available.[9]

- **Low education or health literacy levels.** Given the complexity of today's health care system, communities with low education or health literacy levels are more often in poor health. Specifically, individuals with low education levels and/or limited health literacy skills are less likely to effectively manage chronic conditions, such as high blood pressure, diabetes, asthma or HIV/AIDS.[10] They also are more likely to skip important preventive measures, such as mammograms, Pap smears and annual flu shots.[11] As a result, studies have shown that those with low education and health literacy rates have a higher rate of hospitalization and use of emergency services.[12] Ultimately, individuals must be able to understand and use health information in order to choose a healthy lifestyle, know how to seek medical care and take advantage of preventive measures – making education and health literacy essential tools needed for making decisions that can lead to favorable health outcomes.

- **Environmental challenges.** Environmental challenges, including but not limited to, poor water and air quality, access to sewer lines, or the presence of lead, mold or asbestos can exacerbate illness and lead to poor health outcomes in a community. For example, air quality is often lower in urban environments, which can contribute to chronic illnesses, such as asthma.[13] In addition, challenges such as witnessing or experiencing trauma and violence or living in unstable housing conditions affects an individual's mental and emotional health and can lead to chronic behavioral health conditions.[14]

We also identified characteristics that vary between rural and urban communities and that, gen-

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erally speaking, tend to be much more prevalent in one area than another. These characteristics and parameters are discussed separately below.

Unique Characteristics and Parameters of Vulnerable Rural Communities

- **Declining population, inability to attract new businesses and business closures.** Rural communities are challenged by declining populations because population growth from natural change (births minus deaths) is no longer sufficient to counter migration losses when they occur. According to the U.S. Department of Agriculture (USDA), from April 2010 to July 2012, the estimated population of non-metro counties as a whole fell by close to 44,000 people.[15] Although this may seem like a small decline, the USDA indicates that it is a sizeable downward shift from the 1.3 percent growth these counties experienced during 2004 - 2006.[16] From July 2012 to July 2013, the population in non-metro areas continued this three-year downward trend.[17]

  Such declines may have a ripple effect, leading to other negative impacts, such as business closures. They may change the health or needs of the community, which may in turn affect the viability of certain businesses. When businesses close or a community is unable to attract new businesses, it becomes more difficult for it to retain existing health care services and recruit new providers. As a result, these communities tend to have fewer active doctors and specialists and face difficulties in accessing care, which can complicate early detection and regular treatment of chronic illnesses.

- **Aging population.** Rural communities also tend to be older than non-rural communities. U.S. Census data indicates that close to 18 percent of rural counties' total population is aged 65 or older.[18] This is in contrast to the general average of 14.3 percent in large metropolitan statistical areas (MSAs) and 14.8 percent in other MSAs.[19] Given that older individuals are more likely to have one or more chronic diseases, these communities may face poorer health outcomes. This challenge can be exacerbated if access to health care services in the community is already limited.

Unique Characteristics and Parameters of Vulnerable Urban Communities

- **Lack of access to basic "life needs," such as food, shelter and clothing.** The level of an individual's health is closely connected to their ability to access food, shelter, clothing and other basic life needs. For example, homeless persons face barriers to receiving health care and have higher rates of emergency department (ED) use, inpatient hospitalization and longer hospital stays.[20] In addition, eating well, staying active, and having a safe home, neighborhood and community all influence health. When these social determinants of health are in poor condition or not present or available at all, it will have a negative effect on health outcomes.

- **High disease burden.** Inner cities have a disproportionately high disease burden, which puts them at higher risk of poor health outcomes. For example, they tend to have a high population of individuals living with chronic conditions, including hypertension, emphysema, chronic bronchitis, cancer, diabetes and cardiovascular disease.[21, 22] Vulnerable urban communities also may face stress resulting from their circumstances, such as witnessing or experiencing trauma and violence, which affects their mental and emotional health.[23] Therefore, these populations may have higher incidence of behavioral health conditions, including drug/alcohol abuse, depression, anxiety and recurrent trauma.

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Essential Health Care Services

Before identifying emerging strategies that could better ensure access to health care services in vulnerable communities, we determined it was necessary to identify the essential health care services that should be maintained locally within a community. While acknowledging that the range of health care services needed and the ability of individuals to obtain access to health care services varies widely, access to a baseline of high-quality, safe and effective services must be preserved within vulnerable rural and urban communities.

While we discussed this issue separately for rural and urban communities, we felt strongly that one unified list should apply to both, and in fact all, communities. These essential health care services are listed below in no particular order.

Primary care services. As discussed above, primary care services include not only the diagnosis and treatment of acute and chronic conditions, but the provision of a continuum of services that include preventive, diagnostic, palliative, therapeutic, curative, counseling, rehabilitative and end-of-life services in a manner that is accessible, comprehensive and coordinated. Other emerging primary care models encompass population health initiatives and medical home services. These services could be provided to patients of all ages in many settings (e.g., urgent care clinics, pharmacy-based clinics, etc.) by physicians or other health care providers in the community. Further, primary care may take different forms for different patients. For example, primary care for children is typically provided by a pediatrician; for the elderly it may be through a geriatrician.

Psychiatric and substance use treatment services. These services include a spectrum of acute and chronic mental health and substance use disorder services, such as behavioral health treatment, counseling and psychotherapy. These services also include individual and group therapy sessions, occupational therapy services; services of social workers, trained psychiatric nurses and other professionals trained to work with psychiatric patients, drugs and biologicals furnished to outpatients for therapeutic services, activity therapies, family counseling services, patient education programs and certain diagnostic services.

Emergency and observation services. Emergency services include health care services provided to evaluate and/or treat medical conditions that require immediate and unscheduled medical care.[24] Observation services include hospital outpatient services that are provided in order to help a physician decide if the patient needs to be admitted as an inpatient or can be discharged. Both emergency and observation care services allow for health care providers to treat minor conditions and stabilize patients prior to additional treatment for more serious conditions.

Prenatal care. This includes preventive health care that allows for regular check-ups to treat and prevent potential health problems throughout the course of the pregnancy and promotion of healthy lifestyles that benefit both mother and child.

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Transportation. Transportation services include both medical and personal transportation to allow patients to access care at hospitals and other health care facilities. For example, transportation services could include ambulance services for individuals being transferred from a critical access hospital to a tertiary hospital or trauma center, transportation for patients from the hospital to a skilled-nursing facility for post-acute care services, as well as bus or car transportation for patients to travel to their doctor's appointments.

Diagnostic services. These include testing services that are necessary for the provision of primary health care and provide practitioners with information about the presence, severity and cause of illnesses and diseases in patients. Examples may include, but are not limited to, laboratory services and plain film X-rays.

Home care. Home health care includes a wide range of health care services that can be given for an illness or injury and allows patients to stay in their home. For example, home health care services could include, but would not be limited to, wound care for pressure sores or a surgical wound, patient and caregiver education and intravenous or nutrition therapy. The goal is to help patients regain their independence, and become as self-sufficient as possible.

Dentistry services. These services include, but are not limited to, preventive and basic dentistry services, including prophylactic cleanings and X-rays, for individuals of all ages.

Robust referral structure. In addition to the services listed above, communities should maintain a robust referral structure that customarily provides access to the full spectrum of health care services needed for individuals in the community. This would help promote efficiency by avoiding offering low-volume service, as well as unnecessary duplication of certain services. As an example, referrals to neighboring communities may be provided for specialty physicians (e.g., orthopedists, neurosurgeons or endocrinologists) or for specialized testing. This also would include referrals to entities that may provide access to medications for individuals living in vulnerable rural and urban communities. This referral structure should also include transfer agreements.

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Range of Existing Affiliation Strategies

Many hospitals are affiliating or partnering with other providers to deliver care within their communities. These affiliations, in many instances, have allowed vulnerable communities to enhance or maintain access to essential health services. Below, we highlight these strategies because we believe they have value and could potentially serve as an option for communities to increase services offered, achieve greater economies of scale and financial stability, improve physician recruitment and retention, or increase access to capital and clinical and administrative expertise.

Regional Collaborative

Structure – A flexible, low-risk, low-investment affiliation that allows independent organizations, typically in the same geographic region, to partner on specific initiatives. Each organization remains fully independent, but they join to create a separate entity that manages the logistics of the regional collaborative.

Benefits – A regional collaborative may be used to share best practices related to clinical or operational issues, consolidate purchasing power to obtain more favorable prices on supplies and services, and/or share resources for large capital investments (e.g., information technology infrastructure). It also allows organizations to begin communications with other providers to enable additional affiliation opportunities in the future.

Management Agreement

Structure – Hospitals may enter into a management agreement with another provider to manage a specific service line – such as orthopedics, oncology or cardiology. The managing entity would oversee the service line and ensure it runs smoothly, effectively and provides high-quality services. Hospitals also may contract with another provider or management firm to assume responsibility for the day-to-day operations of the entire hospital. Here, the managing entity may provide budgeting, financial oversight, contracting and purchasing leadership.

Benefits – While the scope of these agreements will differ, in vulnerable communities, these arrangements could allow a hospital to benefit from the management entity's administrative, operational and clinical expertise. They may be able to improve quality and cost savings.

Clinical Affiliation

Structure – An opportunity for two or more entities to come together to jointly operate a specific program or service, without changing the ownership or management of either provider. It allows shared investment in costly resources and the potential to increase collaboration and the sharing of best practices for select specialties.

Benefits – Clinical affiliations have the potential to bring new services or specialty care to a community that may not otherwise have access to those services, while allowing the hospital to remain independent. This could include, for example, telemedicine, cancer care, stroke care, specialized surgery, neurology, cardiac or orthopedic services.

Joint Venture

Structure – Joint ventures allow hospitals to enter into partnerships that are limited to a certain line of business, similar to clinical affiliations. However, in a joint venture, the partners typically create a new governance entity that manages the new business and the parties share ownership in and governance of the new entity.

Benefits – Joint ventures may provide access to capital and shared financial risk, although typically both providers would contribute capital or in-kind contributions (e.g., contribution of real or personal property or intellectual property).

Merger/Acquisition

Structure – A merger or acquisition typically involves the formal purchase of one organization's assets by another or the combination of two organizations' assets into a single entity. They also involve significant costs, including legal costs to effectuate the deal and the administration costs of integrating the organizations together.

Benefits – Mergers and acquisitions may provide many benefits including the ability to jointly contract with private payers, consolidate financial statements and debt financing, improve borrowing power, streamline administrative functions or share administrative and support functions.

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Table 1

Emerging Strategy	Essential Health Care Service: Primary Care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
Addressing the Social Determinants of Health					X				X
Global Budget Payments	X	X	X	X	X	X	X		X
Inpatient/Outpatient Transformation Strategy	X	X	X	X		X			X
Emergency Medical Center	X		X		X	X			X
Urgent Care Center	X					X			X
Virtual Care Strategies	X	X	X						X
Frontier Health System	X	X	X	X	X	X	X		X
Rural Hospital-Health Clinic Strategy	X	X	X	X		X		X	X
Indian Health Services Strategies	X	X	X	X	X	X	X		X

Emerging Strategies

Taking into account the characteristics and parameters of vulnerable communities, as well as the essential health care services set forth above, we identified and created the following strategies as the most promising for ensuring access to health care services in vulnerable communities. While these strategies will not apply to or work for every community, we are presenting a variety so that each community may choose one, or several, that are sustainable and compatible for its needs. Each of these strategies offers the opportunity for communities to ensure access to the essential services described above. Table 1 above, illustrates the essential services which may be maintained or enhanced by each recommended strategy.

Addressing the Social Determinants of Health

In the course of our discussions, we repeatedly grappled with the reality that, in vulnerable communities, even if quality care is available, social challenges often prevent community members from being able to access health care or achieve their health goals. In other words, we recognize that there is an important difference between "lack of presence" and "lack of access" – services may be present in a community, but patients may be unable or unwilling to utilize them as intended. For example, a lack of access to transportation may prevent patients from being able to obtain necessary care, or food insecurity may prevent the ability to adhere to specific diets dictated by certain conditions.

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[25] These forces include

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economic policies and systems, development agendas, social norms, social policies and political systems.[26] Although not a comprehensive list, we identified the following domains of common health-related social challenges:

- housing instability
- utility needs
- food insecurity
- interpersonal violence
- lack of transportation
- lack of adequate family and social support
- low levels of education
- lack of employment/low income
- risky or harmful health behaviors

We determined that addressing these challenges through enhanced clinical-community linkages would aid community members in more effectively accessing available health care services, which would, in turn, improve their health outcomes. Therefore, we set out to construct a model that would bridge the gap between clinical care and community services – those public health and social service supports that aim to address health-related social needs and include many home and community-based services. The model draws upon existing initiatives, including programs developed by Health Leads or the Centers for Medicare & Medicaid Services' (CMS) Accountable Health Communities Model.[27]

Health care provider efforts to date and capabilities in this area vary widely, therefore, this model provides several different paths that providers and their communities could take. While each of these paths generally builds upon the previous path, they may be utilized together or individually by a community. These include:

PATH 1: Screening and Information. Providers wishing to engage in this path would first focus on systematically screening their patients for health-related social needs. Doing so entails developing screening questions and creating an appropriate method to administer the screening. To create appropriate screening questions, providers should either conduct a new or consult an existing community health needs assessment to identify which of the challenges from the above bulleted list are present in their community. They would then create question(s) that correspond to each domain. Questions could be included as a prompt in their electronic health record (EHR) to ensure that all patients are screened.

Once patients' needs are identified, providers should give them information on community resources that might be able to address those needs. To do so, providers would need to compile an inventory of the available community resources and services that address each of the domains they identified as being present in their community. This inventory would include contact information, addresses, hours of operation and other relevant information that a patient would need to access the resources of an organization. It also would need to be updated periodically.

PATH 2: Navigation. Providers wishing to engage in this path of addressing health-related social challenges could build upon the Screening and Information step by providing navigation services to proactively assist patients in overcoming barriers to accessing community services. Specifically, after a provider identifies the resources a patient requires, it would determine what level of navigational support the patient needs. For example, some patients may need assistance gathering the documentation required to access a particular resource; others may require help contacting the organization; still others may feel comfortable without additional assistance. The provider would use this information to create a patient-centered action plan that delineates the patient's next steps, as well as the provider's next steps.

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Next, a provider would track the outcome of these navigation efforts to determine whether the patient accessed the community services and, if so, what services were obtained. It also could track other information, such as how promptly the community services were provided and what the patient's satisfaction level was. This could be done for example, by conducting a follow-up assessment after the initial screening. Doing so yields data the provider can use to refine its program. For example, it would know which resources were able to be accessed most frequently, most promptly, and with what amount of patient satisfaction. These data will allow providers to identify "top performing" community resources, which could, in turn, dictate refinements of the community organizations to which they are referring their patients.

PATH 3: Alignment. Providers wishing to engage in this path of addressing health-related social challenges could build upon the prior two steps by partnering with community stakeholders to more closely align the services that are available with the needs of community members. This could entail creating a community board that includes all stakeholders or another framework for collaboration. If that is the route taken, the community board would conduct a gap analysis that compared available resources with the existing critical needs. Gaps may exist in the types of resources available, but also in the amount of each resource that is available. The data that the provider has been able to collect in the prior two steps will greatly inform this gap analysis – through these data providers will know what portion of their population faces each challenge and how many patients are able to successfully access the necessary resource. Finally, the community board would use the gap analysis to create an improvement plan to re-align available resources to meet the social service needs of the target population.

Federal Statutory and Regulatory Barriers to Implementation of Social Determinant Strategies

1. Limited federal funding. While many hospitals implement these types of services through their existing community benefit programs, increased federal funding would enhance the potential for these programs to address social challenges in vulnerable communities. Currently, there is little direct federal funding available to reimburse hospitals or their communities for these programs. For example, only limited grant funding is available from federal agencies to provide community social services. And, when they are available, those opportunities may be difficult to find. Further, providers in vulnerable communities may not have access to grant writers who would increase their chances of obtaining the award. In addition, federal programs designed to address the social determinants of health are limited in scope. For example, the Accountable Health Communities Model, which would address health-related social needs through enhanced clinical-community linkages that have the potential to increase health outcomes and reduce costs, is only open to 44 participants around the country. Finally, while many federal alternative payment models (i.e., global budgets or accountable care organizations) are built around the concept that providers are financially rewarded if they are able to drive down utilization, including if they do so by addressing social determinants of health, participation in these programs is limited in vulnerable communities.

2. Civil Monetary Penalty (CMP) law. The "beneficiary inducement" provisions in the CMP law are a barrier for health care providers that would like to provide community resources directly to Medicare and Medicaid patients. These provisions prohibit health care providers from offering inducements to a Medicare or Medicaid beneficiary that the provider knows or should know is likely to influence the selection of particular

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providers, practitioners or suppliers. This prohibition also applies to providing assistance to beneficiaries, and while there are exceptions for providing support that promotes access to care or is based on financial need, there are no clear and readily applicable protections for encouraging a patient's follow-through on post-discharge treatment plans. In addition, while there have been some beneficiary inducement waivers included in certain Center for Medicare and Medicaid Innovation (CMMI) programs, they are limited in nature in that they contain restrictions on the type of item or service that may be offered, as well as the dollar value of that item. For example, hospitals have created farmers markets that provide free and healthy food to their communities; they have provided certain patients with air conditioners to help improve respiratory-related illnesses; and they have provided patients with refrigerators so they can keep their insulin cool. However, they are only able to provide these types of assistance to non-Medicare or Medicaid patients. A new legal safe zone would be needed to enable providers to offer the type of assistance beneficiaries need to realize the benefits of their discharge plan.

Global Budget Payments

Global budget payments shift reimbursement for health care services away from volume-based payments to a single payment that encompasses certain costs associated with caring for a patient. We believe global payments have the potential to provide financial certainty for hospitals in vulnerable rural and urban communities. In addition, they could offer communities incentives to contain health care cost growth and improve quality by allowing providers to focus on offering services that improve the health of their communities overall and decrease the need for hospital services.

Global Budget Requirements

In their most basic form, global budget payments provide a fixed amount of reimbursement for a fixed period of time for a specified population – rather than fixed rates for individual services or cases. Therefore, if a provider's costs are less than the budget, they retain the difference; if a provider's costs exceed the budget, the provider must absorb the difference. They may be designed in a way that allows each provider to create a unique plan to meet mandated budgets, thereby allowing vulnerable rural and urban communities autonomy and flexibility to create solutions that work best for their communities.

When designing these programs, many factors must be considered. For example, global payments should be made at a predictable, stable and sufficient level to allow providers to build the infrastructure and capability to redesign care delivery. For vulnerable communities, global payments may need to be inflated above historical payment levels to allow hospitals in these communities to offer services under this model.

Another factor to consider is what type of health care providers would be included in the global budget program. For example, participation may be limited to hospitals, or it could be expanded to include additional health care providers (e.g., physicians). The broader the participation, the more alignment between health care providers and accountability for the health care services offered within a community. In addition, consideration must be given to the payers participating in the global budget program. Participation by all commercial and government-funded health plans affords hospitals the most opportunity to focus their efforts on success, rather than attempting to simultaneously operate under fee-for-service and global budget payment models. However, this could be the most difficult factor to achieve.

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There are many other considerations, including, but not limited to:

- The types of services that will be included in or excluded from the global budget;
- The details around timing and structure of payments and for participating providers, including the potential for up-front payments to providers that would cover the costs associated with building infrastructure and capabilities necessary to redesign care delivery;
- Ability to adjust payments to account for factors outside of a hospital's control;
- Selection of appropriate quality metrics; and
- Hospital access to claims and quality metric data.

Federal Statutory and Regulatory Barriers to Implementation of Global Budgets

1. Fraud and abuse laws. To allow hospitals to form the financial relationships necessary to succeed in a global budget, it is critical to obtain waivers of applicable fraud and abuse laws that inhibit care coordination. Specifically, the Physician Self-Referral Law and the Anti-kickback Statute may not be compatible with the financial arrangements that are necessary between hospitals and other health care providers to implement a global budget.

2. Waivers of current Medicare payment rules. Waivers of many existing Medicare payment rules also would be necessary to provide participating hospitals with maximum flexibility to identify and place beneficiaries in the clinical setting that best service their short- and long-term recovery goals. This includes, but is not limited to, the waiver of discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services, the skilled-nursing facility "three-day rule," and the inpatient rehabilitation facility "60% Rule." These waivers are essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time.

3. Access to timely data. Access to actionable information related to care, payment and cost is essential to the success of a global budget. For example, access to real-time data on patient utilization and spending for services across an episode of care would be necessary to actively manage care offered to patients. Currently, this information is offered to providers on a delayed basis, which prevents them from making necessary decisions to improve care delivery for their patients. Payers and other suppliers of claims and quality metric data must provide reliable, timely data to hospitals participating in global payment arrangements.

Inpatient/Outpatient Transformation Strategy

In recent years, hospitals have faced a decline in the volume of inpatient services, while also seeing an increase in the volume of outpatient services. The inpatient/outpatient transformation strategy (IOTS) would make this challenge work for the hospital and, ultimately, the community by reducing current inpatient capacity and shifting those resources to the delivery of outpatient care.

IOTS Requirements

The IOTS would vary by hospital and community; however, by utilizing this strategy, hospitals would do the following:

- Continue providing inpatient services, but at a capacity that is reduced (i.e., a reduced number of licensed beds) to a level that closely reflects the need of the community for inpatient services;

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- Enhance the outpatient and primary care services offered to the community, which may include an increased focus on outcomes and prioritization of primary care, wellness and prevention; and
- Continue providing emergency services, which would be available to the public 24 hours a day, 7 days a week, 365 days per year.

Federal Statutory and Regulatory Barriers to Implementation of the IOTS

The IOTS could be implemented today and does not require changes to any federal statutory or regulatory provisions. Hospitals considering this option will continue to be subject to all federal statutory and regulatory requirements that apply to hospitals, including, but not limited to, quality requirements and the Medicare Conditions of Participation and other requirements related to the volume and type of inpatient services provided by the hospital.

There may, however, be other barriers that may prevent a hospital from making this transformation. These are described in more detail in the Barriers to Implementation section of this report, but may include a lack of access to resources to make the transition or lack of partnership, buy-in and acceptance from the community.

Emergency Medical Center

The emergency medical center (EMC) would allow existing facilities in vulnerable rural and urban communities to continue providing emergency medical services without having to maintain inpatient beds or provide inpatient acute care services. This would allow hospitals that may be struggling financially, for a variety of reasons, to meet the needs of the community for emergency and outpatient services. As discussed in more detail below, the EMC is different from existing freestanding EDs and would require a new designation at the federal level, and in most cases, at the state level as well.

EMC Requirements

EMCs would be required to provide the following services on an outpatient basis:

- Emergency services, which would be available to the public 24 hours a day, 7 days a week, 365 days a year; and
- Transportation services, either directly or through arrangements with transportation providers, that allow for the timely transfer of patients who require inpatient acute care services.

In addition to emergency and transportation services, EMCs would be able to offer additional health care services needed by a particular community. For example, EMCs would have the ability to provide outpatient services that may include primary care services, observation care, infusion services, hemodialysis, population health and telemedicine services. EMCs also could provide a variety of post-acute care services, including skilled-nursing facility care, home health, hospice and nursing home care. Regardless of the selection of services chosen, it would be necessary for each EMC to be transparent in its marketing so that the EMC clearly conveys to the community the services being offered.

Freestanding EDs exist today, primarily in the two structures described in the text box below. However, they may not be an option for vulnerable communities. For example, struggling hospitals in such communities may not be part of a system, which means they would not have the option of becoming a freestanding ED. In addition, the reimbursement limitations for independent freestanding EDs likely mean they would not be sustainable in vulnerable rural and urban communities.

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FSEDs and IFSEDs Explained

Hospital-based freestanding EDs (FSEDs). FSEDs are associated with an existing hospital, but provide emergency services in a facility that is structurally separate and distinct from that hospital. As provider-based facilities, they are reimbursed for ED services at the rates that would be paid to the existing hospital, including the facility fee.

Independent freestanding EDs (IFSEDs). IFSEDs have been recognized in a limited number of states and provide emergency services without being associated with an existing hospital. Currently, most are not Medicare providers and, as such, are not reimbursed by Medicare for the services provided. Those IFSEDs that are Medicare providers are considered outpatient clinics and are reimbursed under various Medicare Part B payment systems, including the Medicare physician fee schedule and the clinical laboratory fee schedule, but not the outpatient prospective payment system (PPS).

The EMC seeks to solve these challenges. It would only be able to arise from a hospital conversion, but would not need to be part of a system, which would limit the number of EMCs to situations where a hospital already exists. Such hospitals would be required to rescind their current hospital license and certification upon conversion to an EMC and would remain separate from any existing hospital. This "conversion" aspect makes the EMC unlike either the FSED, which continues to be associated with an existing hospital, or an IFSED, which is a new provider that did not exist prior to being an IFSED. The EMC also would include the option for hospitals to revert back to their original status within a limited time period.

EMCs also would be required to meet any requirements set forth in state or federal law and would need a new reimbursement methodology to account for challenges that EMCs will face, including low volume.

Federal Statutory and Regulatory Barriers to Implementation of the EMC

1. No existing designation for EMCs. As indicated above, the EMC is a new designation and would need to be recognized at both the federal and state level. From a federal perspective, this will involve congressional action, as well as the creation of regulations to implement the EMC. More specifically, EMCs would need to meet any Conditions of Participation or other requirements set forth by CMS. This would include staffing requirements and it is anticipated that EMCs would be staffed with an appropriate combination of physicians, medical and nursing personnel that are trained in providing emergency services at a higher level than an urgent care or physician office. It also would include quality measures that each EMC must meet in order to ensure EMCs are providing high-quality health care.

At the state level, each state would need to create a licensure category and certification process for EMCs. While many states have a license designation for FSEDs, very few allow for IFSEDs. Specifically, in 2010, Texas became the first state to allow the operation of an ED without hospital affiliation. Other states have since followed, including Delaware and Rhode Island, and more recently Georgia established state regulations to allow IFSEDs in rural areas. Therefore, it is likely that state licensure and acceptance of the EMC could pose a significant barrier to nationwide implementation of the EMC.

2. Current reimbursement methodology. Federal reimbursement methodologies do not currently account for the low volume or other challenges EMCs would face in vulnerable rural and urban communities. Specifically, because an EMC is not tied to an existing hospital, it would not be able to obtain provider-based reimbursement as FSEDs do. Further, given the low volume EMCs may experience, the Part B payments that may be available to IFSEDs serving Medicare beneficia-

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ries would likely not be sufficient to maintain the financial viability of an EMC.

Since current reimbursement methodologies are not sufficient to address this challenge, a new methodology would be needed to ensure that EMCs have adequate reimbursement to cover costs and create an adequate margin for capitalization. This issue was recently examined by the State of Georgia, through its Rural Hospital Stabilization Committee. This committee examined ED volume in 53 hospitals in counties with a population less than 35,000.[28] Through financial modeling and a series of assumptions, they found that the number of ED patient visits for these hospitals ranged from 11.2 and 27.2 visits per day.[29] This is far lower than the estimated break-even point used by the Urgent Care Association of America of between 35 and 40 visits per day for a free-standing ED.[30] As a result, the committee found that low volumes were one reason why IFSEDs would not be financially viable under the current reimbursement methodology.

Policy makers considering this type of model have proposed a variety of payment options to account for the potential low volumes at EMCs. For example,
the Rural Emergency Acute Care Hospital Act (S.1648), introduced by Sens. Chuck Grassley (R-IA) and Cory Gardner (R-CO), provides cost-based reimbursement for services provided by EMCs in rural settings at a rate of 110 percent of reasonable costs. The Medicare Payment Advisory Commission (MedPAC) has proposed a similar EMC model for rural communities that provides fee-for-service outpatient PPS reimbursement for services provided, as well as an additional fixed payment to cover extra costs and overhead expenses. MedPAC also is considering whether the community in which these emergency facilities are located should be responsible for providing additional funding to support access to emergency services in the community.

3. Staffing. Many states currently include staffing requirements for FSEDs that would be challenging if they also are applied to EMCs. For example, in North Carolina, FSEDs are required to have at least one physician and one nurse on-site at all times, regardless of patient volume.[31] However, this level of staffing is more than what is required for a fully functioning critical access hospital (CAH). When reviewing staffing from a federal regulatory perspective, policy makers would need to be balanced in order to contain costs while at the same time ensuring that the appropriate combination of physicians, medical and nursing personnel are available to provide emergency services.

Urgent Care Centers

In some instances, a vulnerable rural or urban community may only need an access point for urgent medical conditions to be treated on an outpatient basis. In those situations, we believe an urgent care center (UCC) could be a viable alternative – allowing a vulnerable rural or urban community to have a health care resource without having to maintain emergency medical services or inpatient acute care services.

UCC Requirements

UCCs are designed to assist patients with an illness or injury that does not appear to be life-threatening, but requires care within 24 hours. They also provide treatment for these conditions during the days and hours that primary care physician offices are closed. Key components of the UCC often include:

- Patients do not need to make or have an appointment in order to see a health care provider;
- UCCs are open in the evenings and on weekends;

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- X-ray services are provided on-site; and
- UCCs have the capability to perform procedures like suturing and casting.[32]

Beyond this, services offered by a UCC can vary widely depending on a community's needs. Some examples of the types of urgent medical conditions that may be treated at a UCC include: accidents and falls; sprains and strains; moderate back problems; bleeding/cuts that are not bleeding profusely but still require stitches; diagnostic services (including X-rays and laboratory tests); fever or flu; vomiting, diarrhea or dehydration; severe sore throat or cough; or minor broken bones and fractures.

In some communities, UCCs also may function as the primary care practice for their patients by handling ongoing chronic conditions or serving as a formal "medical home" for patients.[33] In addition, the UCC could provide enhanced service lines, such as swing beds, observation, home care or therapy, depending on the needs of the community. As with the EMC, each UCC would need to be transparent in its marketing so that it clearly conveys to the community the services that it offers.

Federal Statutory and Regulatory Barriers to Implementation of the UCC

1. Current reimbursement methodology. Federal reimbursement methodologies may not be sufficient to account for the low volume or other challenges UCCs would face in vulnerable rural and urban communities. Specifically, UCCs bill for services similar to a primary care office and are reimbursed under applicable Medicare Part B payment systems, including the physician fee schedule. Reimbursement from commercial payers will vary based on the contracts negotiated between the UCC and those payers. Under these reimbursement methodologies, the Urgent Care Association of America estimates that the break-even point for an urgent care clinic is approximately 25 visits per day.[34] In vulnerable rural and urban communities, UCCs may not be able to maintain this volume making additional financing necessary to ensure they have adequate reimbursement to cover costs and create an adequate margin for capitalization.

Virtual Care Strategies

We identified telehealth and virtual care strategies as very promising options to help maintain or supplement access to health care services in vulnerable rural and urban communities that have difficulty recruiting or retaining an adequate health care work force. It offers benefits such as immediate, 24/7 access to physicians and other health care providers that otherwise would not be located in these communities, the ability to perform high-tech monitoring without requiring patients to leave their homes and less expensive and more convenient care options for patients. Therefore, virtual care strategies have the potential to result in better access to care, better care and outcomes, lower costs and workforce stability.

Right now, health care providers are using telehealth technologies to fill the need for critical services in a variety of specialty areas and across diverse patient populations. Some of the most common conditions for which patients seek telehealth services are acute respiratory illnesses and skin problems, but the list of possible uses continues to grow. It has been used to provide access to emergency services through secure, interactive, high-definition video and audio equipment in locations that cannot secure board-certified, emergency physicians or critical care nurses. In some instances, a button is even installed at the remote hospital location that may be pushed at any time the hospital needs to connect with an

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emergency physician or critical care nurse, guaranteeing immediate access to these much needed services. Telehealth also has been used to effectively monitor patients on the floors of hospitals or in the intensive care unit, and to provide pharmacy services, including real-time pharmacist reviews of all new hospital medication orders.

As technology advances, the modes in which telehealth services can be provided will increase. For examples, smartphones, tablets or computers may be used to connect patients and physicians directly. Patients can connect through their smartphone for a visit with a physician related to minor illnesses such as colds, flu, bronchitis, allergy problems or rashes.

Currently, reimbursement for telehealth services differs by payer and, for many, broader reimbursement policies would be needed to adequately compensate health care providers for the costs associated with developing and maintaining this model. For example, many state Medicaid programs cover telehealth services to some extent, although the criteria for coverage vary widely from state to state. On the private payer side, by contrast, there has been significant expansion, with many states passing laws requiring private payers to provide coverage for telehealth services. Medicare coverage for telehealth services is particularly restrictive as a result of the program's narrow definition and scope regarding telehealth:

- Telehealth services may be provided only to Medicare beneficiaries who live in, or who use telehealth systems in eligible facilities located in rural Health Professional Shortage Areas, either located outside of an MSA or in a rural census tract, as determined by the Office of Rural Health Policy within the Health Resources and Services Administration (HRSA); or in a county outside of an MSA.
- Medicare does not cover telehealth services provided via store-and-forward technology, except in Alaska and Hawaii.
- Telehealth services will be covered only if the beneficiary is seen at an approved "originating site" authorized by law (including physician offices, hospitals and skilled-nursing facilities).
- Only Medicare-eligible providers (such as physicians, nurse practitioners and clinical psychologists) can provide the services.
- Medicare provides coverage only for a small, defined set of services (including consultation, office visits, pharmacological management and individual and group diabetes self-management training services).[35]

Federal Statutory and Regulatory Barriers to Implementation of Virtual Care Strategies

1. Coverage and current reimbursement methodology. As explained above, coverage by public and private payers varies significantly and whether payers cover and adequately reimburse providers for telehealth services is complex and evolving issue. However, without adequate reimbursement and revenue streams, providers may face obstacles to investing in these technologies. This may be especially detrimental to hospitals that serve vulnerable rural and urban communities – where the need for these services may be the greatest. For Medicare specifically, more comprehensive coverage and payment policies for telehealth services that increase patient access to services in more convenient and efficient ways would likely be necessary to make these strategies work for vulnerable communities. This would include elimination of geographic and setting location requirements and expansion of the types of covered services.

2. Privacy and security laws. Virtual care strategies can facilitate the generation, transmission and storage of tremendous volumes of new electronic health information and, as a result, create some additional operational challenges for health

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care providers in meeting their existing privacy and security obligations under the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and any relevant state privacy laws. When adopting these strategies, health care providers will need to understand how the existing legal and regulatory requirements for safeguarding the privacy and security of a patient's medical information and other data extend to the operation of telehealth programs. In addition, more uniformity among federal and state privacy laws would help facilitate adoption of the virtual care strategies.

3. Fraud and abuse laws. Telehealth relationships must comply with applicable federal health care fraud and abuse laws, such as the False Claims Act. Arrangements between independent providers (e.g., physician collaborations with institutional providers and/or technology companies) may be subject to the Anti-Kickback statute and/or the Stark Law physician self-referral prohibitions. As telehealth utilization and coverage for these services by Medicare, Medicaid and private carriers continues to grow, the potential for exposure to liability under various federal fraud and abuse laws will only increase. However, more uniformity among federal and state fraud and abuse standards would help facilitate adoption of the virtual care strategies.

4. Access to broadband. Many rural communities do not have sufficient and reliable broadband access, which significantly hinders their ability to utilize virtual care strategies. The Federal Communications Commission (FCC) is taking a large role in telehealth to address some of these inequities. Among other things, in 2013, the FCC allocated $400 million through the Healthcare Connect Fund to help rural providers access broadband services. More recently, the FCC announced the formation of a new task force, the Connect2Health Task Force, that "will bring together the expertise of the FCC on the critical intersection of broadband, advanced technology, and health." The Connect2Health Task Force is considering ways to increase adoption of health care technology, including telehealth, by "identifying regulatory barriers and incentives and building stronger partnerships with stakeholders in the areas of telehealth, mobile applications, and telemedicine." These efforts are steps in the right direction to help create robust broadband networks that will facilitate meaningful telehealth utilization.

Frontier Health System (FHS)

We also explored the creation of a strategy to address the unique geographic challenges faced by frontier communities. Frontier communities face challenges similar to other vulnerable rural and urban communities, but many are exacerbated. For example, these communities are extremely geographically isolated and there are often physical barriers, such as mountain ranges or large bodies of water, which hinder the ability to access health care services. Access may be further challenged by weather events such as snowstorms, whiteouts, fog, heavy rains or floods, disparate road conditions or the sheer distance between a patient's home and the necessary health care provider. Frontier communities also have very low population density, resulting in very low patient volume and a weak reimbursement base for supporting necessary infrastructure.

FHS Requirements

As a starting point for creating this strategy, we examined two existing CMS demonstration programs: the Frontier Extended Stay Clinic Model

(FESC) and the Frontier Community Health Integration Project (F-CHIP). While both of these demonstrations are promising, by definition, their design and scope is narrow, allowing only a small number of hospitals to participate.

FESC and F-CHIP Explained

Frontier Community Health Integration Project. The Frontier Community Health Integration Project (F-CHIP) is a budget-neutral demonstration project, mandated by the Medicare Improvements for Patient and Providers Act of 2009 (MIPPA), that would develop and test new models for the delivery of health care services to Medicare beneficiaries in certain frontier communities. The purpose of the demonstration is to improve access and better integrate the delivery of acute care, extended care and other essential health care services for beneficiaries in frontier areas. This model is available to CAHs meeting certain geographic requirements in Alaska, Montana, North Dakota and Wyoming – at the time of its mandate, 71 hospitals met the criteria to participate. While stakeholders presented a variety of design options for this model, the final, CMS-approved model includes three policy changes that allow for enhanced reimbursement for telehealth services, expansion of swing bed capacity to 35 beds (versus 25) and enhanced ambulance reimbursements. Ultimately, 10 frontier CAHs in three states (Montana, North Dakota and Nevada) are participating in this demonstration program, which began in August 2016.

Frontier Extended Stay Clinic Model. The Frontier Extended Stay Clinic (FESC) demonstration, mandated by the Medicare Modernization Act, allowed remote clinics to treat patients for more extended periods of time, including overnight stays, than are entailed in routine clinic visits. It was designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, could not be transferred to acute care hospitals in a timely manner, as well as of patients who needed monitoring and observation for a limited period of time, but did not require hospitalization. Under this program, participating FESCs must have been located in a community that was at least 75 miles from the nearest acute care hospital or CAH, or that was inaccessible by public road. Medicare set the reimbursement rates for these services on a prospective basis for the five clinics that were certified as Medicare providers under this three-year program. This demonstration program ended in April 2013.

Therefore, we created a strategy, similar to an accountable care organization (ACO), to address the health care needs of a broader set of frontier communities, including the extremely low patient volume and the lengthy distance between providers. The FHS would allow for the creation of local, integrated health care organizations for very small, isolated frontier communities. It would serve as a medical home for all patients in its service area, including Medicare and Medicaid beneficiaries. These organizations would include frontier health care providers that join together to coordinate preventive and primary care, extended care, inpatient care and emergency services across local, secondary and tertiary settings.

Similar to ACOs, the primary role of the FHS would be to provide a framework for integrated and coordinated health care as individuals move through the primary and specialized segments of the medical system. However, unlike traditional ACOs, the FHS also would provide transportation services to patients – this would include transporting individuals living in frontier communities to specialized medical care outside of their community, but also enabling those individuals to return to their home town for follow-up care. In addition, the care provided by the FHS would include inpatient and outpatient, swing bed, rural health clinic, ambulance and expanded visiting nurse services. In order to survive and to maintain access to important services for their communities, FHSs would need to aggregate and more efficiently manage the delivery of health care services to reduce unit cost and re-invest savings in care coordination, as well as enhanced preventive and home-based care.

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While frontier communities in many states could benefit from this strategy, certain states may face unique circumstances that must be accounted for in order to successfully implement this strategy. The FHS should be designed in a way that takes into account the differences between frontier states and allows for flexibility.

Federal Statutory and Regulatory Barriers to Implementation of the FHS

1. Current reimbursement methodology. Currently, the different providers within an FHS are paid under different payment methodologies, which does not support economies of scale or care coordination. For example, visiting nursing services are paid on a fee-for-service basis, while all inpatient and outpatient services provided by a CAH are paid based on cost. A new payment methodology would be needed that aligns the incentives of all providers in the FHS and accounts for low patient volume and the distance between providers. We believe that a reimbursement methodology that combines cost-based and pay-for-performance reimbursement would be appropriate for this strategy. Cost-based reimbursement would allow all health care providers to account for the costs of creating integrated FHS organizations and care coordination networks – this may include costs associated with health information technology, chronic disease management tools and education and training for current or new staff. The pay-for-performance element could be a value-based purchasing-like program that rewards the FHS for care coordination, reduced admissions and readmissions, improved quality outcomes and the reduction of health care costs.

2. Waivers of current Medicare payment rules. In addition, regulatory changes would need to be made for this strategy to be implemented. More specifically, the FHS would need a system of waivers that would only apply to services provided by an FHS and may include:

- Changing the CAH 25-bed limit to 35 beds, which would allow for expanded swing bed services;
- Allowing cost-based reimbursement for visiting nurse services (e.g., physical, occupational and speech therapy services as well as services delivered by a home health aide) when furnished in the frontier home setting;
- Waiving the 35-mile ambulance rule to allow FHSs to operate in their regional service areas, which often encompass hundreds or even thousands of square miles, even if another ambulance service is located within 35 miles; or
- Waiving telehealth restrictions.

3. Fraud and abuse laws. To allow health care providers to form the financial relationships necessary to succeed in the FHS, it is critical to obtain waivers of applicable fraud and abuse laws that inhibit care coordination. Specifically, the physician self-referral law and the Anti-kickback Statute with respect to financial arrangements formed by hospitals are not compatible with the FHS.

Rural Hospital-Health Clinic Integration

Currently, many rural hospitals have developed relationships with various types of health clinics in their communities to ensure and expand access to health care services. This is most often seen as a relationship between a rural hospital and a Federally Qualified Health Center (FQHC), which is what we have focused on below. However, we believe this model has the potential to be expanded to include relationships between rural hospitals and all types of health clinics including, but not limited to, Rural Health Clinics and Community Health Clinics.

We acknowledge that in many communities, rural hospitals and FQHCs have strained relationships

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and a lack of trust resulting from years of conflict and competition for patients as well as health care practitioners. In addition, as a result of the regulations governing and operating rural hospitals and FQHCs, these facilities also often have different incentives when providing health care services to the community. Despite these challenges, however, we believe cooperation and collaboration through integration is a way for vulnerable rural communities to better meet community need and stabilize and expand services as those needs change.

FQHC and CAH Explained

FQHC. An FQHC is a community-based outpatient clinic that qualifies for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program and have a governing board of directors.[36] FQHCs provide a range of services including comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

CAH. A CAH is a hospital, certified and structured under a different set of Medicare Conditions of Participation than acute care hospitals. They have a limited size (no more than 25 inpatient beds), short lengths of stays (annual average length of stay of no more than 96 hours for acute inpatient care) and meet certain location and distance requirements. CAHs also provide outpatient care and offer 24/7 emergency care. They receive cost-based reimbursement from Medicare, instead of fee-for-service or fixed reimbursement rates.

Rural Hospital-Health Clinic Requirements

Integration between rural hospitals and health clinics may take the form of a variety of relationships including:

- Contractual collaborations, such as referral and co-location arrangements, or an agreement for the purchase of clinical and/or administrative services between the FQHC and rural hospital;
- Formation of a consortium or network that allows for sharing of clinical and administrative functions, as well as facilitate the continuum of care; or
- Corporate integration (i.e., merging the rural hospital into the FQHC).

Regardless of the level of integration chosen, this strategy would allow each entity to dedicate its resources to a different set of services. For example, in a CAH-FQHC relationship, the CAH would generally continue to provide acute inpatient services, diagnostic and lab services, outpatient surgery and therapeutic services, without having to maintain an outpatient primary care clinic. In contrast, the FQHC would generally focus on providing primary care services, dental services and behavioral health services, without having to maintain a full set of diagnostic or lab services. With each entity focusing its resources on what it does best, the collaboration between a CAH and FQHC would eliminate duplication in services and allow a community to more efficiently use its limited resources.

While working together, rural hospitals and FQHCs also may be able to share access to patient care records or quality improvement programs, which would allow for greater synergy and integration of primary care, behavioral health and oral health, as well as secondary and tertiary care. This integration also could allow for efficiencies of scale between both organizations that may be accomplished by sharing administrative and management and medical leadership functions, consolidating capacity or combining efforts to apply for grants that could increase financial support for personnel, equipment or facilities.

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Federal Statutory and Regulatory Barriers to Implementation of Rural Hospital-Health Clinic Integration

1. Regulatory and reimbursement differences. Rural hospitals and health clinics are required to meet separate and distinct regulatory requirements. In addition, each is paid under its own reimbursement structure, as described above, which has its own set of standards and expectations. Both entities will need to understand the requirements associated with the other entity in order to implement this strategy. Likewise, both entities will need to educate and market the joint relationship in a way that is transparent and clearly conveys to regulators, health care providers and patients the nature of the relationship and services being offered.

2. FQHC regulatory requirements. For relationships between rural hospitals and FQHCs, it is important to note that the HRSA oversees the FQHC program and generally speaking, does not approve relationships where a hospital, municipality or 501(c)(3) corporation owns the FQHC. Historically, however, HRSA has made exceptions if the FQHC has its own independent board of directors. In addition, HRSA has promulgated regulations that set forth additional governance requirements for FQHCs, including that the governing board must have a majority (minimum of 51 percent) of members who are patients of the FQHC and who, as a group, reasonably represent the patient population. There also are restrictions on the percent of non-patient board members who earn 10 percent or more of their incomes from health care-related industries. It is important to take these requirements into consideration when developing any type of integration between a rural hospital and an FQHC.

Indian Health Services Strategies

While developing strategies for vulnerable rural and urban communities, we also reflected on ways in which the access to and delivery of care could be improved for those American Indian and Alaska Native Tribes that receive health care services from the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services. While our task force did not dive deeply into the operations of the IHS program, we did gather feedback from states that are significantly impacted by its operations. As a result, we offer recommendations that may increase access to health care services for this population and improve the quality of care and coordination between the IHS facilities and other health care providers.

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Background on IHS

The IHS program has been developed through several treaties and other agreements between the U.S. government and Indian Tribes and provides for medical services, the services of physicians, or the provision of hospitals for the care of Indian people. As a result, members of 567 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by IHS.

In total, IHS provides a comprehensive health service delivery system for approximately 2.2 million of the nation's estimated 3.7 million American Indians and Alaska Natives – a majority of which live on or near reservations and in rural communities, mostly in the western U.S. and Alaska.[37] It operates 28 hospitals, 62 health centers, 25 health stations and 33 urban Indian health projects.[38] American Indian Tribes and Alaska Native corporations administer an additional 18 hospitals, 282 health centers, 80 health stations and 150 Alaska village clinics.[39]

IHS provides two types of services:

- Direct care to tribal patients through IHS-operated heath care facilities, most of which are located on or near reservations. For tribal members who are covered by IHS health care programs, treatment at these facilities is free.
- Contract health services (CHS), which includes health care services provided by non-IHS facilities to tribal members eligible to receive CHS benefits. These heath care services are funded by annual, fixed appropriations from IHS that pays providers for these services at a Medicare-like rate. These services are only to be used when the treatment or services needed by the patient are not available at an IHS-operated facility.

While this system has had success at delivering care to these communities, American Indian and Alaska Native Tribes have long experienced lower health status when compared with other Americans. When compared to the general U.S. population, their life expectancy is more than four years lower and death rates are significantly higher, including deaths related to chronic liver disease and cirrhosis, diabetes, unintentional injuries, intentional self-harm/suicide and chronic lower respiratory disease.[40]

IHS Strategies

We believe the IHS system could be strengthened through the development of partnerships with non-IHS health care providers. These partnerships could take many forms, but would be made with the goals of increasing access to health care services for this population, improving the quality of care available and promoting coordination of care between the IHS facilities and other health care providers.

We developed a strategy to improve care coordination between IHS facilities and those providing contract health services to American Indians and Alaska Natives. As a first step in this process, IHS facilities would conduct an assessment of the services it currently offers and those available in surrounding communities. IHS services at each facility vary, but specialty services available through the IHS are generally limited. For example, IHS facilities are often unable to provide sufficient behavioral health, specialty dental care and treatment for non-urgent conditions, such as arthritis, allergies and chronic care.[41] In addition, IHS facilities often lack necessary equipment for ancillary services and have few medical specialists on site.[42] These service gaps could be filled by expanding relationships with non-IHS health care providers.

This assessment also should include an examination of which health care providers best allow the IHS system to most efficiently use its limited resources. In some situations, health care providers outside of IHS may be able to offer better quality services at a lower cost. In other cases, the IHS facility may prove to be a better option. The assessment also would include an analysis of

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efficiencies that may be accomplished by sharing administrative and management and medical leadership functions, consolidating capacity or combining efforts to apply for grants that could increase financial support for personnel, equipment or facilities.

Once this assessment is completed, the IHS system would work to develop the relationships needed to expand access to the needed services. This will include ensuring that financial resources are dedicated to the appropriate health care providers and that systems are in place to exchange information among the participants responsible for different aspects of care.

In addition, the IHS may benefit from the other strategies we recommend in this report. For example, IHS can work with non-IHS providers to expand virtual care at its facilities. This could increase access to many areas of health care, particularly specialty care that may be difficult to find in these vulnerable communities (i.e., emergency medical services or appointments with specialists in behavioral health, cardiology, maternal and child health, nephrology, pain management, pediatric behavioral health, rheumatology, wound care and dermatology).

IHS hospitals also could consider partnering with FQHCs in the community. That way, the IHS hospital can focus on providing acute inpatient services, diagnostic and lab services, outpatient surgery and therapeutic services, without having to maintain an outpatient primary care clinic. The FQHC could then focus on providing primary care, dental and behavioral health services, without having to maintain a full set of diagnostic or lab services. With each entity focusing its resources on what it does best, the collaboration between an IHS hospital and an FQHC would eliminate duplication in services and allow the IHS system to more efficiently use its limited resources.

Federal Statutory and Regulatory Barriers to Implementation of IHS Strategies

1. IHS funding. Adequate funding has been a continual challenge for the IHS program and CHS providers. IHS is an appropriated program rather than an entitlement program. That means that a majority of the federal funding available for IHS is appropriated in advance each year in fixed amounts that are then allocated among the different geographic areas and tribes served by the IHS.

These funds have been insufficient to cover the costs of providing health care services to all those eligible for IHS services. As a result, the program typically runs out of money well before the end of the year – creating financial issues for IHS facilities and hampering IHS's ability to reimburse for health care services provided by non-IHS facilities. And, while there are many health care providers that are willing and able to provide health care services to this population, there is little trust that they will be reimbursed for their efforts. Funding for the IHS program will need to be reevaluated to improve care coordination with non-IHS providers and ensure that the right providers are incentivized for providing necessary services. Policy makers may wish to examine funding of other governemnt operated health systems (e.g Veterans Health Administration and the Military Health System) as a part of that reevaluation process.

2. Technical assistance. In addition to the funding addressed above, IHS facilities may collect additional reimbursement for services provided to American Indians and Alaska Natives who are also eligible for other federal programs, including Medicare, Medicaid, the State Children's Health Insurance Program and Veterans Access Choice. Increased funding from these sources allows IHS facilities to expand services; however, they face challenges in collecting this funding because they often lack the technical expertise and assistance

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necessary to bill and collect for these services. In addition, many American Indians and Alaska Natives are eligible for Medicaid but remain uninsured due to enrollment barriers (e.g., lack of knowledge about Medicaid, difficulty completing the enrollment process, language and literacy barriers, and geographic or transportation barriers). Technical assistance for IHS and its constituents would allow IHS facilities to improve the organization's operations.

3. IHS regulations. Currently, IHS hospitals are required to meet the hospital Conditions of Participation. This is onerous given that many IHS hospitals are comparable to small rural hospitals. Their location is often geographically remote and they see a very small volume of inpatient services. Transformation within IHS would be more easily facilitated if they were subject to less burdensome regulations and could meet Conditions of Participation more suited to their needs – e.g., Conditions of Participation similar to CAHs.

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Addressing the Social Determinants of Health: Bon Secours Baltimore Health System

Bon Secours Hospital serves West Baltimore, a socioeconomically disadvantaged neighborhood in Maryland, which has a high prevalence of poverty, chronic disease and health disparities. Most of the patient population is on medical assistance or lacks health insurance. Bon Secours Baltimore Health System leads a wide variety of initiatives to affect the social determinants of health and foster a culture of health in West Baltimore.

They do this by partnering with community stakeholders to more closely align the services that are available with the needs of community members. For example, in 2010, Bon Secours Baltimore Health System took the lead in as the fiduciary organization, forming a coalition of 16 hospitals, health centers and other wellness, educational and community-based organizations that would address the health of this community. The coalition worked with the state of Maryland to have West Baltimore declared a Health Enterprise Zone (HEZ) – allowing the community to receive approximately $4 million from the Maryland Department of Health and Mental Hygience to improve the health of the individuals living within this four/ZIP code community. The funds from the HEZ are used to attract additional primary care physicians, nurses, care coordinators and community health workers to augment preventive care for residents living in the designated ZIP codes. Additionally, community grants will fund fitness equipment in churches, and healthy eating and medication management initiatives to keep people healthy and out of the emergency room.

Initial results in the community have been positive. Care coordination has increased as a result of HEZ's efforts and providers were able to successfully connect over 7,200 patients to a Community Health Worker (CHW) and those CHWs have completed over 7,400 encounters through home visits, phone calls, health screenings and clinic visits. In addition, through the HEZ funding, 85 scholarships have been awarded to residents within the HEZ to pursue health careers. The coalition also offers free fitness classes each week, which reached 3,574 residents and resulted in an average weight decrease of 15 pounds and a decrease in body mass index of 1.5 for participants. The coalition also has been able to offer training classes to train CHWs and provide additional equipment for the community related to cooking, nutrition and chronic disease management.

This coalition continues to evolve and works to enact policy, create programming, and make ultimate decisions for the West Baltimore Health Enterprise Zone project. The coalition also maintains an Advisory Board that is enlisted to offer recommendations for, and insight into, programming and services related to improving cardiovascular and overall health in West Baltimore. Membership of that Advisory Board is primarily comprised of a cross-section of individuals who live, work, play, study, or worship in ZIP codes within the HEZ. Additional members may include representatives of corporations and organizations with particular disease focus interest in the community.

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Barriers to Implementation

Throughout this report, we have identified specific federal statutory and regulatory barriers that would impede transitioning to or implementing our nine emerging strategies. However, there are many other barriers to implementation that may arise at the health care provider, community or state levels. While we cannot capture the full scale of those barriers, we have identified some consistent themes across each of these emerging strategies.

Health Care Provider Barriers

At the health care provider level, transitioning to these new strategies may take longer or require more significant investments of time, effort and finances in vulnerable communities. For example, certain hospitals in vulnerable communities have been unable to meaningfully participate in value-based payment programs or develop and sustain alternative payment models for a variety of reasons. Therefore, they lack experience participating in alternative payment models, such as global budget payments, and may require payment policies and technical assistance that bridges the gap between current fee-for-service and value-based reimbursement models.

In addition, for the virtual care model, credentialing and privileging at the health care provider level may be a barrier to implementation. Specifically, in an effort to ensure the highest quality of care possible for its patients, each health care facility takes steps to verify a health care provider's proficiency through the collection, verification and evaluation of data relevant to the practitioner's professional performance. These credentialing and privileging requirements are exacerbated in the telehealth context because the services provided usually involve two or more health care facilities, both of which credential and privilege each health care provider.

Community Barriers

At the community level, the ability to attract or retain health care providers will remain a challenge regardless of which of these strategies are selected. The AHA Board Committee on Performance Improvement (CPI) has undertaken the topic of workforce, specifically the need for hospitals and health systems to begin to integrate workforce planning and development with hospital strategy and operations. It is imperative that hospitals in vulnerable communities undertake this effort at the same time that they are planning their transformation strategies. The CPI also is formulating its own report that will be a resource for hospitals. That report will enable hospitals and health systems to assess their workforce needs and to commit to developing long-range workforce plans integrated with their new or existing strategies to operate in a very dynamic and evolving health care field.

Furthermore, this task force's report underscores the need for innovation in workforce planning and development to ensure providers are able to deliver care as they transition to these emerging strategies. Specifically, many in the current workforce are not adequately prepared to take on the variety of responsibilities outlined in this report, nor is the education system of the future workforce adequately preparing providers for new, expanded roles that are not hospital-based. For this reason, it is critical that workforce planning and development become integrated into discussions around developing new models of care, new collaborative relationships and new payment structures. Vulnerable communities will need a workforce that is well-educated, culturally competent, nimble and flexible to meet the needs of their populations.

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Moreover, what we learned from our listening sessions around the country is that the concern from the community and its leaders may hinder transformation and implementation of these emerging strategies. Communities, and the community board that governs the hospital, typically do not want to lose their hospital because it serves as the anchor for and economic engine of the community. Conversations related to transformation will be challenging for many vulnerable communities, but community input, buy-in and acceptance are critical for success as hospitals transition to these new strategies.

State Statutory and Regulatory Barriers

State laws also will present barriers to implementation of these strategies. The best examples are the issues related to physician licensure across state lines that would be required for broad implementation of virtual care strategies. State licensure laws can be major obstacles for facilities wanting to provide telehealth services to patients in other states because of the current lack of portability of health professional licenses between states. The harmonization of state laws to foster increased physician licensure portability, greater licensure portability for nurse practitioners, physician assistants and other health professionals, increased flexibility of the physical examination requirement for online prescribing; and clarification of medical malpractice insurance rules for telehealth encounters would facilitate the adoption of virtual care strategies.

The Interstate Medical Licensure Compact (IMLC) and the Nurse Licensure Compact (NLC) are two promising avenues to address these state licensure issues. The IMLC offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states, increasing access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies. As of the date this report is published, 16 states have joined this Compact. The NLC offers a multi-state license to nurses to practice in their home state and in other Compact-participating states. Under this Compact, nurses have the opportunity to practice across state lines and it enables state boards of nursing to cooperate and coordinate standardization of requirements, resulting in safer, coordinated care. As of August 2016, 25 states have joined the NLC.

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Advocacy Agenda and Assistance Strategy

In this report, we discuss specific federal policies and issues that could impede or create an appropriate climate for transitioning to a different payment model or model of care delivery in relation to each of our recommended strategies. Generally speaking, these barriers naturally lead to the development of an advocacy agenda, as well as a vulnerable community assistance strategy, that will help facilitate the adoption of the emerging strategies we set forth above.

Advocacy Agenda

The ability to successfully adopt many of the strategies we describe above is dependent on numerous federal policy changes. Therefore, we recommend that the AHA advocate for the:

- Modification of existing Medicare Conditions of Participation to allow for the formation of the strategies identified above, where necessary;
- Creation of new Medicare payment methodologies and transitional payments, as appropriate, that would allow for successful implementation of the strategies identified above, while covering necessary costs, promoting predictability and stability and aligning provider incentives to increase accountability for health care services offered within a community;
- Creation of new and expansion of existing demonstration projects being conducted by CMMI and other federal agencies that promote and fund opportunities for communities to maintain access to essential health care services;
- Modification of laws that prevent integration of health care providers and provision of services including, but not limited to, fraud and abuse (Anti-Kickback Law and Stark Law), antitrust and CMP laws and artificial barriers such as those that prevent a rural hospital from owning an FQHC.
- Modification of existing Medicare payment rules that stymie health care providers' ability to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals including, but not limited to, discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services and the inpatient rehabilitation facility "60% Rule;" and
- Expansion of Medicare coverage and payment for telehealth, including a more flexible approach to adding new telehealth services to Medicare.

We also note that while the above recommendations focus on a federal advocacy agenda, states will play an important role too, such as with physician licensure and credentialing across state lines required for telehealth services. Therefore, we also recommend that the AHA continue to work with the state hospital associations to address state-level issues, as appropriate.

Vulnerable Community Assistance Strategy

By their very nature, vulnerable communities and the hospitals that serve them may not have all the resources they need to successfully adopt one or more of the strategies set forth in this report. Therefore, we recommend that the AHA provide communities and health care providers, including hospitals, with operational tools to facilitate such adoption. For example, we believe the association could assist by:

- Providing assistance in analyzing financial data or conducting data analytics to determine the feasibility of adopting a particular model or the outcomes and efficacy of each model;
- Creating community relations toolkits to assist hospitals in creating opportunities

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for community input, partnership, buy-in and acceptance of their transformation by their community;

- Providing information related to grants that may provide financial assistance for certain strategies;
- Facilitating the creation of learning networks to bring hospitals together for information and idea sharing; and
- Offering curricula, developed in partnership with third parties, to promote best practices, identify cutting-edge strategies, operationalize innovation activities and adapt successful approaches from elsewhere into hospitals' own organizations.

Conclusion

In this report, we have worked to identify and set forth characteristics and parameters, strategies and solutions can appropriately identify and account for the variation in access to health services in communities around the country. But, this is only the beginning. To fully ensure access to essential health care services, we will all need to do our part – vulnerable communities, the hospitals that serve them, and the association that serves us all. Vulnerable communities will need to make significant investments of time, effort and finances. Hospitals will need to build upon their current infrastructure for health information technology, patient and family education, care management and discharge planning. They will need to align in ways they have not before, which will involve forming new and different contractual relationships that build valuable partnerships and incentivize successful strategies. The AHA should advocate for policies that allow these transformations, and provide the tools that facilitate their occurrence.

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Case Examples and Best Practices

Addressing the Social Determinants of Health: Lehigh Valley Health Network, Pa.

Lehigh Valley Health Network (LVHN) is working to help address one of the most prevalent health-related social needs in its community – homelessness. It became generally aware of the problem through its Community Health Needs Assessment (CHNA), but did not have information on the number or identity of the homeless patients it was serving. Therefore, with the goal of changing the way health care was delivered to the homeless in its area, LVHN founded the Street Medicine Program. The program is wide-ranging, but one facet is the recent completion of a research study that screened for homelessness in the ED using a newly developed screening tool. The tool screens ED patients using four questions based on the Departments of Health and Human Services, Housing and Urban Development, and Veterans Affairs definitions of homelessness. It is designed to be short and completed quickly, which facilitates compliance with completion. Through this screening tool, LVHN was able to quantify that, at all hospital sites, the prevalence of homelessness was far higher than anticipated. This has led to allocation of more and more targeted resources to address the problem.

When a patient answers affirmatively to any one of the four questions in the screening tool, several activities are triggered. First, the provider takes an in-depth social history to obtain more details on the barriers to care that the patient faces. In order to improve awareness and identification of barriers to care, the Street Medicine team has provided education on homelessness and health care to the ED and inpatient providers, nurses and case managers. Next, if the ED provider feels it is appropriate, the Street Medicine team is called for a consultation. They begin to establish a relationship with the patient, and use their social history, as well as other forthcoming information, to provide information on community resources that can help address the patient's needs, such as homeless shelters, food pantries, soup kitchens, food stamp programs, and health insurance. The team also provides both personalized assistance to help the patient obtain needed resources and provides certain resources themselves, such as access to free medications and lab tests needed to facilitate safe discharge from the hospital setting. They have put a particular emphasis on helping patients gather documentation and fill out the appropriate forms to obtain health insurance and, subsequently, connect with a primary care physician in a more traditional setting. As a result, they have seen a rise in the rate of insurance for their homeless population from 24 percent in February 2015 to 70 percent from January through May 2016.

The LVHN Street Medicine team also is working to identify and address the many disconnects it has identified between the needs of the homeless population and the resources available to help them, particularly with regard to their health care needs. Thus, in addition to the screening tool and hospital-based consultation services, it has established free clinics within homeless shelters and soup kitchens, and the team also delivers health care on the street for those that are unwilling or unable to visit the clinics.

"We developed a health care delivery system that put free clinics in homeless shelters and soup kitchens and a street team that seeks out those who live in the shadows of our society. This simple idea would change the trajectory of families we treat now and hopefully forever."

Brett Feldman, Director of LVHN's Street Medicine Program

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Addressing the Social Determinants of Health: ProMedica Health System, Ohio

ProMedica's efforts to address food insecurity in its community began with an initiative to battle obesity. It first identified this as an issue in its CHNA, finding that Toledo consistently ranked one of the most obese communities in the country. ProMedica determined that one of the root causes of the problem was food insecurity and, in particular, a lack of access to nutritious, affordable food. As such, they began providing educational programs at schools and to parents on nutrition, including recommendations for how families could purchase healthy food on very limited budgets.

In an effort to address food insecurity more directly, in 2014, ProMedica created a two-part screening tool that is embedded in its EHR and administered as part of the inpatient admission intake process. The questions are taken from a larger U.S. Department of Agriculture screening tool and focus on whether a patient is concerned that their food supply will run out before they are able to purchase more.

ProMedica asks patients to respond either "yes" or "no" to two statements:

1. **Within the past 12 months, we worried whether our food would run out before we got money to buy more.**
2. **Within the past 12 months, the food we bought just did not last and we did not have money to get more.**

ProMedica runs a daily report that indicates which patients answered either of the tool's questions affirmatively; hospital staff then confirm the positive screen with the patient. Then, upon discharge, the patient receives a care package that contains one day's worth of shelf-stable food, such as crackers, cereal and packaged fruit. ProMedica also provides him or her with a Community Resource Guide that includes information on food resources specific to the community in which the patient lives. They are currently developing a follow-up protocol to determine whether the patients successfully accessed any of the resources.

To further assist patients on an ongoing basis, ProMedica created the ProMedica Food Pharmacy, for which patients obtain a prescription through one of ProMedica's primary care physician practices. ProMedica believes that tying the prescription to a physician visit increases the likelihood of patient participation, as they know it is in their best health interest. In addition, if the physician is concerned about the patient's ability to access the Food Pharmacy in a timely manner, due to, for example, transportation challenges, or if they feel the patient is in immediate need, they are able to provide the patient with an "emergency food bag" that contains a day or so worth of shelf-stable food for their entire family.

The Food Pharmacy offers patients two to three days' worth of food for their entire household, per visit. Patients can return once per month for up to six months, at which time they can return to their physician for another prescription if they are still in need. In addition, the patient is offered nutrition counseling from a registered dietitian, healthy recipes and a connection to community resources. Patients are able to choose their own foods from the pantry with assistance from trained staff who consider the patient's needs and health conditions. From January through April 2016, the Pharmacy provided healthy, nutritious food to almost 5,000 individuals representing almost 2,000 households.

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Addressing the Social Determinants of Health: Kaiser Permanente, Calif.

Kaiser Permanente is working to address the social determinants of health for a targeted, high-cost portion of its members. To do so, Kaiser partnered with a social needs screening and referral vendor and aims to address all patients' basic resource needs as a standard part of quality care. One of the initiatives they are testing is a call center that proactively reaches out to members identified as being at the highest risk of becoming "super-utilizers" (i.e., in the top 1 percent of predicted utilization according to their illness burden).

Under this initiative, trained staff ask these members if they would like to participate in a phone-screening session about social needs. If the member agrees, they are asked a set of questions related to food insecurity, homelessness, transportation availability and financial difficulties. Members that screen positive are offered the opportunity to enroll in Kaiser's social needs program, which connects them with existing resources in the community, such as food banks and tenants' rights associations, or at Kaiser itself, such as medical financial assistance. In addition, Kaiser calls enrolled members every 10 to 14 days to further assist them until they connect with resources and to assess how well their needs are being met.

Currently, Kaiser has one call center serving three of its Southern California medical centers. Two of these locations are more urban in nature and one is rural; initial data have revealed important differences between the sites. Kaiser has determined that it is important for the call center employees to have knowledge of the communities in which the members live so the members feel that they have a greater connection to the community. In order to facilitate this, these call center employees have toured the areas where the targeted members live and met with community leaders.

Kaiser has found that 78 percent of screened members have at least one unmet social need, and the average screened member has 3.5. In addition, of the members with unmet needs, 74 percent agree to enroll in the social needs program. Kaiser is in the process of analyzing the success of referrals to outside agencies to identify top resources; better understand the resource gaps within a defined geography; develop a community-alignment strategy; and, ultimately, increase the number of successful resource connections.

"We believe that adopting a 'whole patient' perspective for our high-cost, high-need patients will give us the best chance of improving their health outcomes. To achieve this goal, we aim to partner with existing community resources, identify gaps in linking with those resources, and (in the process) demonstrate the value of addressing the social determinants of health."

Dr. Nirav Shah, Senior Vice President and Chief Operating Officer for Clinical Operations, Kaiser

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Global Budgets: Maryland All-Payer Global Budget Revenue Program

In January 2014, the state of Maryland established a Global Budget Revenue Program (GBR) as its primary approach to moving Maryland hospitals away from the volume-driven, fee-for-service system and toward the value-driven approach of the new Maryland waiver. This model builds on Maryland's experience with its "Total Patient Revenue" system that established fixed global budgets for certain rural hospitals on the basis of historical trends in the cost of providing care for the specific populations they serve.

Under the GBR, Maryland hospitals receive a pre-established budget for all inpatient and outpatient services provided to all Maryland resident patients, regardless of payer, within a calendar year. Each hospital operating under the global payment budget receives annual adjustments for inflation, changes in payer mix, population/demographics and the impact of quality-based payment programs. There are no explicit adjustments for changes in patient volume or case mix/severity.

There are several commitments and benchmarks for financial success in Maryland's demonstration project. First, state-wide all-payer cost growth for included services is limited to 3.58 percent per capita per year. In addition, the cost growth per Maryland Medicare beneficiary for all Medicare services must be below the national Medicare per beneficiary average over five years, and may not exceed the national average by more than one percentage point in any given year. Finally, as part of the demonstration, the state also committed to create hospital savings of at least $330 million for Medicare over five years.

Maryland's hospitals also must meet enhanced quality benchmarks. Specifically, in aggregate, they must reduce their 30-day Medicare readmission rate to the national average within five years, after having the third-highest statewide average prior to the project's start, and reduce their potentially preventable complication rate by 30 percent over the five-year period.

Early results have been positive. Operating margins have increased from 3 to 5 percent for rural hospitals. In addition, the occurrence of hospital-acquired conditions declined by 25 percent in the first year of statewide participation in the demonstration.

However, there are characteristics that have contributed to the demonstration's success that may not be present in every state. For example, all payers participate in the global payment in Maryland, including commercial providers. This allows hospitals to focus their efforts on success under the global payment, rather than attempting to simultaneously operate under fee-for-service and global budget payment models. Another important factor is that average spending per beneficiary in Maryland has historically been higher than in most other states. Further, Medicare and Medicaid both pay an average of 94 percent of charges in Maryland, which is higher than what is observed on average nationally.

Despite a largely positive experience under the demonstration so far, Maryland's hospitals face potential challenges to continued success. A key metric of the project's success is the growth rate of total,

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all provider (Parts A and B) Medicare spending per beneficiary; however, non-hospital providers are not included in the regulatory model even though they can significantly contribute to increased utilization and beneficiary spending through no fault of the hospitals. Additionally, Maryland's hospitals are responsible for meeting the demonstration's goals, regardless of factors that may shift the comparison to national benchmarks that they need to achieve. For example, Maryland's hospitals must reduce their readmissions rate to the national average or below; however, hospitals nationally also are incentivized to reduce their readmission rates through the Hospital Readmissions Reduction Program. Hospitals in Maryland also are concerned about the lack of a payment mechanism to account for needed capital reinvestment in hospital facilities.

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Global Budgets: Pennsylvania Rural Health Transformation

Pennsylvania's rural hospitals face significant financial challenges, as payment pressures and volume fluctuations have negatively impacted their finances. Between 2013 and 2015, the median operating margin of rural hospitals declined from 2 percent to zero percent, and 20 percent of rural hospitals have reported negative operating margins for each of the last three years.

To help address this trend, Pennsylvania is considering a move to global budgets for rural hospitals, which would align payment incentives across payers and lessen incentives to focus on inpatient care. The Pennsylvania Department of Health has proposed that six hospitals fully participate in 2017, with an increase to 30 hospitals by 2019. To meet this timeline, the initial six hospitals will declare their interest in participating and develop their care transformation plans and budgets prior to the end of 2016.

Similar to the Maryland model, Pennsylvania hopes to engage all payers in global payment through a gainsharing model. In years one and two, hospitals would retain all savings created by the program, while in year three they may gain up to 75 percent of savings created. Thereafter, hospitals and payers would equally split shared programmatic savings created through global budgets.

It is anticipated that some of the proposed savings are to be created through reduced ED visits, hospital admissions and readmissions. Additional value, however, could to be created through more efficient management of administrative services, including supply chain, improved productivity, service redesign and utilization of care management services.

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Inpatient Outpatient Transformation Strategy: Carolinas HealthCare System Anson, N.C.

Carolinas HealthCare System Anson recently transformed the services it offered, with the goal of improving health status in Anson County, which is challenged, both in terms of economics and health. For example, this community had a median household income of $33,870, far lower than the median household income of $51,939 nationwide.[44] This community also had an overall health ranking of 84 out of 100 counties in North Carolina. The hospital struggled, both financially and in its ability to improve the long-term health status of its community.

Carolinas HealthCare System (Carolinas) recognized that it would have to transform its model of delivering care in order for this hospital to remain viable. Carolinas was committed to creating a future state that included:

- Enhancing patient and community outcomes through personal and virtual connectivity of Carolinas' network of specialized services;
- Providing and supporting a team of health care professionals for primary and preventive care;
- Enhancing the availability of specialist physicians;
- Providing improved access to appropriate services through telemedicine and other services; and
- Developing a flexible, cost-effective new facility for the evolving care needed to serve the community.

The result of this work was a new facility that replaced the existing hospital, included a reduced inpatient capacity from 52 beds to 15 and allowed the hospital to offer enhanced outpatient and primary care services to the community. These services include a patient-centered medical home, increased ED capacity and increased behavioral health services. The hospital developed new patient flow and care coordination models that focus not only on improving outcomes, prioritizing primary care, wellness and prevention, but also on improving patient flow and screening so that each patient is treated in the most appropriate setting.

As part of this transformation, Carolinas proactively fostered relationships with community organizations focused on improving the health status of Anson County residents. It worked closely with the local county government (including the Anson County Manager and the Anson Board of Commissioners) and the Anson County School Board of Education throughout this process. The relationship with the Board of Education allowed the hospital to proactively plan initiatives important to education and health of the approximately 2,000 students in the school system, including an active partnership that prepares the next generation workforce through Carolinas' Youth Career Connect Partnership.

As Carolinas moves forward with this new model, it will continue to work with community health partners, including health departments, churches and schools, to coordinate care and increase the focus on health and wellness in the community. Largely as a result of this hands-on, active partnership with the community, early results of the transformation are positive. For example, ED visits have decreased and primary care volumes have increased. In addition, Carolinas has transitioned 2,631 patients into the new primary care/medical home model in the first year – which is significant given that the total population of the hospital's service area is only 25,765.

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Urgent Care Center: Doctors Medical Center, California

Doctors Medical Center (DMC) in San Pablo, CA had been struggling financially for many years, despite having received funds from two parcel taxes, neighboring community hospitals and the state. And, even though it was on the brink of closure for almost a decade, the consensus from the community was that everything should be done to stop a closure. By 2014, however, it was clear that this was no longer possible. At that point, DMC faced significant financial challenges. It had a high cost structure, but a poor payer mix that was dominated by Medicaid, Medicare and uninsured patients. In addition, its ED was being used primarily as a substitute for primary or urgent care – the hospital had approximately 40,000 ED visits each year, with only 11 percent requiring inpatient admission. And, DMC faced issues related to seismic compliance – an issue that is unique to California but would have required the hospital to expend $100 million to rebuild to be compliant with earthquake standards.

As a result, the Hospital Council and Contra Costa Health Services came together to form a Regional Planning Group (RPG) charged with developing and evaluating innovative strategies for providing sustainable health care services in the West Contra Costa County area. In addition to its lead organizations, the RPG included representatives from Doctors Medical Center, the West Contra Costa Health Care District, the Contra Costa County Board of Supervisors and area hospitals. To support the work of the RPG, member hospitals of the Hospital Council funded a technical advisory group (TAG) made up of experts in the fields of health care law, finance, and reimbursement.

In the short-term, the RPG discussed streamlining hospital services or converting DMC to a satellite ED with no inpatient beds. In the long-term, they discussed additional options of conversion to a basic or extended urgent care as well as a modified satellite ED that would include access to specialty services. The TAG conducted a financial and legal analysis of each model considered to determine which would be feasible. Ultimately, the RPG concluded that an urgent care center was the most financially sustainable option, and the only option supported under current California law. On April 21, 2015 DMC closed its doors. With support from area hospitals, an urgent care center opened the day before at a community health center located across the street.

While the urgent care center has provided an access point for care for those patients with non-life threatening injuries, the community is still adjusting to the impact of DMC's closure. For example, the remaining hospital in West Contra Costa County, Kaiser Richmond, has been overwhelmed with volume (it only has 50 beds and 15 ED stations). Hospitals further outside the service area have also been impacted because, as Kaiser Richmond fills, the overflow continues to go out of the county. This situation is occurring at the same time that hospitals in neighboring cities and counties are experiencing record ED and inpatient volumes, exacerbating ED wait times and patient transfers.

In addition, the community still has some challenges ahead as it works to ensure access to health care is fully addressed. The county is home to Chevron and other oil refineries and the community must work to ensure it is prepared for a mass casualty incident or other disaster. In addition, they must ensure they have the capacity to handle primary care needs.

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Urgent Care Center: Our Lady of the Lake Regional Medical Center, La.

In 2012, Earl K. Long Medical Center (LMC), a state-run safety-net hospital and home to several clinical sites for the Louisiana State University School of Medicine, closed, reducing access to much needed health care services for Baton Rouge's most vulnerable residents. As a result of this closure, Our Lady of the Lake Regional Medical Center (OLOL) developed and implemented numerous strategies to sustain access to high-quality care for this community. They included:

- Taking on local graduate medical education training.
- Addressing the confusion and disruption in patient care stemming from the closure by reaching out to the community, primarily through churches and town hall-style gatherings, to let people know that even though LMC was closing, they could still go to OLOL clinics to receive ambulatory care. OLOL then made process changes and implemented enhanced staffing models at these clinics to decrease wait times for new patient appointments from an average of eight months to less than 30 days.
- Working to ensure that OLOL and other facilities in surrounding communities could absorb that volume. For example, OLOL added 25 beds to address this need, including a mixture of regular emergency beds, fast-track beds for patients with non-emergent conditions, trauma bays and treatment beds for people with minor-to-moderate illness.
- Building a separate pediatric ED.

In addition, recognizing that many of LMC's ED visits were for non-emergency conditions, OLOL immediately opened an urgent care clinic in north Baton Rouge at the time LMC closed. OLOL then opened a second urgent care center in its mid-city clinic when local hospital resources were further stressed by the closure of the ED at Baton Rouge General Medical Center's mid-city facility. Both urgent care centers provide services for non-emergency conditions including ear or eye infection, fever, cuts that may need stitches, possible broken bones or simple fractures, severe sore throat, sprains and strains, and vomiting and diarrhea.

These urgent care facilities had 29,419 visits in their first year; 29,521 visits in their second year; and are on track to have a total of 52,784 in their third year of operation. As a frame of reference, LMC had approximately 30,000 visits in its ED annually. Therefore OLOL's urgent care centers are proving to be a resource and significant access point to health care for this community.

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Virtual Care Strategies: Freeman Health System, Mo.

Freeman Health System is a locally owned, not-for-profit that includes Freeman Hospital West, Freeman Hospital East, Freeman Neosho Hospital and Ozark Center, as well as two urgent care clinics, dozens of physician clinics and a variety of specialty services. In an effort to improve access to health care services, Freeman has partnered with area schools to provide timely health care to students, faculty and staff in an easily accessible venue – the school health clinic program.

Freeman has established four separate programs to date, and while each is uniquely developed to suit the needs of the school, all of these programs allow school health clinics to improve the physical and mental health of students, increase access to health care and decrease the time lost from school to receive health care services through the use of telehealth.

Each program has three components:

- **Telecommunications** – By using digital technologies, Freeman is able to assist in the delivery of medical care, health education and public health services by connecting health care providers in its clinics to school nursing staff. Services that are offered to schools include: audiovisual conferencing between the school nurse and a nurse practitioner to determine whether a student is able to return to class or needs further evaluation or treatment; physical exam by a nurse practitioner, or physician, with diagnosis and treatment of illness and minor injuries; access to behavioral health professionals (on and off site); health and nutrition education, counseling and wellness promotion; and prescription for medications when necessary for treatment of acute illnesses or conditions.

- **Priority scheduling** – For students who need further treatment, the program offers priority scheduling. This allows students to get an appointment with a health care provider at a Freeman clinic immediately, provided the child's parent has given consent.

- **School transport** – In situations where parents have difficulties getting students to an appointment due to work or lack of transportation, some school districts elect to provide transportation from the school to a designated Freeman provider. The school will work with the student's parents to make these transportation arrangements.

Although these programs are relatively new, Freeman has already seen early successes in the Neosho School Disctrict school clinic program. In the first six months, 179 students and faculty utilized the Freeman school clinic program via telecommunication and/or priority access at Freeman Neosho Physician Group. Freeman hopes to expand these programs to include broader access to wellness promotion. In the meantime, however, they are focused on increasing utilization of these programs by educating parents, schools and local employers about these programs and the benefits they offer.

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Virtual Care Strategies: Copper Queen Community Hospital, Ariz.

Copper Queen Community Hospital (CQCH) is located in a geographically remote area of Arizona near the U.S. border with Mexico and has a service area of approximately 2,500 square miles. The 14-bed acute-care critical access hospital (CAH) is the largest non-government employer in the city of Bisbee, serving more than 6,000 Bisbee residents and many of Cochise County's 140,000 residents. The hospital's mission is to maintain and support access to basic primary care throughout southeastern Cochise County and to provide its patients with the highest quality services. One of the biggest challenges for CQCH, however, is providing care for patients who need specialty health care services. CQCH has chosen to meet this need of its community through the creation of a "hospital without walls" concept that makes care for specialty services available through virtual care strategies. These services are provided in collaboration with several tertiary care hospitals in Arizona and bring specialists to patient's bedsides, without having the actual physician on-site. Currently, CQCH offers virtual care services in the areas of trauma, endocrinology, neurology, cardiology, cardio pulmonology, burn and pediatrics.

In one of its newest telemedicine relationships, CQCH has teamed up with Tucson Medical Center to offer endocrinology services. CQCH will have a board-certified endocrinologist available for telemedicine endocrinology appointments. Patients will initially be seen by an on-site physician for a primary care visit, which will then be immediately followed by their telemedicine appointment with the endocrinologist. This relationship will increase access to critical services for the Cochise County community, including diagnosis and treatment of diabetes, thyroid disorders, adrenal and pituitary gland disorders, metabolic disorders, menstrual irregularities, osteoporosis and calcium disorders.

CQCH also offers burn services through a relationship with The Grossman Burn Center at St. Luke's Medical Center in Phoenix – a plastic surgery-based burn center that works to restore patients to as close to a pre-injury status as possible (functionally, emotionally and cosmetically). The tele-burn program allows the Grossman Burn Center's credentialed burn specialists to provide bedside care in CQCH's ED via a large telemedicine monitor. The on-site tele-burn team collaborates to give patients a physical examination using a stethoscope and a fiber optic camera connected to the telemedicine system. When more extensive care is needed, patients are transferred to St. Luke's Medical Center.

"I am a strong advocate of telemedicine services. Through them, we are able to bring specialty care directly to our patients without time consuming and costly transport out of town and away from their family. Our partnerships with other health care organizations are fundamental to bringing this level of expertise to our patients."

Jim Dickson, Chief Executive Officer, Copper Queen Community Hospital

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Virtual Care Strategies: The Medical Alumni Volunteer Expert Network, Calif.

The Medical Alumni Volunteer Expert Network (The MAVEN Project) is a California nonprofit organization created to address the unmet health care needs of underserved and vulnerable populations that seek health care services at safety-net clinics. This project recruits a team of semi-retired, retired and other experienced physicians from around the country to serve the specific needs of vulnerable patient populations that seek care at various types of health centers (e.g., FQHCs, free clinics and community health clinics).

Specialist and primary care volunteer physicians are matched with the physicians, nurse practitioners and physician assistants already working at the health centers. These volunteer physicians provide remote video consultations and evaluations for patients needing specialty care (together with health center providers), as well as teaching, mentoring and providing advice for local health care providers. Telehealth technology is used to link volunteers' laptops and desktops to health center equipment that enables medical data exchange, videoconferencing and message dialogue between volunteers and health center providers. As a result, patients enjoy enhanced access to expert specialists and primary care physicians while remaining in an environment where they feel comfortable and accompanied by a primary care provider they already trust.

Currently, The MAVEN Project has completed its initial three pilot programs – two in vulnerable rural communities (Western Massachusetts and Central Valley California) and one in a vulnerable urban community (Massachusetts). To date, The MAVEN Project's volunteer physicians have provided over 265 medical specialty consultations and conducted educational "lunch and learn" sessions for clinic providers.

The MAVEN Project has successfully overcome many challenges – including technology, credentialing of volunteers, and malpractice insurance for participating volunteers. Informed by the "lessons learned" from its pilots and the evaluation currently being completed by RAND Corporation, The MAVEN Project is focused on expanding and scaling within California and Massachusetts, in Florida and beyond. This involves additional volunteer recruitment, new sites and a focus on financial sustainability.

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05-02-2017 00096

Virtual Care Strategies: The North Carolina Telepsychiatry Network

In 2013, North Carolina faced a significant shortage of psychiatrists, which limited access to psychiatry services. Specifically, 28 counties did not have a psychiatrist and 18 counties had only one. In addition, only five counties had addiction psychiatrists and only 13 had physicians that specialize in addiction and chemical dependency.[45]

In an effort to improve access to psychiatry services, the North Carolina General Assembly established the North Carolina Statewide Telepsychiatry Program (NC-STeP), which was launched in January 2014 and appropriated $4 million to the program for fiscal years 2013-2015.

NC-STeP is administered by East Carolina University's Center for Telepsychiatry and e-Behavioral Health. By January 2015, 57 hospitals were participating in the network and NC-STeP was operating five clinical provider hubs. The program provides patients with face-to-face interaction with providers through real-time videoconferencing technology. Video conferencing is facilitated using mobile carts and desktop units. A web portal also has been designed and implemented that combines scheduling, EHRs, health information exchange functions and data management systems.[46]

NC-STeP was modeled after South Carolina's use of telepsychiatry, which has increased access to care for rural communities. A March 2014 study of that program by the North Carolina Center for Public Policy Research found that the use of telepsychiatry so far in South Carolina shows that patients spend less time waiting in hospital EDs and have a lower likelihood of returning for treatment. The study also found fewer involuntary commitments to state psychiatric hospitals and higher satisfaction for telepsychiatry patients. More specifically:

- The length of stay for patients in EDs waiting to be discharged to inpatient treatment declined from 48 hours to 22.5 hours.
- The percentage of patients who had to return for treatment within 30 days at one hospital declined from 20 percent to 8 percent.
- The number of involuntary commitments to local hospitals or state psychiatric hospitals decreased by 33 percent.
- Eighty-eight percent of patients agreed or strongly agreed that they were satisfied with the telepsychiatry services they received.

NC-STeP hopes to have similar results, as it rolls out this program and improves access to psychiatry services across the state. As of July 2016, NC-STeP has enabled over 21,000 patient encounters. EDs have seen short lengths of stay, fewer involuntary commitments and less recidivism. In addition, the program has generated measurable cost savings. According to Sy Saeed, M.D., the director of NC-STeP, the state has already generated $5 million to $6 million in cost savings simply by preventing unnecessary hospitalization with this program.[47]

05-02-2017 00097

Fully Integrated CAH-FQHC: Springfield Medical Care Systems Inc., Vt.

Today, Springfield Medical Care Systems (SMCS) Inc., is an FQHC that operates a fully integrated critical access hospital. SMCS serves nearly 25,000 individuals in 14 towns throughout Windsor and Windham Counties in Vermont, and Sullivan and Cheshire Counties in New Hampshire. SMCS currently operates 10 health center locations and Springfield Hospital (SH).

However, in 2009, SMCS was only the corporate entity that owned SH. At that time, SH was evaluating ways to improve access to primary care. In an effort to improve the delivery of primary care services, SH had employed all of the primary care practices in their service area – this situation was not financially sustainable. At the same time, with primary services incorporated under the SH umbrella, it was hard for management to operate an effective and efficient primary care strategy for the community. SH also was looking for ways to improve access to behavioral health services and affordable prescription drugs for its patients.

SH determined the best way to improve access to these services was to develop an FQHC that could focus directly on these services. In order to do this, SH and Springfield Medical Care Systems Inc., the parent-holding company for SH, underwent significant corporate and governance restructuring to satisfy the regulations governing FQHCs. This ultimately resulted in the following:

- SMCS is now the operating company for the FQHC and SH is a wholly owned subsidiary of SMCS and the FQHC.
- Specialty provider services remain as part of the SH operating structure.
- All primary care sites and outpatient behavioral health services were transferred from SH to SMCS.
- This structure has allowed SMCS to administer all primary care and acute care activities using a single executive team that is employed by the FQHC, avoiding duplication of costs and promoting a system-like feel.
- The FQHC and SH have separate boards with up to four members that overlap on both boards.
- The FQHC board has overall governing authority and retains certain reserved authorities over the SH board.
- A Community Advisory Board provides input to the FQHC board and increases the level of community and individual patient engagement in the ownership of this delivery system.

One of the biggest challenges associated with this transformation was changing the perspective from which SMCS leadership and the community viewed the delivery of health care services. Rather than the hospital-focused viewpoint they had in the past, it became important for the organization to examine ways in which the hospital could support the FQHC.

As a result of this relationship, SMCS has increased the number of residents in its medical home to 25,000 – a 25 percent increase – because the FQHC was better able to monitor these services. They also have created a process to make sure that individuals arriving at the SH ED without a primary care provider are directed to and given an appointment to see a primary care provider within five days of the

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ED visit. They have seen significant success with this new process; approximately 95 percent of these individuals leave with primary care appointments, and 80 percent actually keep these appointments.

In addition, SMCS was able to dramatically increase access to behavioral health services, including integration of licensed independent clinical social workers into each primary care site and comprehensive substance abuse counseling. It also has launched two dental sites. The results on the community have been positive and health outcomes have improved significantly – in fact, according to Robert Wood Johnson Foundation County Health 2014 rankings, Windsor County, Vt., (from where a majority of SH's patients live) moved from ninth to fourth out of 14 in health outcomes.

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Fully Integrated CAH-FQHC: Gifford Medical Center, Vt.

Gifford Medical Center (Gifford) is a fully integrated CAH-FQHC developed in an effort to increase the primary care services offered to the city of Randolph and its surrounding community, and in particular for the uninsured, isolated and medically vulnerable. It also was interest of improving dental care and mental health services for Medicaid patients and the uninsured. The FQHC designation opened the door to federal dollars that could support these efforts.

Gifford underwent corporate and governance restructuring to satisfy the regulations governing FQHCs. And, like in the SMSC example above, now has separate boards for the FQHC and hospital that allows for some overlap of members between the boards. The FQHC board has overall governing authority and retains certain reserved authorities over the hospital board. The FQHC and hospital also share infrastructure, including billing, human resources, finance, information technology, administration, development and quality. This improves efficiency and provides the best use of existing resources.

The FQHC-CAH integrated structure also has allowed Gifford to enhance the services it offers, since the FQHC reimbursement structure better covers the costs of providing behavioral health services. Gifford has added both a psychiatrist and psychologist to its behavioral health team and has embedded two clinical social workers into its primary care practice at its FQHC. This offers patients the convenience of having psychological and substance abuse evaluations conducted at the time of their primary care visit. In addition, Gifford has entered into agreements with area dentists to provide care to Medicaid patients – a service it was not able to offer before creating an FQHC.

"This assistance from the federal government allows us to develop programs for dentistry, psychiatry, and mental health that are hugely important for the community," says Chief Operating Officer Barbara Quealy. "It also allows us to place a bigger focus on primary care. It means we can take better care of our Medicaid patients, offering them services that we couldn't before, and that's huge."

Barbara Quealy, Chief Operating Officer, Gifford Medical Center

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Partially Integrated CAH-FQHC: Coal County Community Health Center & Sakakawea Medical Center, N.D.

Coal County Community Health Center (CCCHC), an FQHC, and Sakakawea Medical Center (SMC) have implemented a successful relationship between an FQHC and a CAH, without full integration. This CAH-FQHC partnership has resulted in a more efficient allocation of resources and services between the organizations and improved patient care.

CCCHC operates three health center locations, including an FQHC located in Beulah. SMC is a 25-bed CAH located in Hazen. In addition to standard acute-care services, SMC provides hospice and home health services, along with senior Basic Care Services. CCCHC's FQHC in Beulah and SMC are located roughly 10 miles apart and serve a population of approximately 15,000 individuals. These facilities had a long history of conflict and competition for this limited market share.

Despite that history, in 2011, when CCCHC was experiencing significant financial challenges and had terminated its relationship with its CEO, it turned to SMC for assistance. At that time, SMC provided interim leadership and assistance with a variety of functions, including revenue cycle, operational issues and employee morale. This interim relationship helped mend the strained relationship between CCCHC and SMC. It also allowed for more efficient utilization of resources, which improved the financial position of both organizations. As a result, the two organizations decided to make this integration permanent.

This model and further collaboration has allowed the organizations to eliminate duplicate services, improve population health, enhance community awareness of local services, maintain adequate human and facility infrastructure, and better monitor and adapt to changes in health care delivery. Today, each organization maintains a separate structure and board governance. However, they share a CEO, other staff and resources, and had cross-representation on the other's governance board. The organizations also adopted a common mission: *"Working together as partners to enhance the lives of area residents by providing a neighborhood of patient-centered healthcare services that promote wellness, prevention, and care coordination."*

CCCHC providers staff the ED and provide care for their patients at SMC. Over the past year, SMC has converted its provider-based rural health clinic (RHC) to an FQHC service delivery site, and CCCHC has worked with another hospital to convert yet another provider-based RHC located in Killdeer to a CCCHC service delivery site. CCCHC and SMC also are working together as participants in a Medicare ACO and commercial insurance value-based contract, embracing population health and care coordination in the primary care, hospital and community settings.

In addition, today, CCCHC and SMC work together to conduct a collaborative CHNA that also involves the local nursing home, ambulance service and public health agency. These health care providers have collectively developed a collaborative strategic plan and health improvement plan and meet periodically to update each other on progress towards the individual organization initiatives. This cooperative planning has resulted in improved patient care and improved health for the community.

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05-02-2017 00101

The Collaboration Model: Cary Medical Center/Pines Health Services, Maine

Cary Medical Center, a small rural acute care hospital located in Caribou, Maine and Pines Health Services, an FQHC, have created a unique model of collaboration that has current and future advantages, including improving the health status of the population served and growing the long-term financial position of both entities.

While each entity remains independent with its own Board of Directors, the two work closely together in partnership. For example, representatives of the hospital board serve on the board of the FQHC; and members of the FQHC board serve on the hospital board. In addition, the leadership of the FQHC participates in the hospital's senior management team and meet weekly with the hospital's leadership group. The two organizations also conduct joint strategic planning every two years. The ability to partner strategically has led to many benefits for the community, including increased access to primary care, development of new services, access to medical specialists that are recruited to the community, and capital improvements that are able to be funded as a result of this partnership.

The overall impact of the partnership has been substantial in improving access to health care services for their communities. The hospital provides a 'Community Grant' to the FQHC that helps support its services. The two organizations also support the employment of non-FQHC specialty physicians (e.g. orthopedics, hematology/oncology, general and urologic surgery, ophthalmology, pathology and hospitalist medicine). The hospital and the FQHC work closely in managing patients who are struggling financially and may be in need of acute care including hospitalization or other hospital-based treatment. In addition, the FQHC has improved access to low income patients through a sliding fee scale – leading to a dramatic increase in the access to health care services for low income individuals.

By working together, both the hospital and the FQHC have made it possible to preserve and expand health care services in Northern Maine. The collaboration of the hospital's in-patient case management and the out-patient case managers of the FQHC enhance the health status of patients, particularly at time of hospital discharge. The FQHC case managers also help to address issues of patients with multiple ED visits, chronic diseases, and other needs related to the social determinants of health. In addition, the FQHC manages a highly effective Prescription Assistance Program for patients without prescription coverage, helping them to comply with their prescribed medication. The program has generated millions of dollars in savings by providing eligible patients with free or reduced cost prescription medication. The FQHC also has integrated behavioral health services in the primary care physician office setting.

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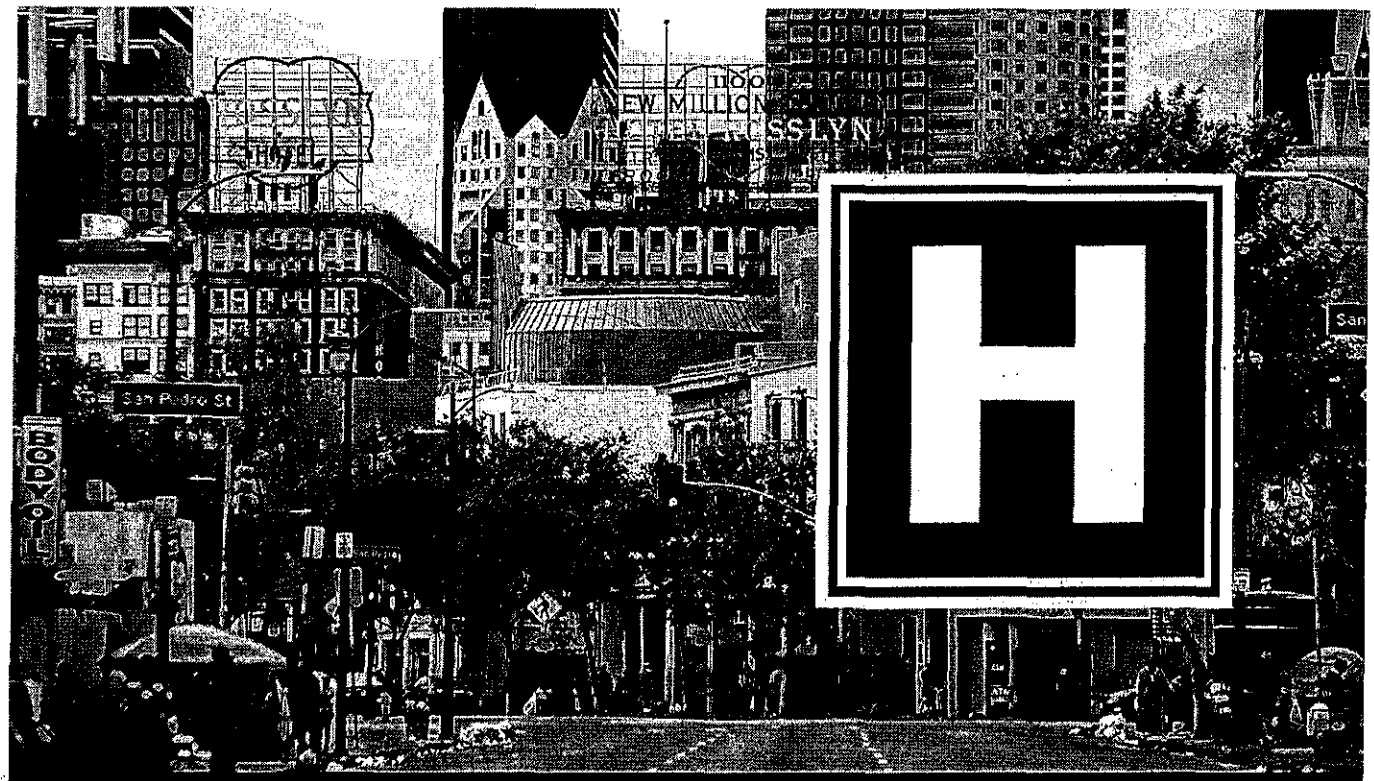


Task Force on Ensuring Access in Vulnerable Communities

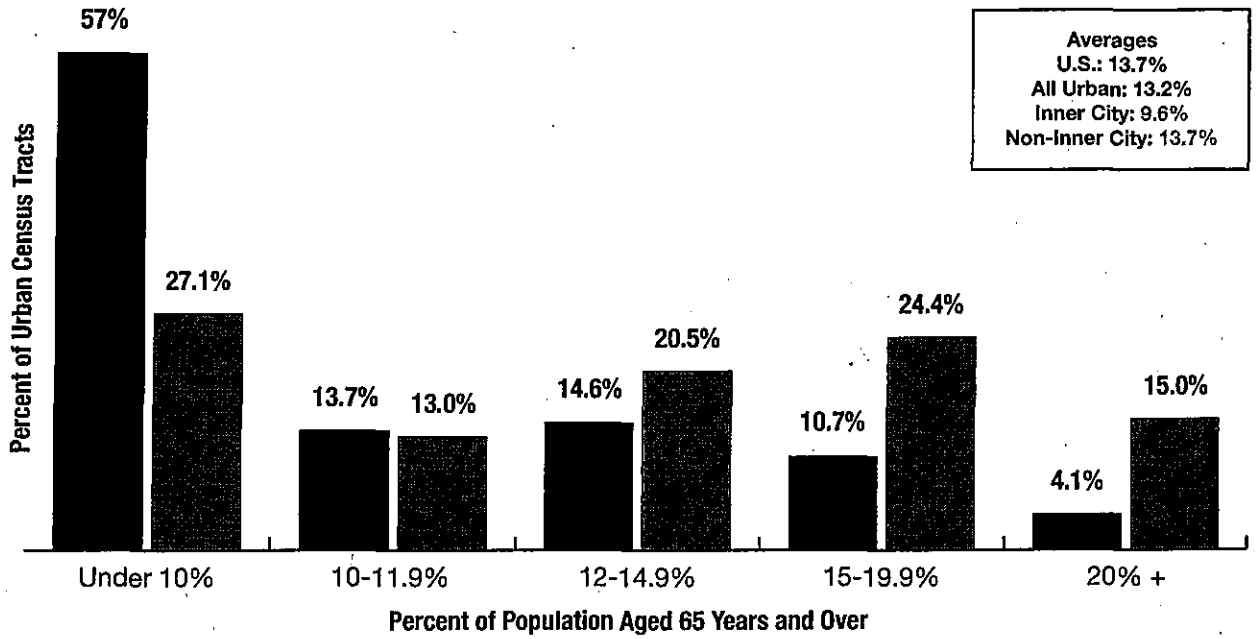
Urban Chartbook

The task force defined a vulnerable community as a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions. They then worked to identify the characteristics and parameters that would identify such vulnerable rural and urban communities. In doing so, they relied upon personal experiences, as well as an analysis of financial data and other information from qualitative sources related to vulnerable rural and urban communities. This document contains metrics related to urban communities and the hospitals that serve them. For the full report, visit *www.aha.org/ensuringaccess*.

November 29, 2016

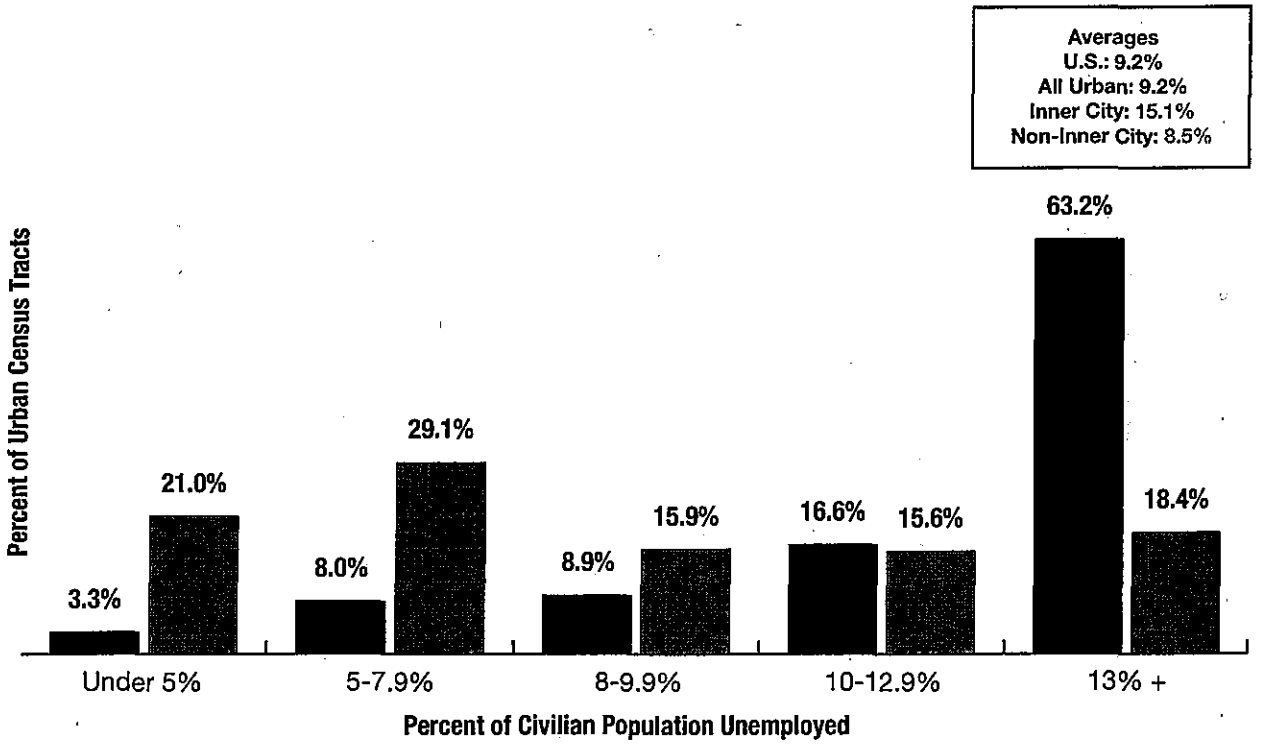
American Hospital Association

Percent of Urban Census Tracts by Population Aged 65 Years and Over



Source: State of the Inner City Economies (SICE) database, Initiative for a Competitive Inner City (ICIC). Notes: Inner cities are defined by ICIC using data from the U.S. Census Bureau's 2011 American Community Survey (ACS) 5-Year Estimate for all U.S. cities with populations greater than 75,000. The data in the chart are from the 2014 ACS 5-Year Estimate.

Percent of Urban Census Tracts by Percent of Unemployment



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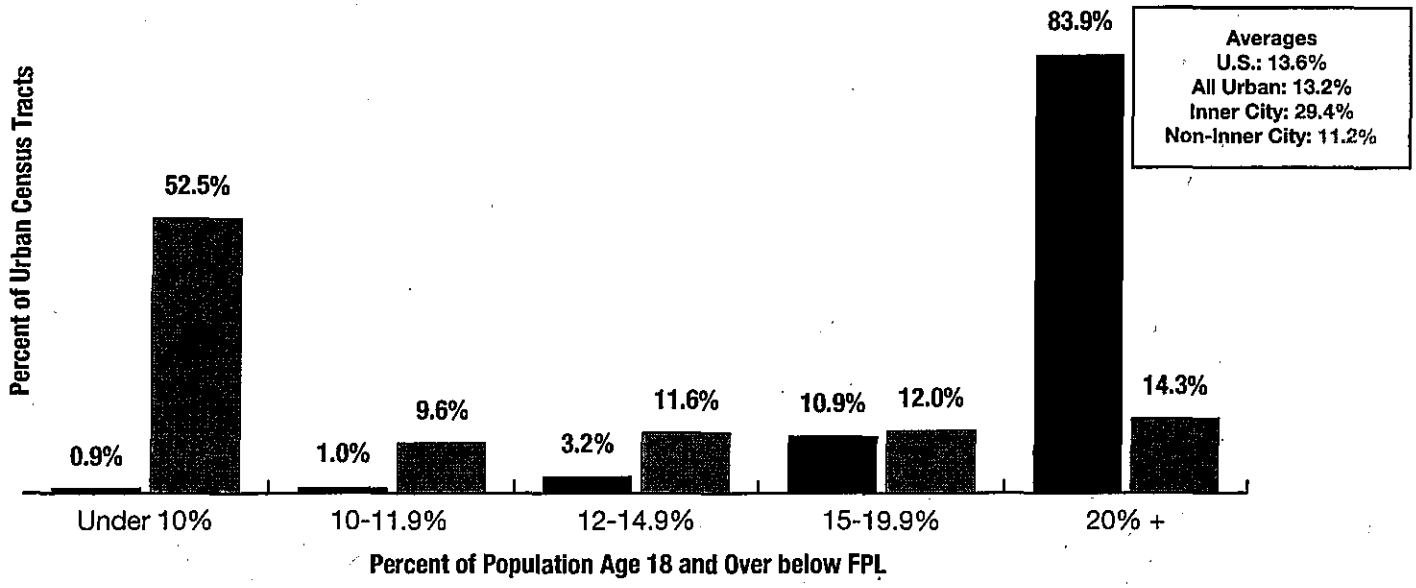
Percent of Urban Census Tracts by Population Age 18 & Over Below Federal Poverty Level



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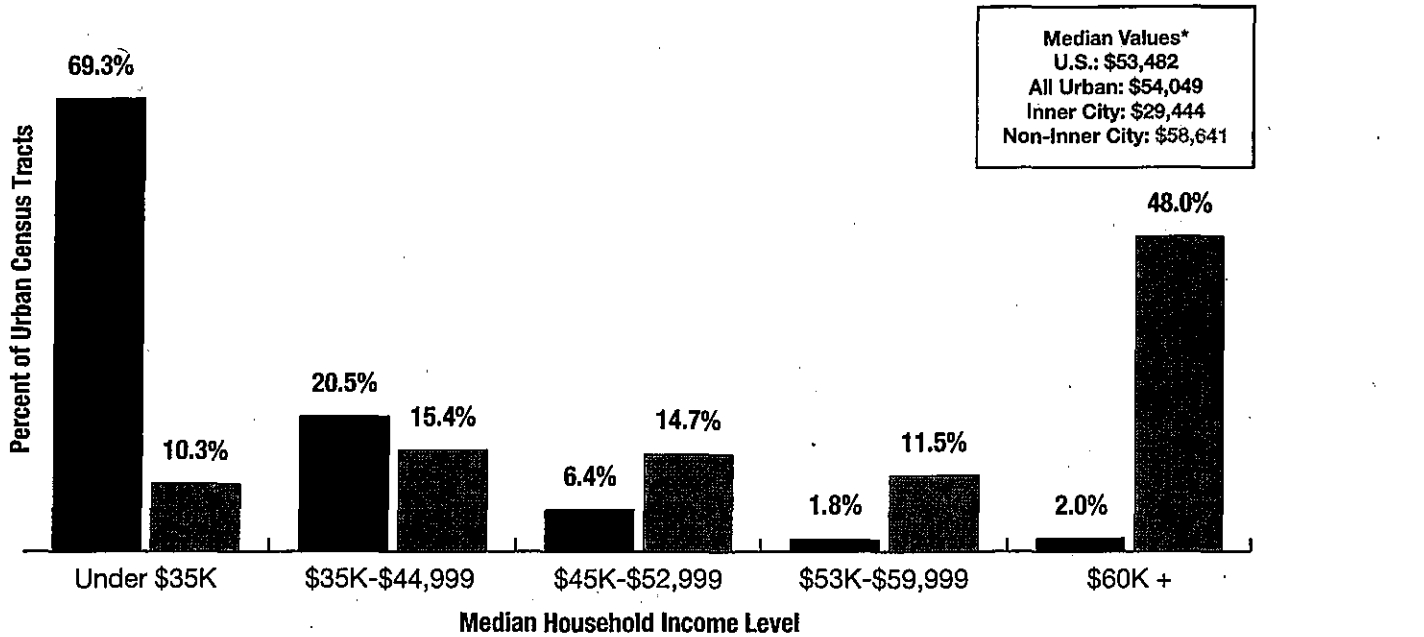
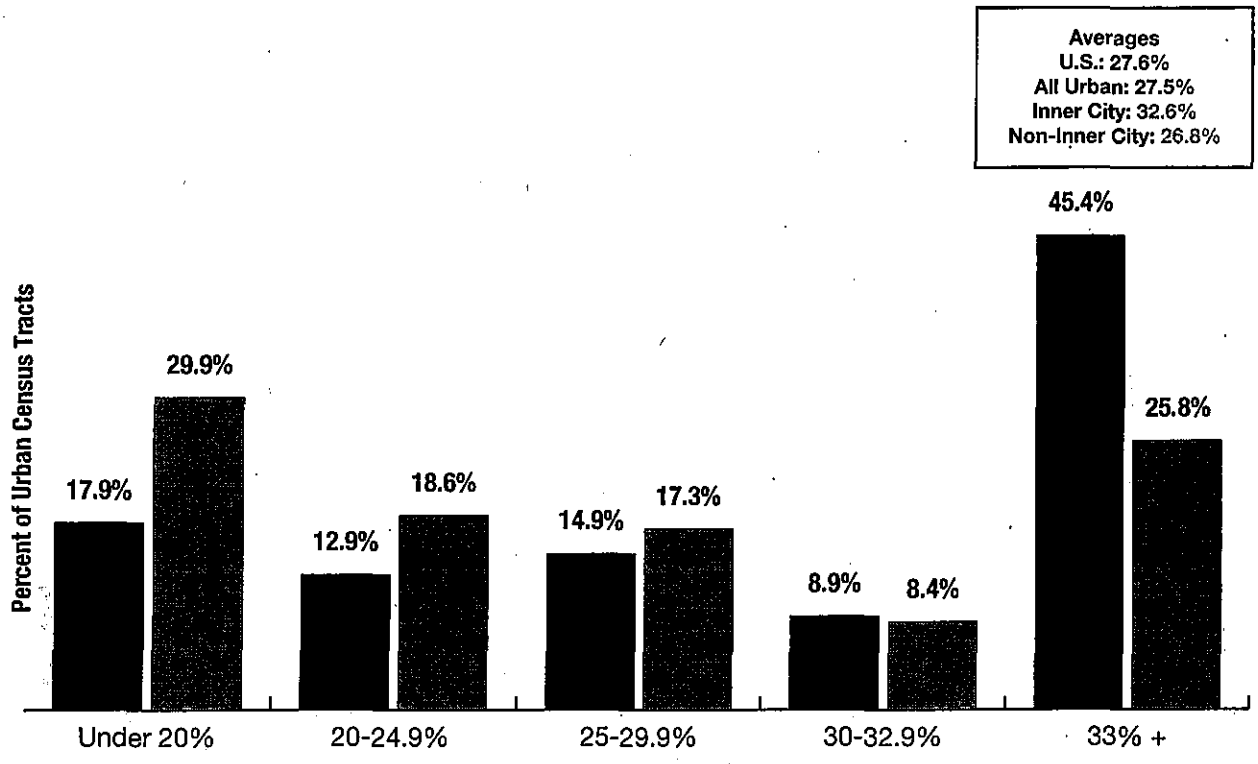
Percent of Urban Census Tracts by Median Household Income Level



Source: State of the Inner City Economies (SICE) database, Initiative for a Competitive Inner City (ICIC). Notes: Inner cities are defined by ICIC using data from the U.S. Census Bureau's 2011 American Community Survey (ACS) 5-Year Estimate for all U.S. cities with populations greater than 75,000. The data in the chart are from the 2014 ACS 5-Year Estimate. * The U.S. median value is taken directly from the 2014 ACS 5-Year Estimate; however, all other median values are the medians of the individual census tract median household incomes for the relevant categories.

Percent of Urban Census Tracts by Households Where the Householder Lives Alone



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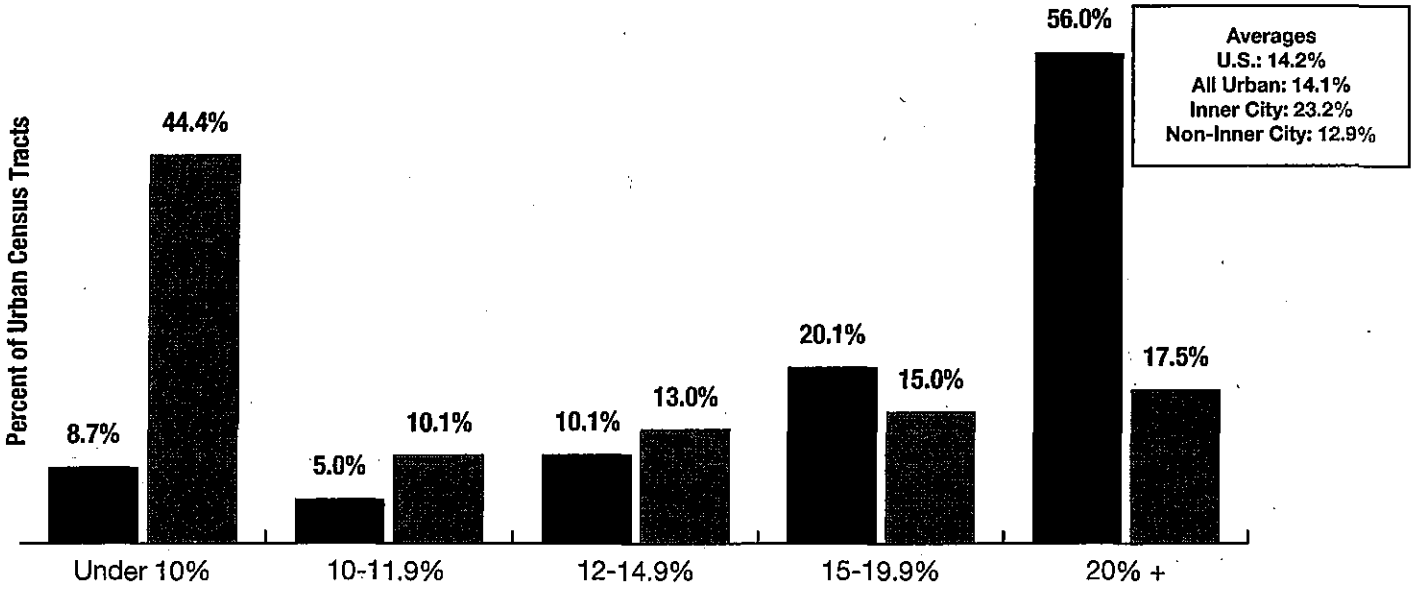
Percent of Urban Census Tracts by Population with No Health Insurance Coverage



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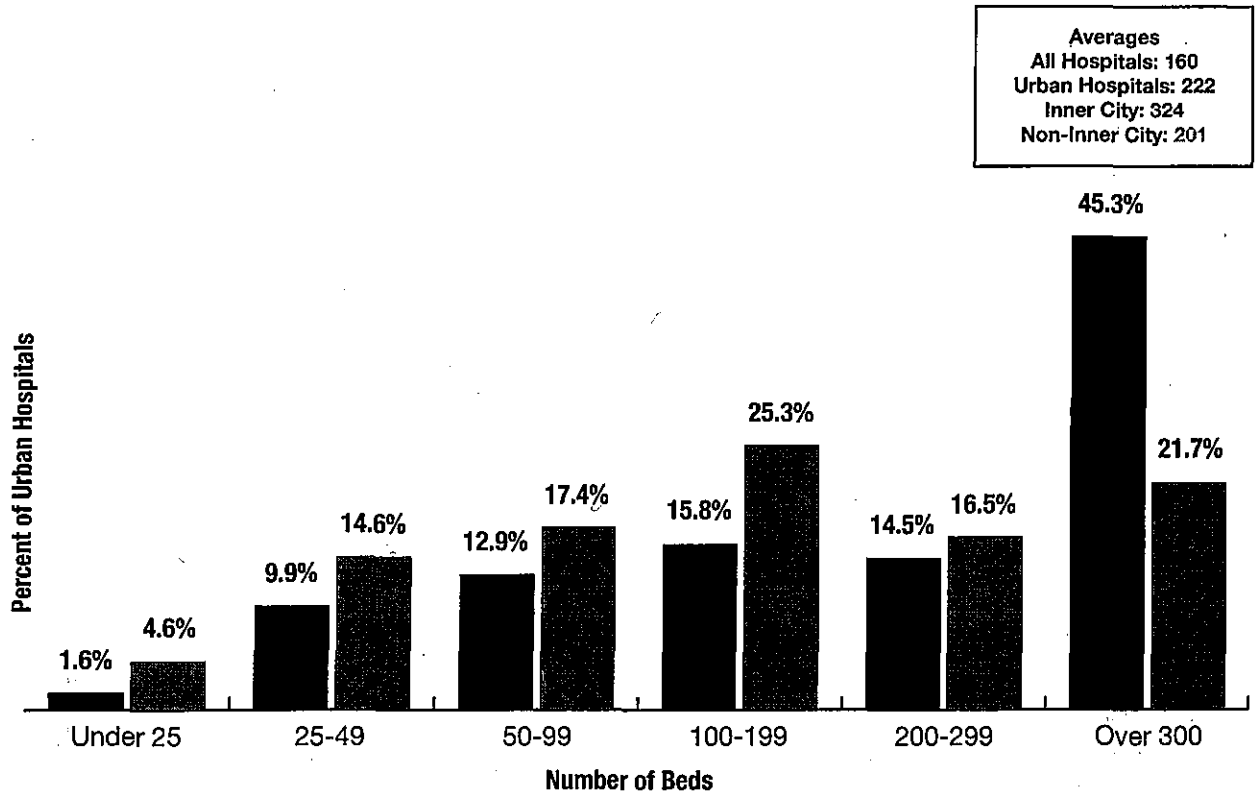
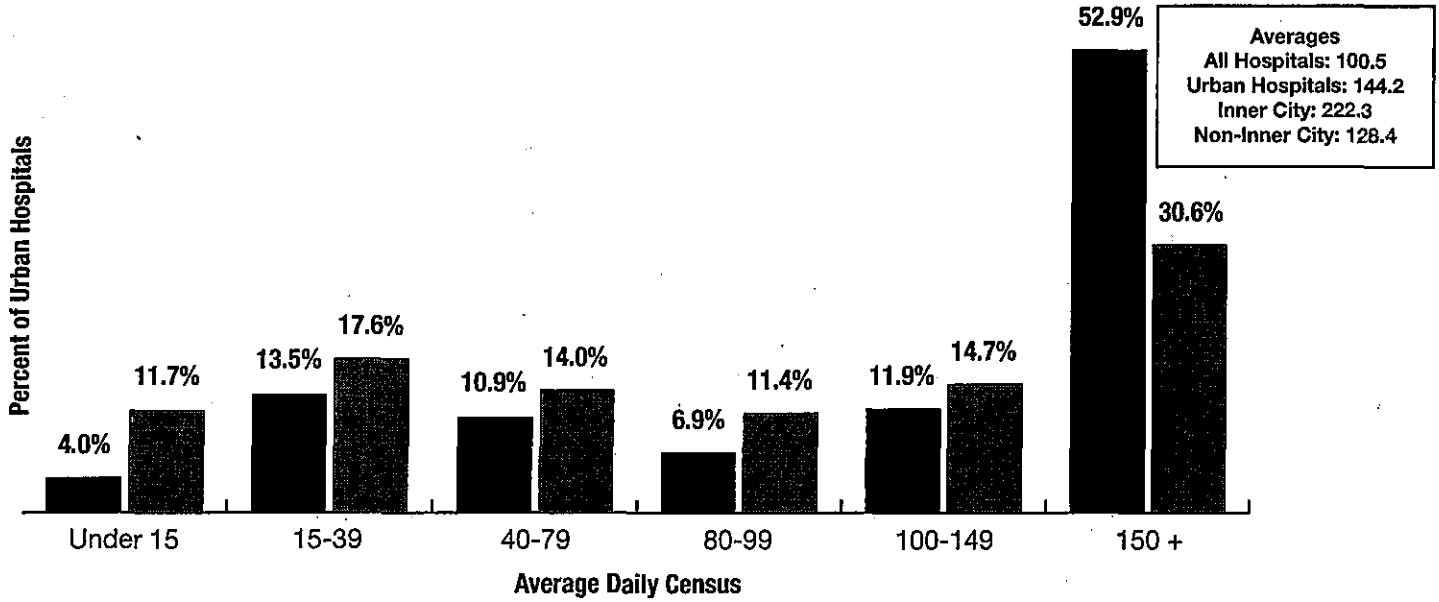
Data on Hospital Size

Percent of Urban Hospitals by Bed Size



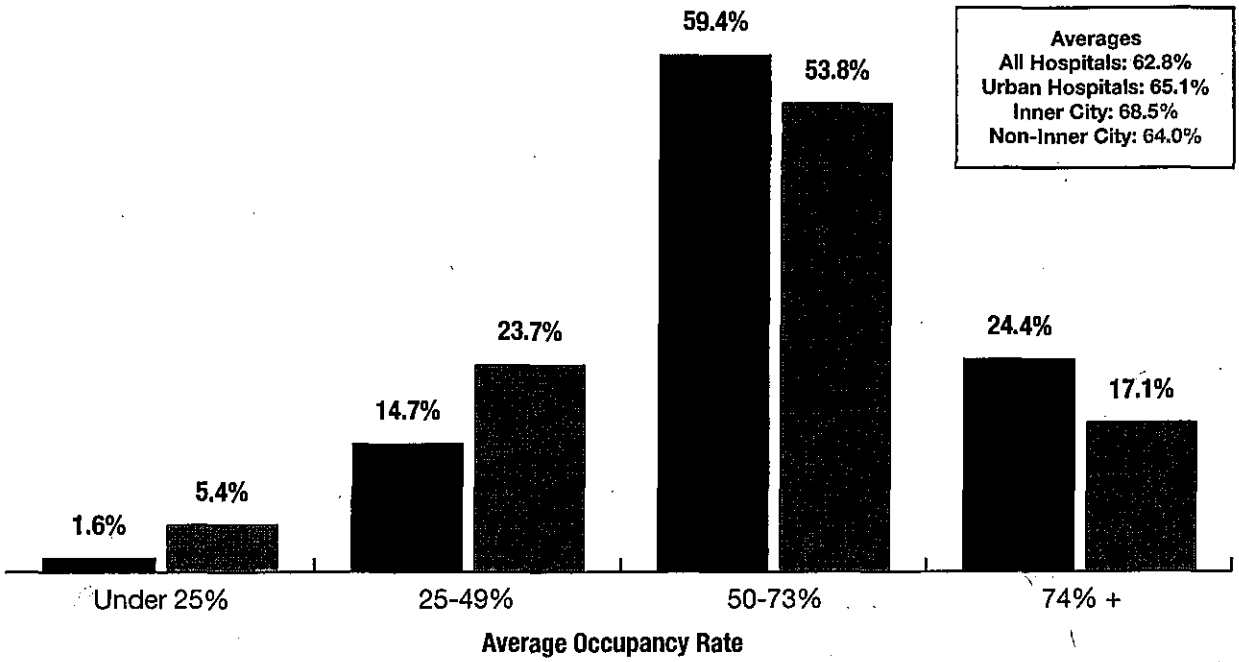
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey Averages

Percent of Urban Hospitals by Average Daily Census



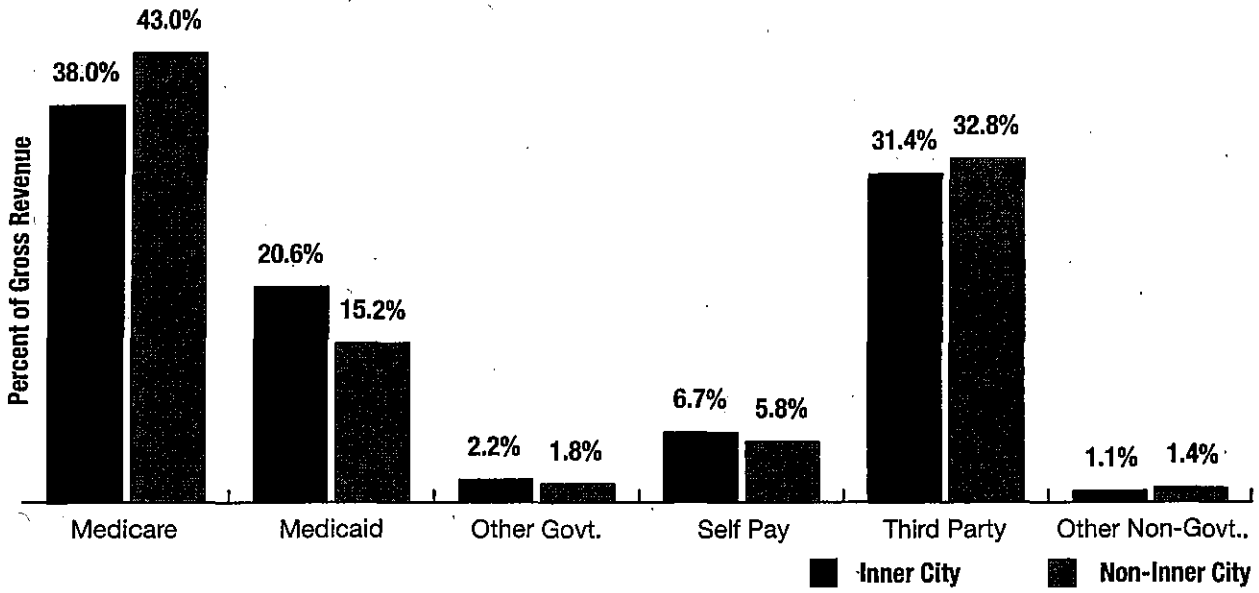
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Average Occupancy Rates



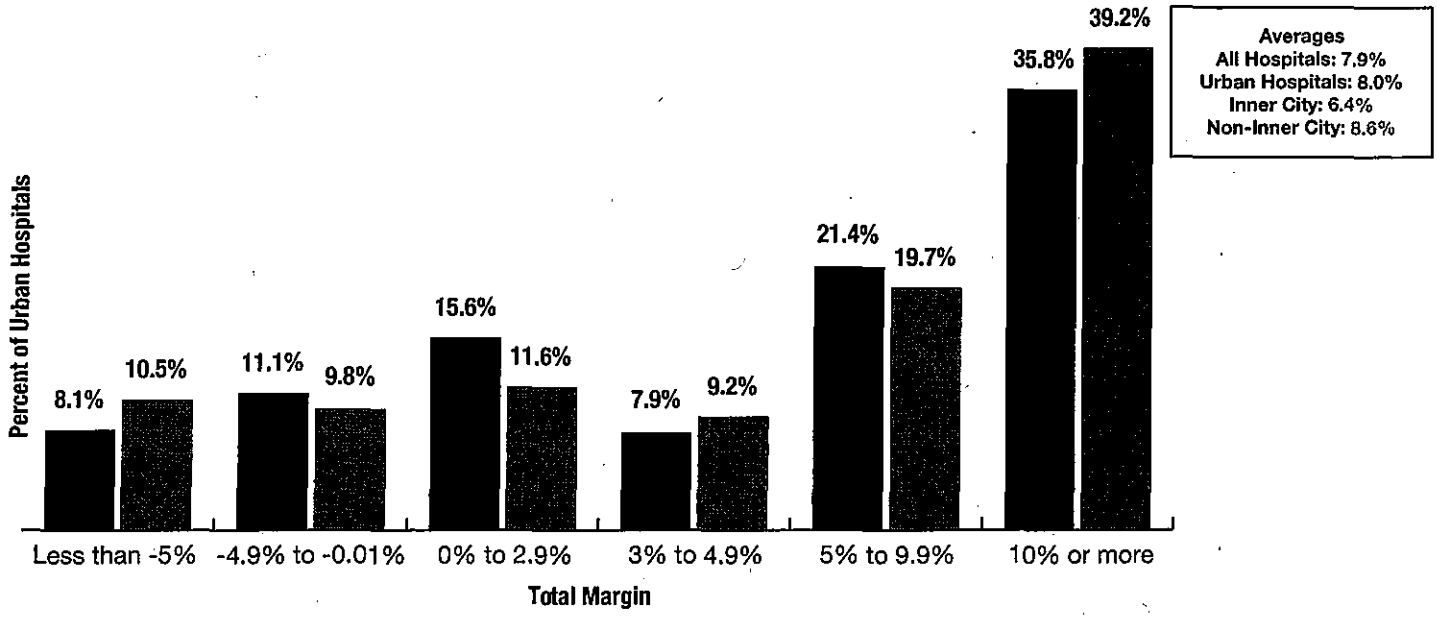
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Gross Revenue by Payer Type for Urban Hospitals



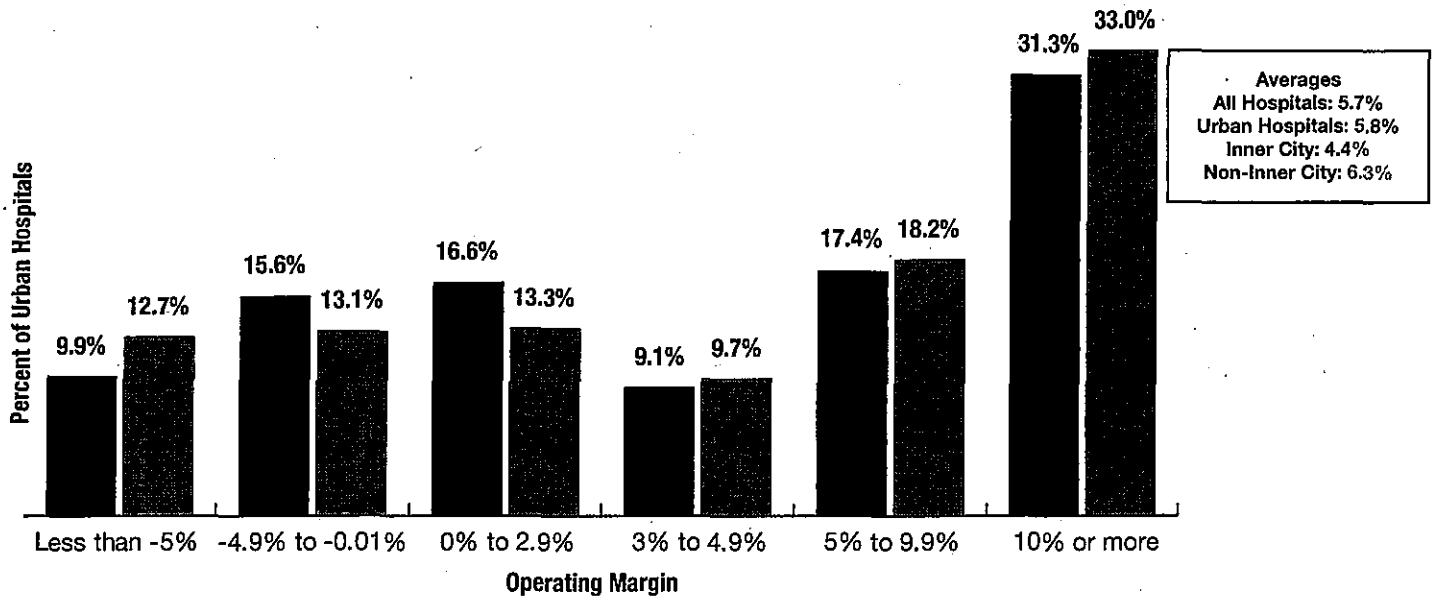
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Total Margin



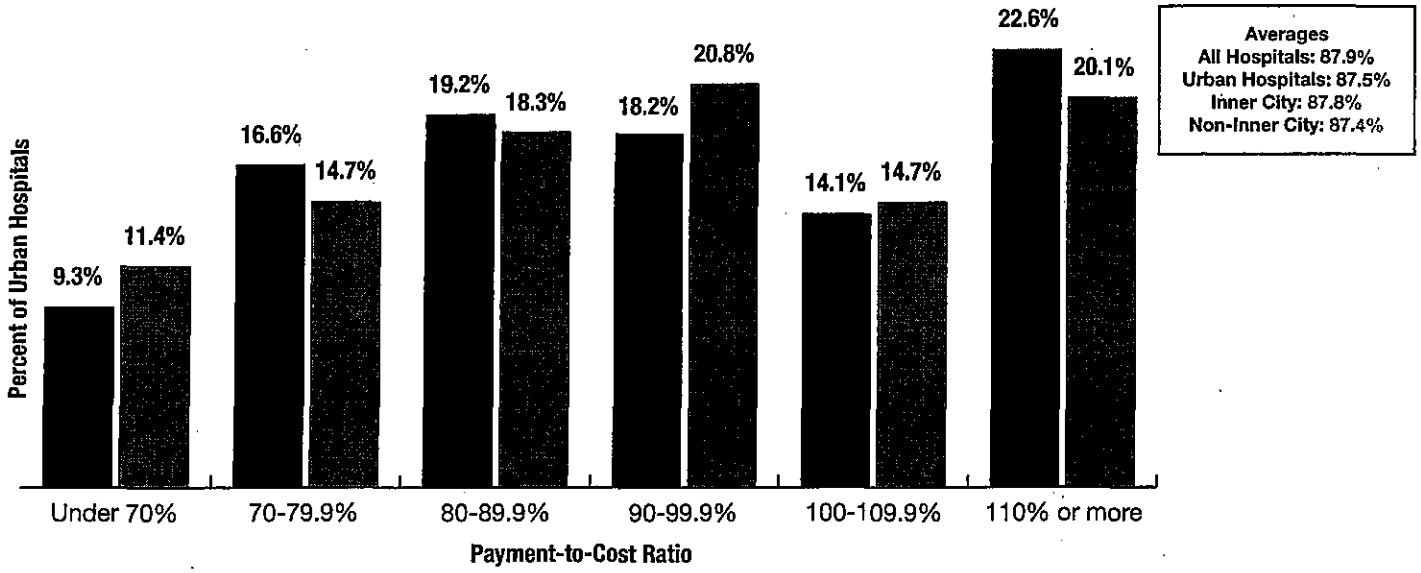
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Operating Margin



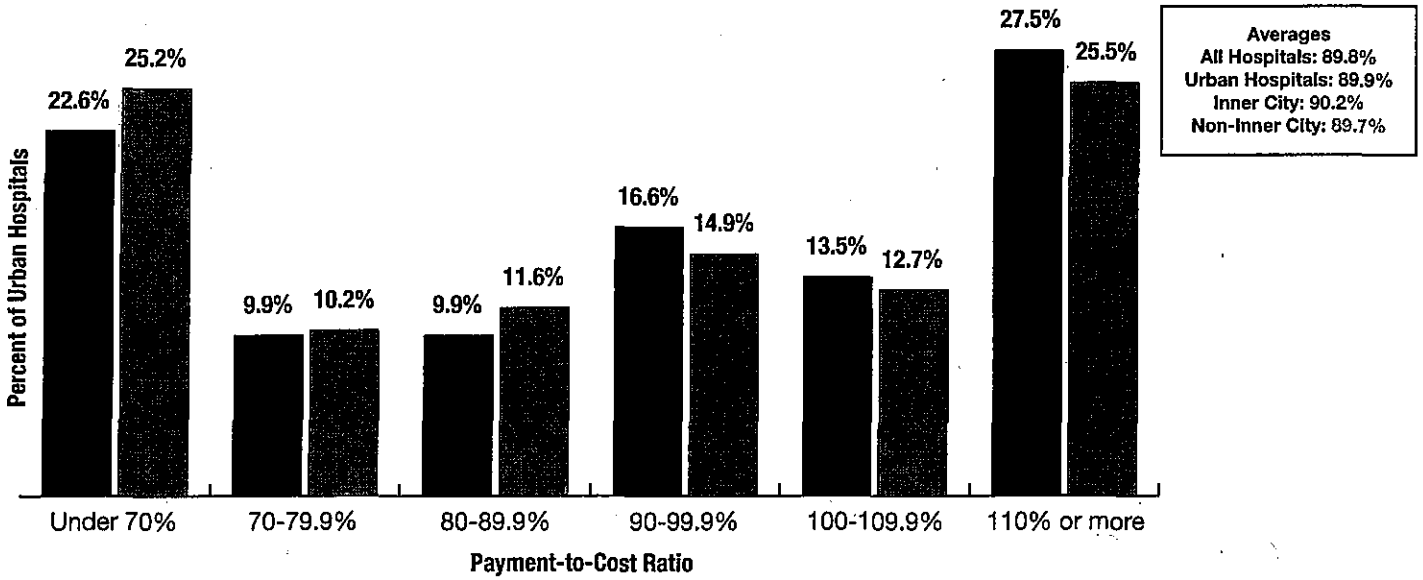
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Medicare Payment-to-Cost Ratio



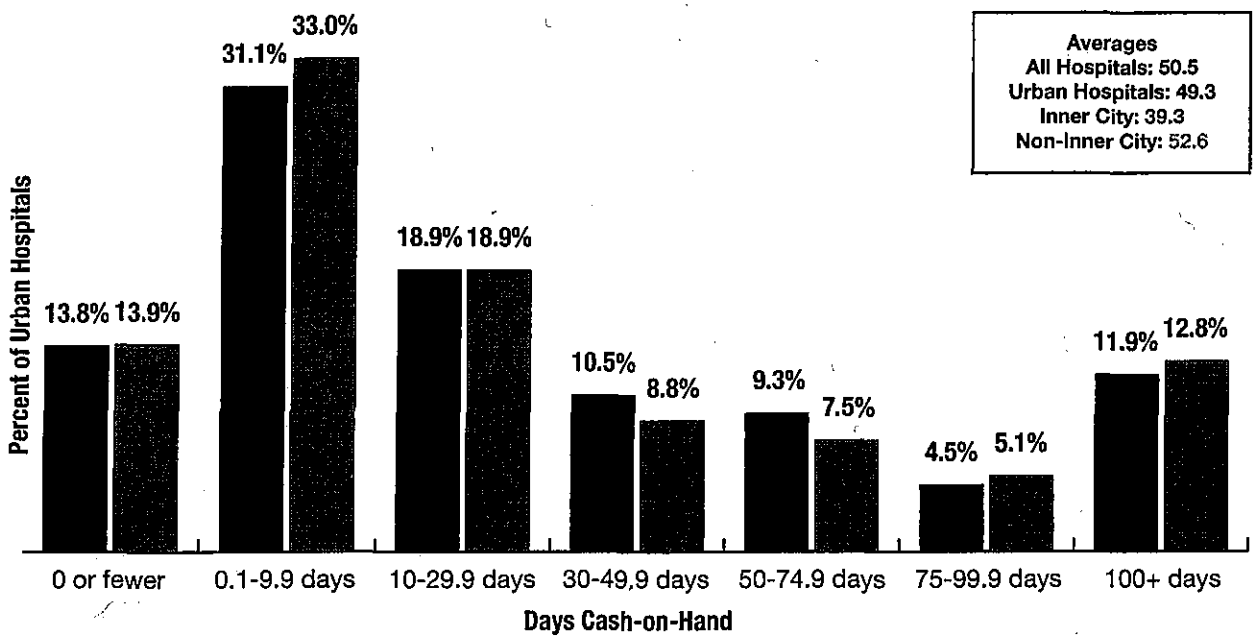
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Medicaid Payment-to-Cost Ratio



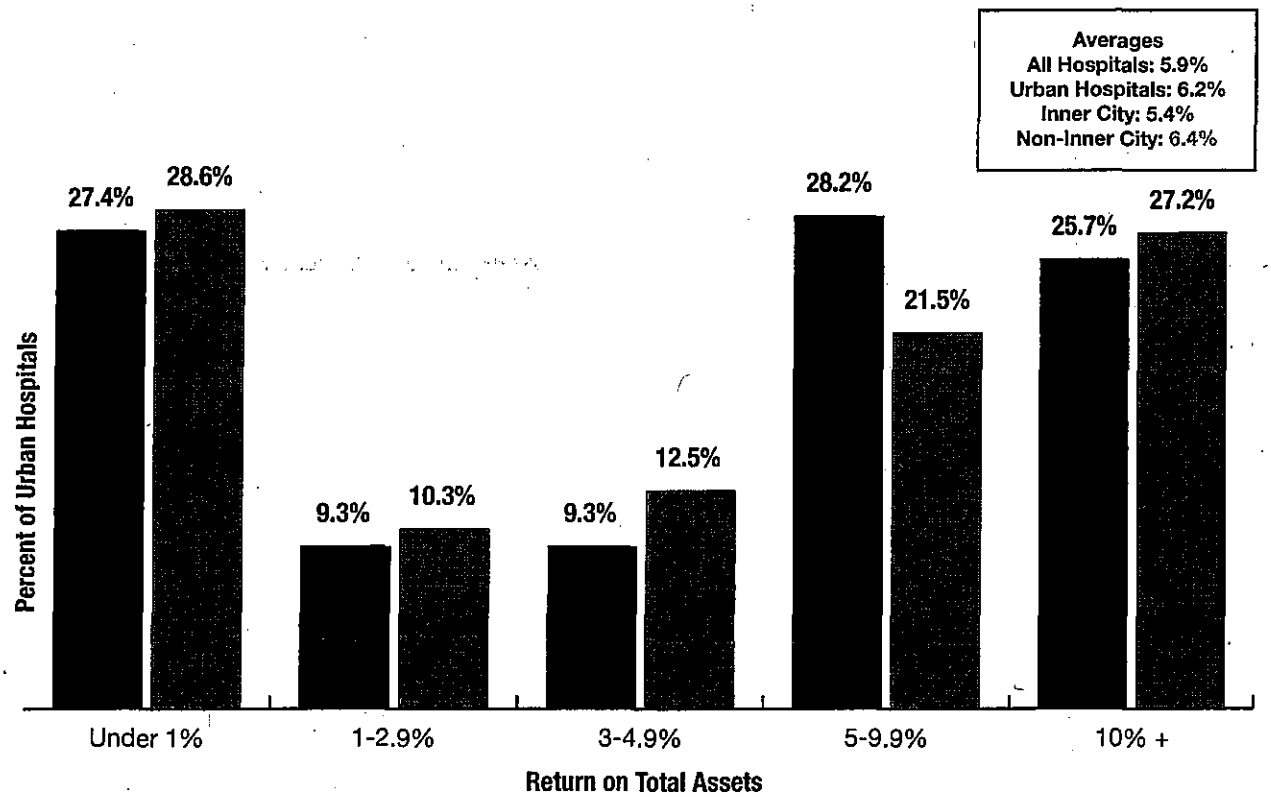
Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Days Cash-on-Hand



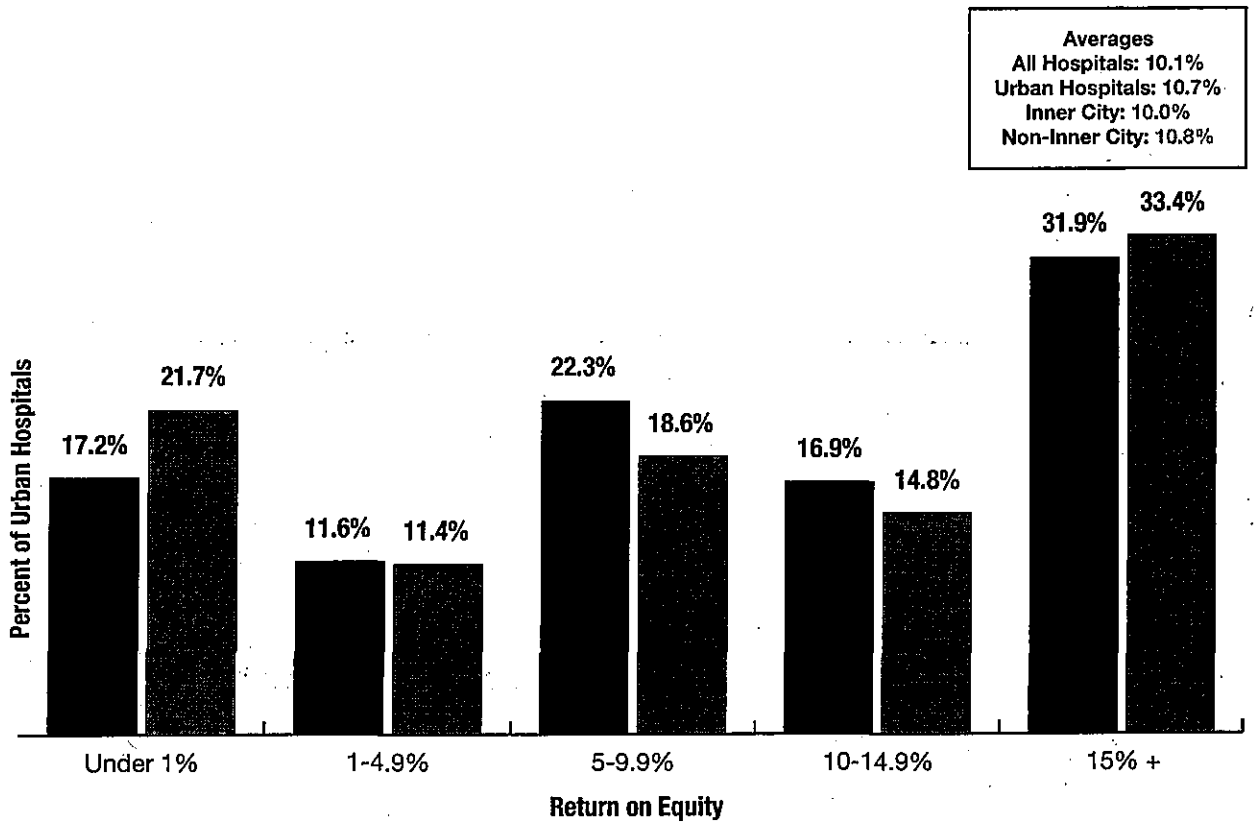
Source: Centers for Medicare and Medicaid Services, FY 2013 Medicare Cost Report Data, 4th Quarter 2015 data release. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Return on Total Assets



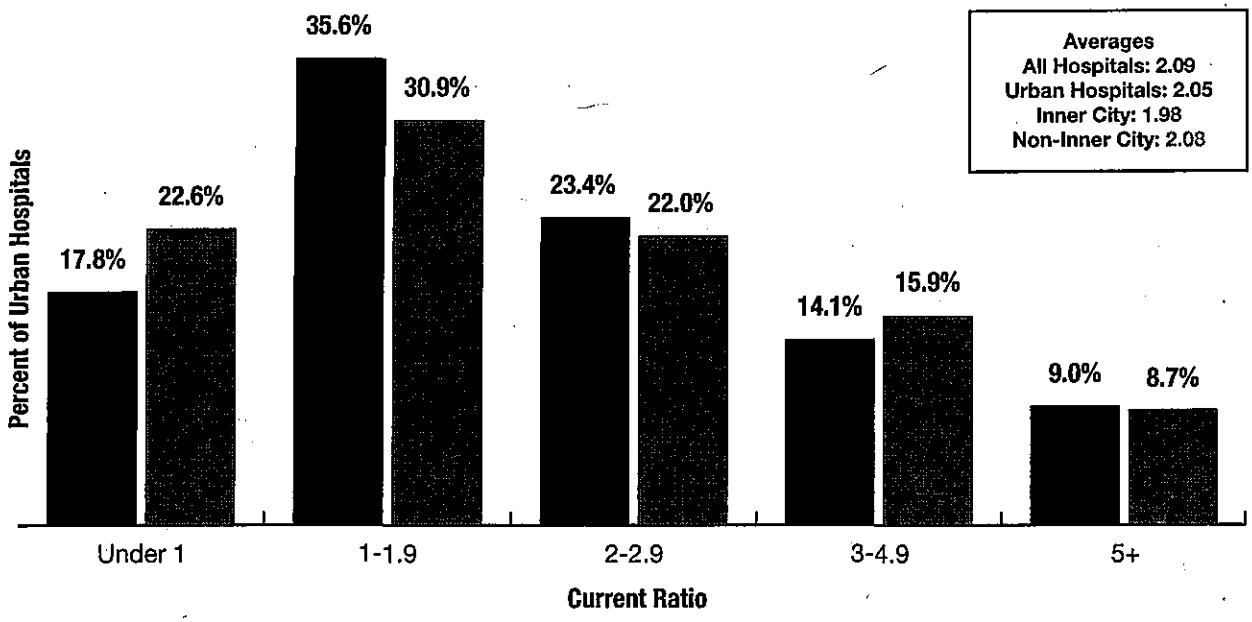
Source: Centers for Medicare and Medicaid Services, FY 2013 Medicare Cost Report Data, 4th Quarter 2015 data release. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Average Return on Equity Ratio



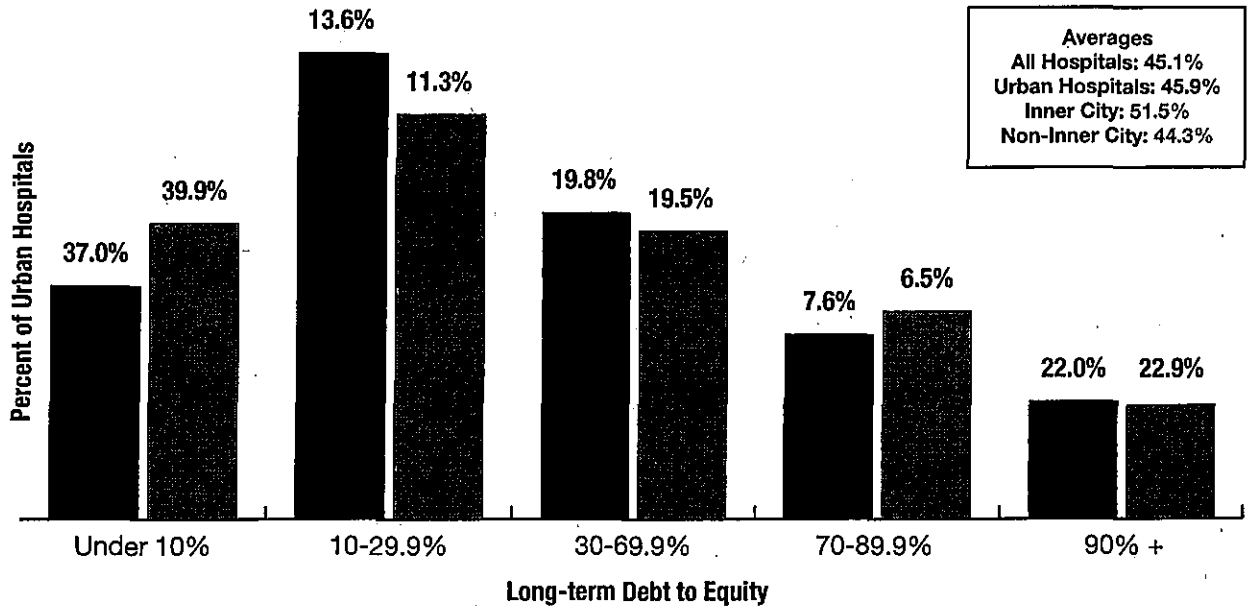
Source: Centers for Medicare and Medicaid Services, FY 2013 Medicare Cost Report Data, 4th Quarter 2015 data release. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Current Ratio



Source: Centers for Medicare and Medicaid Services, FY 2013 Medicare Cost Report Data, 4th Quarter 2015 data release. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Percent of Urban Hospitals by Long-term Debt to Equity



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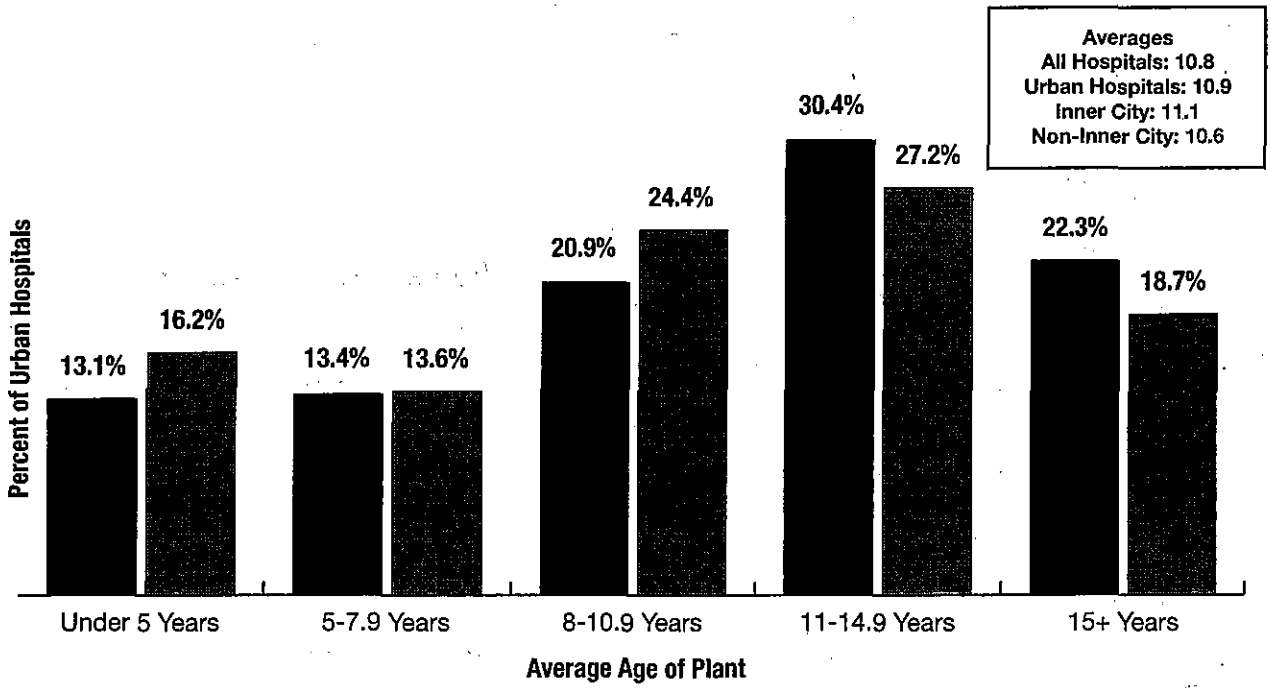
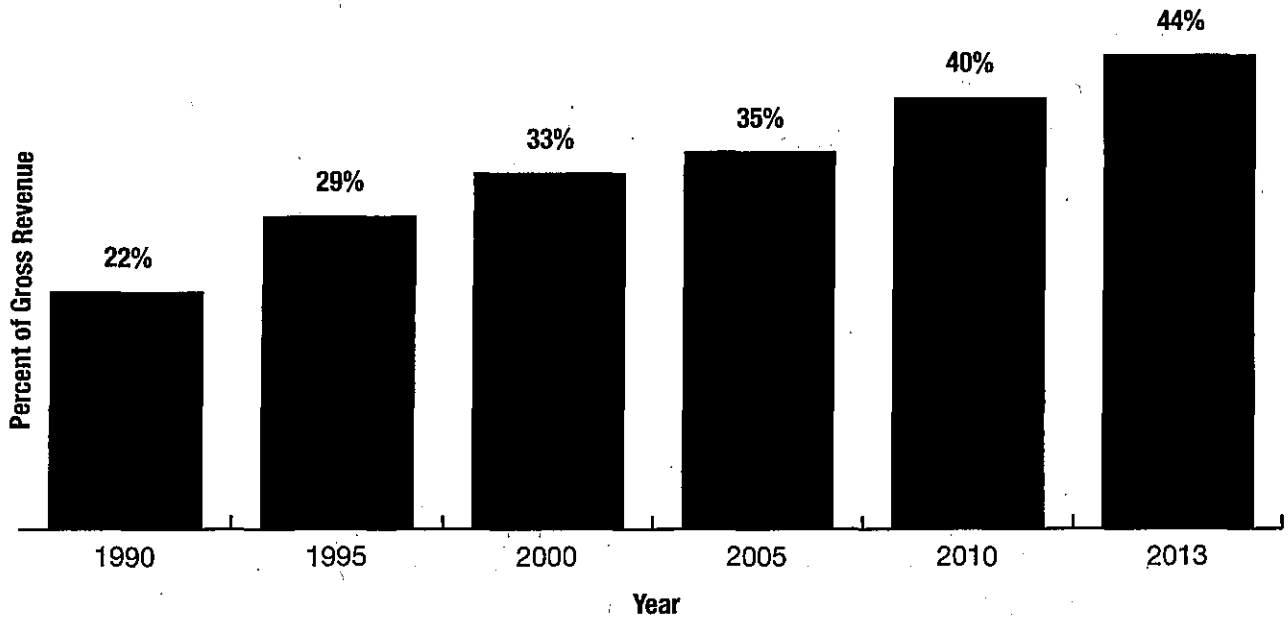
Percent of Urban Hospitals by Average Age of Plant



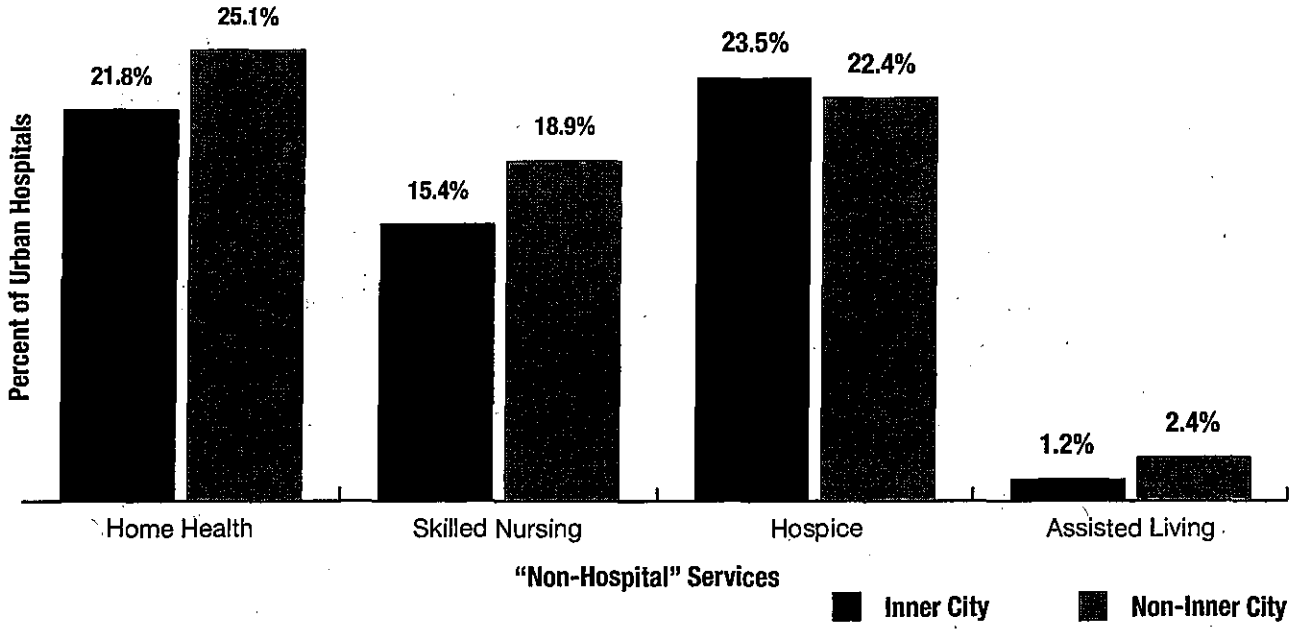
Source: Centers for Medicare and Medicaid Services, FY 2013 Medicare Cost Report Data, 4th Quarter 2015 data release. Inner cities are defined by Initiative for a Competitive Inner City Averages

Outpatient as a Percent of Urban Hospital Total Gross Revenue



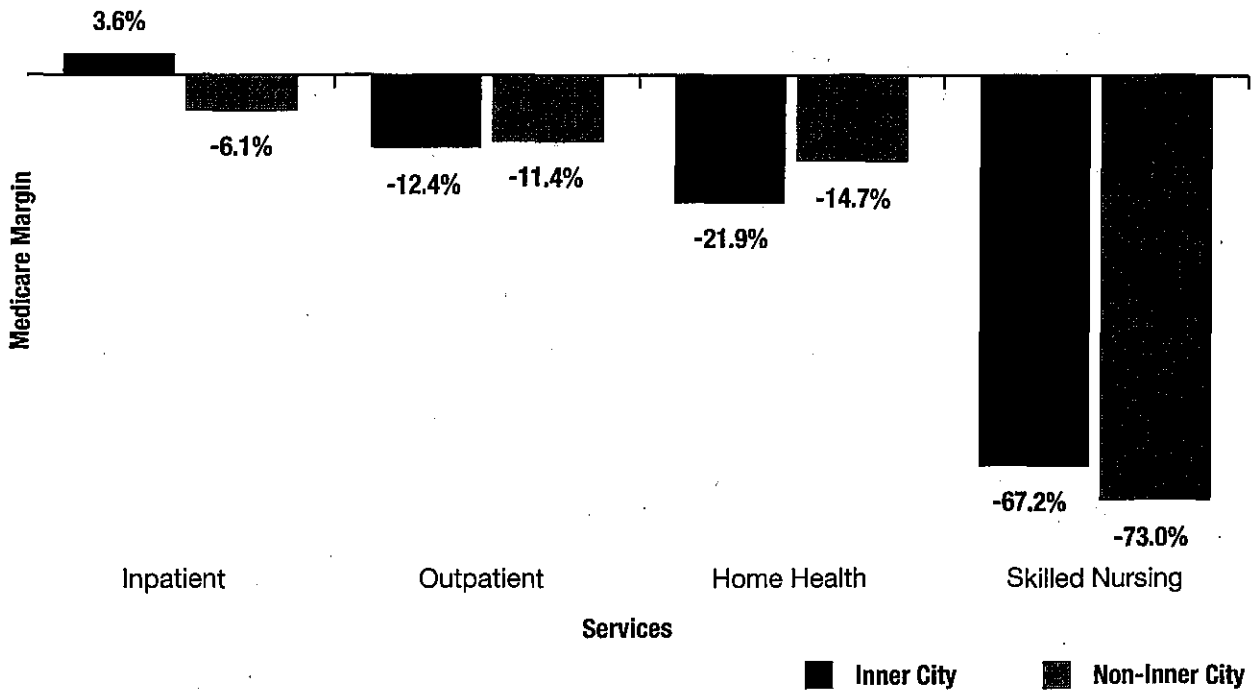
Source: Health Forum, 2013 AHA Annual Survey of Hospitals

Percent of Urban Hospitals offering "Non-Hospital" Services



Source: Health Forum, 2013 AHA Annual Survey of Hospitals. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

Medicare Margins by Service for Urban Hospitals



Source: Vaida Health Data Consultants analysis of Centers for Medicare and Medicaid Services, HCRIS Database, September 30, 2014 Update. Uses Medicare cost accounting rules to determine allowable costs. Full assignment of costs using generally accepted accounting principles would result in lower margins. Inner cities are defined by Initiative for a Competitive Inner City using data from the U.S. Census Bureau's 2011 American Community Survey 5-Year Estimate for all U.S. cities with populations greater than 75,000.

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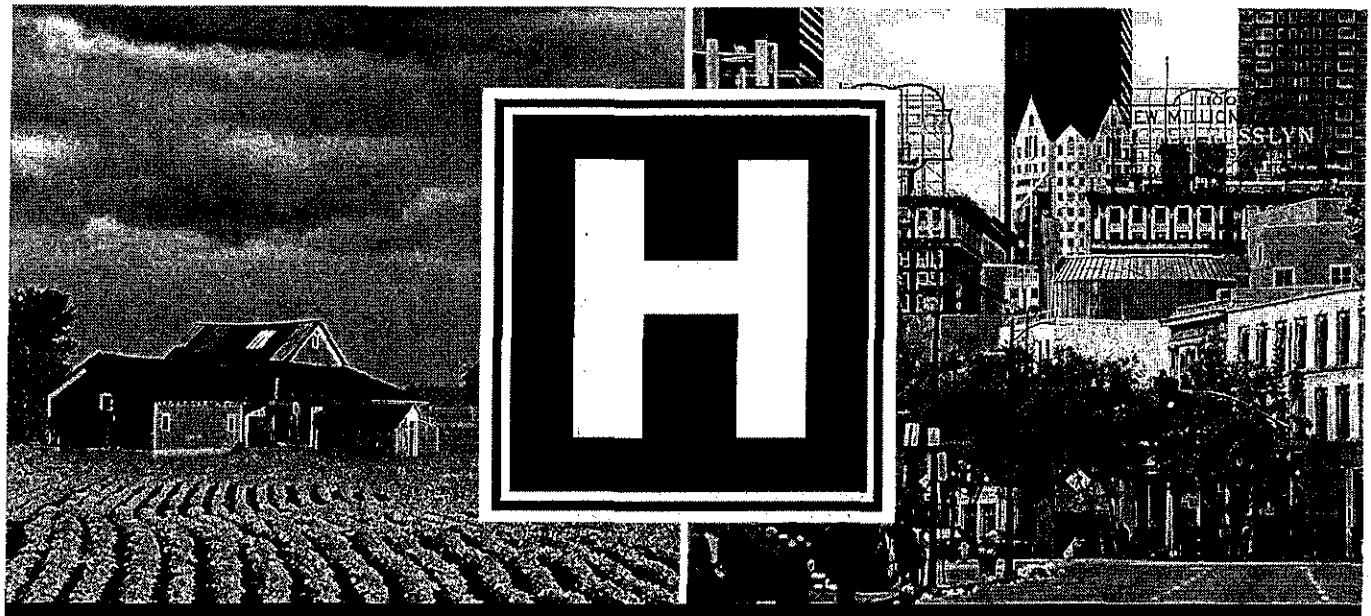

Task Force on Ensuring Access in Vulnerable Communities

Millions of Americans living in vulnerable rural and urban communities depend upon their hospital as an important, and often only, source of care. However, these communities and their hospitals face many challenges. As the hospital field engages in its most significant transformation to date, some communities may be at risk for losing access to health care services. It will be necessary for payers and health care providers to work together to develop strategies that support the preservation of health care services for all Americans.

Recognizing this, the American Hospital Association (AHA) Board of Trustees, in 2015, created a task force to address these challenges and examine ways in which hospitals can help ensure access to health care services in vulnerable communities. The task force considered a number of integrated, comprehensive strategies to reform health care delivery and payment. Their report sets forth a menu of options from which communities may select based on their unique needs, support structures and preferences. The ultimate goal is to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential services they should strive to maintain locally, and the delivery system options that will allow them to do so. While the task force's focus was on vulnerable communities, these strategies may have broader applicability for all communities as hospitals redefine how they provide better, more integrated care.

November 29, 2016

American Hospital Association

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Characteristics and Parameters of Vulnerable Communities

The task force defined a vulnerable community as a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions. While the reasons a population may be deemed vulnerable vary widely, the task force found there is no formulaic, defined set of factors that can determine whether or not a community is vulnerable. However, they created a list of characteristics and parameters, of which one or more may be necessary and sufficient to identify a vulnerable rural or urban community.

Characteristics and Parameters of Vulnerable Rural Communities

- Declining population, inability to attract new businesses and business closures
- Aging population

Characteristics and Parameters of Vulnerable Communities

- Lack of access to primary care services
- Poor economy, high unemployment rates and limited economic resources
- High rates of uninsurance or underinsurance
- Cultural differences
- Low education or health literacy levels
- Environmental challenges

Characteristics and Parameters of Vulnerable Urban Communities

- Lack of access to basic "life needs," such as food, shelter and clothing
- High disease burden

Essential Health Care Services

The range of health care services needed and the ability of individuals to obtain access to health care services varies widely in each community. The task force determined, however, that access to a baseline of high-quality, safe and effective services must be preserved. Table 1 below highlights the essential health care services identified by the task force and illustrates those which may be maintained or enhanced by each emerging strategy.

Table 1

Emerging Strategy	Primary care	Psychiatric and substance use treatment services	ED and observation care	Prenatal care	Transportation	Diagnostic services	Home care	Dentistry services	Robust referral structure
	Essential Health Care Service								
Addressing the Social Determinants of Health					X				X
Global Budget Payments	X	X	X	X	X	X	X		X
Inpatient/Outpatient Transformation Strategy	X	X	X	X		X			X
Emergency Medical Center	X		X		X	X			X
Urgent Care Center	X					X			X
Virtual Care Strategies	X	X	X						X
Frontier Health System	X	X	X	X	X	X	X		X
Rural Hospital-Health Clinic Strategy	X	X	X	X		X		X	X
Indian Health Services Strategies	X	X	X	X	X	X	X		X

Emerging Strategies to Ensure Access to Health Care Service

Addressing the Social Determinants of Health

Social challenges often prevent individuals from accessing health care or achieving health goals. This strategy includes screening patients to identify unmet social needs; providing navigation services to assist patients in accessing community services; and encouraging alignment between clinical and community services to ensure they are available and responsive to patient needs.

Global Budgets

Global budgets provide a fixed amount of reimbursement for a specified population over a designated period of time. They may be designed in a way that allows each provider to create a unique plan to meet mandated budgets, thereby allowing vulnerable communities autonomy and flexibility to create solutions that work best for them.

Inpatient/Outpatient Transformation Strategy

This strategy involves a hospital reducing inpatient capacity to a level that closely reflects the needs of the community. The hospital would then enhance the outpatient and primary care services they offer.

Emergency Medical Center (EMC)

The EMC allows existing facilities to meet a community's need for emergency and outpatient services, without having to provide inpatient acute care services. EMCs provide emergency services (24 hours a day, 365 days a year) and transportation services. They also would provide outpatient services and post-acute care services, depending on a community's needs.

Urgent Care Center (UCC)

UCCs allow existing facilities to maintain an access point for urgent medical conditions that can be treated on an outpatient basis. They are able to assist patients with an illness or injury that does not appear to be life-threatening, but requires care within 24 hours.

Virtual Care Strategies

Virtual care strategies may be used to maintain or supplement access to health care services. These strategies could offer benefits such as immediate, 24/7 access to physicians and other health care providers, the ability to perform high-tech monitoring and less expensive and more convenient care options for patients.

Frontier Health System

This strategy addresses challenges faced by frontier communities, including extreme geographic isolation and low population density. It provides a framework for coordinated health care as individuals move through primary and specialized segments of the medical system.

Rural Hospital-Health Clinic Strategy

This strategy allows for integration between rural hospitals and various types of health centers in their communities (e.g., Federally Qualified Health Centers and Rural Health Clinics). These partnerships also could facilitate integration of primary, behavioral and oral health and allow for economies of scale between both organizations.

Indian Health Services (IHS) Strategies

This strategy includes development of partnerships between IHS and non-IHS health care providers aimed at increasing access to health care services for Native American and Alaska Native Tribes and improving the quality of care available and promoting care coordination.

To learn more about these strategies and explore case examples, please see the full report at *www.aha.org/ensuringaccess*.

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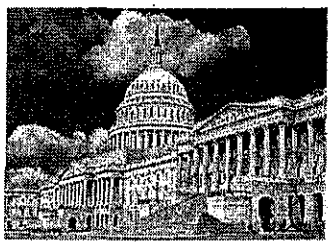
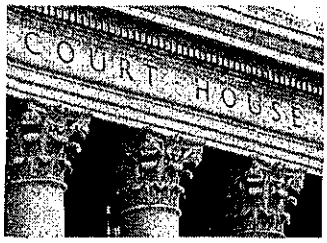
Barriers to Implementation

The task force identified four types of barriers that could impede transitioning to or implementing these emerging strategies:



Federal Barriers

Many federal policies serve as barriers to successful implementation of these strategies. These include, but are not limited to, fraud and abuse laws and Medicare payment rules.

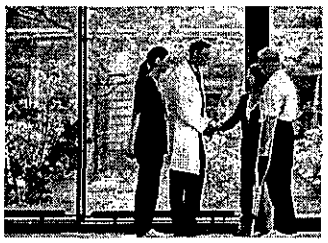


State Barriers

State laws also present barriers to implementation of these strategies. For example, issues related to clinician licensure across state lines must be addressed for broad implementation of virtual care strategies.

Community Barriers

At the community level, the ability to attract or retain health care providers will remain a challenge, regardless of which of these strategies are selected. Community input, buy-in and acceptance will be critical for success as hospitals transition to these new strategies.



Provider Barriers

Transitioning to these new strategies also may be challenging. For example, it may take longer or require significant investments of time, effort and finances for providers to implement these strategies.

Advocacy Agenda and Assistance Strategy

Successful implementation of these emerging strategies by vulnerable communities is dependent on numerous public policy changes. The task force recommends that AHA develop an advocacy strategy to facilitate adoption of these emerging strategies. This includes advocating for:

- Creation of new Medicare payment methodologies and transitional payments, as appropriate, that would allow for successful implementation of the strategies identified above;
- Creation of new and expansion of existing federal demonstration projects;
- Modification of existing Medicare Conditions of Participation to allow for the formation of the strategies identified above, where necessary;
- Modification of laws that prevent integration of health care providers and the provision of health services;
- Modification of the existing Medicare payment rules that stymie health care providers' ability to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals; and
- Expansion of Medicare coverage and payment for telehealth.

Even with public policy changes, vulnerable communities and the hospitals that serve them may not have the resources they need to successfully adopt these emerging strategies. AHA will explore providing operational tools and resources to assist our member hospitals and health systems, including toolkits, data analyses, information on grant opportunities, and convening learning networks for information and idea sharing.

To learn more about the work of the AHA Task Force on Ensuring Access in Vulnerable Communities, please visit *www.aha.org/ensuringaccess*.

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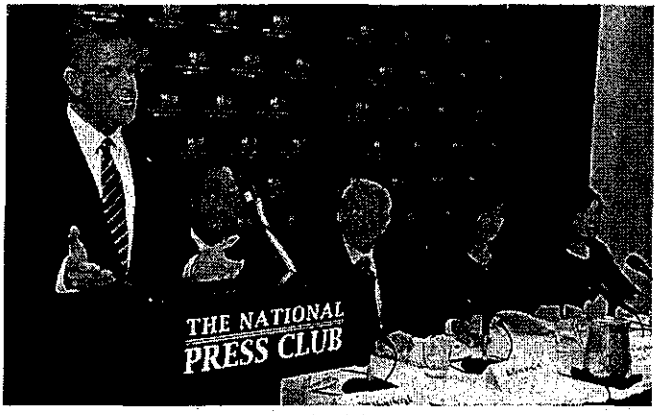
Discussion Guide for Health Care Boards and Leadership



AHA President & CEO Rick Pollack spoke at a Washington, D.C. press event to unveil this report. From left: AHA Chairman Jim Skogsbergh, president & CEO of Advocate Health Care, IL; Bob Henkel, president & CEO of Ascension Healthcare, MO; Christina Campos, administrator of Guadalupe County Hospital, NM, & Karen Teitelbaum, president & CEO of Sinai Health System, IL.

The questions below can be used to guide discussion about the vulnerable populations your health care organization serves and steps your board and leadership can take to ensure ongoing access to health care services.

Use of this discussion guide can be tailored for your board's needs as part of the agenda for a board education session, leadership retreat, or strategic planning session. The executive staff and all board members should be prepared to address local examples/information as part of this discussion.

1. The report defines a vulnerable community as "a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions" and page 2 of this summary lists characteristics that may make a community vulnerable. ***Which of the populations or communities we serve could be considered vulnerable? And why?***
2. The essential health care services identified in Table 2 below, should be available in every community. ***Which, if any, of these services are not available in the vulnerable communities our organization serves?***
3. ***Which of the vulnerable communities we serve are less likely to have access to or are not likely to utilize one or more of these essential health care services?***
4. ***Which of the emerging strategies identified on page 3 are most likely to further improve access to essential health care services for the vulnerable populations our organization serves?***
5. ***What are the implications of implementing these strategies in our organization and community?*** Some areas to consider include strategic compatibility, financial, clinical, workforce, technology, partnerships with other community organizations, and legal and regulatory compliance.
6. Several barriers to implementation are identified in the Task Force Report and many are listed on page 4. ***Which of these barriers is our organization most likely to encounter? How can we as a board and as an organization advocate to overcome them?***
7. ***What role(s) should our board play in gaining input, buy-in and acceptance from the community to implement new strategies for ensuring access?***
   Some examples include:
   - » facilitate community conversations,
   - » be prepared to respond to questions from community members, and
   - » invite community leaders and organizations to provide input into our organization's strategic planning process.
8. ***What assistance, such as education, tools, training and other resources, will our board need to effectively fulfill its community liaison role(s)?***

Table 2: Essential Health Care Services

Primary care	Psychiatric & substance use treatment services	ED & observation care
Prenatal care	Transportation	Diagnostic services
Home care	Dentistry services	Robust referral structure

Please contact Priya Bathija at *pbathija@aha.org* to provide feedback about your board and leadership discussion.

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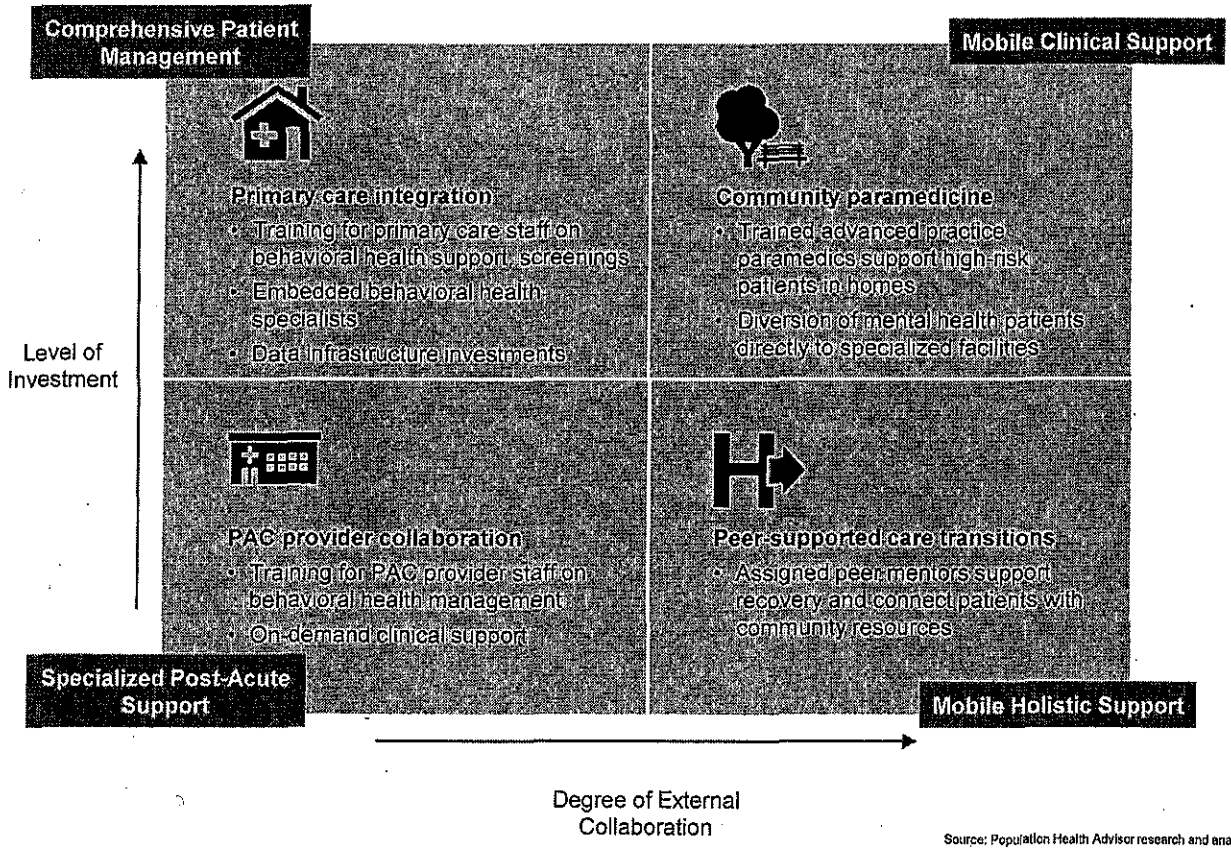
Unmet Behavioral Health Needs Lead to Avoidable Admissions

Strong Collaborations and Partnerships Key to Successful Integration

Patients with behavioral health comorbidities utilize more health care resources than patients without those conditions. When behavioral health conditions are left untreated, cost of care for these patients increases. Nationally, the cost impact of ineffective treatment of comorbid behavioral health conditions has been estimated at $350 billion spent annually on unnecessary medical and surgical services, indicating the significant impact that integrated care can have on avoidable admissions.

Successful behavioral health integration models require building new collaborations with mental health providers and community partners. These initiatives span the care continuum to support patients in managing their conditions and encourage appropriate utilization. As organizations consider implementing behavioral health integration models, leaders should be mindful of the investments needed in both the care management infrastructure and in relationship building with external providers.

Integration Models Vary in Collaboration, Investment Levels



Source: Population Health Advisor research and analysis.

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Hospital-SNF Collaboration for Behavioral Health Patients

Dedicated Hospital Resources Improve SNF Management of Complex Patients

Case in Brief: HealthEast Care System

- Four-hospital health system with 665 combined beds and 14 clinics located in St. Paul, MN
- **Challenge:** Medically complex behavioral health patients lingered in system acute care hospitals as post-acute providers were reluctant to admit patients; patients were also being readmitted because post-acute provider staff lacked resources and training to manage patients with high behavioral health needs
- **Solution:** Established collaborative partnership with Cerenity Senior Care comprised of formal clinical training and ongoing support to manage specific patient population. This ongoing support involved dedicated HealthEast physician support for SNF patients to avoid unnecessary readmissions to the hospital
- **Results:** 52% increase in referrals made to Cerenity Senior Care, indicating increased ability to manage behaviorally complex patients[1]

Program History

Hospital-SNF Partnership Formed to Support Behaviorally Complex Patients

- HealthEast hospital staff had difficulty placing medically complex behavioral health patients into appropriate post-acute care facilities and experienced high LOS for those patients. Furthermore, patients sent to local PAC providers eventually were readmitted to the hospitals after facilities struggled to manage these patients.
- To address the reluctance of its PAC providers to accept these patients and their lack of training and support in managing these patients once admitted, HealthEast formed a collaborative partnership with a local SNF, Cerenity Senior Care in 2011. This partnership built trust while providing specialized support for behaviorally complex patients.

Patient Eligibility

Targeted Patients Exhibit both Medical and Behavioral Complexity

- Traumatic brain injury patients with significant medical acuity (e.g., motor vehicle accident victim who develops behavioral issues with complex medical condition)
- Patients with non-traumatic brain injury, but with behavioral and mental issues (e.g., stroke, coma, neurosurgical intervention patients with behavioral issues)
- Cognitive dysfunction with acute medical complexity (e.g., post-cardiac bypass surgery with delirium)

Program Staffing

Increased Availability of Behavioral Health Specialists Supports SNF Providers

- HealthEast hired a behavioral analyst to investigate the organization's care plans and improve handling of behavioral issues
- HealthEast physicians are available to consult Cerenity physicians via phone or via outpatient appointment to avoid unnecessary readmissions

1) Research contact left the organization before providing data on collaboration impact on avoidable admissions. The Population Health Advisor team is currently following up with the organization for their calculated metrics.

Source: Population Health Advisor research and analysis.

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Collaboration Leads to Reduced Behavioral Health Utilization

Dedicated Staff and Training Equip SNF Providers for Complex Cases

Program Operations

On-Demand Support Helps Prevent Patients From Returning to Hospital

- When SNF physicians need additional assistance for a medically and behaviorally complex patient, they can either bring the patient to an assigned HealthEast physician at an outpatient clinic or call a dedicated support line with a psychiatrist and cognitive dysfunction-trained physician
- This support system allows SNF providers to better manage behaviorally complex patients in the post-acute care setting, preventing readmissions and decreasing avoidable admissions to the hospital

Real-Time Clinical Support

Outpatient Clinic
Patient seen at physician clinic to avoid unnecessary readmission

Physician Support Line
Hospital team available over the phone for on-demand consults

Stakeholder Engagement

Staff Training Prepares SNF Staff for Complex Patient Management

- In addition to providing dedicated physician support to avoid readmissions, HealthEast collaborated with Cerenity Senior Care to train staff to handle behaviorally and medically complex patients

Collaborative Hospital-SNF Training Shares Protocols for Behaviorally Complex Patient Management

Protocols Around Patient Mental Capacity

Problem: SNF inexperienced in assessing capacity for patient decision-making and determining decision-maker → **Solution:** Hospital shares its ethical principles for substituted judgment and beneficence

Clinical Training for Medication Management

Problem: Mandated dose reduction in SNF raises concerns about return of symptoms → **Solution:** Hospital and SNF physicians discuss procedures for safely tapering medications

Program Impact

52%
Increase in referrals made to Cerenity Senior Care after partnership[1]

Funding

Funding for this program was provided by HealthEast

1) Research contact left the organization before providing data on collaboration impact on avoidable admissions. The Population Health Advisor team is currently following up with the organization for their direct metrics.

Source: Population Health Advisor research and analysis.

Primary Care Integration Model Provides Multi-Layered Support

Screening Protocol Identifies Patients for Behavioral Health Interventions

Case in Brief: Intermountain Healthcare

- 22-hospital health system with 185 physician clinics and a health insurance company based in Salt Lake City, UT
- **Challenge:** Clinic staff identified treatment of patients with co-morbid mental conditions as a key difficulty requiring dedicated resources and a new approach to treatment
- **Solution:** Developed mental health integration model (MHI) that embeds mental health providers into primary care sites, incorporates screening and triage protocols for behavioral health patients to connect them with appropriate support, and uses an advanced MHI/depression registry that tracks data and outcomes to build a predictive risk model for depression
- **Results:** Average overall medical expenses of newly diagnosed MHI patients were $667 less per patient than expenses of control group patients, and newly diagnosed depression patients were 54% less likely to present in the ED than control group patients[1]

Program History

Patient, Family Engagement Central to MHI Model

- Intermountain developed the MHI model in 1998 with a cross-continuum team of clinical and non-clinical staff, patients, and representatives of the National Alliance of Mental Illness. Patient and family engagement serves as the cornerstone of the MHI model and enables the MHI team to develop a self-management focused, culturally competent care plan. By early 2010, 82 clinics had adopted the MHI model.

Patient Eligibility

Screening Utilizes In-Depth Psychosocial Assessment

- Providers have autonomy within their clinics to determine their own screening procedures, but generally, the PCP or designated support staff provide patients with an MHI screening packet if behavioral health indicators are identified (e.g., social withdrawal, sudden changes in appetite, etc.).
- The screening packet includes a comprehensive assessment of behavioral health and chronic disease risk factors, global impairment, and family support. Based on this assessment, the provider determines the overall health risk of the patient and family.
  Depending on the risk level, the provider assigns patients to either routine care, collaborative care, or mental health specialty care.

Program Staffing

Embedded Mental Health Providers Offer Consults, Self-Management Focused Interventions

- The primary care physician (PCP) and an MHI coordinator form the core of the MHI provider team. The MHI coordinator enters patient information into the EHR system, facilitates coordination between team members, and helps patients and families navigate through the MHI model.
- Care managers and/or health advocates may also support PCPs by working with the patient to encourage adherence, track outcomes, and coordinate with the team.
- Mental health specialists[2] collaborate with both the care team and patients. In some clinics, a psychologist, APRN, or social worker is embedded in the clinic while a remote psychiatrist and/or APRN staffed within the hospital offers training and additional consults and support

1) Data published in 2010: Of $667 total cost difference, $379 (or 57%) attributable to difference in inpatient medical and psychiatric admissions.
2) Specialist positions can be filled by clinical psychologists, social workers, advanced practice registered nurse (APRN), psychiatrists, or other mental health professionals.

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Model Lowers Cost of Care with Sustainable Funding

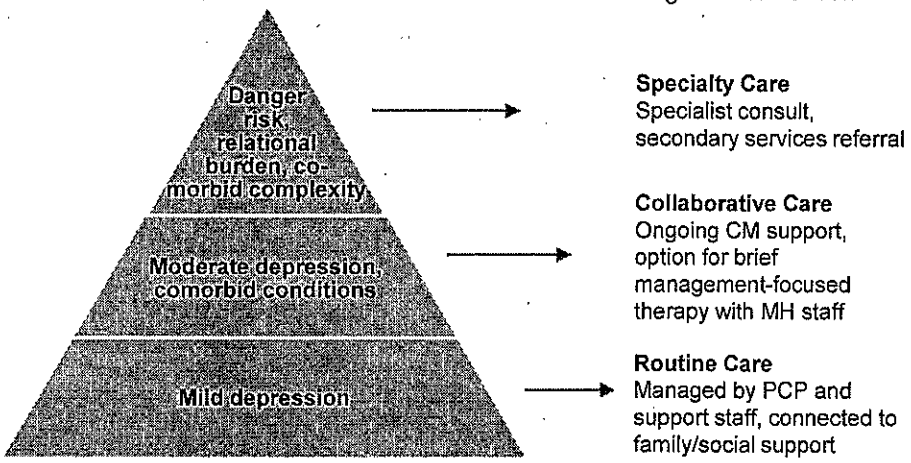
Individual Clinics Responsible for Financial Modeling of MHI Integration

Program Operations

Treatment Cascade Assigns MHI Team Members by Patient Risk

- Intermountain Healthcare believes that each primary care team member is responsible for treating behavioral health patients. Intermountain's treatment cascade involves three different levels of care.

Sample Triage Pathway for Depression Care



- After treatment is initiated, the MHI providers use a follow-up MHI packet to assess improvement and determine whether to revise the care plan.

"Routinization" Process Guides System-wide Implementation

- From 1998 to 2010, the MHI model has spread from one pilot clinic to 82 both within Utah and out of state.
- Based on the experience of early pilot clinics, Intermountain developed a scorecard that guides collaborative adoption across a three-phase "routinization" process. As clinics adopt the MHI model, providers and administrators use this scorecard to guide their decisions and evaluate readiness. The scorecard is divided into five areas: leadership and team culture, workflow, information systems, cost, and community resources.

Stakeholder Engagement

Provider Strategy

- After implementation of the MHI model, providers demonstrated a significant increase in their confidence in working with behavioral health patients and their families, doubling from 40% to 80% of providers reporting confidence in one clinic

Program Impact

$667

Reduction in overall medical expenses for newly diagnosed MHI patients compared to control group[1]

Funding

While grant funding offset some of the MHI implementation, each clinic must submit a pro forma detailing how it will fund the model before officially implementing it. Services are also targeted to insurance coverage.[2]

1) Data published in 2010, of $667 total cost difference, $379, or 57%, attributable to difference in inpatient medical and psychiatric admissions.
2) Based on Advisory Board Company research, some organizations can breakeven on integrated behavioral health in 3-6 months.

Source: Population Health Advisor research and analysis.

Peer Bridgers Support Behavioral Health Care Transitions

Trained Peer Support Counselors Target High-Risk, High-Utilizer Patients

Case in Brief: OptumHealth Pierce County Regional Support Network

- OptumHealth serves as the Regional Support Network (RSN) for Pierce County, Washington, where it coordinates mental health care for approximately 135K Medicaid beneficiaries
- **Challenge:** Mental health patients post-discharge faced significant challenges in recovery due to barriers in accessing resources, leading to frequent readmissions
- **Solution:** Implemented Peer Bridger Program, where trained peer support counselors assist patients as they leave the inpatient setting, connecting them to primary care, setting them up with community resources, and assisting them in obtaining benefits, among other tasks
- **Results:** 79% reduction in hospital admissions for patients enrolled in the program compared to 1 year prior to enrollment, resulting in $550K in cost savings

Program History

Pilot Success Leads to Additional Peer Support Programs

- In July 2010, OptumHealth Pierce County Regional Support Network (RSN) implemented the Peer Bridgers in partnership with Recovery Innovations, Inc., a community nonprofit provider of mental health and peer-support training and consultation services
- The program has served 125 patients since its inception
- After the success of the Peer Bridger program, OptumHealth Pierce County RSN implemented four additional peer support programs focused on patient engagement and recovery

Patient Eligibility

Program Targets High-Risk, High-Utilizer Patients

- Uninsured individuals and Medicaid enrollees are eligible for Peer Bridger support when discharged home from the inpatient setting
- Patients with two or more hospitalizations in one year and high support needs, including homelessness and unemployment issues

Program Staffing

Trained Peer Support Counselors Connect with Patients Through Shared Experiences

- Across all five of OptumHealth Pierce County RSN peer engagement programs (Peer Bridgers, Peer Whole-Health Coach, Addiction Recovery Coach, Peer Engagement Coach, Family Peer Coach), contracted providers employ 248 peer support counselors
- Peer Bridgers are trained peer support counselors who have personally experienced a major mental condition and are successfully managing their recovery
- Peer counselor certification training takes 40 hours and uses a state-approved curriculum

Source: Population Health Advisor research and analysis.

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Peer Bridgers Link Patients to Community/Medical Services

Transition Support Reduces Hospitalizations, Leads to Cost Savings

Program Operations

Peer Bridgers Provide Holistic and Logistical Support for Vulnerable Patients

- Peer Bridgers meet with patients while they are still hospitalized to establish trust and explain the program
- Peer Bridgers develop Wellness Recovery Action Plans (WRAP) to guide patient recovery, help patients adjust back to the community, educate on wellness self-management skills, and connect patients to mental heath providers, community services, benefits, and other social services
- On average, Peer Bridgers work with patients for 14 days post-discharge, although they may work with some patients for up to three months on an individual case-by-case basis

Peer Bridger Transition and Recovery Support

- Build an individualized and positive relationship based on shared experiences
- Model community adjustment and wellness self-management skills

Connect patients to community and social services including public benefits, housing, grocery shopping, support groups, etc.

Assist patients with accessing medical services including appointments with primary care or mental health providers and accessing medications

Stakeholder Engagement

Patient Engagement Strategy

- Peer Bridgers connect with patients through sharing their past experiences with mental illness and recovery. By modeling their own recovery for patients, Peer Bridgers instill a positive outlook and promote personal responsibility.

Program Impact

79%

Reduction in overall hospitalizations for population of 125 patients assisted by Peer Bridgers

$550K

Total cost savings of program over first three years after subtracting program costs

Funding

- OptumHealth Pierce County RSN is contracted by the state of Washington to coordinate mental health services for roughly 135K Medicaid beneficiaries
- OptumHealth Pierce County RSN contracts with Recovery Innovations, Inc., to provide the Peer Bridger service to community providers

Source: Population Health Advisor research and analysis.

Advanced Practice Paramedics Avert Unnecessary Utilization

Behavioral Health Patients Directed to Most Appropriate Site of Care

Case in Brief: Wake County Emergency Medical Services (EMS)

- EMS organization in Wake County, North Carolina, that partnered with Duke Raleigh Hospital, other providers, Community Care of Wake and Johnson Counties (CCWJC), one of 14 networks within Community Care of North Carolina[1] that provides population health services for Medicaid, Medicare, and commercially-insured populations, and Capital Care Collaborative (CCC), CCWJC's sister organization for the uninsured population
- **Challenge:** Across North Carolina, a shortage of psychiatric beds and funding for community programs led to increased calls from mental health patients to EMS providers for transport to medical EDs. This inappropriate utilization of health care resources increased cost of care for the population and strained medical ED resources.
- **Solution:** Wake County EMS developed the Advanced Practice Paramedic (APP) program where specially trained paramedics provide a range of home-based services for high-risk patients and divert behavioral health patients away from medical EDs based on screening protocols and a close collaboration with community partners.
- **Results:** Of a sample of 25 APP-assigned patients, 72% experienced a decrease in ED visits, and their total ED visits dropped 34% from 641 to 424 between 2012 to 2014, representing a cost savings of approximately $325K[2].

Programmatic History

Multi-Stakeholder Collaboration Leads to Program Implementation

- In 2009, Community Care of Wake and Johnson Counties (CCWJC) initiated this collaboration with the Wake County community paramedicine program as part of its comprehensive plan to improve health outcomes and decrease costs for its patient populations.

Patient Identification

Protocols to Divert High-Risk Behavioral Health Patients Away From ED and Hospital

- All mental health and substance abuse patients are eligible for diversion directly to a mental health facility based on screening protocol
- Additionally, patients are identified in one of three ways for APP support:
  - Automated referral based on number of ambulance calls (4 times in any rolling 30-day time period)
  - Referrals from other community partners and hospital groups (includes recently discharged patients for care and coordination support to reduce readmissions)
  - Referral from EMS staff based on observation

Program Staffing

APP Coverage Spans County

- 16 FTE APP positions staff five teams during the day and two at night, with two supervisor positions
- Patients are typically assigned geographically to an APP for monitoring visits, but all APPs have access to information for the full panel for emergent cases that may arise
- APPs split their time roughly evenly between responding to 911 calls, monitoring high-risk patients, and quality management tasks
- APPs receive 200 hours of lecture-based and clinical instruction prior to serving as APPs

1) Statewide nonprofit.
2) Methodology did not account for possible reduction in avoided inpatient admissions as a result of proper mental health treatment.

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05-02-2017 00132

APPs Collaborate with Area Providers, Update Care Plans

APP Monitoring Reduces Downstream Utilization of High-Risk Patients

Program Operations

APPs Incorporated into Multi-Disciplinary Care Teams, Connect Patients to Appropriate Services

Diversion of Mental Health Patients to Appropriate Facilities

- APPs screen patients who have mental health or substance abuse issues as their primary complaint. Those that pass the medical screening protocol are eligible to be transferred directly to a community mental health or substance abuse facility rather than the ED.
- In all cases the APP completes a phone consultation with personnel at the appropriate facility for potential placement. Law enforcement or EMS may provide transport to these locations; there the APP completes their care with a face-to-face report to the mental health facility personnel.

High-Risk Patient Monitoring

- APPs work with a multi-disciplinary care management team[1] to monitor diabetes and CHF patients, who may also have medication adherence and/or behavioral health issues. The team educates these patients, conducts medication reconciliation, and makes sure they understand their care plans and disease-specific red flags.
- The multidisciplinary team provides feedback to primary care, specialty, and hospital providers on what their home situation is like and whether there are any additional barriers to care that providers may not have known about beforehand

Stakeholder Engagement

Community Partner Strategy

- APPs, provider organizations, CCC, and CCWJC meet at least bimonthly to discuss high risk patients. In these meetings, community care managers affiliated with CCWJC and CCC, hospitals, and other care teams will collaborate on care plan development to ensure consistent information exchange across organizations.
- A data sharing agreement among the APPs, CCWJC, and CCC allows access to IT systems that provide patient health, utilization and care management information. APPs can document in the system on shared patients to promote seamless collaboration and communication among the teams and providers.

Program Impact

$325K

Estimated cost savings to Duke Raleigh Hospital due to a 34% reduction in ED visits between 2012 and 2014 for a sample of 25 managed patients[2]

350

Patients diverted from the hospital between 2010-2013

Funding

Funding for the APPs is currently provided by Wake County. Wake County EMS is not reimbursed for home visits or transportation to non-hospital destinations, but are in the process of collecting evidence to justify reimbursement.

1) Includes staff from CCWJC, CCC, hospital providers, state agencies.
2) Methodology did not account for possible reduction in avoided inpatient admissions as a result of proper mental health treatment.

Source: Population Health Advisor research and analysis.

05-02-2017 00133

Related Resources to Inflect Avoidable Utilization

Supporting Execution of Your Most Pressing Cross-Continuum Initiatives

Reducing Avoidable Utilization

Improving Pain Management

Offers strategies to reduce pain-related avoidable utilization. Includes details on providing structured support for providers in managing pain patients and developing patient-centered pain management services.

Elective Surgeries

Profiles two organizations' efforts to reduce unnecessary elective joint replacement and spine surgeries. Describes the primary components of elective surgery right-sizing strategies including: clear clinical appropriateness criteria, standardized assessment protocols, and pre-surgical case review.

ED

Reducing Avoidable ED Utilization

Provides an overview of how to design a comprehensive ED avoidance strategy. Offers recommendations on increasing patient access to care outside of the ED, tactics to educate patients on improving self-management and the appropriate use of available health services, and targeted measures for diverting those particularly complex patients.

Redesigning the Care Team

Community Paramedicine Research Brief

Profiles of best-in-class community paramedicine programs, with detail on staffing, roles and responsibilities, payer mix, funding sources, patient eligibility criteria, referral pathways, and cost savings.

Rx

Integrated Pharmacy Models in Primary Care

Strategies for building an integrated pharmacy program including details on team composition and staffing, clinical triggers for identifying patients, engagement tactics, and financial considerations.

Refining Care Management Model

Care Management Strategy Guide

Two-part facilitated discussion on care management program goals, care team staffing and deployment models, patient enrollment and management, care coordination, and performance improvement.

Care Management Enrollment for Complex Managed Medicare Patients

Tactics to improve care management outreach and enrollment for managed Medicaid patients, including details on branding and marketing, and outreach protocols for patients and other providers.

Tactics for Promoting PCP Referrals to Care Management

Best practices for educating PCPs about when and how to refer patients to care management, including information on education format and structure, staff responsibilities, feedback loops, and associated tools.

For more information, contact us at pha@advisory.com

EXHIBIT F

SVMC LICENSE

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0057

General Hospital

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

St. Vincent's Medical Center of Bridgeport, CT d/b/a St. Vincent's Medical Center is hereby licensed to maintain and operate a General Hospital.

St. Vincent's Medical Center is located at 2800 Main Street, Bridgeport, CT 06606-4201.

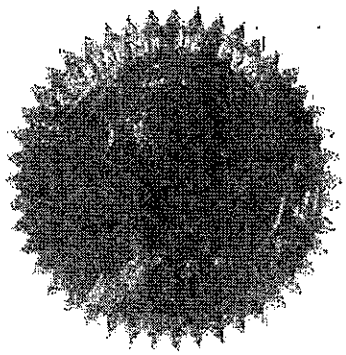
The maximum number of beds shall not exceed at any time:

47 Bassinets
473 General Hospital Beds

This license expires September 30, 2017 and may be revoked for cause at any time.
Dated at Hartford, Connecticut, October 1, 2015. RENEWAL.

Satellites:

Family Health Center, 760-762 Lindley Street, Bridgeport, CT
The St. Vincent's Center for Wound Healing, 115 Technology Drive, Trumbull, CT
St. Vincent's Behavioral Health Center-Westport, 47 Long Lots Road, Westport, CT
St. Vincent's Outpatient Behavioral Health-Bridgeport, 2400 Main Street, Bridgeport, CT
St. Vincent's Outpatient Behavioral Health-Norwalk, 1 Lois Street, Norwalk, CT
St. Vincent's Center for Wound Healing-Stratford, 3272 Main Street, Stratford, CT



Jewel Mullen, MD, MPH, MPA
Commissioner

EXHIBIT G

CV

DIMITRO HRISOVULOS
203 332 3505
dhrisovulos@swchc.org

QUALIFICATIONS

CHIEF FINANCIAL OFFICER

Thirty-three years of experience as CFO in manufacturing, construction and community health centers. Strengths include, financial statements, financial analysis, budgeting, cash management, and internal and external reporting.

EDUCATION

B.S., Business Administration — University of Economics and Commerce, Istanbul, Turkey

M.B.A. Long Island University ,Brooklyn NY

PROFESSIONAL EXPERIENCE

Chief Financial Officer 1991-Present
Southwest CHC Inc., Bridgeport , CT

- Manage financial and accounting functions for Community Health Center generating annual visits over 120,000 and having a budget of 20M annually. Accountability extends to financial statements, cash flow analysis, budgets, Medicaid and Medicare reimbursement, long-term capital plans, strategic financial planning. Supervise and oversee the accounting, billing and IT departments. As management team member, participate in strategic planning, including forecasting and investment strategies.
- Corporate liaison with lenders and auditors. Report directly to CEO.
- Selected Contributions:
  - Secured capital financing of 8Million for the construction of two Clinical sites.
  - Reduced accounts receivable days to 21.
  - Improved working capital reserves to 1.8 M.
  - Over achieved goals of growth of the Five year long-term planning ended in 2012.
  - Maintained visit cost below projected levels.

Chief Financial Officer 1988-1991
Joseph Addabo Community Health Center Inc., Far Rockaway, NY

Chief Financial Officer 1981-1988

Rael Automatic Sprinkler Co., Long Island , NY

Controller 1978-1981

Nandy Knits, Inc .,Long Island ,NY

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Home: (203) 389-9732
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Office: (203) 332-3504
tkrause@swchc.org

EXPERIENCE

SOUTHWEST COMMUNITY HEALTH CENTER **BRIDGEPORT, CT**
Joint Commission-accredited, federally-qualified community health center serving 22,000 uninsured/ underinsured patients at five medical office sites, seven school-based health centers and eight homeless shelters in south and west sections of Bridgeport.
CHIEF OPERATIONS OFFICER 2002-Present
Responsible for directing and leading the non-clinical care activities of the organization with an operating budget of $23 million and 250 employees. With other officers, develops organizational strategy and program development to achieve the organization's mission and goals. Proficient in financial management, human resources, information systems, risk management, business and clinical operations, contract negotiations, property management.

- Developed eight new clinical sites from planning phase thru occupancy.
- Oversaw complete "re-engineering" of organization.
- Coordinated Joint Commission accreditations, state licensure, health information management, emergency preparedness, and corporate compliance activities.

MIDSTATE MEDICAL CENTER **MERIDEN, CT**
Member community hospital of the Hartford Health Care Corporation serving central Connecticut cities including Meriden, Wallingford and Cheshire.
DIRECTOR, PRACTICE MANAGEMENT 1995-2001
Responsible for the establishment and maintenance of positive relationships between the medical center and medical staff. Advised and implemented all phases of physician practice management. Assisted Chief of Staff and Medical Affairs with medical staff development. Helped plan and develop joint physician-hospital programs and services.

- Consulted individually with area practices on issues of practice management, utilization, reimbursement, personnel administration, risk management, physician recruitment. Helped develop Medical Staff Development Plan.
- Conducted physician and office staff programs in information systems, coding, practice management. Member of Physician-Hospital Organization (PHO).
- Administered all phases of the development of new medical office space from lease negotiation through occupancy. Established twenty-one (21) physician office locations. Established new clinical services including PET Scan.

COMMUNITY HEALTH CARE PLAN **NEW HAVEN, CT**
LONG WHARF HEALTH CENTER

Largest health center in a mixed-model, multispecialty, HMO network serving over 30,000 patients with 120,000 medical encounters, 30 primary care providers and 20 specialists.

ADMINISTRATOR 1989-1995

Responsible for planning, directing and coordinating all of the health center's non-patient care activities including personnel policies and programs for 250 FTE's in an union environment, financial policies and management for an operating budget of $22 million.

- Member of six-person interdisciplinary team selected to implement a network computerized practice management system.
- Implemented additional in-house services to reduce costs and increase revenue (CT Scanning, Holter Monitoring, GYN and GI Procedure Rooms).
- Coordinated the center's accreditation for National Committee on Quality Assurance (NCQA), American College of Radiology- Mammography Program, CMS's CLIA Laboratory Program.

BERKSHIRE MEDICAL CENTER **PITTSFIELD, MA**

Largest medical center in western Massachusetts with 272 beds. A major teaching affiliate of the University of Massachusetts Medical Center.

ADMINISTRATIVE DIRECTOR-PROFESSIONAL SERVICES 1985-1989

Responsible for the operations of four departments (Radiology, Dental, Medical Education/ Residency Programs, Radiation Oncology) with a combined staff of 105 FTE's and annual operating budgets of $3\5 million.

- Administered the creation of the Cancer Institute of the Berkshires by planning services, coordinating construction, selecting equipment and orienting staff to the $3 million facility.
- Coordinated the introduction of new imaging services (MRI, Cardiac Catheterization) from planning phase through implementation which further strengthened the position of the medical center.
- Implemented the cross training of staff in five clinical areas resulting in improved staff moral, greater depth to departments and reduced expense.

ARH REGIONAL MEDICAL CENTER **HAZARD, KY**
Largest hospital in southeastern Kentucky with 200 beds and affiliated primary care center network. Operating unit of the Appalachian Regional Healthcare System.
ASSISTANT ADMINISTRATOR- PROFESSIONAL SERVICES 1981-1985
Responsible for the operations of five hospital departments (Laboratory, Pharmacy, Radiology, Physical Therapy, Respiratory Therapy) and three primary care centers staffed by 14 providers.

- Key member of administrative team who produced three consecutive years of operating surpluses reversing trend of chronic losses over the prior 20 years.
- Helped develop and implement the conversion of the hospital to a Level II medical center; included development of programs, physician recruitment.
- Successfully represented the hospital before regulatory, regional planning, licensure and accreditation organizations.

EDUCATION

- MPH, School of Medicine, Yale University
- MA, School of Corporate Communications, Fairfield University
- BA, College of Liberal Arts, Fairfield University
- Certificate, Healthcare Safety Professional, International Association for Healthcare Security and Safety

PROFESSIONAL ASSOCIATIONS

- American College of Healthcare Executives
- Medical Group Management Association- Certified Medical Practice Executive

COMMUNITY SERVICE

- Orange Visiting Nurses Association- Chairman
- International Center at Yale- Host, Volunteer
- Mentor/ Preceptor: Yale University, Fairfield University, Southern CT State University, University of Bridgeport
- Guest Lecturer, Yale University School of Nursing

* * *

DARA THOMAS RICHARDS, MD
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dararichards@sbcglobal.net

EMPLOYMENT

Chief Medical Officer, Southwest Community Health Center, Bridgeport, CT (2015-present)

Pediatrician, Southwest Community Health Center, Bridgeport, CT (1998-present)

TRAINING & EDUCATION

Pediatrics Residency, Yale-New Haven Hospital, New Haven, CT (1995-98)

M. D., Yale University School of Medicine, New Haven, CT (1991-95)

B. S., Biology, Yale University, New Haven, CT (1987-91)

HOSPITAL APPOINTMENTS

Attending, Bridgeport Hospital, Bridgeport, CT (1998-present)

Attending, Yale-New Haven Hospital, New Haven, CT (1998-present)

ACADEMIC APPOINTMENTS

Clinical Faculty, Fairfield University School of Nursing (2013-present)

Faculty Associate, Sacred Heart University Nursing Program (2001-present)

Clinical Instructor, Pediatrics, Yale School of Medicine (1999-2009)

HONORS/AWARDS

Lauren Weinstein Award (1995)
Presented at Yale School of Medicine Commencement Ceremonies for displaying courage, perseverance, and compassion and daring to reach for the best.

William and Charlotte Cadbury Scholar (1994)
Recognized by National Medical Fellowships, Inc. for outstanding achievement.

New Haven Foundation Graduate and Professional Elm/Ivy Award (1993)
Presented for outstanding community service.

Yale School of Medicine Distinguished Community Service Award (1993)

PUBLICATIONS

Cohen C, Rice EN, Thomas DE. Diabetes insipidus as a hallmark neuroendocrine complication of neonatal meningitis. Curr Opin in Ped 1998; 10:449-452.

Thomas DE, Leventhal JM, Friedlaender E. Referrals to a hospital-based child abuse

committee: a comparison of the 1960s and 1990s. *Child Abuse & Neglect* 2001; 25:203-213.

Urry DW, Haynes B, Thomas D, Harris RD. A method for fixation of elastin demonstrated by stress/strain characterization. *Biochem Biophys Res Commun* 1988; 151 (2):686-92.

RESEARCH

"The Identification of Differences in Child Maltreatment Cases from 1968-69 and 1990-91" (Medical Student Thesis), Department of Pediatrics, Yale University School of Medicine; Thesis Advisor: Dr. John Leventhal (1992-94)

"The Distribution of GABA-containing Neurons in Monkey Fetal Cortex" (Senior Essay), Department of Neuroanatomy, Yale University; Advisor: Dr. Michael Schwartz (1990-91)

"A Method for the Fixation of Elastin Demonstrated by Stress/Strain Characterization," Department of Neurophysics, University of Alabama at Birmingham; Advisor: Dr. Dan W. Urry (1986-88)

PROFESSIONAL RECOGNITION

Fellow of the American Academy of Pediatrics (FAAP)

BOARD CERTIFICATION

ABP Board Certified in General Pediatrics (1998)

LICENSURE

Connecticut

REFERENCES

Available upon request.

Katherine S. Yacavone

15 Copper Valley Court • Cheshire, CT 06410 • (203) 218-4505

Experience:

Southwest Community Health Center, Inc. August 1997 – Present

Bridgeport, CT

President/Chief Executive Officer

- Appointed by the Board of Directors to plan, coordinate, and evaluate all operations and programs to ensure delivery of primary health care services to the Bridgeport community.
- Oversee agency budget of $22 million for fiscal year 2017.
- Coordinate all legislative activities, advocate on-local, state, and federal levels regarding community health center issues.
- Ensure compliance with all federal, state and Joint Commission mandates and reporting requirements.
- Manage 240 multidisciplinary staff and is responsible for staff hiring, terminating and issuing of disciplinary actions.
- Staff and coordinate Board of Directors activities. Represent agency on several Boards and advisory committees.

Chief Operations Officer July 1993 - July 1997

- Oversaw daily health center operations including satellite facilities and program s.
- Initiated and implemented program planning, marketing, community activities in collaboration with health center officers.
- Executed disciplinary procedures in absence of CEO.
- Interacted with health care and social support agencies in community.
- Wrote grants- for the community health center.

Health Care Consultant May 1992 - June 1993

- Specialized in grant writing for federal, state and foundation/corporate grants.
- Consulted on administration for health care organizations including program development, planning and evaluation.

Hartford Primary Care Consortium. Inc. June 1988 - April 1992

Hartford, CT

Executive Director

- Managed agency functions and responsibility for $750, 000 budget while performing fundraising and grant writing functions.
- Administered several city-wide health care projects composed of city health providers.
- Staff to Board of Directors.

- Managed employee benefits.
- Participated on State and City Task Forces concerning health issues.

Charter Oak Terrace/Rice Heights Health Center November 1986 — June 1988
Hartford, CT
Marketing Director

- Supervised community outreach program staff and risk management
- Implemented federally funded Homeless Health Care Program on a city-wide basis.
- Contributed to grant/proposal writing securing $450,000 in grant funds in 1987.

Health Systems Agency of North Central Connecticut June 1984 — June 1988
Hartford, CT
Staff Associate

- Coordinated the development and production of the 1985 Health Systems Plan and the 1985-1986 Annual Implementation Plan.
- Developed and Wrote "Physical Health Profile" for the Community Council of Greater Hartford-(for use by United-Way)
- Assisted in the research and analysis of the Hebrew Home and Hospital's Certificate of Need application for a new facility.

Education

University of Connecticut	Master of Social Work 1984
University of Connecticut	Bachelor of Arts, Honors 1972

Professional Affiliations

2008 - Present	Connecticut Council on Medical Assistance Program Oversight
2002 - Present	Advisory Committee, Fairfield University School of Nursing
1998 – 2011	Board of Directors, Southwestern Area Health Education Center
1997 - Present	Board of Directors, Bridgeport Child Advocacy Coalition
1996 - Present	Board of Directors, Community Health Center Association of Connecticut
1995 - 2010	Board of Directors, Community Health Network of Connecticut Foundation
1989 - Present	National Association of Community Health Centers

Community Affiliations

2001 — 2010 Vice Chair, Cheshire Democratic Town Committee

2001 — Present Cheshire Federated Democratic Women's Club *(Non dues paying member)*

1996 — Present Cheshire Democratic Town Committee member *(Non dues paying member)*

EXHIBIT H

RELEVANT ARTICLES

Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings

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Objectives. To compare health care use and spending of Medicaid enrollees seen at federally qualified health centers versus non–health center settings in a context of significant growth.

Methods. Using fee-for-service Medicaid claims from 13 states in 2009, we compared patients receiving the majority of their primary care in federally qualified health centers with propensity score–matched comparison groups receiving primary care in other settings.

Results. We found that health center patients had lower use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care and 25% fewer admissions and 27% lower spending on inpatient care. Total spending was 24% lower for health center patients.

Conclusions. Our analysis of 2009 Medicaid claims, which includes the largest sample of states and more recent data than do previous multistate claims studies, demonstrates that the health center program has provided a cost-efficient setting for primary care for Medicaid enrollees. (*Am J Public Health.* 2016;106:1981–1989. doi:10.2105/AJPH.2016.303341)

A central pillar of the Affordable Care Act (ACA; Pub L No. 111–148) is the expansion of the Medicaid program to include adults younger than 65 years with incomes up to 133% of the federal poverty level. Roughly half of states have formally expanded their Medicaid programs, and even nonexpansion states have seen increased enrollment stemming from greater public awareness and streamlined enrollment processes.[1] Medicaid expansion has raised concerns about the financial sustainability of the program and the availability of health care providers to see the newly insured.[2] To improve access to care for the medically underserved, including the newly insured, the ACA also called for $11 billion in funding for federally qualified health centers.[3,4]

Federally qualified health centers receive grants under Section 330 of the US Public Health Service Act and currently provide comprehensive primary care to roughly 23 million patients[5] in medically needy areas and roughly 1 out of 7 Medicaid enrollees.[6] For brevity, we will use the term "health center" throughout this article to refer to these federally qualified health centers. Health centers are required to provide nonclinical enabling services that support access to primary care, such as case management and transportation. Health centers are required to be located in, or provide services to, medically underserved communities, and they are required to have more than half of their governing board be health center patients that represent the population served. Because of the likelihood of an expanded role for health centers in the Medicaid program and ongoing concerns regarding the costs of the program, it is critical to understand whether the setting of primary care for Medicaid recipients has any association with health service utilization and spending.

The design and requirements of the health center program may be particularly well suited to the complex social and primary care needs of Medicaid patients. For example, the enabling services provided by health centers may result in physical and mental health issues being addressed earlier and in a more coordinated manner, resulting in lower health care use and spending for other services. Although the conceptual underpinnings of the program are clear, the empirical evidence regarding the impact of health center care on use and spending has been conflicting. Previous studies of Medicaid enrollees receiving primary care in health centers have found some associations with lower health care use. A study of 2008 Colorado Medicaid data found health center use to be associated with lower likelihoods of emergency department (ED) visit, inpatient

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hospitalization, 90-day readmission, and preventable hospitalization.[7]

Two multistate Medicaid claims studies (a 4-state study using 1994–1995 data and a 5-state study of 1992 data) found health center use to be associated with fewer preventable ED visits and hospitalizations.[8,9] By contrast, other studies have found that health center care was associated with higher use and spending. A 3-state study of 2003–2004 Medicaid claims found greater outpatient and total spending for health center patients compared with physician office care,[10] and a study of 2004–2008 data from a national survey of adults included a subgroup analysis of Medicaid patients that found health center care to be associated with more ED visits than is non–health center care.[11] Overall, the literature on this topic is limited by analyses that capture varying or incomplete utilization and spending outcomes, study a small number of states, use older data that may not reflect current practice patterns, or use limited methods for adjusting for differences in health center and non–health center patient populations.

We compared utilization and spending between health center and non–health center Medicaid enrollees using data from a large number of US states, which can provide important insight because of the variability in Medicaid programs across states. We also examined a broader set of health care services than have previous studies, including primary care, other outpatient care, prescription drugs, ED use, and inpatient care. Finally, we compared health center and non–health center patients with a propensity score–matching approach, which can provide a more robust adjustment for observed differences between health center and non–health center patients.

Although our use of 2009 data does not allow us to analyze the effect of ACA Medicaid expansions that began in 2014, post-ACA claims are not yet available for this data set. Our data year allows us to examine a larger number of Medicaid patients and states than do more recent years. In more recent years of Medicaid claims, the increasing prevalence of Medicaid managed care inhibits cross-plan and cross-state comparison, because these claims do not contain service-level expenditures and vary in data quality across states.

METHODS

We examined the cross-sectional association between primary care setting and a set of utilization and spending outcomes among fee-for-service Medicaid enrollees in 13 states in 2009. The 13 states in our analysis were Alabama, California, Colorado, Connecticut, Florida, Iowa, Illinois, Mississippi, Montana, North Carolina, Vermont, Texas, and West Virginia (Table 1). We emphasized the following factors when choosing states to include in the analysis: geographic diversity, variation in size, presence of a large number of health centers and health center Medicaid patients, likelihood of claims data being available in a timely manner, and high prevalence of fee-for-service Medicaid claims. The number of states we included was limited by our funds available for data purchase.

Data Collection

We obtained claims from the Medicaid Analytic eXtract files. We constructed an analytic data set from Medicaid Analytic eXtract files that focused on adult, nonelderly (aged 18–65 years), fee-for-service users of ambulatory primary care services. We excluded all dental, transportation, and long-term care claims from our analysis. Because claims data for utilization and spending data may not be reliable for Medicaid managed care patients, we excluded all claims in months of data when an enrollee was in a medical managed care program. We also excluded single months of fee-for-service data that fell between 2 months of managed care enrollment. Other notable exclusions were patients with restricted benefits anytime during the year, those who delivered a baby during the year, and those who had changing eligibility over the year. (A full listing and description of exclusions are available as a supplement to the online version of this article at http://www.ajph.org.)

We examined use or spending for primary care, other (nonprimary) outpatient care, prescription drugs, ED care, inpatient care, and total health care spending, which represents the sum of the previously listed spending categories. Spending for each type of utilization represented the sum of total payments from Medicaid and third-party payers. Our spending variable did not include federal support to health centers that occurs outside the context of the Medicaid fee-for-service visit, such as federally backed loan guarantees for capital improvement projects and the ability to forgo purchase of private malpractice insurance because the federal government assumes responsibility for malpractice settlement and judgment costs.[12]

Our main independent variable of interest was the type of primary care setting. We categorized patients as either health center or non–health center patients on the basis of whether more than half of their primary care visits occurred in a health center. We also conducted analyses dividing non–health center patients into 3 subgroups: physician office patients, hospital outpatients, and mixed use patients, where the mixed use category comprised those who did not have a majority of primary care visits in any 1 setting. To determine primary care setting, we used the national provider identifier, claim type, and place of service in each claim. We created a listing of health center identifiers from Health Resources and Services Administration databases and Medicare and Medicaid cost reports and linked that information to the National Plan and Provider Enumeration System.[13]

Our adjusted analyses included covariates to account for factors that influenced health care utilization and spending. Covariates were patient demographics (age, race/ethnicity, gender), insurance characteristics (eligibility category, months of eligibility, Temporary Aid for Needy Families program indicator), disease burden, and US state. For disease burden, we used the Chronic Illness and Disability Payment System for Medicaid with the Medicaid Rx model and created binary variables for each category of diagnosis (e.g., cardiovascular, low) and medication group (e.g., diabetes) included in sufficient volume in our study sample.[14,15]

One barrier to adjustment in health center analyses is that Medicaid generally pays health centers on a per-visit (vs fee-for-service) basis. Although health centers are required to use diagnosis codes for billing and quality reporting, the lack of service-level (as opposed to encounter-level) claims may lead to health centers applying a lower volume of diagnosis codes and the potential for underdetection of disease burden for health center patients when using claims-based risk adjustment. Our adjustment method mitigates this risk by drawing from

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TABLE 1—Medicaid Enrollee Characteristics by Primary Care Setting: United States, 2009

Characteristic	Health Center, No. (%) or Mean ±SD	Non-Health Center, No. (%) or Mean ±SD			
		Combined	Physician Office	Hospital Outpatient	Mixed Use[a]
Enrollees	144 076 (14)	894 898 (86)	460 198 (44)	95 599 (9)	339 101 (33)
Age, y	41.3 ±13.1	40.0 ±13.7	41.3 ±14.0	40.5 ±13.4	38.1 ±13.3
Female	(67.0)	(67.0)	(69.1)	(62.9)	(65.1)
Race/ethnicity					
Non-Hispanic White	(40.2)	(42.1)	(41.7)	(38.0)	(43.8)
Hispanic or Latino	(23.3)	(22.8)	(25.7)	(21.0)	(19.4)
Non-Hispanic Black	(20.1)	(19.9)	(18.9)	(22.9)	(20.5)
Non-Hispanic Asian	(2.5)	(2.2)	(2.9)	(1.8)	(1.5)
Hispanic or Latino and >1 race	(2.9)	(0.9)	(0.9)	(1.9)	(0.7)
Non-Hispanic Native Hawaiian	(2.2)	(2.5)	(3.0)	(1.7)	(2.1)
Non-Hispanic American Indian	(0.7)	(0.7)	(0.4)	(0.9)	(1.1)
Non-Hispanic and >1 race	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)
Unknown	(8.0)	(8.8)	(6.5)	(11.7)	(11.0)
State					
California	(51.4)	(39.2)	(33.1)	(44.0)	(46.1)
Illinois	(7.2)	(5.4)	(5.6)	(3.3)	(5.7)
West Virginia	(7.0)	(5.6)	(7.5)	(2.2)	(3.8)
Florida	(6.9)	(12.7)	(13.5)	(18.2)	(10.0)
Texas	(6.9)	(16.9)	(24.2)	(6.2)	(10.0)
Colorado	(6.0)	(4.9)	(0.7)	(10.3)	(9.3)
Connecticut	(5.9)	(2.4)	(2.5)	(4.7)	(1.7)
Mississippi	(4.9)	(7.7)	(7.3)	(4.0)	(9.3)
Iowa	(2.0)	(2.8)	(2.5)	(4.7)	(2.6)
Vermont	(1.2)	(1.0)	(1.4)	(0.4)	(0.6)
North Carolina	(0.5)	(1.3)	(1.6)	(1.6)	(0.9)
Alabama	(0.1)	(0.1)	(0.1)	(0.3)	(0.1)
Montana	(<0.1)	(<0.1)	(<0.1)	(0.2)	(<0.1)
Medicaid eligibility group					
Cash, adult	(34.7)	(26.4)	(22.4)	(33.0)	(30.0)
Cash, disabled	(42.6)	(51.1)	(51.8)	(44.2)	(52.1)
Medically needy, adult	(6.7)	(7.2)	(8.6)	(4.3)	(6.1)
Medically needy, disabled	(3.1)	(2.7)	(2.6)	(3.9)	(2.6)
Other, adult	(3.1)	(2.4)	(2.5)	(2.2)	(2.3)
Other, disabled	(4.4)	(2.8)	(2.8)	(3.8)	(2.4)
Poverty, adult	(4.3)	(6.5)	(8.6)	(6.9)	(3.5)
Poverty, disabled	(1.2)	(1.0)	(0.8)	(1.7)	(1.0)
TANF eligible[b]	(5.8)	(4.2)	(4.0)	(4.1)	(4.5)
Residing in MSA[c]	(82.2)	(79.9)	(82.2)	(89.2)	(74.2)
Eligible months	9.9 ±3.3	9.9 ±3.3	9.9 ±3.3	9.2 ±3.7	10.2 ±3.1
Minimum distance from nearest health center, km	4.8 ±6.7	9.7 ±13.1	9.3 ±12.2	7.7 ±11.8	10.9 ±14.4
CDPS risk score[d]	0.90 ±1.00	1.11 ±1.34	1.12 ±1.34	1.37 ±1.78	1.03 ±1.18
Use and spending					
Primary care					
Visits, no.	7.6 ±7.8	8.6 ±8.9	8.5 ±8.0	8.2 ±10.2	8.9 ±9.7
Spending, $	1 430 ±2 312	2 090 ±6 687	1 366 ±4 656	2 153 ±6 383	3 053 ±8 686

Continued

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TABLE 1—*Continued*

Characteristic	Health Center, No. (%) or Mean ±SD	Non-Health Center, No. (%) or Mean ±SD			
		Combined	Physician Office	Hospital Outpatient	Mixed Use[a]
Other outpatient[e]					
Visits, no.	12.2 ±39.4	16.7 ±45.5	17.8 ±49.3	13.2 ±36.2	16.1 ±42.2
Spending, $	1 965 ±6 820	3 748 ±11 278	3 799 ±11 611	3 224 ±11 283	3 825 ±10 804
Prescription drug spending, $	2 324 ±5 457	2 765 ±14 540	2 805 ±9 469	2 986 ±36 839	2 649 ±7 324
Emergency department					
Visits, no.	1.2 ±3.0	1.4 ±3.4	1.1 ±2.8	2.7±5.6	1.3 ±3.2
Spending, $	216 ±634	236 ±713	181 ±559	492 ±1 229	240 ±686
Inpatient					
Visits, no. (SD)	0.2 ±0.8	0.3 ±1.2	0.3 ±1.0	0.6 ±2.0	0.3 ±1.0
Length of stay,[f] no. (SD)	0.8 ±5.3	1.4 ±7.5	1.2 ±6.3	3.1 ±13.1	1.2 ±6.6
Spending, $ (SD)	1 496 ±9 879	2 324 ±13 264	1 910 ±10 494	5 610 ±25 508	1 959 ±11 315
Total spending, $ (SD)	7 518 ±15 196	11 306 ±26 165	10 189 ±21 102	14 699 ±49 810	11 865 ±22 310

Note. CDPS = Chronic Disability Payment System; MSA = metropolitan statistical area; TANF = Temporary Aid for Needy Families. Characteristics are derived from the setting where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. The sample size was n = 1 038 974.

[a]Mixed use refers to enrollees for whom no single setting accounts for > 50% of primary care visits.

[b]Enrollee is eligible for TANF program in any month during the data year.

[c]Patient resides in a MSA.

[d]CDPS risk score derived from concurrent risk weights is shown here as an indicator of severity of illness. These values were not used in the model; rather, we used binary variables for 69 of the individual CDPS diagnoses.

[e]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[f]Total annualized inpatient length of stay in days.

claims across all service types (inpatient, nonprimary care outpatient, and prescription drugs) to characterize disease severity. We also controlled for 2 geographic variables: residing in a metropolitan statistical area[16] and the distance from where the patient lived (using the centroid of the residence zip code)[17] to the closest health center delivery site.

Statistical Analyses

We conducted basic descriptive analyses of patient characteristics, utilization, and spending by assigned primary care setting. Because the characteristics of health center patients are unlike those of patients seen in other settings, we used propensity score methods to balance potential observed confounders.[18] The propensity score–matching method is a technique for selecting non–health center users who are matched with health center users on potentially confounding covariates. This matching approach results in groups that are comparable on the basis of the covariates, regardless of correct model specification of outcomes and covariates, which is required in the standard generalized linear model.

We estimated propensity scores using a logistic regression model in which receiving treatment in a health center is predicted by the covariates we have described. We matched health center patients and non–health center patients with replacement using the nearest neighbor matching method. We then developed a series of generalized linear models to assess the effect of primary care setting on utilization and expense outcomes on the matched sample. We used a log link, assuming negative binomial distribution for utilization and γ-distribution for expenses. (Further details on the propensity score match and statistical models are available as a supplement to the online version of this article at http://www.ajph.org.)

We expressed our results in terms of the estimated mean of utilization or spending for each primary care setting and percentage difference in utilization or spending associated with the health center primary care setting relative to the non–health center comparison group. We conducted a main analysis with all states pooled, comparing health center to non–health center patients. In secondary analyses, we compared health center patients to physician office, hospital outpatients, and mixed use patients separately. Because Medicaid programs may vary significantly by state, we also performed separate state-by-state analyses. We conducted sensitivity analysis of a range of subgroup populations, including disabled beneficiaries and recipients of Temporary Aid for Needy Families benefits (not shown). We considered results to be statistically significant using a threshold of $P < .005$ on the basis of the Bonferroni method of correction for multiple comparisons.[19] We carried out all analyses with SAS version 9.4 (SAS Institute, Cary, NC). All reported P values are 2-sided.

RESULTS

Our final analyses included 144 076 health center Medicaid patients and 894 898 non–health center patients (Table 1). Roughly two thirds of patients were female, and they had an average age of 41 years. Most patients were from racial/ethnic minority groups. On an unadjusted basis, health center patients had lower levels of utilization and expense across all service types.

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Before propensity score matching, health center and non–health center users differed substantially across several covariates, including state, Medicaid eligibility category, distance from the nearest health center site, and disease burden. After matching, observed confounders were balanced (data available as a supplement to the online version of this article at http://www.ajph.org).

When compared with non–health center patients, patients receiving most of their primary care in health centers experienced lower utilization and spending for all services examined (Table 2). The largest differences were in other outpatient visits (15.7 vs 12.2; –22% difference; CI = –21%, –24%) and spending ($2948 vs $1964; –33% difference; CI = –32%, –35%) as well as inpatient admissions (0.25 vs 0.19; –25% difference; CI = –22%, –27%) and spending ($2047 vs $1496; –27% difference; CI = –24%, –30%). Total spending was lower for health center patients ($9889 vs $7518; –24% difference; CI = –23%, –25%). Differences in ED services were smaller in magnitude, although health center patients still had lower ED use (1.3 vs 1.2 visits; –11% difference; CI = –10%, –13%) and spending ($244 vs $216; –11% difference; CI = –10%, –13%).

When compared with the physician office, hospital outpatient, and mixed use groups (Table 3), the pattern of consistently lower use and spending for all services held for health center patients in comparison with hospital outpatients and mixed use patients. When compared with physician office patients, there was no difference in primary care use for health center patients, and health center patients had higher primary care spending ($1184 vs $1430; 21% difference; CI = 18%, 24%), more ED visits (1.0 vs 1.2; 16% difference; CI = 14%, 18%), and more ED spending ($186 vs $216; 16% difference; CI = 13%, 18%). Health center patients had lower use and spending across other services and lower total spending.

When comparing health center patients to non–health center patients in each of the 13 study states, we found trends in findings that were generally consistent across states (Table 4). Total spending was lower for health center patients across all 13 states. In 3 states (Connecticut, Illinois, and Texas), health center patients had higher primary care use or spending, and in Illinois, health center patients had higher ED use.

DISCUSSION

In this study of fee-for-service adult Medicaid enrollees across 13 states, we found that patients who received the majority of their primary care in health centers had lower total health care use and spending than did matched patients who receive primary care in other settings. The finding of lower total spending for health center patients was robust across all primary care comparison settings and states that we examined.

When comparing the full range of outcomes across states, we found that most states had the same patterns as our main analyses that pooled all states. The general consistency of these findings suggests that there may be a distinct association between health center primary care setting and health care use and spending because each state administers the Medicaid program independently, with variation in financing, management, and care programs. Some individual states did have

TABLE 2—Use and Expense for Health Center Patients Compared With Matched Non–Health Center Patients: United States, 2009

Variable	Non–Health Center (n = 144 075), Estimate (95% CI)	Health Center (n = 144 075), Estimate (95% CI)	Difference,[a] % (95% CI)
Primary care			
Visits, no.	8.2 (8.2, 8.3)	7.6 (7.6, 7.7)	–7 (–8, –7)
Spending, $	1845 (1815, 1876)	1430 (1418, 1442)	–23 (–24, –21)
Other outpatient care[b]			
Visits, no.	15.7 (15.5, 15.9)	12.2 (12.0, 12.4)	–22 (–24, –21)
Spending, $	2948 (2900, 2996)	1964 (1930, 2000)	–33 (–35, –32)
Prescription drug spending, $	2704 (2664, 2744)	2324 (2296, 2352)	–14 (–16, –12)
Emergency department			
Visits, no.	1.3 (1.3, 1.4)	1.2 (1.2, 1.2)	–11 (–13, –10)
Spending, $	244 (240, 247)	216 (213, 219)	–11 (–13, –10)
Inpatient			
Admissions, no.	0.25 (0.25, 0.26)	0.19 (0.19, 0.20)	–25 (–27, –22)
Length of stay,[c] d	1.1 (1.1, 1.2)	0.8 (0.8, 0.9)	–26 (–29, –23)
Spending, $	2047 (1987, 2114)	1496 (1446, 1548)	–27 (–30, –24)
Total spending, $	9889 (9784, 9996)	7518 (7440, 7597)	–24 (–25, –23)

Note. CI = confidence interval. Primary care setting is determined by where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. Each health center patient was matched with 1 non–health center patient on the basis of the logit of propensity score, which was estimated using a logistic regression adjusting for patient demographics (age, race/ethnicity, gender), insurance characteristics (Medicaid eligibility category, months of eligibility, Temporary Aid for Needy Families program beneficiary indicator), disease burden (on the basis of binary disease diagnosis variables from the Chronic Illness and Disability Payment System), state, residence in a metropolitan statistical area, and distance from the closest health center delivery site.

[a]A negative percentage difference reflects lower health center utilization or spending.

[b]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[c]Total annualized inpatient length of stay in days.

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TABLE 3—Use and Expense for Health Center Patients Compared With Matched Physician Office, Hospital Outpatient, and Mixed Use Patients: United States, 2009

Utilization or Cost	Health Center (n = 144 076), Estimate (95% CI)	Physician Office (n = 144 074)		Hospital Outpatient (n = 144 071)		Mixed Use[a] (n = 144 074)	
		Estimate (95% CI)	Difference From Health Center, % (95% CI)[b]	Estimate (95% CI)	Difference From Health Center, % (95% CI)[b]	Estimate (95% CI)	Difference From Health Center, % (95% CI)[b]
Primary care							
Visits, no.	7.6 (7.6, 7.7)	7.6 (7.6, 7.7)	0 (−1, 0)	7.7 (7.7, 7.8)	−1 (−2, −1)	8.6 (8.6, 8.7)	−12 (−12, −11)
Spending, $	1 430 (1 418, 1 442)	1 184 (1 158, 1 211)	21 (18, 24)	1 974 (1 944, 2 004)	−28 (−29, −26)	2 315 (2 283, 2 347)	−38 (−39, −37)
Other outpatient care[c]							
Visits, no.	12.2 (12, 12.5)	14.4 (14.2, 14.7)	−15 (−17, −13)	13.5 (13.3, 13.7)	−9 (−11, −7)	18.5 (18.2, 18.8)	−34 (−35, −32)
Spending, $	1 970 (1 935, 2 006)	2 842 (2 787, 2 897)	−31 (−32, −29)	3 066 (3 015, 3 117)	−36 (−37, −34)	3 170 (3 125, 3 217)	−38 (−39, −36)
Prescription drug spending, $	2 324 (2 296, 2 352)	2 716 (2 680, 2 752)	−14 (−16, −13)	3 051 (2 964, 3 140)	−24 (−26, −21)	2 709 (2 673, 2 746)	−14 (−16, −13)
Emergency department							
Visits, no.	1.2 (1.2, 1.2)	1 (1, 1)	16 (14, 18)	2.6 (2.5, 2.6)	−54 (−54, −53)	1.4 (1.4–1.4)	−13 (−15, −12)
Spending, $	216 (213, 219)	186 (184, 189)	16 (13, 18)	480 (473, 486)	−55 (−56, −54)	249 (245, 252)	−13 (−15, −11)
Inpatient							
Admissions, no.	0.19 (0.19, 0.20)	0.22 (0.21, 0.22)	−11 (−14, −8)	0.60 (0.59, 0.61)	−68 (−69, −67)	0.24 (0.24, 0.25)	−21 (−23, −19)
Length of stay,[d] d	0.8 (0.8, 0.9)	0.9 (0.9, 0.95)	−9 (−13, −4)	2.8 (2.7, 2.9)	−70 (−71, −69)	1.11 (1.1, 1.1)	−24 (−27, −20)
Spending, $	1 496 (1 446, 1 548)	1 757 (1 702, 1 814)	−15 (−19, −11)	4 908 (4 799, 5 018)	−70 (−71, −68)	1 893 (1 834, 1 953)	−21 (−24, −17)
Total spending, $	7 530 (7 452, 7 609)	8 791 (8 691, 8 891)	−14 (−16, −13)	13 629 (13 467, 13 793)	−45 (−46, −44)	10 439 (10 337, 10 542)	−28 (−29, −27)

Note. CI = confidence interval. Primary care setting is determined by where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. Each health center patient was matched with 1 patient from the physician office, hospital outpatient, and mixed use settings on the basis of the logit of propensity score, which was estimated using a multinomial logistic regression adjusting for patient demographics (age, race/ethnicity, gender), insurance characteristics (Medicaid eligibility category, months of eligibility, Temporary Aid for Needy Families program beneficiary indicator), disease burden (on the basis of binary disease diagnosis variables from the Chronic Illness and Disability Payment System), state, residence in a metropolitan statistical area, and distance from the closest health center delivery site.

[a]Mixed use indicates enrollees, where no single setting accounts for > 50% of primary care visits.

[b]The negative percentage difference reflects lower health center utilization or spending.

[c]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[d]Total annualized inpatient length of stay in days.

results that varied from the trend observed when all states were pooled. Connecticut, Illinois, and Texas had higher primary care use or spending for health center patients, and Illinois had higher ED use for non–health center patients.

When examining different forms of non–health center primary care settings (physician office, hospital outpatient, and mixed use), we found that most of our main findings held, except that health center patients had more primary care spending and ED use and spending than did physician office patients.

One potential interpretation of our results is that if health centers provide comparable or higher levels of quality, lower spending may mean that they are an efficient form of primary care. Two other recent studies of health center primary care have used data from the Medical Expenditure Panel Survey[11] and Medicare claims,[20] and they similarly found lower overall health care use or spending for health center patients. With respect to quality of care, short-term studies (most often 1–2 years) using administrative or survey data have generally found process-based measures of quality to be comparable or higher among health centers for similar patient populations.[11,21,22] Studies using ecologic designs have also demonstrated that the establishment or expansion of health centers in an area is associated with long-term declines in mortality.[23,24] Recent high-profile studies of Medicaid have brought intense controversy over the cost of the program.[25] States that are considering expansion of their Medicaid programs are engaged in discussions of how to manage health care spending for newly insured patients. If our observation of lower use and cost among health center patients is owing to health centers providing a more

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TABLE 4—Adjusted Percentage Difference (95% CI) in Utilization and Spending, Health Center Patients Compared With Non–Health Center Patients, by State: United States, 2009

Variable	AL, % Difference (95% CI)	CA, % Difference (95% CI)	CO, % Difference (95% CI)	CT, % Difference (95% CI)	FL, % Difference (95% CI)	IA, % Difference (95% CI)	IL, % Difference (95% CI)	MS, % Difference (95% CI)	NC, % Difference (95% CI)	TX, % Difference (95% CI)	VT, % Difference (95% CI)	WV, % Difference (95% CI)
Matched health center patients, no.	132	74 028	8640	8481	9947	2945	10 371	7113	748	9909	1728	10 022
Primary care												
Visits	−16 (−36, 10)	−10 (−11, −9)	−17 (−19, −14)	35 (31, 40)	−23 (−25, −21)	−3 (−7, 1)	6 (4, 9)	−10 (−12, −8)	−20 (−27, −12)	−9 (−11, −7)	−1 (−7, 5)	−15 (−16, −13)
Spending	−38 (−60, −5)	−37 (−38, −35)	−11 (−16, −6)	5 (−1, 11)	−31 (−34, −28)	−34 (−40, −26)	11 (5, 18)	−23 (−29, −15)	−33 (−44, −20)	19 (15, 24)	−1 (−11, 12)	−13 (−17, −9)
Other outpatient[a]												
Visits	−48 (−77, 15)	−12 (−14, −9)	−25 (−32, −17)	−23 (−28, −18)	−44 (−49, −39)	−6 (−14, 2)	−4 (−11, 4)	1 (−7, 9)	−26 (−41, −6)	−37 (−42, −32)	−19 (−31, −5)	−15 (−20, −10)
Spending	−84 (−94, −51)	−37 (−39, −36)	−42 (−49, −34)	−33 (−40, −26)	−54 (−59, −48)	−26 (−39, −10)	−25 (−30, −19)	−32 (−41, −23)	−33 (−48, −13)	−38 (−42, −34)	−23 (−37, −5)	−24 (−31, −16)
Prescription spending	−30 (−64, 38)	0 (−2, 2)	−31 (−36, −25)	−5 (−9, 0)	−22 (−26, −16)	−12 (−22, −2)	−26 (−36, −14)	−3 (−10, 4)	−35 (−49, −17)	−20 (−26, −15)	−11 (−21, 1)	−18 (−21, −14)
Emergency department												
Visits	11 (−47, 132)	−6 (−9, −3)	−4 (−10, 2)	−1 (−7, 6)	−40 (−43, −36)	−40 (−45, −34)	16 (9, 25)	−3 (−8, 2)	21 (−2, 51)	−9 (−14, −3)	−9 (−21, 5)	−15 (−20, −10)
Spending	16 (−53, 184)	−5 (−8, −2)	−10 (−16, −3)	−3 (−9, 4)	−41 (−45, −37)	−45 (−50, −39)	1 (−7, 10)	−5 (−10, 0)	13 (−10, 41)	−4 (−10, 2)	−6 (−19, 9)	−18 (−23, −12)
Inpatient												
Admissions	No estimate	−17 (−21, −14)	−12 (−23, 1)	−24 (−32, −16)	−28 (−35, −19)	−45 (−56, −33)	−33 (−42, −24)	−19 (−28, −10)	−26 (−48, 6)	−1 (−11, 10)	−24 (−48, 11)	−6 (−15, 4)
Length of stay[b]	No estimate	−15 (−20, −10)	−3 (−23, 24)	−30 (−40, −19)	−24 (−35, −10)	−44 (−58, −27)	−44 (−53, −33)	−10 (−22, 4)	−9 (−42, 44)	−4 (−17, 11)	−13 (−41, 28)	−5 (−17, 10)
Spending	−5 (−24, 19)	−13 (−19, −8)	−9 (−28, 16)	−31 (−40, −20)	−29 (−39, −18)	−41 (−56, −20)	−50 (−59, −39)	−13 (−24, 0)	−23 (−49, 18)	−14 (−27, 1)	−21 (−46, 15)	−11 (−22, 2)
Total spending	−63 (−78, −37)	−22 (−23, −20)	−26 (−30, −21)	−19 (−23, −15)	−32 (−36, −29)	−27 (−32, −21)	−27 (−31, −22)	−19 (−24, −14)	−29 (−40, −15)	−22 (−26, −18)	−15 (−24, −6)	−18 (−21, −14)

Note. CI = confidence interval. "No estimate" means that models for that outcome did not converge and no estimate was reached. Primary care setting was determined by where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. Each health center patient was matched with 1 non–health center patient on the basis of the logit of propensity score, which was estimated using a logistic regression adjusting for patient demographics (age, race/ethnicity, gender), insurance characteristics (Medicaid eligibility category, months of eligibility, Temporary Aid for Needy Families program beneficiary indicator), disease burden (determined by binary disease diagnosis variables from the Chronic Illness and Disability Payment System), state, residence in a metropolitan statistical area, and distance from the closest health center delivery site. The negative percentage difference reflects lower health center utilization or spending.

[a]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[b]Total annualized inpatient length of stay in days.

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efficient form of primary care, then health center program growth may provide an avenue for expanding Medicaid in a cost-efficient manner.

A second interpretation is that the patterns of utilization and cost reflect characteristics of the health care network accessed by health center patients—as opposed to aspects of care within the health center. If health center providers tend to refer patients to other care settings that have lower use rates or lower spending (because of access or practice patterns), the nature of those referral networks may lead to the observed differences in use and spending. Although utilization of lower cost specialty and inpatient care networks may be a desirable outcome, policymakers and Medicaid administrators must ensure that it does not limit access to high-quality care. For example, in a recent national survey of health centers conducted in 2009 and 2013, health center leaders reported increasing difficulty obtaining specialty or subspecialty appointments for their Medicaid patients.[26]

A third interpretation is that health center patients may be different from those in physician offices and hospital outpatient practices in ways that we are unable to account for with our data. Our propensity score–matching techniques adjust for confounding stemming from factors such as patient demographics, type of Medicaid insurance, and the disease burden observed in our data. However, we are unable to control for potential confounding because of factors that are not observed in our data set, and we are unaware of any studies that identify factors that drive Medicaid patients' choice of health centers for primary care. In particular, administrative claims data provide limited insight into important patient characteristics that may influence utilization and spending, such as healthy behaviors and lifestyle.

If our findings are driven by health center Medicaid patients being systematically healthier in ways not observable in claims data, this would highlight the importance of ongoing work to improve measurements of health and incorporate them into risk adjustment and payment schemes.[27,28] Health centers have long been known for serving vulnerable populations with high chronic disease burdens and health care needs. As health centers increasingly participate in accountable care organizations and shared savings arrangements with payers, it will be important for health centers and other providers to thoroughly document the health needs of their patients and communicate that information in a clear and compelling manner to payers and policymakers.

Other limitations in the scope of our analysis are also important to note. Our cross-sectional study cannot provide evidence of a causal relationship between health center care and health care use and spending. Although our study includes a large number of patients across several states, our study sample excludes important groups of enrollees (e.g., Medicaid managed care enrollees, Medicaid–Medicare dual eligible enrollees, long-term care recipients, and children), which limits the generalizability of findings across the Medicaid program. In particular, because Medicaid managed care has grown to become the dominant mode of administration for the Medicaid programs, ongoing study of the association between primary care setting and health care spending in the context of managed care is important.

We examined only Medicaid utilization and spending; we did not assess quality of care and cannot make conclusions about cost effectiveness or overall costs from a societal perspective. For example, health centers receive some federal financial support outside the scope of Medicaid fee-for-service payment, and some programs (such as the 340b drug pricing program, which is prevalent among health centers)[29] may lower Medicaid spending for health center patients. Health centers also receive federally supported technical assistance on quality improvement as well as federal grant funding outside Medicaid payments that we are unable to account for in our analyses. In addition, we cannot account for the unobserved heterogeneity across patients of different settings that is not captured with propensity score adjustment. Finally, although we classified settings of primary care into health center, hospital outpatient, and physician offices, it is important to acknowledge the wide variation in organizational structure and practices within these settings. Future work should analyze the role of organizational characteristics in the relationship between primary care setting and utilization, cost, and quality of care.

Cost reduction will continue to play an important role in ongoing efforts to improve the US health care system. Our analyses showed that Medicaid patients who obtain primary care at health centers had lower use and spending than did similar patients in other primary care settings. Although we hypothesize several potential causes for this association, future studies should work to empirically identify the mechanisms at work that lead to the compelling utilization and cost differences found in this study. As more Medicaid data become available for the years after the implementation of the ACA, it will also be critical to examine whether the associations we observed differ for more recent cohorts. AJPH

CONTRIBUTORS

R. S. Nocon drafted the article. R. S. Nocon, S. M. Lee, D. B. Mukamel, Y. Cao, and L. M. White conducted data analyses. R. S. Nocon, R. Sharma, Q. Ngo-Metzger, D. B. Mukamel, L. Shi, M. H. Chin, and E. S. Huang conceptualized the study. All authors interpreted results, provided critical revision, and approved the final version of the article.

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HUMAN PARTICIPANT PROTECTION

This study was deemed exempt by the University of Chicago, Biological Sciences Division institutional review board.

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Transforming a Family Medicine Center and Residency Program Into a Federally Qualified Health Center

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Abstract

The authors describe a family medicine center before and after a merger between the Keck School of Medicine of the University of Southern California, the California Hospital Medical Center, and the Eisner Pediatric and Family Medical Center in 2012. The merger provided new opportunities to stabilize the financial base of a clinical practice struggling financially and to enhance the training of residents and other health professionals in primary care, which motivated the partners to consider this new model. After 18 months of negotiations, they were able to convert the family medicine center and residency program into a new federally qualified health center. The benefits to this new model include an increase in both patient volume and the quality of education, supporting residency accreditation; a greater number of residents from U.S. medical schools; enhanced education and preparation of primary care physicians for practice in medically underserved communities; enhanced reimbursements and new opportunities for state, local, and federal grants; and quality improvement and new information technology. The partners overcame academic, administrative, legal, and regulatory obstacles, communication barriers, and differences in culture and expectations to achieve this merger. Keys to their success include the commitment of the leaders at the three institutions to the goals of the merger, a dedicated project manager and consultants, opportunities for new revenue sources and reimbursements, and support from a pioneering charitable foundation. The authors conclude by discussing the implications of using community health centers as the focal point for training primary care clinicians and addressing workforce shortages.

Many have written about the projected primary care physician shortage. Yet, most medical students continue to choose specialty training rather than careers in primary care.[1]

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If current trends continue, the physician workforce will be unable to meet the projected need for primary care physicians with the advent of the Patient Protection and Affordable Care Act (ACA),[2,3] particularly in low-income and rural communities.[4–6]

Some have proposed reconsidering where physicians are trained as one solution to the primary care workforce shortage, particularly in medically underserved communities.[7] Hospital-based family medicine residencies increasingly are becoming unsustainable because many academic medical centers (AMCs) care for uninsured patients, which poses a financial threat to clinical practices and their AMC sponsors.[8] This strain and proposed reductions in federal funding for graduate medical education (GME)[9,10] have contributed to the decline in the number of family medicine residencies in the United States.[11]

As hospital-based residencies become less feasible, physicians' offices, clinics, and other ambulatory settings provide alternative venues for GME training in primary care.[12] These venues offer clear benefits for training primary care clinicians,[13] including teaching disease management models[14] and promoting interprofessional team-based care.[15,16] However, the current GME payment structure does not easily support such ambulatory care-based training programs. Community health centers (CHCs),[17] however, have promise as future training sites because of their role in the health care safety net.[18,19] Currently, over 8,000 CHCs serve over 20 million low-income patients annually in the United States.[20] Under the ACA, the number of CHCs could double and play an even larger role in serving both the newly insured and those who remain uninsured.[21] However, CHCs have a particularly difficult time recruiting and retaining a primary care workforce given the competition for the limited and declining pool of trained primary care clinicians.[22] Still, although health professionals trained in CHCs may be more likely to practice in medically underserved areas, there are few training programs formally preparing physicians to work in such settings.[20,23]

Linking a university and a hospital-based residency program with a CHC creates a new set of challenges. Morris and Chen[9] noted that a successful CHC-based residency program requires that the institutions that govern such programs share a mission of education, service,

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innovation, and flexibility. However, as described in another study, administrative problems and governance issues were the primary obstacles in establishing effective partnerships for such CHC-based residency programs.[24] Moreover, managing federally funded CHCs requires compliance with federal rules concerning volume, access, and quality of care at each site. These rules may be incompatible with the requirements of the residency program accrediting boards because residency programs also must ensure sufficient time for faculty teaching and, among residents, for learning. Meeting these requirements is particularly challenging for family medicine residency programs because of the required faculty-to-resident ratios, practice space requirements, a curriculum that includes a specific number of hospital-based rotations, and Medicare regulations governing GME-supported activities.[25]

In this article, we describe the conversion of a family medicine center and residency program into a jointly operated clinical and educational collaboration involving a university medical school, a community hospital, and a CHC. We also identify barriers, keys to success, and lessons learned that we hope will inform other efforts to build health-center-focused training programs. To prepare this article, we first conducted guided interviews with key leaders from each of the three partner organizations, including the Keck School of Medicine of the University of Southern California (USC), the California Hospital Medical Center (CHMC), and the Eisner Pediatric and Family Medical Center (EPFMC). We also interviewed the residents, clinicians, and faculty at the original family medicine center. We asked interviewees about their motivations for the merger (financial, patient care, organizational, and training), their expectations in achieving the merger, challenges and keys to success in the merger process, and lessons learned. Additionally, we reviewed grant proposals, affiliation agreements, progress reports, meeting minutes, and other documents related to the merger process. In this article, we describe the changes that occurred in the family medicine center before and after the merger in five areas: structure and governance; revenues and finances; quality improvement and information technology; volume of care; and the residency program (see Table 1 for a comparison of the family medicine center before and after the merger).

The Family Medicine Center and Residency Program Before the Merger

This merger involved three organizations —the Department of Family Medicine at the Keck School of Medicine of USC; CHMC, a community acute care hospital in downtown Los Angeles and sponsor of the residency program; and EPFMC, a federally qualified health center (FQHC). Each has a long history of serving South Los Angeles,[26–28] which includes some of the nation's most impoverished communities.[29] Under a contract with CHMC, USC has operated the residency program since 1984 and continues to oversee the clinical services. Although all three institutions are geographically close, there had been little clinical integration before the merger, so this formal affiliation process required transferring assets, personnel, and clinical and administrative functions between the partner institutions.

Table 1

Overview of a Family Medicine Center Before and After a Merger in 2012 Between the Keck School of Medicine of the University of Southern California (USC), the California Hospital Medical Center (CHMC), and the Eisner Pediatric and Family Medical Center

Characteristic	Before merger	After merger
Structure	Family medicine center operates as an independent component of the USC patient care system	Family medicine center designated as a federally qualified health center (FQHC)
Governance	Inadequate attention devoted to the overall management of the family medicine center and residency program	• Innovative tripartite governance committee established • More attention paid to the residency program by CHMC
Volume of care	11,600 patients	• 13,600 patients
Revenues and finances	• $673,000 annual operating deficit • Reimbursement below costs particularly for patients enrolled in public programs • No reimbursement for uninsured patients	• $150,000 Tranquada grant for managing seniors and people with disabilities • $125,000 medical home demonstration grant from L.A. Care • Changed to cost-based reimbursement for Medi-Cal as FQHC • $600,000 Health Resources and Services Administration start-up grant as a new access point • Annual operating allocation of $600,000 • Healthy Way LA (LA County 1115b waiver funds)
Information technology	No health information technology in place	Adopted electronic medical records, patient care management system, and billing system
Quality improvement	Little focus on quality assurance and improvement and systems of care	Designated as medical home demonstration site by L.A. Care
Residency program	24 residents; not many U.S. medical school graduates; few placed through the National Resident Matching Program	New class of residents, all U.S. medical school graduates; all placed through the National Resident Matching Program

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Each institution had a different motivation for pursuing the conversion of the family medicine center. Before the merger, the family medicine center, for example, had inadequate patient management systems, and their quality improvement and billing systems met the needs of a university such as USC but not those of a busy community-based practice with patients with complex health and social problems. Also, the family medicine center had no operable health information technology system that aligned with federal requirements.[30]

In addition, our review of residency review committee reports showed a consistent underperformance in the number of patients seen by the residents at the family medicine center, leading to the residency committee citing deficiencies in their accreditation reports. In 2010, the family medicine center reported just over 11,000 patient visits, fewer than the federally required number based on the number of residents. In addition, its patient volume and payer mix was insufficient to maintain fiscal solvency—most patients were covered by Medi-Cal (California state Medicaid), and the volume of patients was not high enough to compensate for the relatively low per-visit reimbursement rate from the Medi-Cal program.

Contributing to this less-than-optimal patient care volume at the family medicine center was the time required for educational activities. Both faculty and residents had non-clinical-care responsibilities that limited their ability to see patients, thus limiting the center's ability to generate the revenue needed to support the clinical enterprise. This setup challenged the financial underpinning of the family medicine center, which relied entirely on patient care reimbursement and GME payments (which it received through a contract with CHMC). As a result, the family medicine center was operating with an annualized deficit of over $650,000. The unstable financial state of the center made it difficult to recruit and retain faculty and residents. Before the merger, the residency program could not fill its classes with graduates of U.S. medical schools, and leaders at CHMC proposed closing it.

Meanwhile, EPFMC pursued the merger as an opportunity to incorporate medical education into the hospital to expand its commitment to the community and to begin to solve its workforce challenges.

Because of these ongoing problems, USC considered converting the family medicine center into an FQHC under the auspices of the university. USC leaders, however, rejected this approach because the university could not comply with the federal regulation that required a 51% consumer majority on the governing board of a health center.[31] An alternative solution was to merge with EPFMC, an existing FQHC located in close proximity to the family medicine center. A grant from a local foundation provided the resources for USC to hire a project manager to oversee the merger, consultants for grant writing and organizational transformation, and program evaluation.

Completing the Merger

Leaders at the three partner institutions (CHMC, USC, and EPFMC) identified the administrative and legal obstacles to the merger, established committees and subcommittees for overseeing the transformation, convened meetings between the clinical and teaching faculty, and submitted a federal Health Resources and Services Administration (HRSA) grant proposal. With the guidance of a project manager, they developed affiliation agreements and governance arrangements and completed personnel and asset transfers. After 18 months of planning and difficult negotiations, USC successfully transferred the family medicine center to EPFMC. This merger alone was an achievement for the partner institutions, given the complexity of their organizations, the delicacy of their negotiations, and the risks associated with the transfer for all parties.

Structure and governance

This merger brought about some important changes to the roles and responsibilities of each institution. The previously independent family medicine center became an FQHC governed by an innovative partnership and an oversight committee with members from all three partner institutions serving both clinical and administrative functions. Under the new model, some areas of responsibility overlap, whereas others are specific to each of the partner institutions. CHMC, for example, continues to sponsor the residency program and contracts with USC for faculty time. Responsibility for clinical operations and management shifted from USC to EPFMC, whereas EPFMC maintained control of its employees and other management functions. Both USC and CHMC now

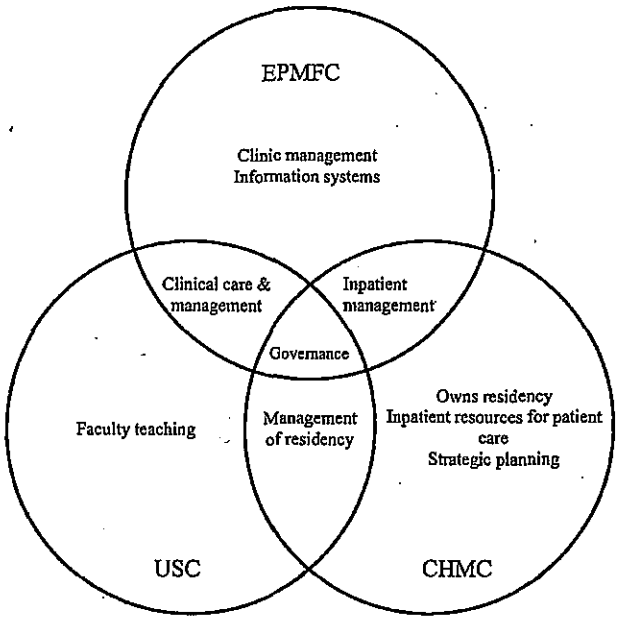

Figure 1 Governance and management model for a family medicine center after a merger between the Keck School of Medicine of the University of Southern California (USC), the California Hospital Medical Center (CHMC), and the Eisner Pediatric and Family Medical Center (EPFMC), 2012.

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occupy one seat on the EPFMC board of directors, and new committees that were established to monitor the transformation process include representatives from each institution (see Figure 1).

The merger removed the responsibility for many of the day-to-day administrative tasks of running a clinical practice from the faculty, allowing them to concentrate instead on teaching. For EPFMC, the merger provided both new teaching opportunities and faculty positions for the clinical staff and access to a new network of subspecialty physicians. Teaching residents now engages physicians at the family medicine center in education as well as clinical service activities.

Revenues and finances

The merger provided new opportunities for expanding and stabilizing funding for clinical operations at the family medicine center, and the $650,000 annual operating deficit was replaced with new funding sources. For example, the ACA provides funding for new and expanded CHCs, called new access points.[32] On behalf of the partner institutions, in January 2011, EPFMC submitted the application to HRSA to designate the family medicine center as a new access point.[20] HRSA approved the application a year later designating the family medicine center as an FQHC, which entitled it to receive cost-based reimbursement for Medi-Cal patients, $600,000 in start-up funding, and ongoing operational grants.

In addition to this federal revenue source, the family medicine center tapped into local funding sources for serving the uninsured, because EPFMC had existing contracts with the Los Angeles County Department of Health Services. These funding sources included programs funded under the State of California's 1115b Medicaid waiver, in which the family medicine center previously was ineligible to participate because it had not been part of the Los Angeles County Public Private Partnership Program.[33] Under this waiver, the family medicine center converted the Medi-Cal Seniors and Persons with Disabilities (SPD) group into a managed care plan, which acted as an additional source of revenue. Because of EPFMC's relationship with the L.A. Care health plan, they were able to secure a $125,000 grant to support SPD patients assigned to the family medicine center.[34] Through the same relationship with L.A. Care, the family medicine center secured a medical home demonstration grant. These new grants and contracts erased the family medicine center's existing deficit, and today the center operates with a balanced budget.

Quality improvement and information technology

As an existing FQHC, EPFMC brought years of experience running a program for low-income and working families, including cultural and linguistic systems for patient care management, front office and appointment systems, quality improvement, appointment scheduling, patient education materials, and clinical management tools. Additionally, EPFMC provided health information technology that has allowed the family medicine center to improve its workflow by introducing new patient registration, billing, patient management systems, and electronic medical records to its day-to-day operations.

Volume of care

In the year after the merger, patient volume at the family medicine center increased from 11,600 patients to over 13,600 patients. As a result, the family medicine center is operating more efficiently and is serving not only a more diverse population but also more patients with chronic illnesses, with whom the faculty and residents are trying to establish ongoing relationships.

The residency program

In the year after the merger, the quality of the medical school graduates applying to the residency program improved dramatically. In 2012, the residency program filled all eight first-year slots with U.S.-trained medical students, all of whom who entered the National Resident Matching Program for the class of 2012.[35]

Lessons Learned

This collaboration is an innovative model for training family medicine residents in a CHC. It combines the benefits of a community-based teaching program closely affiliated with a medical school and a community hospital with those of a training program focused on the principles of primary care and community health. These changes are important for the management of the family medicine center, but they also enhance the residents' educational experiences by exposing them to these new systems that are based on performance, quality, and efficiency in a safety net setting.

The partner institutions overcame significant barriers to bring about this merger, including several administrative and legal obstacles related to governance, personnel, procurements, contracts, and leases, which the literature has shown other large organizations have found difficult to overcome.[36] Addressing personnel issues was particularly difficult because staff had to agree to transfer their employment from USC to EPFMC. In addition, legal counsel from all three partner institutions often raised seemingly insurmountable issues throughout the merger process.

Although all three partner institutions had worked together in the past, the culture underlying each remained quite different. Safety net hospitals and health centers focus on the delivery of care and must overcome the health, economic, and social disparities of their patients. USC, a university, however, must address its academic mission. The administrative difficulty in merging these organizations was exacerbated by these different cultures and business processes. USC recognized the need to adapt to a new environment that emphasized higher levels of clinical productivity, strict governance regulations for FQHCs, and addressing the family medicine center's financial deficits. EPFMC recognized the challenges and time needed for teaching residents, achieving accreditation faculty-to-resident ratios, and meeting Medicare and Medicaid GME regulations about training residents in nonhospital settings.

In addition, the lack of effective and timely communication among the partner institutions threatened to delay the merger. In some cases, the project manager was unable to obtain financial and other data needed for grant applications and other administrative tasks in a timely fashion. The communication between the partner institutions was often limited by the restrictions posed by nondisclosure

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and confidentiality agreements and a desire to avoid creating anxiety among the staff and residents. In addition, the staff, residents, and faculty at the family medicine center were unaware entirely of some milestones in the merger, such as when the transfer would occur, who would be affected, and how it might change clinical care or residency training activities or their jobs. Finally, leaders at the partner institutions are busy executives without the discretionary resources and time to accomplish the myriad tasks that were necessary to bring about the merger.

In solving all of these problems, we identified four key lessons for success:

1. Leaders at the three partner institutions brought an unrelenting commitment to achieving the ultimate goal, which helped to eliminate some of the communication problems that resulted from the cultural differences and expectations among the partners. This commitment has been critical to the success of other health center organized teaching programs and proved to be important to the success of ours as well.[9,37] These leaders were able to expedite the approval process through their own complex organizations in what otherwise would have been a long process of review and revision. Instead, they met all the deadlines for submitting grant proposals and materials for overcoming these obstacles.
2. Hiring a project director and consultants facilitated the resolution of many of the obstacles faced. The project director kept the project on track and navigated the merger efficiently in spite of the busy schedules of the leaders at the partner institutions. The project manager served as a liaison between all the committees, developed and implemented project timelines, communicated with government officials, and wrote grant proposals.
3. The opportunities for securing additional federal and local revenue sources motivated all parties to move quickly to facilitate the merger, submit applications for funding, and secure access to new funding streams. Because of this efficiency, the parties were able to establish a financially stable structure for the family medicine center and the residency program that set it on a course toward sustainability.
4. Financial support from a pioneering local foundation provided the resources needed for infrastructure development, grant writing, legal counsel, and other administrative tasks.

Although the merger process was a success, this partnership is only the beginning of the transformation process. The partner institutions face ongoing challenges, including developing or improving systems to ensure and better the quality both of the patient care delivered at the family medicine center and the training provided by the residency program. The merger has brought to the family medicine center a patient population with significant chronic diseases and mental health problems that will require the practice to reconfigure its patient care delivery system to emphasize continuous care and chronic disease management under a patient-centered medical home model. Going forward, the center must identify the appropriate clinical leaders and empower them with clear and well-defined lines of authority, accountability, and governance structures within the collaborative framework. It must also promote the family medicine center as an integral setting for training residents and other health professional students in patient care.

Going Forward

Connecting a clinical practice and training program that are financially struggling to an FQHC can help to stabilize their financial base while maintaining the role that academic and inpatient institutions play in their management. Replicating our model with other primary care residencies in the United States also could help to close the gap between the need for and supply of primary care physicians serving CHCs and other safety net providers. In addition, training residents in a CHC will give future physicians a better understanding of the social determinants of health and how community agencies can promote the health of families and communities.[38]

To expand the number of community-based training sites, however, will require a review of the regulations governing residency programs, many of which now act as barriers to transforming such practices to better align them with the goals of primary care. Leaders also should consider combining innovative approaches to training with new ways of delivering care with the goal of transforming training programs into settings where research and development in deploying policy initiatives takes place, such as the patient-centered medical home[39] and accountable care organization models.[40] Moreover, leaders should consider expanding this model *through* the Teaching Health Center Graduate Medical Education program,[41] which is designed to increase the number of primary care residents and dentists trained in community-based ambulatory patient care settings. Finally, we recommend that institutions considering such mergers continue to study their effects on the cost of health care, patients' access to care, and the quality of care delivered.

Acknowledgments: The authors wish to thank the leaders of the three partner organizations who participated in interviews and shared data. They also wish to thank Christine Feifer, DrPH, the staff, faculty, and residents of the family medicine center, the Keck School of Medicine of USC, the California Hospital Medical Center, and the Eisner Pediatric and Family Medical Center, who agreed to be interviewed for the study component of this merger process.

Funding/Support: The study component of this merger process was supported by a generous grant from the Unihealth Foundation, Los Angeles, California.

Other disclosures: None.

Ethical approval: The study component of this merger process was submitted and approved by the USC institutional review board for the protection of human subjects.

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EXHIBIT I

LETTERS OF SUPPORT

February 15, 2017

Dear Office of Healthcare Access,

On behalf of the Bridgeport Regional Business Council (BRBC), representing over 700 member companies in the greater Bridgeport Area, I am writing to you today to support the Certificate of Need application of St. Vincent's Medical Center to transition the operation of its Family Health Center outpatient primary health care programs to the Southwest Community Health Center, a Federally Qualified Health Center serving residents in Bridgeport.

Southwest Community Health Center is a Federally Qualified Health Center (FQHC) serving Greater Bridgeport. Southwest serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level, uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, Southwest provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach.

In addition to its principal site in Bridgeport, Southwest operates seven Bridgeport School Based Health Center sites, including the Read School Health Center, located one block from St. Vincent's Medical Center. It also operates four additional health and mental health sites of care in Bridgeport.

The collaboration that St. Vincent's Medical Center and Southwest Community Health Center has developed is one that will ensure that primary health care resources within Greater Bridgeport are maximized and coordinated. In addition, Southwest is accredited as a Primary Care Medical Home, and brings with it benefits that a hospital-based clinic cannot provide, including malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment and other costs associated with providing patient services at an FQHC.

An important community benefit will be the expanded and enhanced specialty care that St. Vincent's will provide to patients of the clinic. This will reduce the current extended wait times for patients to see specialty care providers in critical specialties such as cardiology, neurology, gastroenterology and podiatry, for example. The combination of these two organizations providing complementary services will help ensure that a majority of the health care needs of the community are being addressed.

In addition, the transition helps to meet the triple aim of healthcare: providing healthcare at the lowest cost possible, with the best quality outcomes and a high level of patient satisfaction.

This collaboration will expand and enhance services and reduce duplication of services, providing comprehensive primary care, behavioral health and specialty care to patients served in this area.

The BRBC urges you to support unconditionally this transition for the benefit of both this area's patients and our local communities.

Sincerely,

Mickey Herbert

Mickey Herbert
President and CEO

10 Middle Street, 14th Floor, Bridgeport, Connecticut 06604
(203) 335-3800 (ph); (203) 266-0105 (fax); herbert@brbc.org

City of Bridgeport

Department of Health & Social Services

999 Broad Street, Bridgeport, Connecticut 06604
Telephone (203) 576-7680 * Fax (203) 576-8311

JOSEPH P. GANIM
Mayor

Maritza Bond, MPH
Director of Health and Social Services

February 21, 2017

Dear Office of Healthcare Access,

This letter is written to support the Certificate of Need application of St. Vincent's Medical Center to transition the operation of its Family Health Center outpatient primary health care programs to the Southwest Community Health Center, a Federally Qualified Health Center serving residents in Bridgeport.

Southwest Community Health Center is a Federally Qualified Health Center (FQHC) serving Greater Bridgeport. Southwest serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level, uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, Southwest provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach.

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In addition, the transition helps to meet the triple aim of healthcare: providing healthcare at the lowest cost possible, with the best quality outcomes and a high level of patient satisfaction.

This collaboration will expand and enhance services and reduce duplication of services, providing comprehensive primary care, behavioral health and specialty care to patients served in this area.

I (we) urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Sincerely,

M. Bond

Maritza Bond, MPH
Director of Health
City of Bridgeport
999 Broad St
Bridgeport, CT 06604

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE JASON D. PERILLO
ONE HUNDRED THIRTEENTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
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HOUSE REPUBLICAN WHIP

MEMBER
EXECUTIVE AND LEGISLATIVE NOMINATIONS COMMITTEE
FINANCE, REVENUE AND BONDING COMMITTEE
PUBLIC HEALTH COMMITTEE

February 24, 2017

Dear Office of Healthcare Access,

This letter is written to support the Certificate of Need application of St. Vincent's Medical Center to transition the operation of its Family Health Center outpatient primary health care programs to the Southwest Community Health Center, a Federally Qualified Health Center serving residents in Bridgeport.

Southwest Community Health Center is a Federally Qualified Health Center (FQHC) serving Greater Bridgeport. Southwest serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level, uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, Southwest provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach.

In addition to its principal site in Bridgeport, Southwest operates seven Bridgeport School Based Health Center sites, including the Read School Health Center, located one block from St. Vincent's Medical Center. It also operates four additional health and mental health sites of care in Bridgeport.

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The collaboration that St. Vincent's Medical Center and Southwest Community Health Center has developed is one that will ensure that primary health care resources within Greater Bridgeport are maximized and coordinated. In addition, Southwest is accredited as a Primary Care Medical Home, and brings with it benefits that a hospital-based clinic cannot provide, including malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment and other costs associated with providing patient services at an FQHC.

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This collaboration will expand and enhance services and reduce duplication of services, providing comprehensive primary care, behavioral health and specialty care to patients served in this area.

I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Sincerely,

Jason Perillo
State Representative
Shelton, 113th District

cc: Dianne Auger, Senior Vice President
St. Vincent's Medical Center

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

Representative Christopher Rosario
CHIEF MAJORITY WHIP
128th Assembly District
City of Bridgeport

Legislative Office Building
Hartford, Connecticut 06106
Office: (860) 240-1375
Christopher.Rosario@cga.ct.gov

CHAIRMAN
BLACK & PUERTO RICAN CAUCUS

MEMBER
APPROPRIATIONS COMMITTEE
EDUCATION COMMITTEE
LABOR COMMITTEE
TRANSPORTATION COMMITTEE

APPROPRIATIONS SUBCOMMITTEE CHAIR
ELEMENTARY EDUCATION

February 2017

Office of Health Care Access
P.O. Box 340308
410 Capitol Avenue
Hartford, CT 06134

To Who It May Concern,

This letter is written to support the Certificate of Need application of St. Vincent's Medical Center to transition the operation of its Family Health Center outpatient primary health care programs to the Southwest Community Health Center, a Federally Qualified Health Center serving residents in Bridgeport.

Southwest Community Health Center is a Federally Qualified Health Center (FQHC) serving Greater Bridgeport. Southwest serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level, uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, Southwest provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach.

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In addition, the transition helps to meet the triple aim of healthcare: providing healthcare at the lowest cost possible, with the best quality outcomes and a high level of patient satisfaction.

This collaboration will expand and enhance services and reduce duplication of services, providing comprehensive primary care, behavioral health and specialty care to patients served in this area.

I (we) urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Sincerely,

Christopher Rosario
State Representative – 128th District

cc: Dianne Auger, Senior Vice President
St. Vincent's Medical Center
file

United Way
of Coastal Fairfield County

LIVE UNITED
United Way

February 8, 2017

Dear Office of Healthcare Access,

This letter is written to support the Certificate of Need application of St. Vincent's Medical Center to transition the operation of its Family Health Center outpatient primary health care programs to the Southwest Community Health Center, a Federally Qualified Health Center serving residents in Bridgeport.

Southwest Community Health Center is a Federally Qualified Health Center (FQHC) serving Greater Bridgeport. Southwest serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level, uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, Southwest provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach.

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855 Main Street • 10th Floor • Bridgeport, CT 06604-4915
tel 203-334-5106 • fax 203-334-3297
unitedwaycfc.org

05-02-2017 00171

In addition, the transition helps to meet the triple aim of healthcare: providing healthcare at the lowest cost possible, with the best quality outcomes and a high level of patient satisfaction.

This collaboration will expand and enhance services and reduce duplication of services, providing comprehensive primary care, behavioral health and specialty care to patients served in this area.

I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Most Sincerely,

Merle Berke-Schlessel, Esq.
President and CEO

MBS/dlr

EXHIBIT J

LETTER OF INTENT

SOUTHWEST COMMUNITY HEALTH CENTER, INC.

AND

ST. VINCENT'S MEDICAL CENTER

LETTER OF INTENT

February 7, 2017

*This Letter of Intent (this "**LOI**") sets forth the intentions and understanding of the parties with respect to a transfer of certain assets of St. Vincent's Medical Center ("**St. Vincent's**") to Southwest Community Health Center, Inc. ("**Southwest**" and together with St. Vincent's, each a "**Party**" and collectively, the "**Parties**"). Such transfer of certain assets of St. Vincent's to Southwest is referred to herein as the "**Contemplated Asset Transfer.**"*

I. Parties.

St. Vincent's, located in Bridgeport, Connecticut, is a tertiary care hospital that provides community-based primary care services, including internal medicine, women's health care services and pediatric care and some specialty services at its Lindley Street location ("***Clinic Location***") to the patients of the City of Bridgeport and the surrounding communities (the "***Community***").

Southwest, a federally qualified health center, also located in Bridgeport, provides outpatient primary care services, including pediatrics, internal medicine, behavioral healthcare, substance abuse, dental care and women's health care services ("***Primary Care Services***") to individuals in need of such services in the Community.

II. Background.

Southwest believes that it can fulfill its health care mission by maintaining and expanding access to the Primary Care Services in the Community by creating a satellite clinic which it would operate at the Clinic Location. The Parties are fully committed to working closely with each other to effectuate a transfer of care and certain assets relating to St. Vincent's clinic operations at the Clinic Location. From and after the closing of the Contemplated Asset Transfer, it is contemplated that Southwest will provide primary care services at the Clinic Location to the former patients of St. Vincent's that have elected to continue their treatment with Southwest at the Clinic Location as well as other new community patients who seek services at the Clinic Location, and that Southwest will continue to offer primary care clinical training experience for St. Vincent's medical residents in its graduate medical educational programs (the "***Residents***") upon Southwest beginning to provide Primary Care Services at the Southwest-operated Clinic Location.

III. Guiding Principles.

St. Vincent's and Southwest share a mutual commitment to provide Primary Care Services to members of the Community. The Parties recognize that the transfer of certain of St. Vincent's' assets to Southwest will support their respective missions, identities and community roles. The transfer of care is intended to be seamless and expand and enhance the amount and type of Primary Care Services available to the Community.

IV. Confidentiality/Publicity.

That certain Confidentiality Agreement, dated February 4, 2016, by and between St. Vincent's and Southwest (the "***Confidentiality Agreement***"), a copy of which is attached hereto as Annex A, is incorporated herein by reference.

V. Access; Conduct of Business.

Each Party shall provide the other Party access to their respective facilities, books and records and shall cause their respective officers, managers, employees, accountants and other agents and representatives to cooperate fully with such other Party and its representatives in connection with such other Party's due diligence investigation related to the Contemplated Asset Transfer. Each Party acknowledges and agrees that the scope of its respective due diligence shall take into account such Party's role in the transaction as transferor or transferee, as applicable. Neither Party shall be under any obligation to continue with its due diligence investigation or negotiations regarding the Definitive Agreements (defined below) if, at any time, the results of its due diligence investigation are not satisfactory to such Party for any reason in its sole discretion. If either Party determines not to continue its due diligence investigation or negotiations, it shall notify the other Party in writing and this LOI will terminate as of the date of such notice.

Until the Definitive Agreements have been duly executed and delivered by the Parties (and as may be more fully set forth therein), or until the termination of the LOI as of the Regulatory Approvals Date (as defined below) or the Outside Date (defined below) or as set forth in the preceding paragraph, St. Vincent's shall conduct its business at the Clinic Location only in the ordinary course consistent with past practice and shall not engage in any extraordinary transactions.

VI. Expenses.

Each Party will be responsible for its own fees and expenses related to its evaluation of and entry into the Contemplated Asset Transfer described herein, except as expressly provided otherwise herein, or agreed to in writing. Notwithstanding the preceding sentence, (i) St. Vincent's will pay any and all fees and expenses related to obtaining the Certificate of Need (as defined below), provided that Southwest will pay any and all fees and expenses related to any legal or other advice it elects to obtain in connection with the Certificate of Need; and (ii) Southwest will pay any and all fees and expenses related to obtaining approval for the Change of Scope Request (as defined below).

VII. Exclusivity; Right of First Refusal.

Prior to the expiration of this LOI, in accordance with the terms described herein, St. Vincent's agrees not to enter into any agreement involving the transfer of assets or operations with respect to the Clinic Operations with any other Federally Qualified Health Center or community health centers that receive funding under Section 330 of the Public Health Service Act (*"FQHCs"*), other than Southwest, unless Southwest first receives a written offer from St. Vincent's to engage in the same transaction on equal or better terms than such other FQHC. Southwest will have fifteen (15) business days to consider any such written offer.

VIII. General Terms.

Transfer of Assets: St. Vincent's shall sell, transfer and convey to Southwest, and Southwest shall acquire and accept from St. Vincent's, certain assets of St. Vincent's, including such furniture, machinery, fixtures, equipment, operational assets (but generally excluding contracts), client lists, business and client records, and intellectual property associated with the conduct of the St. Vincent's' services and identified pursuant to a mutually agreeable Asset Transfer Agreement and related documents (collectively, the "***Assets***").

Medical Records: The Parties will enter into a Medical Records Custody Agreement wherein Southwest agrees to maintain custody of the medical records of St. Vincent's patients cared for at the Clinic Location in accordance with the applicable State and Federal regulatory requirements.

Sublease: Southwest shall sublease a portion of the premises leased by St. Vincent's at the Clinic Location under a certain Lease Agreement dated as of December 11, 2006, by and between St. Vincent's and Roy Realty, L.L.C. (the "Landlord"), as amended (the "***Lease***"), pursuant to a sublease agreement by and between Southwest and St. Vincent's (the *"**Sublease**"*). The parties shall cooperate in good faith with the Landlord to prepare the documentation effecting the Sublease. Any leasehold improvement allowances under the Lease shall be proportionally allocated to Southwest in connection with the Sublease in a manner to be determined by the Parties in their sole discretion and set forth in the Definitive Agreements.

Consideration: The consideration for the Contemplated Asset Transfer shall be the agreement of Southwest to: (1) provide Primary Care Services, including internal medicine, women's health care services, behavioral health and pediatric care to members of the community served by St. Vincent's; (2) enter into the Sublease; and (3) solely to the extent expressly agreed to by Southwest in the Definitive Agreements, assume certain clinical service obligations of St.

Vincent's. In addition, (1) the Parties will discuss whether and the extent to which St. Vincent's would compensate Southwest for direct and indirect graduate medical education expenses associated with the teaching of medical residents who have clinical rotations at the Southwest operated-Clinic Location; and (2) for a period of five (5) years following the Closing Date, St. Vincent's will pay to Southwest certain subsidies in such amounts and on such terms and conditions as shall be mutually agreed to by the Parties and provided for in the Asset Transfer Agreement or other Definitive Agreement (the ***"Community Benefit Grant"***). In order to comply with certain safe harbor provisions for Federally Qualified Health Centers under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, such funds shall not place restrictions on patients' freedom of choice or the independent medical judgment of health care professionals providing services.

Employment Matters: Southwest will advertise available employment positions at the Southwest-operated Clinic Location, and St. Vincent's will permit its employees to be available to be interviewed by Southwest concerning prospective employment by Southwest prior to the Closing Date. Southwest will give hiring preference to employees of St. Vincent's that meet Southwest's credentialing requirements and employment policies over other prospective hires not affiliated with St. Vincent's. Subject to receipt and review of employment applications, background and reference checks, any offer of employment to an employee of St. Vincent's shall (i) be made on terms and conditions of employment as are reasonably determined by Southwest, taking into account such employee's current role, title and compensation at St. Vincent's, (ii) commence as of the Closing Date (as defined below), and (iii) be contingent upon completion of the closing of the Contemplated Asset Transfer. Effective as of the Closing Date, St. Vincent's will terminate the employment of all of its employees who are employed by St. Vincent's on the Closing Date, and who accept such offers of employment and are hired by Southwest.

Client Notices: For a period of nine (9) months following the Closing Date, St. Vincent's will provide marketing services to inform current and prospective clients of the Contemplated Asset Transfer and the continuation of the provision of Primary Care Services at the Southwest-operated Clinic Location, the type and extent of such marketing services to be determined by the Parties in their sole discretion and set forth in the Definitive Agreements. Promptly following the Closing Date and subject to applicable laws and regulations, St. Vincent's shall deliver notices, in a form mutually agreeable to the Parties, to each client of the Clinic Location within

the period of three (3) years prior to the Closing Date, notifying them of the closing of the Contemplated Asset Transfer.

Residency Program: Following the closing of the Contemplated Asset Transfer, Southwest will permit up to eight (8) residents, or such greater number of residents as may be agreed by the Parties from time to time, at any one time in internal medicine to rotate through and receive training at the Southwest-operated Clinic Location. Southwest acknowledges that the residents will provide services in all respects in a manner consistent with the Ethical and Religious Directives for Catholic Health Care Services as published by the United States Conference of Catholic Bishops, Washington, D.C. of the Roman Catholic Church or its successor as amended from time to time and as interpreted by Bishop of the Diocese of Bridgeport. A copy of such Directives is available at http://www.usccb.org/about/doctrine/ethical-and-religious-directives/. In the event that a resident is limited in the care he or she may provide to a patient of the Clinic Location by virtue of the Ethical and Religious Directives for Catholic Health Care Services, such resident shall be required to refer the patient to a qualified Southwest provider at the Clinic Location who can provide the medical service. St. Vincent's will continue to manage the resident rotation program; provided, however, Southwest will retain responsibility for all patient services rendered by the residents. Notwithstanding, St. Vincent's shall maintain professional liability coverage for the residents who provide services at the Southwest-operated Clinic Location. The agreement between the Parties with respect to the residency program will be set forth in a separate agreement between the Parties (the "Residency Agreement").

Teaching Physicians: Teaching physicians for residents at the Southwest-operated Clinic Location will be St. Vincent's teaching physicians leased or otherwise contracted to Southwest. The Parties will enter into an agreement, on terms acceptable to the Parties in their sole discretion, addressing such leasing or other contractual arrangement (the ***"Teaching Physician Agreement"***).

Specialty Services: The Parties will discuss the possibility of St. Vincent's providing certain specialty services at the Southwest-operated Clinic Location for patients of Southwest at the Clinic Location. Southwest shall be responsible for contracting directly with a third-party for the provision of women's health care services.

Operating Committee: During the five (5) year period associated with the Community Benefit Grant, the Parties shall form a joint advisory committee focused on coordinating services at the Clinic Location in a manner that enhances quality, access, patient outcomes and the cost-

effectiveness of care (the "Operating Committee"). The size and charter of the Operating Committee will be determined by the Parties.

Quality Committee: For as long as St. Vincent's provides specialty services at the Southwest-operated Clinic Location, the Parties shall form a quality committee focused on the quality and safety of clinical services provided at the Clinic Location (the "Quality Committee"). The size and charter of the Quality Committee will be determined by the Parties.

Definitive Documents: The Parties shall prepare initial drafts of the Asset Transfer Agreement and related documents, including but not limited to a Bill of Sale, Medical Records Custody Agreement, Sublease, Residency Agreement, Teaching Physician Agreement, Form of Patient Notice and Charter of the Joint Operating Committee (collectively, the "***Definitive Agreements***"), containing reasonable and customary representations, warranties, indemnities, conditions, covenants and agreements by St. Vincent's and Southwest.

Regulatory Matters: The parties anticipate that certain government and/or regulatory approvals will be required to consummate the Contemplated Asset Transfer. Southwest agrees to cooperate (in accordance with Section 4 of the Confidentiality Agreement) with St. Vincent's' efforts to obtain a Certificate of Need (the "***Certificate of Need***") from the State of Connecticut Office of Health Care Access to terminate providing healthcare services in Connecticut at the Clinic Location. In addition, Southwest will file a Change of Scope request (the "***Change of Scope Request***") with the Health Resources & Services Administration (the "***HRSA***") in order to begin providing services at the Clinic Location. The parties agree to work in good faith to obtain the Certificate of Need and HRSA approval for the Change of Scope Request as soon as possible, but in any event before September 30, 2017 (the "***Regulatory Approvals Date***").

Conditions to Closing: The closing of the Contemplated Asset Transfer shall be subject to the following conditions:

1. Execution of the Definitive Agreements, on mutually agreeable terms and conditions, with respect to the Contemplated Asset Transfer and related documentation;

2. Completion by each of Southwest and St. Vincent's and their respective representatives of a due diligence investigation of the other Party, the results of which are satisfactory to

Southwest and St. Vincent's, as the case may be, in its sole discretion;

3. No material adverse change in St. Vincent's or Southwest's business, condition, assets, operations or prospects;

4. Receipt of the Certificate of Need approval and HRSA approval of the Change of Scope Request; and

5. Receipt of any necessary internal and third party approvals, consents, permits, licenses, etc. (including, without limitation any applicable regulatory and/or governmental agency approvals and landlord consent to the Sublease).

Subject to the satisfaction of all conditions precedent to closing, the Parties intend that the Contemplated Asset Transfer described in this LOI shall close on or about September 30, 2017 (the "***Closing Date***").

This LOI is not intended to constitute a complete statement of the Contemplated Asset Transfer and does not create a legally binding agreement or commitment of either Party, except as to this paragraph, and Sections IV, V, VI and VII hereof, each of which is intended to be legally binding. This LOI may be executed in any number of counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. The executed counterparts may be delivered by PDF or facsimile and such PDF or facsimile counterparts shall be deemed originals. This LOI shall be governed and construed and enforced in accordance with the laws of the State of Connecticut, without regard to conflicts of laws principles. The binding provisions of this LOI shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, executors, legal representatives, successors and permitted assigns. The binding provisions of this LOI may be amended, modified, changed, waived, discharged, or terminated only by an instrument in writing signed by the Party against which such amendment, modification, change, waiver, discharge or termination is sought to be enforced. Unless sooner terminated in accordance with the terms hereof, this LOI shall expire and terminate as of December 31, 2017 (the "***Outside Date***"), or, if either the Certificate of Need or the approval of the Change of Scope Request is denied, this LOI shall expire and terminate as of ten (10) days after the denial date, unless the Parties mutually agree in writing to extend the LOI term.

[*Signature page follows.*]

IN WITNESS WHEREOF, the parties have executed this LOI as of the date set forth above.

SOUTHWEST COMMUNITY HEALTH CENTER, INC.

By: Katherine S. Yacavone
Name: Katherine S. Yacavone
Title: President/CEO

ST. VINCENT'S MEDICAL CENTER

By: Vincent C. Caponi
Name: Vincent C. Caponi
Title: President and CEO

Annex A

Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

CONFIDENTIALITY AGREEMENT, dated as of February 4, 2016, by and among St. Vincent's Medical Center ("*St. Vincent's*") and Southwest Community Health Center, Inc. ("*Southwest*").

WHEREAS, St. Vincent's and Southwest (collectively, the "*Parties*" and each, a "*Party*") desire to enter into discussions for the purpose of exploring a potential alignment strategy with respect to St. Vincent's Family Health Clinic (the "*Potential Alignment*"); and

WHEREAS, the Parties intend such discussions to be confidential and may disclose certain confidential and proprietary information to each other in connection with their discussions regarding the Potential Alignment; and

WHEREAS, the Parties desire to enter into this Agreement to protect the confidentiality of such discussions and information.

NOW THEREFORE, in consideration of the agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

1. Confidentiality.

a. The Parties each agree not to disclose this Agreement, the subject matter of this Agreement or any potential transactions or dealings contemplated hereby to any third parties except for their professional, legal and financial advisors, officers, directors, senior management and executive employees. In the case of St. Vincent's, this exception also includes Ascension Health and its affiliates (and their respective professional, legal and financial advisors, officers, directors, senior management and executive employees) and St. Vincent's President's/Strategic Council. Each Party shall be responsible to ensure that any individuals receiving information related to the Potential Alignment shall themselves abide by the terms of this Agreement.

b. The Parties further recognize and agree that certain confidential and proprietary information relating to the operations of the Parties and their affiliates (such confidential and proprietary information is hereinafter referred to as the "*Confidential Information*") may have been or may be exchanged between the Parties in the conduct of their discussions. Confidential Information, in whatever form, media or stage of development may include, without limitation, financial statements of each Party and such Party's affiliates, the number of procedures and charges for such procedures in such Party's existing health care facilities, summaries and projections, marketing reports, planning and operational materials, plans and specifications, forms of contracts and agreements, intellectual and intangible property of such Party, trade secrets, the identity of vendors of goods and services and the terms by which vendors supply goods and services to such Party, information concerning budgeting models and analyses, program and data bases, patient lists, price lists and data relating to the pricing of services marketed or provided by such Party or any of its affiliates, information contained in procedural manuals, memoranda, guides, computer programs and records and the operations of such Party, any information marked "Confidential" by the Party disclosing such information and any information disclosed in writing without a conspicuously designated "Confidential" or "Proprietary" that would be apparent to a reasonable person, familiar with the Party's business and the industry in which it operates, that such information is of a confidential or proprietary nature the maintenance of which is important to the Party. A Party receiving Confidential Information is referred to herein as the "Receiving Party." A Party disclosing Confidential Information is referred to herein as the "Disclosing Party."

c. All Confidential Information at all times shall be maintained by the Receiving Party as confidential consistent with the terms of this Agreement and, without the appropriate prior written consent of the Disclosing Party, shall not be used for any purpose other than in support of efforts to explore possible dealings related to the Potential Alignment.

d. Notwithstanding any provisions of this Agreement, no obligation of confidentiality shall exist as to:

(i) information or materials that are in the public domain at the time of the disclosure by the Disclosing Party to the Receiving Party or thereafter become part of the public domain through no act or omission of the Receiving Party;

(ii) information that the Receiving Party can demonstrate was already in its possession prior to the date of disclosure hereunder and was not subject to any obligation of confidentiality;

(iii) information that was lawfully disclosed to the Receiving Party after the date hereof by a third party who has a lawful right to disclose such information and is not subject to any confidentiality obligations;

(iv) information independently developed by the Receiving Party without reliance on the Confidential Information provided by the Disclosing Party; or

(v) information approved for release by written authorization of the Disclosing Party, but only to the extent of such authorization.

e. If a Receiving Party is requested or required by a governmental agency or instrumentality to disclose any Confidential Information, such Receiving Party will provide the Disclosing Party with prompt notice of such request so that the Disclosing Party may seek any appropriate protective orders and/or waive compliance with the provisions of this Agreement. If a protective order cannot be obtained or a waiver is not provided, but the Receiving Party is still required to disclose Confidential Information to the government agency or instrumentality, the Receiving Party will furnish only that portion of the Confidential Information that it is advised by counsel is legally required and, at the request of the Disclosing Party, will use reasonable efforts to obtain assurance that confidential treatment will be accorded such Confidential Information, it being understood that such reasonable efforts shall be at the cost and expense of the Disclosing Party.

f. Confidential Information provided by a Disclosing Party shall be deemed to be the property of the Disclosing Party. This Agreement shall not be interpreted or construed as granting any license or other right under or with respect to any trade secret or other proprietary right of the Disclosing Party.

g. The Receiving Party acknowledges that the Confidential Information received from the Disclosing Party hereunder constitutes valuable confidential, commercial, business and proprietary information of the Disclosing Party and that serious economic disadvantage or irreparable harm may result for the Disclosing Party if the Receiving Party breaches its nondisclosure obligations under this Agreement. Accordingly, in the event of threat of disclosure of any Confidential Information, or breach of this Agreement by the Receiving Party, the Disclosing Party shall be entitled to injunctive relief, specific performance and other equitable relief, without proof of monetary damages or the need to post a bond.

h. The Receiving Party understands and acknowledges that neither the Disclosing Party nor any of its representatives makes any representation or warranty, express or implied, as to the accuracy or completeness of the Confidential Information. The Receiving Party agrees that neither the Disclosing Party nor any of its representatives shall have any liability to the Receiving Party or to any of its representatives relating to or resulting from the use of the Confidential Information or any errors therein or omissions therefrom, it being understood and agreed that any representations or warranties with respect to such Confidential Information shall be set forth in the definitive documents with respect to a Potential Alignment when, as and if executed between the Parties ("*Definitive Documents*").

i. If the Parties discontinue discussions or agree not to enter into a Potential Alignment, or if a Disclosing Party requests the return of its Confidential Information at any time for any reason, the Receiving Party will return to the Disclosing Party all Confidential Information and copies thereof (regardless how such Confidential Information or copies are maintained) in the Receiving Party's possession. Notwithstanding the return of any Confidential Information to the Disclosing Party or any termination or expiration of this Agreement, the rights and obligations of the Parties with respect to confidentiality of the Confidential Information, including but not limited to any Confidential Information that remains in the possession of a Receiving Party, shall survive.

2. Publicity. Neither of the Parties hereto nor their affiliates will make any public announcement and will keep strictly confidential the existence of this Agreement and the discussions regarding the Potential Alignment, and will not issue any press release or other public statement relating thereto, without the express consent of the other Party hereto.

3. Binding Commitment. The terms of this Agreement are intended to create legal and binding obligations of the Parties; provided, however, that this Agreement does not, and is not intended to create, any legal obligation of any Party to continue discussions regarding a Potential Alignment, to enter into any Potential Alignment or to obligate any Party to refrain from entering into any agreement or negotiation with any third party.

4. Expenses; . Each Party shall be responsible for its own legal, consulting and other expenses incurred in connection with the negotiation of this Agreement and of discussions regarding any Potential Alignment, as well as the negotiation of the Definitive Documents and the consummation of any Potential Alignment, unless the Parties otherwise agree in writing. If the Parties enter into Definitive Documents with respect to a Potential Alignment, and if the Potential Alignment described in the Definitive Documents would require certificate of need approval by the State of Connecticut Department of Public Health Office of Health Care Access ("OHCA"), (i) Southwest acknowledges and agrees that it will be a co-applicant with St. Vincent's on the certificate of need application filed with OHCA and agrees to cooperate with St. Vincent's in the preparation of such application and participate in any hearing or appeal associated with such application as requested by St. Vincent's, and (ii) Southwest shall not be required to incur any costs or expenses associated with St. Vincent's preparation of, or any filing fees associated with, such application; provided, that Southwest shall be solely responsible for costs or expenses associated with any legal, consulting or other services Southwest chooses to obtain in connection with the cooperation or participation described in clause (i) of this sentence.

5. Governing Law. This Agreement shall be governed by the substantive laws of the State of Connecticut without regard to the conflicts of law principles thereof. The Parties consent to the jurisdiction of the courts of the State of Connecticut and of any federal court located in Connecticut in connection with any action or proceeding arising out of this Agreement. The Parties waive any objection they may have to the laying of venue in the state or federal courts located in Fairfield County, Connecticut in connection with any action or proceeding arising out of this Agreement.

6. Entirety. This Agreement constitutes the entire understanding and agreement between the Parties with respect to its subject matter and supersedes all prior or contemporaneous agreements, representations, warranties and understandings of the Parties, whether oral or written.

7. Miscellaneous. Neither Party may transfer or assign all or any of its rights, obligations or benefits hereunder in whole or in part to any third party, without the prior written consent of the other Party, except that St. Vincent's may assign its rights hereunder to an entity controlling, controlled by or under common control with St. Vincent's. This Agreement may be amended only by written agreement, signed by a duly authorized officer of each Party. This Agreement may be executed in counterparts (and the same may be delivered by means of facsimile or pdf file), each of which shall be deemed an original and to constitute one and the same instrument. No failure or delay by a Party in exercising its rights hereunder shall operate as a waiver or preclude any further or other exercise of such rights. The unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provisions of this Agreement, which shall remain in full force and effect, and the unenforceable provision shall be deemed modified to the minimum extent required to permit its enforcement in a manner most closely approximating the intention of the Parties as expressed herein.

8. Compliance. The Parties wish to comply with applicable trade regulation and antitrust laws. The exchange of Confidential Information as contemplated by this Agreement is simply to facilitate discussions with respect to the Potential Alignment as set forth above. The Parties agree that for the purpose of such discussions the following topics shall not be discussed or any information relating thereto shared between the Parties unless and until the Parties have determined whether a procedure for the exchange of such information is necessary and have agreed upon such procedure:

a. fee schedules, pricing, rate or other reimbursement information;
b. salaries and benefits;
c. marketing plans, market evaluations or strategic plans;
d. material strategic or proprietary information about present or future patients, and referral sources;
e. negotiations with payors such as insurance companies and managed care plans; and
f. any other confidential information that could be used to reduce competition between the Parties.

The Parties acknowledge and agree that they remain as competitors and that they shall operate their respective businesses in the ordinary course of business at all times while this Agreement is in effect. Notwithstanding the foregoing, the Parties acknowledge that, depending on the structure of a Potential Alignment, Definitive Documents may need to address the transition of patients or employees, or other matters relating to the transition of care, and the Parties agree to reasonably cooperate with each other, subject to applicable legal requirements, with respect to these matters.

9. HIPAA. Notwithstanding any provision of this Agreement to the contrary, the Parties agree to comply with all state and federal laws and regulations concerning the confidentiality of individually identifiable healthcare information, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and the regulations promulgated thereunder. Evaluation of the Confidential Information shall be considered part of the healthcare operations of the Parties hereto, provided that the Parties will not disclose to each other protected patient health information of a particular patient.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date set forth above.

ST. VINCENT'S MEDICAL CENTER

By: _____
Name: Stuart Marcus, M.D.
Title: President and Chief Executive Officer

SOUTHWEST COMMUNITY HEALTH CENTER, INC.

By: _____
Name:
Title:

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date set forth above.

ST. VINCENT'S MEDICAL CENTER

By: _____
Name: Stuart Marcus, M.D.
Title: President and Chief Executive Officer

SOUTHWEST COMMUNITY HEALTH CENTER, INC.

By: Katherine S. Yacavone
Name: Katherine S. Yacavone
Title: President/CEO

EXHIBIT K

CHARITY CARE POLICIES

TRUST. VINCENT'S

Summary of Financial Assistance Policy

St. Vincent's Medical Center has a commitment to and respect for each person's dignity with a special concern for those who struggle with barriers to access healthcare services. St. Vincent's Medical Center has an equal commitment to manage its healthcare resources as a service to the entire community. In furtherance of these principles, St. Vincent's Medical Center provides financial assistance for certain individuals who receive emergency or other medically necessary care from St. Vincent's Medical Center This summary provides a brief overview of St. Vincent's Medical Center Financial Assistance Policy.

Who Is Eligible?

You may be able to get financial assistance. Financial assistance is generally determined by your total household income as compared to the Federal Poverty Level. If your income is less than or equal to 250 % of the Federal Poverty Level, you will receive a 100% charity care write-off on the portion of the charges for which you are responsible, except for a small flat charge for services] . If your income is above 250 % of the Federal Poverty Level but does not exceed 400 % of the Federal Poverty Level, you may receive discounted rates on a sliding scale. Patients who are eligible for financial assistance will not be charged more for eligible care than the amounts generally billed to patients with insurance coverage.

What Services Are Covered?

The Financial Assistance Policy applies to emergency and other medically necessary care. These terms are defined in the Financial Assistance Policy. Elective services are not covered by the Financial Assistance Policy.

How Can I Apply?

To apply for financial assistance, you typically will complete a written application and provide supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Policy application.

How Can I Get Help with an Application?

For help with a Financial Assistance Policy application, you may contact Charity Financial Counselor at 203-576-6257.

How Can I Get More Information?

Copies of the Financial Assistance Policy and Financial Assistance Policy application form are available at stvincents.org/financial-assistance and at the Charity Financial Counselor and Patient Access department. Free copies of the Financial Assistance Policy and Financial Assistance Policy application also can be obtained by mail by Contacting Charity Financial Counselor 203-576-6257 also Patient Access 203-576-5074 and Customer Service 203-576-5384. Additional information about the Financial Assistance Policy also is available at Charity Financial Counselor at St. Vincent's Medical Center or by telephone at 203-576-6257.

What If I Am Not Eligible?

If you do not qualify for financial assistance under the Financial Assistance Policy, you may qualify for other types of assistance. For more information, please contact Charity Financial Counselor at St. Vincent's Medical Center or by telephone at 203-576-5384

Translations of the Financial Assistance Policy, the Financial Assistance Policy application, and this plain language summary are available in the following languages upon request: English, Spanish and Portuguese.

gentler hands / SHARPER MINDS

Elizabeth Pereira - Charity Counselor Patient Access
(203) 576-6257 / F (203) 382-2430
2800 Main Street, Bridgeport, CT, 06606 / epereira@stvincents.org

St.Vincent's Medical Center

ST. VINCENT'S MEDICAL CENTER

FINANCIAL ASSISTANCE POLICY
Effective as of July 1, 2016

POLICY/PRINCIPLES

It is the policy of St. Vincent's Medical Center (the "Organization") to ensure a socially just practice for providing emergency or other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not emergency care or otherwise medically necessary.

3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- "**Community**" means the City of Bridgeport, Connecticut, and the Towns of Fairfield, Easton, Monroe, Trumbull and Stratford, Connecticut.
- "**Emergency Care**" means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention may result in:
  a. Placing the health of the individual (or, with respect to a pregnant woman, her unborn child) in serious jeopardy; or
  b. Serious impairment to bodily functions; or
  c. Serious dysfunction of any bodily organ or part; or
  d. With respect to a pregnant woman who is having contractions –

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

- "**Medically Necessary Care**" means care that is determined to be medically necessary following a determination of clinical merit by a licensed provider. In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- "**Organization**" means St. Vincent's Medical Center.
- "**Patient**" means those persons who receive emergency or medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.
2. At a minimum, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the calculated AGB charges. The sliding scale discount is set forth on Attachment 1 to this Policy.
3. Patients with demonstrated financial needs with income greater than 400% of the FPL may be eligible for consideration under a "Means Test" for some discount of their charges for services from the Organization based on a substantive assessment of their ability to pay. To complete the "Means Test" assessment, St. Vincent's Medical Center will require the following documentation:
    a. household family size
    b. annual income
    c. household expenses
    d. medical expenses
    e. disability expenses

    A Patient eligible for the "Means Test" discount will not be charged more than the calculated AGB charges.
4. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant's failure to complete a financial assistance application ("FAP Application").
5. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
6. The process for Patients and families to appeal an Organization's decisions regarding eligibility for financial assistance is as follows:

a. The patient or family member may submit a letter in writing to the St. Vincent's Medical Center's Charity Appeals Committee (the "Appeals Committee") appealing the financial assistance decision. The financial assistance decision will include instructions on how to submit a request to the appeals committee.
b. All appeals will be considered by the Appeals Committee, and decisions of the Appeals Committee, will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by St. Vincent's Medical Center.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.
2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.
3. Free Bed Funds – are gifts provided to the Organization to endow a "free bed" that can be used to provide medical care to those who cannot afford it. It is not a governmental program but a charitable donation administered by the Organization.
4. Other Assistance Funds such as, but not limited to, grants and St. Vincent's Medical Center Foundation, Inc. (Swim Across the Sound).

To be eligible for the Free Bed Fund and Other Assistance Funds, a patient must meet the specific criteria of the fund. See Attachment 2.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained by contacting the Charity Financial Counselor at St. Vincent's Medical Center at 203-576-6257, in writing at 2800 Main Street, Bridgeport CT, 06606, Attention: Charity Financial Counselor or emailing Financial.Assistance@Stvincents.org.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process. The FAP Application and FAP Application Instructions are available on line at stvincents.org/financial-assistance or by contacting the Charity Financial Counselor at St. Vincent's Medical Center at 203-576-6257, in writing at 2800 Main Street, Bridgeport CT, 06606, Attention: Charity Financial Counselor or emailing Financial.Assistance@Stvincents.org.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained by calling the Patient Customer Service Call Center at 203-576-5384, in writing at 2720 Main Street, Bridgeport CT, 06606 Attention: Customer Service Department or visit us on line at stvincents.org/financial-assistance.

Interpretation

This policy is intended to comply with 501(r), except where specifically indicated. This policy, together with all applicable procedures, shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

Attachment 1

ST. VINCENT'S MEDICAL CENTER

SLIDING SCALE DISCOUNT
Effective as of July 1, 2016

Based on Federal Poverty Guidelines (FPL)

Hospital Based Inpatient & Outpatient Services

Monthly Income		250% Charity Care	350%	400%
Family Size	1	2,475	3,465	3,960
	2	3,338	4,673	5,340
	3	4,200	5,880	6,720
	4	5,063	7,088	8,100
	5	5,925	8,295	9,480
	6	6,788	9,503	10,860
	7	7,652	10,713	12,243
	8	8,519	11,926	13,630

Annual Income Income as a % of FPL		250%	350%	400%
Family Size	1	$29,700	41,580	47,520
	2	$40,050	56,070	64,080
	3	$50,400	70,560	80,640
	4	$60,750	85,050	97,200
	5	$71,100	99,540	113,760
	6	$81,450	114,030	130,320
	7	$91,825	128,555	146,920
	8	$102,225	143,115	163,560
SVHS Discount		**100%**	**80%**	**70%**

Attachment 2

St. Vincent's Medical Center
Free Bed Funds

Below is a listing of the Free Bed Funds listing of St Vincent's Medical Center.
If you believe you may qualify for one of the Free Bed funds listed below, you may request to have your case for financial assistance presented to St. Vincent's Medical Center. The Executive Director of Revenue Cycle has the authority to grant free bed funds based on financial and personal need. To obtain further information, including an application, please contact a Financial Counselor at 203-576-6257.

Baker Fund

Available to Bridgeport Fire & Police Departments. The patient must present verification that he/she is a member of the Bridgeport Fire or Police department.

Harral Fund

Member of St. Augustine's Parish. The patient must present a letter from St. Augustine's Parish (Bridgeport,.CT) confirming patient's membership status.

Hubbell Fund

Alumni of St. Vincent's College or Bridgeport Hospital School of Nursing, who reside in Bridgeport and are active in the Nursing of the Sick.

Klein Fund

Funds to assist pediatric patients. Must provide a copy of patient's birth certificate or Baptismal certificate.

Ladies of Charity Fund

Letter verifying membership in the Ladies of Charity organization.

Conlin Fund

Assistance for low-income patients. Must provide proof of income and assets and a letter of denial from available third party sources.

Brodbeck Fund

Emergency room services. Must provide proof of income and assets and a letter of denial from available third party sources.

SOUTHWEST
COMMUNITY HEALTH CENTER

THE SLIDING FEE DISCOUNT POLICY

Sliding Fee Discount Schedule (SFDS)

- Patients either uninsured or underinsured who have personal or household income below the 200% of Federal Poverty Level (FPL) are eligible to receive Sliding Fee Discount on services provided by SW.
- A corresponding SFDS to the fees must be established and be based on a patient's ability to pay.
- The SFDS must correspond to the SW established fee schedules.
- Eligibility for the SFDS is based only on a patient's annual income and family size under the U.S. Department of Health and Human Services (HHS) annual Federal Poverty Guidelines (FPG)
- Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. *(Source; NHSC SFDP Mar. 2016)
- Income includes: earnings, unemployment compensation, worker's compensation, Social Security Income, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count. * (Source; NHSC SFDP Mar. 2016)
- Patient will fill out Sliding Fee Eligibility Form, sign it and provide required documentation to qualify for the discount.
- Income verification; discussed and documented in Patient Check-in procedures
- Eligibility determination process must be conducted in an efficient, respectful, and culturally appropriate manner.
- Eligibility determination process must be documented.
- Required documentation must be given to the patient in writing.

- Patient's eligibility for the SFDS should be renewed every twelve months.
- The SFDS must have at least three discount pay classes above 100 percent and at or below 200 percent of the FPG.
- Exception to this is the E IS Program (Part C) sliding fee SFDS.
- Charges for patients with annual income less the 100% of the prevailing FPG, will be charged a nominal fee.
- Nominal charge must be a fixed fee that does not reflect true value of service(s) provided.
- If certain procedures require devices or supplies other than the customary medical or dental supplies, patients in the "below 100%"category will be required to pay the established fee for these costs.
- Financial Counselors (FC) must explain to the patient the additional charges.
- Patient privacy and confidentiality must be protected throughout the process.
- Patients refusing to provide required documentation to assess income and family size, will be considered ineligible for Sliding Fee discounts.
- The SFDS must be revised annually, to reflect annual updates to the FPG.
- The Sliding Fee Eligibility form has to be also in Spanish.
- The SFDS must be reviewed and approved every year by the Board of Directors.

SOUTHWEST
COMMUNITY HEALTH CENTER

Annual Household Income Table

Effective: February 29, 2016

SLIDING FEE DISCOUNT CATEGORIES

To qualify for category A you must produce any of the following documents;

Income Tax Form 1040(most current) Soc.Security,Disability ,Unemployment

If employed last four pay stubs to detrmine current income. This is in addtion to 1040

Family size must be documented

Eligibility for all other categories requires documentation

Poverty levels are adjusted annualy based on the published Federal Income Poverty Table.

Family Size	Income level A Bellow100% FPL	income level B 101% - 133% of FPL	Income level C 134% - 166% of FPL	income level D 167% - 200% of FPL	income level E Above 200% of FPL
1	0 - 11,880	11,881 - 15,800	15,801 - 19,721	19,722 - 23,760	23,761 - and up
2	0 - 16,020	16,021 - 21,307	21,308 - 26,593	26,594 - 32,040	32,041 - and up
3	0 - 20,160	20,161 - 26,813	26,814 - 33,466	33,467 - 40,320	40,321 - and up
4	0 - 24,300	24,301 - 32,319	32,320 - 40,338	40,339 - 48,600	48,601 - and up
5	0 - 28,440	28,441 - 37,825	37,826 - 47,210	47,211 - 56,880	56,881 - and up
6	0 - 32,580	32,581 - 43,331	43,332 - 54,083	54,084 - 65,160	65,161 - and up
7	0 - 36,730	36,731 - 48,851	48,852 - 60,972	60,973 - 73,460	73,461 - and up
8	0 - 40,890	40,891 - 54,384	54,385 - 67,877	67,878 - 81,780	81,781 - and up
9	0 - 45,050	45,051 - 59,917	59,918 - 74,783	74,784 - 90,100	90,101 - and up
10	0 - 49,210	49,211 - 65,449	65,450 - 81,689	81,690 - 98,420	98,421 - and up

CURRENT DISCOUNTS

INCOME CATEGORIES

	A	B	C	D	E
MEDICAL SERVICES	Nominal fee $20.00	70.0%	60.0%	50.0%	0.0%
DENTAL SERVICES	Nominal fee $30.00	*40.0%*	30.0%	20.0%	0.0%
BEHAVIORAL HEALTH SERVICES	Nominal fee $ 10.00	*85.0%*	80.0%	75.0%	0.0%

EXHIBIT L

AUDITED FINANCIAL STATEMENTS

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

MEMBER OF ASCENSION HEALTH, A SUBSIDIARY OF ASCENSION HEALTH ALLIANCE, D/B/A ASCENSION

CONSOLIDATED FINANCIAL STATEMENTS

SEPTEMBER 30, 2016 AND 2015

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

CONTENTS

MARCUM
ACCOUNTANTS & ADVISORS

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
St. Vincent's Medical Center

We have audited the accompanying financial statements of St. Vincent's Medical Center and Subsidiaries (the Medical Center), which comprise the consolidated balance sheets as of September 30, 2016 and 2015, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting polices used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Marcum LLP ▪ City Place II ▪ 185 Asylum Street ▪ 17th Floor ▪ Hartford, Connecticut 06103 ▪ Phone 860.760.0600 ▪ Fax 860.760.0601 ▪ www.marcumllp.com

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of the Medical Center as of September 30, 2016 and 2015, and the consolidated results of their operations and changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1, effective January 1, 2016, St. Vincent's Health Services Corporation (SVHS) distributed its membership interest in the Medical Center to Ascension Health, and Ascension Health contributed its membership interest in SVHS to the Medical Center. Upon the effectiveness of these transactions, Ascension Health became the sole member of the Medical Center, and the Medical Center became the sole member of SVHS. The accompanying 2015 consolidated financial statements include subsidiaries of SVHS that became subsidiaries of the Medical Center in 2016 and were not formerly included in the Medical Center's previously issued 2015 consolidated financial statements. Our opinion is not modified with respect to this matter.

Marcum LLP

Hartford, CT
February 17, 2017

05-02-2017 00204

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(Dollars in Thousands)

SEPTEMBER 30, 2016 AND 2015

	2016	2015
Assets		
Current Assets		
Cash and cash equivalents	$ 6,656	$ 7,449
Accounts receivable, less allowance for doubtful accounts ($20,300 in 2016 and $27,400 in 2015)	46,108	70,492
Inventories and other current assets	17,349	18,213
Total Current Assets	70,113	96,154
Interest in Investments Held by Ascension	38,914	321,091
Board-Designated Investments and Assets Limited as to Use		
Noncurrent pledges receivable, net	357	628
Board-designated investments	16,720	14,201
Temporarily or permanently restricted	28,388	28,284
Total Board-Designated Investments and Assets Limited as to Use	45,465	43,113
Property and Equipment		
Land and improvements	14,582	14,523
Buildings, leasehold improvements and equipment	487,938	475,278
Construction in progress	6,401	8,634
	508,921	498,435
Less accumulated depreciation	(317,582)	(296,408)
Total Property and Equipment, net	191,339	202,027
Capitalized Software Costs, net	20,230	22,967
Other Assets	16,722	15,956
Total Assets	$ 382,783	$ 701,308

The accompanying notes are an integral part of these consolidated financial statements.

05-02-2017 00205

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS (CONTINUED)

(Dollars in Thousands)

SEPTEMBER 30, 2016 AND 2015

	2016	2015
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued liabilities	$ 44,100	$ 46,545
Current portion of long-term debt	1,500	1,614
Due to System, net	6,305	4,223
Estimated third-party payor settlements	17,909	9,476
Other current liabilities	--	484
Total Current Liabilities	69,814	62,342
Noncurrent Liabilities		
Long-term debt	54,346	54,935
Self-insurance liabilities	3,879	3,803
Pension and other postretirement liabilities	23,317	8,113
Other liabilities	11,815	10,497
Total Noncurrent Liabilities	93,357	77,348
Total Liabilities	163,171	139,690
Net Assets		
Unrestricted	191,357	533,334
Temporarily restricted	15,307	15,414
Permanently restricted	12,948	12,870
Total Net Assets	219,612	561,618
Total Liabilities and Net Assets	$ 382,783	$ 701,308

The accompanying notes are an integral part of these consolidated financial statements.

05-02-2017 00206

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

(Dollars in Thousands)

FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015

	2016	2015
Operating Revenues		
Net patient service revenue	$ 483,465	$ 466,454
Less provision for doubtful accounts	26,362	24,067
Net patient service revenue, less provision for doubtful accounts	457,103	442,387
Other revenues	47,394	44,801
Net assets released from restrictions for operations	1,961	1,307
Total Operating Revenues	506,458	488,495
Operating Expenses		
Salaries and wages	218,910	225,187
Employee benefits	53,186	53,194
Purchased services	71,436	57,091
Professional fees	26,032	23,155
Supplies	58,754	57,684
Insurance	9,960	9,187
Interest	1,800	1,791
Depreciation and amortization	27,221	26,783
Provider tax	24,306	18,202
Other	35,550	35,927
Total Operating Expenses Before Restructuring Losses	527,155	508,201
Loss from Operations Before Restructuring Losses	(20,697)	(19,706)
Restructuring Losses	(2,187)	--
Loss from Operations	(22,884)	(19,706)
Nonoperating Gains (Losses)		
Investment return, net	8,031	(12,409)
Other	(1,091)	(768)
Total Nonoperating Gains (Losses), net	6,940	(13,177)
Deficiency of Revenues and Gains Over Expenses and Losses	(15,944)	(32,883)

The accompanying notes are an integral part of these consolidated financial statements.

05-02-2017 00207

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (CONTINUED)

(Dollars in Thousands)

FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015

	2016	2015
Unrestricted Net Assets		
Deficiency of revenues and gains over expenses and losses	$ (15,944)	$ (32,883)
Transfers to System	(328,194)	(31,246)
Net assets released from restrictions for property acquisitions	619	43
Pension and other postretirement liability adjustments	1,751	1,015
Other	(209)	--
Decrease in Unrestricted Net Assets	(341,977)	(63,071)
Temporarily Restricted Net Assets		
Contributions	1,964	1,261
Investment return	1,256	1,266
Net change in unrealized losses on investments	(574)	(1,480)
Net assets released from restrictions	(2,580)	(1,350)
Other	(173)	(33)
Decrease in Temporarily Restricted Net Assets	(107)	(336)
Permanently Restricted Net Assets		
Contributions	78	107
Increase in Permanently Restricted Net Assets	78	107
Decrease in Net Assets	(342,006)	(63,300)
Net Assets - Beginning	561,618	624,918
Net Assets - Ending	$ 219,612	$ 561,618

The accompanying notes are an integral part of these consolidated financial statements.

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

(Dollars in Thousands)

FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015

	2016	2015
Cash Flows from Operating Activities		
Decrease in net assets	$ (342,006)	$ (63,300)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	27,221	26,783
Pension and other postretirement liability adjustments	(1,751)	(1,015)
Restricted contributions and net investment return	(3,298)	(2,634)
Net change in unrealized (gains) losses on investments	(3,006)	21,886
Transfers to System, net	328,194	31,246
Changes in operating assets and liabilities:		
Interest in investments held by Ascension	(6,133)	45,373
Accounts receivable, net	24,384	(2,903)
Inventories and other current assets	864	3,364
Accounts payable and accrued liabilities	(2,445)	(8,732)
Estimated third-party payor settlements	8,433	(1,166)
Other current liabilities	(484)	149
Pension and other postretirement liabilities	15,204	6,914
Other liabilities	1,394	693
Net Cash Provided by Operating Activities	46,571	56,658
Cash Flows from Investing Activities		
Property and equipment additions	(10,693)	(15,861)
Software in development	(3,103)	(2,267)
Decrease in assets limited as to use - restricted	(2,352)	(2,526)
Increase in other assets	(766)	(3,159)
Net Cash Used in Investing Activities	(16,914)	(23,813)

The accompanying notes are an integral part of these consolidated financial statements.

05-02-2017 00209

ST. VINCENT'S MEDICAL CENTER AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

(Dollars in Thousands)

FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015

	2016	2015
Cash Flows from Financing Activities		
Transfers to System	$ (33,045)	$ (30,491)
Repayment of long-term debt	(703)	(839)
Restricted contributions and net investment return	3,298	2,634
Net Cash Used in Financing Activities	(30,450)	(28,696)
Net Change in Cash and Cash Equivalents	(793)	4,149
Cash and Cash Equivalents - Beginning	7,449	3,300
Cash and Cash Equivalents - Ending	$ 6,656	$ 7,449

The accompanying notes are an integral part of these consolidated financial statements.

05-02-2017 00210

NON-PROFIT

Applicant: St. Vincent's Medical Center
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY16 Actual Results	(2) FY17 Projected W/out CON	(3) FY17 Projected Incremental	(4) FY17 Projected With CON	(5) FY18 Projected W/out CON	(6) FY18 Projected Incremental	(7) FY18 Projected With CON	(8) FY19 Projected W/out CON	(9) FY19 Projected Incremental	(10) FY19 Projected With CON	(11) FY20 Projected W/out CON	(12) FY20 Projected Incremental	(13) FY20 Projected With CON
	Description													
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$1,548,392	$1,465,459		$1,465,459	1,427,000		$1,427,000	$1,469,810		$1,469,810	$1,513,904		$1,513,904
2	Less: Allowances	$1,040,692	$954,390		$954,390	928,300		$928,300	$956,149		$956,149	$984,833		$984,833
3	Less: Charity Care	$24,235	$25,000		$25,000	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
4	Less: Other Deductions	$0	$0		$0			$0	$0		$0			$0
	Net Patient Service Revenue	$483,465	$486,069	$0	$486,069	$473,700	($350)	$473,350	$487,911	($700)	$487,211	$502,548	$0	$502,548
5	Medicare	$186,816	$186,816		$186,816	$182,100	($10)	$182,090	$187,563	($20)	$187,543	$193,190	($20)	$193,170
6	Medicaid	$91,720	$91,720		$91,720	$89,400	($325)	$89,075	$92,082	($650)	$91,432	$94,844	($650)	$94,194
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	$278,536	$278,536	$0	$278,536	$271,500	($335)	$271,165	$279,645	($670)	$278,975	$288,034	($670)	$287,364
9	Commercial Insurers	$197,001	$197,001		$197,001	$192,000		$192,000	$197,760		$197,760	$203,693		$203,693
10	Uninsured	$25,649	$25,649		$25,649	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
11	Self Pay	$17,648	$17,648		$17,648	$17,200	($15)	$17,185	$17,716	($30)	$17,686	$18,247	($30)	$18,217
12	Workers Compensation				$0			$0			$0			$0
13	Other	($35,369)	($32,765)		($32,765)	($32,000)		($32,000)	($32,960)		($32,960)	($33,949)		($33,949)
	Total Non-Government	$204,929	$207,533	$0	$207,533	$202,200	($15)	$202,185	$208,266	($30)	$208,236	$214,514	($30)	$214,484
	Net Patient Service Revenue[a] (Government+Non-Government)	$483,465	$486,069	$0	$486,069	$473,700	($350)	$473,350	$487,911	($700)	$487,211	$502,548	($700)	$501,848
14	Less: Provision for Bad Debts	$26,362	$26,362		$26,362	$25,700		$25,700	$26,471		$26,471	$27,265		$27,265
	Net Patient Service Revenue less provision for bad debts	$457,103	$459,707	$0	$459,707	$448,000	($350)	$447,650	$461,440	($700)	$460,740	$475,283	$0	$475,283
15	Other Operating Revenue	$47,394	$46,475		$46,475	$45,000		$45,000	$46,350		$46,350	$47,741		$47,741
17	Net Assets Released from Restrictions	$1,961	$2,000		$2,000	$2,000		$2,000	$2,060		$2,060	$2,122		$2,122
	TOTAL OPERATING REVENUE	$506,458	$508,182	$0	$508,182	$495,000	($350)	$494,650	$509,850	($700)	$509,150	$525,146	$0	$525,146
B.	OPERATING EXPENSES													
1	Salaries and Wages	$218,910	$209,925		$209,925	$195,200	($719)	$194,481	$201,056	($1,438)	$199,618	$207,088	($1,438)	$205,650
2	Fringe Benefits	$53,186	$52,839		$52,839	$51,300	($232)	$51,068	$52,839	($464)	$52,375	$54,424	($464)	$53,960
3	Physicians Fees	$19,867	$19,867		$19,867	$19,300	($283)	$19,017	$19,879	($566)	$19,313	$20,475	($566)	$19,909
4	Supplies and Drugs	$58,754	$56,813		$56,813	$55,100	($29)	$55,071	$56,753	($58)	$56,695	$58,456	($58)	$58,398
5	Depreciation and Amortization	$27,221	$26,610		$26,610	$25,800	$45	$25,845	$26,574	$90	$26,664	$27,371	$90	$27,461
6	Provision for Bad Debts-Other[b]	$1,279	$1,279		$1,279	$1,200	$0	$1,200	$1,236	$0	$1,236	$1,273	$0	$1,273
7	Interest Expense	$1,800	$2,003		$2,003	$2,000	$0	$2,000	$2,060	$0	$2,060	$2,122	$0	$2,122
8	Malpractice Insurance Cost	$9,960	$9,960		$9,960	$10,200	$6	$10,206	$10,506	$12	$10,518	$10,821	$12	$10,833
9	Lease Expense	$8,025	$8,025		$8,025	$8,200	($92)	$8,108	$8,446	($184)	$8,262	$8,699	($184)	$8,515
10	Other Operating Expenses	$130,340	$129,861		$129,861	$119,500	$764	$120,264	$123,085	$664	$123,749	$126,778	$664	$127,442
	TOTAL OPERATING EXPENSES	$529,342	$517,182	$0	$517,182	$487,800	($540)	$487,260	$502,434	($1,944)	$500,490	$517,507	($1,944)	$515,563
	INCOME/(LOSS) FROM OPERATIONS	($22,884)	($9,000)	$0	($9,000)	$7,200	$190	$7,390	$7,416	$1,244	$8,660	$7,639	$1,944	$9,583
	NON-OPERATING REVENUE	$6,940	$6,940		$6,940	$0		$0	0		$0	0		$0
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	($15,944)	($2,060)	$0	($2,060)	$7,200	$190	$7,390	$7,416	$1,244	$8,660	$7,639	$1,944	$9,583
	Principal Payments				$0			$0			$0			$0
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	-4.5%	-1.7%	0.0%	-1.7%	1.5%	-54.3%	1.5%	1.5%	-177.7%	1.7%	1.5%	0.0%	1.8%
2	Hospital Non Operating Margin	1.4%	1.3%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	-3.1%	-0.4%	0.0%	-0.4%	1.5%	-54.3%	1.5%	1.5%	-177.7%	1.7%	1.5%	0.0%	1.8%
D.	FTEs	2,894	2,542		2,542	2,470	(10)	2,460	2,470	(20)	2,450	2,470	(20)	2,450
E.	VOLUME STATISTICS[c]													
1	Inpatient Discharges	16,201	16,201		16,201	15,100	0	15,100	15,100		15,100	15,100		15,100
2	Outpatient Visits	602,810	602,810		602,810	614,870	(7,500)	607,370	627,170	(15,000)	612,170	639,710	(15,000)	624,710
	TOTAL VOLUME	619,011	619,011	0	619,011	629,970	(7,500)	622,470	642,270	(15,000)	627,270	654,810	(15,000)	639,810

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT M

SVMC BOARD RESOLUTION

WHEREAS, St. Vincent's Medical Center (the "Medical Center") operates the Family Health Center located at 762 Lindley Street, Bridgeport, Connecticut (the "Family Health Center"), which provides community-based primary care services, including internal medicine, women's health care services, pediatric care and certain specialty services to patients of Bridgeport and the surrounding communities (the "Community"); and

WHEREAS, Southwest Community Health Center, Inc. ("SWCHC"), a federally qualified health center, also located in Bridgeport, Connecticut, provides outpatient primary care services, including pediatrics, internal medicine, behavioral healthcare, substance abuse, dental care and women's health care services ("Primary Care Services") to individuals in need of such services in the Community; and

WHEREAS, the Medical Center and SWCHC share a mutual commitment to provide Primary Care Services to members of the Community and have determined that through collaboration they have the opportunity to expand access to health care services and enhance quality oversight of the healthcare provided at the Family Health Center, while concurrently reducing the cost of providing these services; and

WHEREAS, such collaboration would include, among other things, (i) the Medical Center's transfer to Southwest of certain assets relating to the Family Health Center, (ii) SWCHC's sublease of a portion of the premises leased by the Medical Center at 762 Lindley Street, (iii) SWCHC's agreement to provide Primary Care Services to members of the community served by St. Vincent's, and (iv) the Medical Center's provision of a community benefit grant for a period of five years to subsidize the operations of SWCHC at 762 Lindley Street and certain specialty services to members of the community; and

WHEREAS, management has presented to the Executive Committee a proposed letter of intent between the Medical Center and Southwest outlining the proposed collaboration between the Medical Center and SWCHC and in a form approved in principle by the Board of Directors of SWCHC; and

WHEREAS, after due consideration, on January 10, 2017, the Executive Committee of the Board of Directors determined that it is in the best interest of the Medical Center and patients in the Community, and in furtherance of the Medical Center's charitable and exempt purposes, to enter into the letter of intent in the form presented to the Executive Committee with such changes therein as the Medical Center deemed necessary or appropriate (the "Letter of Intent"), and the Medical Center has executed and delivered the Letter of Intent to SWCHC.

NOW, THEREFORE, BE IT

RESOLVED, that the Board of Directors hereby ratifies, confirms and approves in all respects the Medical Center's execution and delivery of the Letter of Intent in the form presented at this meeting, and all documents, instruments, agreements and certificates referenced therein or required in accordance with the terms thereof; and be it further

RESOLVED, the President and Chief Executive Officer of the Medical Center or his designee (each, an "Authorized Officer") is hereby authorized and empowered, in the name and on behalf of the Medical Center, to negotiate, execute and deliver any and all definitive documents, instruments, agreements and certificates as contemplated by the Letter of Intent or as such Authorized Officer shall deem necessary or appropriate in connection with the transactions contemplated by the Letter of Intent, all in such form as such Authorized Officer shall approve,

such approval to be conclusively evidenced by the Authorized Officer's execution and delivery thereof; and be it further

RESOLVED, that each Authorized Officer is hereby authorized, empowered and directed, in the name and on behalf of the Medical Center, to take or cause to be taken any and all acts necessary or appropriate to effectuate the transactions contemplated by the Letter of Intent, including, without limitation, submitting a Certificate of Need Application to the State of Connecticut Department of Public Health, Office of Health Care Access, and the execution, delivery and/or filing of all notices or documents and the payment of all fees contemplated by or required in connection therewith; and be it further

RESOLVED, that each Authorized Officer is hereby authorized, empowered and directed, in the name and on behalf of the Medical Center, to take such other and further actions, including the execution and delivery of such documents, certificates, agreements or instruments, and the provision of such notices and obtaining of such third party consents, as they or any one of them shall deem necessary, appropriate or desirable to carry out the purpose and intent of the foregoing resolutions and to effectuate the transactions contemplated thereby; and be it further

RESOLVED, that all actions previously taken by any of the Authorized Officers or any representative of the Medical Center in furtherance of any of the foregoing resolutions or the transactions contemplated thereby are hereby approved, ratified and confirmed; and be it further

RESOLVED, that any Authorized Officer be, and hereby is, authorized to certify the adoption of these resolutions.

Olejarz, Barbara

From: Carney, Brian
Sent: Thursday, June 01, 2017 9:20 AM
To: Kurt.bassett@stvincents.org
Cc: Riggott, Kaila; Fernandes, David; Rival, Jessica; Olejarz, Barbara
Subject: Completeness letter for Docket 17-32165-CON
Attachments: 32165 St Vincent Termination of Primary Care.pdf; 32165 St Vincent Termination of Primary Care.docx

Good morning Mr. Bassett,

Please see the attached completeness letter in the above referenced matter. Please confirm receipt of this email and provide your written responses to OHCA no later than **July 31, 2017, 4:30 pm.**

Sincerely,
Brian A. Carney

Brian Carney, MBA
Associate Research Analyst
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134-0308
Phone - 860-418-7014
brian.carney@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Via Email Only

June 1, 2017

Mr. Kurt Bassett
Director of Strategic Planning
St. Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606
Kurt.bassett@stvincents.org

RE: Certificate of Need Application: Docket Number: 17-32165-CON
Termination of Primary Care Clinic Services
Certificate of Need Completeness Letter

Dear Mr.Bassett:

On May 2, 2017, OHCA received the Certificate of Need application from St. Vincent's Medical Center ("Applicant" or "Hospital") seeking authorization to terminate primary care clinic services at the Family Health Center ("FHC"), located at 762 Lindley Street, Bridgeport, CT. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 215** and reference "**Docket Number: 17-32165-CON**."

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **July 31, 2017, 4:30 p.m.,** otherwise your application will be automatically considered withdrawn.

1) In regard to the new specialty services planned for the Lindley Street location (page 14 of the application):
    a. provide the expected start date for each new service;
    b. explain whether additional physicians will need to be hired; and
    c. confirm that all specialty service physicians at this location will accept Medicaid.

2) Page 12 of the application states the wait times for cardiology, endocrinology, neurology, gastroenterology and ophthalmology range from three to six months.
    a. describe how the proposal will help reduce specialty care wait times;
    b. explain the anticipated timeframe for accomplishing this goal; and
    c. provide an estimate of future wait times anticipated for each specialty service, following adoption of the proposal.

3) Page 7 of the application states that the Applicant will enter into a five-year Community Benefit and Support Agreement with Southwest Community Health Center, Inc. ("SWCHC") to provide financial support to cover SWCHC's transition and other "ramp up" expenses at the Lindley Street service location.
    a. provide an estimate of the financial support dollar amount that will be committed in total and on a yearly basis;
    b. explain where the financial support commitment appears in the Financial Worksheet (if not included, revise worksheet to include the financial support commitment); and
    c. provide a copy of the proposed SWCHC Community Benefit and Support Agreement.

4) Revise the FY 2020 "Projected Incremental" column on Financial Worksheet A (page 211) as it appears to be incorrect. Both "Net Patient Service Revenue" and "Total Operating Revenue" reflect $0, resulting in "Income from Operations" of $1,944,000. Adjust the FY 2020 "Projected With CON" as necessary, based on your changes to the incremental column.

5) Provide an explanation for the FY 2017 decline in Pediatric Care (-1.5%) and Specialty Care Clinic (-7.7%) visits (Table 5 on page 25 of the application).

6) Please explain the basis for the projected Specialty Care Clinic visit increases of 26%, 22% and 7% respectively, for FY 2018, FY 2019 and FY 2020.

7) Revise Table 6 on page 26 of the application. "Current Year" should be based on the most recently completed fiscal year (FY 2016) - include projections through FY 2020.

8) Provide SWCHC's projected FY 2018–FY 2020 patient volume and payer mix for Adult Primary Care and Pediatric Care services at the Lindley Street location. Will SWCHC be able to accommodate the entire SVC primary care patient population currently served at the Lindley Street service location?

9) Will any new or additional facilities fees be imposed following the transition of primary care services to SWCHC?

If you have any questions concerning this letter, please contact Kaila Riggott at (860) 418-7037.

Sincerely,

Brian A. Carney
Associate Research Analyst

Olejarz, Barbara

From: Bassett, Kurt <Kurt.Bassett@ascension.org>
Sent: Thursday, June 01, 2017 9:39 AM
To: Carney, Brian
Cc: Riggott, Kaila; Fernandes, David; Rival, Jessica; Olejarz, Barbara
Subject: RE: Completeness letter for Docket 17-32165-CON

Email received.

Kurt Bassett
Director – Strategic Planning
St. Vincent's Health Services
2800 Main Street
Bridgeport, CT 06606
Office: **475-210-6264**
(Please note new office number)

From: Carney, Brian [mailto:Brian.Carney@ct.gov]
Sent: Thursday, June 01, 2017 9:20 AM
To: Bassett, Kurt
Cc: Riggott, Kaila; Fernandes, David; Rival, Jessica; Olejarz, Barbara
Subject: Completeness letter for Docket 17-32165-CON

Good morning Mr. Bassett,

Please see the attached completeness letter in the above referenced matter. Please confirm receipt of this email and provide your written responses to OHCA no later than **July 31, 2017, 4:30 pm.**

Sincerely,
Brian A. Carney

Brian Carney, MBA
Associate Research Analyst
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134-0308
Phone - 860-418-7014
brian.carney@ct.gov

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User, OHCA

From: Feldman, Joan <JFeldman@goodwin.com>
Sent: Monday, July 31, 2017 11:39 AM
To: User, OHCA; Riggott, Kaila
Subject: Docket Number: 17 - 32165-CON
Attachments: CON Application.pdf

Kaila:
Attached for your consideration, you will find the responses to your letter dated June 1, 2017 in connection with St. Vincent's Medical Center's application to terminate its primary care clinic services.
Thank you.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

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SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

July 31, 2017

By email: OHCA@ct.gov

Mr. Brian A. Carney
Associate Research Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

Re: Certificate of Need Application: Docket Number: 17-32165-CON
Termination of Primary Care Clinical Services
Certificate of Need Completeness Letter

Dear Mr. Carney:

Reference is made to OHCA's letter to St. Vincent's Medical Center dated June 1, 2017. Set forth below are each of the questions included in the letter followed by our response.

1) In regard to the new specialty services planned for the Lindley Street location (page 14 of the application):

   a. provide the expected start date for each new service;

   The specialty services will no longer be located at the Lindley Street Location as previously planned and as represented in the above-referenced CON application. Instead, the St. Vincent's specialty clinics will be at a new medical office building leased by the St. Vincent's Medical Center located at 2979 Main Street, Bridgeport, Connecticut, approximately .4 tenths of a mile from the Lindley Street Location. Since submitting the above-referenced CON application, St. Vincent's Medical Center has had fully updated and furnished specialty space become available. This Main Street space is much larger, has ample parking, is on a bus route, and is beautifully built out. There will be a care coordinator stationed at the Lindley Street Location who will be responsible for scheduling the specialty visits at 2979 Main Street so the referral is seamless. The expense saved by St. Vincent's Medical Center in not having to renovate the Lindley Street Location will help finance the additional specialty services. The new schedule of services is planned to commence as follows:

Endocrinology - January 2018
Infectious Disease - January 2018
Gastroenterology - March 2018
Cardiology - January 2018
Podiatry - January 2018
General Surgery - January 2018
Ophthalmology - January 2018
Neurology - January 2018
Orthopedics - January 2018
Nephrology - January 2018
Rheumatology - March 2018
Pulmonology - March 2018
Nutritional Counseling - January 2018

b. explain whether additional physicians will need to be hired; and

To the extent that there is additional capacity for our physicians who are currently covering our specialty clinics, St. Vincent's Medical Center will use these same physicians to cover the specialty clinic hours by adding additional hours to their schedule. New Physicians will be hired to cover the pulmonology and rheumatology specialty clinics. In addition, additional cardiology and orthopedic physicians will be contracted to cover additional hours. Plans also call for including one full time gastroenterologist.

c. confirm that all specialty service physicians at this location will accept Medicaid.

All specialty physicians will accept Medicaid patients.

2) Page 12 of the application states the wait times for cardiology, endocrinology, neurology, gastroenterology and ophthalmology range from three to six months.

a. describe how the proposal will help reduce specialty care wait times;

Cardiology clinic offerings are increasing from 6 hours per month to 60 hours per month, endocrinology hours are doubling from 3 hour to 6 hours monthly, neurology clinic hours are doubling from 6 hours to 12 hours monthly, and ophthalmology clinic hours are doubling from 3 to 6 hours monthly. Gastroenterology hours are increasing dramatically from 9 hours monthly to 80 hours monthly. All of these additional hours will create ample new appointment slots which can be filled with these patients who would currently need to be put on a wait list.

Specialty	Now hours per Month	Proposed hours per Month
cardiology	6	60
endocrinology	3	6
neurology	6	12
ophthalmology	3	6
gastroenterology	9	80
rheumatology	0	6
infectious disease	6	8
general surgery	12	24
Neurology	6	12
orthopedics	3	48
nephrology	3	6
podiatry	6	12
nutritional counseling	8	32
pulmonary	0	16

b. explain the anticipated timeframe for accomplishing this goal;

We anticipate that we will start scheduling patients immediately and it is likely that by 4 to 6 months after the new specialty clinic schedule is implemented that the current wait lists will be significantly reduced and soon comparable to wait times for patients seeing specialists in private practice.

c. provide an estimate of future wait times anticipated for each specialty service, following adoption of the proposal.

Endocrinology - Less than 2 weeks
Infectious Disease - Approximately 2 weeks
Gastroenterology - Less than 2 weeks
Cardiology - Less than 1 week
Podiatry - Less than 2 weeks
General Surgery - Less than 2 weeks
Ophthalmology - Approximately 2 weeks
Neurology - Less than 2 weeks
Orthopedics - Less than 2 weeks
Nephrology - Approximately 2 weeks
Rheumatology - Approximately 2 weeks
Pulmonary- Less than 2 weeks
Nutritional Counseling - Approximately 2 weeks

3) Page 7 of the application states that the Applicant will enter into a five-year Community Benefit and Support Agreement with Southwest Community Health Center, Inc. ("SWCHC") to provide financial support to cover SWCHC's transition and other "ramp up" expenses at the Lindley Street service location.

   a. provide an estimate of the financial support dollar amount that will be committed in total and on a yearly basis;

      Financial support for the first year is up to $964,649.
      Financial support for the second year is up to $954,297.
      Financial support for the third year is up to $889,905.
      Financial support for the fourth year is up to $740,807.
      Financial support for the fifth year is up to $716,150.

   b. explain where the financial support commitment appears in the Financial Worksheet (if not included, revise worksheet to include the financial support commitment); and

      Financial Support is included in "Other Expenses". Please see revised Financial Worksheet (Attachment SVMC Table A.1)

   c. provide a copy of the proposed SWCHC Community Benefit and Support Agreement.

      Please see attached hereto.

4) Revise the FY 2020 "Projected Incremental" column on Financial Worksheet A (page 211) as it appears to be incorrect. Both "Net Patient Service Revenue" and "Total Operating Revenue" reflect $0, resulting in "Income from Operations" of $1,944,000.

Adjust the FY 2020 "Projected With CON" as necessary, based on your changes to the incremental column.

Please see revised Attachment SVMC Table A.1 to reflect adjusted operating income for 2020 at column "s", line 51.

5) Provide an explanation for the FY 2017 decline in Pediatric Care (-1.5%) and Specialty Care Clinic (-7.7%) visits (Table 5 on page 25 of the application).

Pediatrics had a physician unexpectedly out on FMLA for approximately two months which resulted in reduced hours for pediatric patients. Specialty clinics hours were reduced resulting in reduced clinic hours for nephrology 4 hours/month; cardiology 8 hours/month; and infectious disease 4 hours/month based upon reduced physician availability.

6) Please explain the basis for the projected Specialty Care Clinic visit increases of 26%, 22% and 7% respectively, for FY 2018, FY 2019 and FY 2020.

Specialty clinic hours will be increased dramatically from approximately 60 hours per month to over 300 hours per month. During the first two years, visits are projected to grow based on current wait list patients as well as new SWCHC patients. Such increase in visits will carry into year two as full clinic potential is realized and will eventually begin to level off in year three as we meet the specialty needs of area patients.

7) Revise Table 6 on page 26 of the application. "Current Year" should be based on the most recently completed fiscal year (FY 2016) - include projections through FY 2020.

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2016**		Projected							
			FY 2017**		FY 2018**		FY 2019**		FY 2020**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	2,225	10%	2,198	10%	523	10%	640	10%	685	10%
Medicaid*	14,239	64%	14,066	64%	3,344	64%	4,096	64%	4,384	64%
CHAMPUS & TriCare	0	0%	0	0%	0	0%	0	0%	0	0%
Total Government	**16,464**	**74%**	**16,264**	**74%**	**3,876**	**74%**	**4,736**	**74%**	**5,069**	**74%**
Commercial Insurers	445	2%	440	2%	95	2%	128	2%	137	2%
Uninsured	5,340	24%	5,274	24%	1,254	24%	1,536	24%	1,644	24%
Workers Compensation	0	0%	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**5,785**	**26%**	**5,714**	**26%**	**1,349**	**26%**	**1,664**	**26%**	**1,781**	**26%**
Total Payer Mix	**22,249**	**100%**	**21,978**	**100%**	**5,225**	**100%**	**6,400**	**100%**	**6,850**	**100%**

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

8) Provide SWCHC's projected FY 2018-FY 2020 patient volume and payer mix for Adult Primary Care and Pediatric Care services at the Lindley Street location. Will SWCHC be able to accommodate the entire SVMC primary care patient population currently served at the Lindley Street service location? - Yes

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2018**	FY 2019**	FY 2020**
Adult Primary Care	17,344	17,344	17,344
Pediatric Care	7,800	7,800	7,800
Total	25,144	25,144	25,144

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

SWCHC Projected Payer Mix

	Percentage 2018	Volume 2018	Percentage 2019	Volume 2019	Percentage 2020	Volume 2020
COMMERCIAL	4%	1006	5%	1258	5%	1258
SELF PAY	22%	5532	21%	5280	20%	5029
MEDICARE	10%	2514	10%	2514	10%	2514
MEDICAID	64%	16,092	64%	16,092	65%	16,343

SWCHC has committed to allowing the St. Vincent's Medical Center's internal medicine residents to continue to rotate through Lindley Street Location and SWCHC will staff the primary care and pediatric services to cover all the Lindley Street Location patients.

9) Will any new or additional facilities fees be imposed following the transition of primary care services to SWCHC?

No new fees or additional facility fees will be imposed as a result of this proposal.

If you have any questions regarding the above or the attached information, please contact the undersigned.

Very truly yours,

Joan Feldman, Esq.
Shipman & Goodwin LLP
On behalf of
Kurt Bassett
Director of Strategic Planning
St. Vincent's Medical Center

Cc: Kaila Riggott (Kaila.Riggott@ct.gov)

Enclosures

NON-PROFIT

Applicant: St. Vincent's Medical Center

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY16 Actual	(2) FY17 Projected	(3) FY17 Projected	(4) FY17 Projected	(5) FY18 Projected	(6) FY18 Projected	(7) FY18 Projected	(8) FY19 Projected	(9) FY19 Projected	(10) FY19 Projected	(11) FY20 Projected	(12) FY20 Projected	(13) FY20 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$1,548,392	$1,465,459		$1,465,459	1,427,000		$1,427,000	$1,469,810		$1,469,810	$1,513,904		$1,513,904
2	Less: Allowances	$1,040,692	$954,390		$954,390	928,300		$928,300	$956,149		$956,149	$984,833		$984,833
3	Less: Charity Care	$24,235	$25,000		$25,000	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
4	Less: Other Deductions	$0	$0		$0			$0	$0		$0			$0
	Net Patient Service Revenue	**$483,465**	**$486,069**	**$0**	**$486,069**	**$473,700**	**($350)**	**$473,350**	**$487,911**	**($700)**	**$487,211**	**$502,548**	**$0**	**$502,548**
5	Medicare	$186,816	$186,816		$186,816	$182,100	($10)	$182,090	$187,563	($20)	$187,543	$193,190	($20)	$193,170
6	Medicaid	$91,720	$91,720		$91,720	$89,400	($325)	$89,075	$92,082	($650)	$91,432	$94,844	($650)	$94,194
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$278,536**	**$278,536**	**$0**	**$278,536**	**$271,500**	**($335)**	**$271,165**	**$279,645**	**($670)**	**$278,975**	**$288,034**	**($670)**	**$287,364**
9	Commercial Insurers	$197,001	$197,001		$197,001	$192,000		$192,000	$197,760		$197,760	$203,693		$203,693
10	Uninsured	$25,649	$25,649		$25,649	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
11	Self Pay	$17,648	$17,648		$17,648	$17,200	($15)	$17,185	$17,716	($30)	$17,686	$18,247	($30)	$18,217
12	Workers Compensation				$0			$0			$0			$0
13	Other	($35,369)	($32,765)		($32,765)	($32,000)		($32,000)	($32,960)		($32,960)	($33,949)		($33,949)
	Total Non-Government	**$204,929**	**$207,533**	**$0**	**$207,533**	**$202,200**	**($15)**	**$202,185**	**$208,266**	**($30)**	**$208,236**	**$214,514**	**($30)**	**$214,484**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$483,465**	**$486,069**	**$0**	**$486,069**	**$473,700**	**($350)**	**$473,350**	**$487,911**	**($700)**	**$487,211**	**$502,548**	**($700)**	**$501,848**
14	Less: Provision for Bad Debts	$26,362	$26,362		**$26,362**	$25,700		**$25,700**	$26,471		**$26,471**	$27,265		**$27,265**
	Net Patient Service Revenue less provision for bad debts	**$457,103**	**$459,707**	**$0**	**$459,707**	**$448,000**	**($350)**	**$447,650**	**$461,440**	**($700)**	**$460,740**	**$475,283**	**($700)**	**$474,583**
15	Other Operating Revenue	$47,394	$46,475		**$46,475**	$45,000		**$45,000**	$46,350		**$46,350**	$47,741		**$47,741**
17	Net Assets Released from Restrictions	$1,961	$2,000		**$2,000**	$2,000		**$2,000**	$2,060		**$2,060**	$2,122		**$2,122**
	TOTAL OPERATING REVENUE	**$506,458**	**$508,182**	**$0**	**$508,182**	**$495,000**	**($350)**	**$494,650**	**$509,850**	**($700)**	**$509,150**	**$525,146**	**($700)**	**$524,446**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$218,910	$209,925		$209,925	$195,200	($719)	$194,481	$201,056	($1,438)	$199,618	$207,088	($1,438)	$205,650
2	Fringe Benefits	$53,186	$52,839		$52,839	$51,300	($232)	$51,068	$52,839	($464)	$52,375	$54,424	($464)	$53,960
3	Physicians Fees	$19,867	$19,867		$19,867	$19,300	($283)	$19,017	$19,879	($566)	$19,313	$20,475	($566)	$19,909
4	Supplies and Drugs	$58,754	$56,813		$56,813	$55,100	($29)	$55,071	$56,753	($58)	$56,695	$58,456	($58)	$58,398
5	Depreciation and Amortization	$27,221	$26,610		$26,610	$25,800	$45	$25,845	$26,574	$90	$26,664	$27,371	$90	$27,461
6	Provision for Bad Debts-Other[b]	$1,279	$1,279		$1,279	$1,200	$0	$1,200	$1,236	$0	$1,236	$1,273	$0	$1,273
7	Interest Expense	$1,800	$2,003		$2,003	$2,000	$0	$2,000	$2,060	$0	$2,060	$2,122	$0	$2,122
8	Malpractice Insurance Cost	$9,960	$9,960		$9,960	$10,200	$6	$10,206	$10,506	$12	$10,518	$10,821	$12	$10,833
9	Lease Expense	$8,025	$8,025		$8,025	$8,200	($92)	$8,108	$8,446	($184)	$8,262	$8,699	($184)	$8,515
10	Other Operating Expenses	$130,340	$129,861		$129,861	$119,500	$932	$120,432	$123,085	$959	$124,044	$126,778	$922	$127,700
	TOTAL OPERATING EXPENSES	**$529,342**	**$517,182**	**$0**	**$517,182**	**$487,800**	**($372)**	**$487,428**	**$502,434**	**($1,649)**	**$500,785**	**$517,507**	**($1,686)**	**$515,821**
	INCOME/(LOSS) FROM OPERATIONS	**($22,884)**	**($9,000)**	**$0**	**($9,000)**	**$7,200**	**$22**	**$7,222**	**$7,416**	**$949**	**$8,365**	**$7,639**	**$986**	**$8,625**
	NON-OPERATING REVENUE	**$6,940**	$6,940		**$6,940**	**$0**		**$0**	0		**$0**	0		**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**($15,944)**	**($2,060)**	**$0**	**($2,060)**	**$7,200**	**$22**	**$7,222**	**$7,416**	**$949**	**$8,365**	**$7,639**	**$986**	**$8,625**
	Principal Payments				**$0**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**-4.5%**	**-1.7%**	**0.0%**	**-1.7%**	**1.5%**	**-6.3%**	**1.5%**	**1.5%**	**-135.6%**	**1.6%**	**1.5%**	**-140.9%**	**1.6%**
2	Hospital Non Operating Margin	**1.4%**	**1.3%**	**0.0%**	**1.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-3.1%**	**-0.4%**	**0.0%**	**-0.4%**	**1.5%**	**-6.3%**	**1.5%**	**1.5%**	**-135.6%**	**1.6%**	**1.5%**	**-140.9%**	**1.6%**
D.	**FTEs**	**2,894**	**2,542**		**2,542**	2,470	(10)	**2,460**	2,470	(20)	**2,450**	2,470	(20)	**2,450**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	16,201	16,201		**16,201**	15,100	0	**15,100**	15,100		**15,100**	15,100		**15,100**
2	Outpatient Visits	602,810	602,810		**602,810**	614,870	(7,500)	**607,370**	627,170	(15,000)	**612,170**	639,710	(15,000)	**624,710**
	TOTAL VOLUME	**619,011**	**619,011**	**0**	**619,011**	**629,970**	**(7,500)**	**622,470**	**642,270**	**(15,000)**	**627,270**	**654,810**	**(15,000)**	**639,810**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

COMMUNITY BENEFIT GRANT AGREEMENT

This AGREEMENT (this "Agreement") is entered into as of _____ ____, 2017 (the "Effective Date"), by and between Southwest Community Health Center, Inc. ("SWCHC") and St. Vincent's Medical Center ("Hospital") (individually a "Party," and collectively the "Parties").

BACKGROUND

The Hospital is a charitable, nonprofit corporation pursuant to Section 501(c)(3) of the Internal Revenue Code and an acute care hospital and medical center located in Bridgeport, Connecticut.

In furtherance of its Mission, the Hospital has historically operated a primary care clinic located at 762 Lindley Street, Bridgeport, Connecticut (the "Lindley Street Location"), serving uninsured and underinsured patients (the "Lindley Street Clinic"). To date, the Lindley Street Clinic's focus has been on providing a medically underserved population of patients in the greater Bridgeport area (the "Service Area") with access to quality primary care services (the "Services"). The Hospital believes that the Services are important to the greater Bridgeport community (the "Community").

The Hospital has determined that the most efficient and effective way to ensure that individuals and families in the Service Area have increased access to such Services is to work with a provider with proven experience in providing primary care medical and other services to medically underserved populations and which is capable of assuming the responsibility of providing the Services to individuals and families in the Service Area.

SWCHC is a federally qualified health center ("FQHC") that receives federal grant support from the Health Resources and Services Administration ("HRSA") within the United States Department of Health and Human Services ("DHHS") pursuant to Section 330 of the Public Health Service Act, to provide, or arrange for the provision of, high quality, cost-effective, community-based comprehensive primary and preventive health care and related services (including, but not limited to, ancillary and enabling services) to medically underserved communities in the Service Area, regardless of the individual's or family's ability to pay for such services.

Because SWCHC is able to provide more comprehensive primary care services to the same patient population that utilizes the Lindley Street Clinic, the Hospital has proposed to SWCHC that SWCHC assume full responsibility for the Lindley Street Clinic. The Hospital, in turn, will allocate more of its resources to providing specialty medical services to the Community. Subject to state and federal regulatory approvals, SWCHC is desirous of assuming operational responsibility for the Lindley Street Clinic, as it would fully complement the other primary care services offered by SWCHC. To facilitate the transition of the Lindley

Street Clinic from the Hospital to SWCHC and support the availability of health care services for underserved persons in the Community, and in furtherance of the Hospital's Mission, and recognizing the interest of Service Area residents and governmental agencies in having a comprehensive primary care health center provide health care services in the Service Area, the Hospital intends to provide a community benefit grant ("Community Benefit Grant").

Simultaneously with the execution and delivery of this Agreement, the Parties are entering into a Master Agreement (the "Master Agreement"), and certain other agreements referenced in the Master Agreement, setting forth the terms and conditions on which SWCHC will assume full responsibility for the operation of the Lindley Street Clinic.

NOW, THEREFORE, in consideration of the covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually agreed as follows:

1. **Compliance**. It is the intention of the Parties hereto that this Agreement fully comply with the requirements of 42 U.S.C. 1320a-7b(b)(3)(I) and 42 C.F.R. §1001.952(w) and all other applicable laws and regulations. To the extent that it is determined by either Party's legal counsel or the Federal government that this Agreement is not fully compliant with any applicable law or regulation, the Parties agree to reform it to fully comply. Specifically,

1.1 The amount of the Community Benefit Grant will not be conditioned or varied based upon (or otherwise determined by taking into account in any way) the volume or value of any referrals or other business generated between SWCHC and the Hospital, which referrals or business are reimbursed, in whole or in part, under Medicare, Medicaid, CHIP, or any other federal health care program;

1.2 The amount of the Community Benefit Grant will contribute meaningfully to SWCHC's ability to maintain or increase the availability, or enhance the quality, of the services provided to the medically underserved populations at the Lindley Street Clinic. During the Term of this Agreement, and upon any renewals of this Agreement, the Parties will re-evaluate the Agreement annually to ensure that the Community Benefit Grant is satisfying, and is reasonably expected to continue satisfying, this standard, and will document such evaluation contemporaneously. The Parties will make such documentation available to the Secretary of DHHS upon request;

1.3 The Community Benefit Grant relates directly to services provided by SWCHC as part of the scope of SWCHC's Section 330 of the Public Health Service Act ("Section 330") grant, and SWCHC reasonably expects the arrangement to contribute meaningfully to SWCHC's ability to maintain or increase the access, or enhance the quality, of services provided to a medically underserved population;

1.4 SWCHC and the Hospital agree that each Party's health care professionals retain the right to refer patients to any providers they deem appropriate, based on their

professional judgment, and that all patients served by either Party retain the right to request referrals to any providers of their choosing. During the term of the Agreement, SWCHC shall provide its patients with notice, in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient, of their freedom to choose any willing provider or supplier. For the avoidance of doubt, the Parties understand and agree that SWCHC will retain the right to contract with other providers/suppliers;

1.5 SWCHC and Hospital agree to maintain a list of all agreements between the Parties. This list shall be centrally located, updated regularly, and maintained in a manner that preserves the historical record of arrangement, and made available for review by the Secretary of the DHHS upon request; and

1.6 All SWCHC patients shall be advised, upon request, of the existence and nature of this Agreement in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient

2. **Grant Funds**.

2.1 The Hospital shall provide funding to cover certain operational deficits and costs incurred by SWCHC relating to the Lindley Street Clinic for the period of _____, 2017 through_____, 2018 (the "First Period"), the period of _____, 2018 through _____, 2019 (the "Second Period"), the period of _____, 2019 through _____, 2020 (the "Third Period"), the period of _____, 2020 through _____, 2021 (the "Fourth Period"), and the period of _____, 2021 through September 30, 2022 (the "Fifth Period") (collectively, such funding is referred to as the "Grant Funds" and each such period is referred to as a "Period"). The Grant Funds are intended to contribute meaningfully to SWCHC's ability to maintain or increase the availability, or enhance the quality, of health care services provided to the medically underserved populations served by the Lindley Street Clinic (the "Permitted Purpose"). The amount of the Grant Funds paid by the Hospital to SWCHC for each quarter during the Term shall be based on a review of the Lindley Street Clinic's budgeted activities versus its actual activities as further described in this Section 2, subject to the maximum amounts set forth in Section 2.2 of this Agreement.

2.2 Notwithstanding anything to the contrary set forth in this Agreement:

(a) For the First Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $964,649, including a $150,000 contingency fund for unexpected expenses unrelated to clinical operations for such First Period;

(b) For the Second Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $954,297, including a $100,000 contingency fund for unexpected expenses unrelated to clinical operations for such Second Period;

(c) For the Third Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $889,905, including a $75,000 contingency fund for unexpected expenses unrelated to clinical operations for such Third Period;

(d) For the Fourth Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $740,807; and

(e) For the Fifth Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $716,150.

The term "Contingency Fund" shall refer to the contingency funds set forth above for each of the First, Second and Third Periods. The term "Maximum Community Benefit Grant" shall refer the maximum amounts set forth above for each Period.

2.3 The Parties shall meet on a quarterly basis to discuss the reasonableness of expenses during the previous quarter and to perform the reconciliation referred to below with respect to Grant Funds for the then-current quarter.

(a) With respect to the first quarter during the Term, the Hospital shall advance by no later than the first day of such first quarter, an amount equal to (i) twenty-five percent (25%) of the Maximum Community Benefit Grant for the First Period less (ii) the Contingency Amount for the First Period, or Two Hundred Three Thousand Six Hundred Sixty-Two and 25/100 Dollars ($203,662.25).

(b) After the first quarter during the Term, the Grant Funds will be paid to SWCHC in quarterly installments (each, a "Quarterly Installment") in an amount equal to (i) twenty-five percent (25%) of the difference between the Maximum Community Benefit Grant for the applicable Period less (ii) the Contingency Fund for the applicable Period, subject to the maximum amounts set forth in Section 2.5 and subject to the reconciliation process described in Section 2.3(c).

(c) After the first quarter during the Term, SWCHC shall provide the Hospital with a profit and loss statement for previous quarter with respect to the Lindley Street Clinic's teaching services (such services, as agreed by the Parties, are referred to as "Teaching Services") and non-teaching services (such services, as agreed by the Parties, are referred to as "Non-Teaching Services") (the "Quarterly P&L"). If the Quarterly P&L has a loss for the Teaching Services and Non-Teaching Services for such previous quarter as a result of lower than budgeted revenues or greater than budgeted expenses (so long as such expenses are of a type set forth in the Lindley Street Clinic budget or are otherwise approved by both Parties), then the Quarterly Installment will be increased by the amount of such loss; provided that in no event will the total Grant Funds for any Period exceed the maximum amount specified in Section 2.2 of this Agreement. If the Quarterly P&L has a profit for the Teaching Services and Non-Teaching Services for such previous quarter, the Quarterly Installment will be reduced by the amount of such profit or, if requested by the Hospital, shall be returned to the Hospital by SWCHC within 45 days.

(d) Payment of the Quarterly Installment will be due within forty-five (45) days of such reconciliation.

2.4 The Contingency Fund or any portion thereof will only be paid to SWCHC based on need and as agreed upon by SWCHC and the Hospital.

2.5 The Parties will meet at least annually to review the Lindley Street Clinic budget for the upcoming Period and the profit and loss statement for the Lindley Street Clinic's Teaching Services and Non-Teaching Services for the prior Period (the "Annual P&L"). If the Annual P&L has a profit with respect to such Teaching Services and Non-Teaching Services for such prior Period independent of any Grant Funds paid to SWCHC, then SWCHC shall return to the Hospital an amount of Grant Funds equal to the amount of such profit.

2.6 If, at any time during the term of this Agreement, the core financial assumptions prove faulty (e.g., material change in payer mix or patient volume) and/or other exigent circumstances occur such that SWCHC is unable to operate the Lindley Street Clinic in accordance with such core assumptions and/or there are unanticipated material deviations between the Lindley Street Clinic budget and actual financial performance, either Party may request a special meeting of the Parties to determine what reasonable options are available to address the circumstances, including but not limited to an adjustment in the Lindley Street Clinic budget and the Grant Funds amount; provided, however, that in no event will the Grant Funds amount exceed the applicable limit set forth in Section 2.5 of this Agreement.

2.7 SWCHC covenants and agrees that it will use the Grant Funds only for the Permitted Purpose and for no other purpose and further that the Grant Funds shall not be used for any activity that would violate the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor (the "Directives").

2.8 The obligation of the Hospital to pay any Deficit Grant Funds shall be subject to the fulfillment of the following conditions precedent:

(a) SWCHC shall provide to the Hospital an executed certification in the form of Exhibit A hereto, prior to the first day of each quarterly period during the Term of this Agreement.

(b) The representations and warranties contained in Section 6 of the Master Agreement shall be true and correct on and as of the date of each payment of Deficit Grant Funds as though made on and as of such date; SWCHC shall have complied with the covenants set forth in Section 16 of this Agreement; and no default under this Agreement shall have occurred or be continuing on the date of such payment or would result from the making of such payment.

(c) The payment of the Community Benefit Grant shall not contravene any federal, state of local law, rule or regulation applicable to the Hospital or SWCHC.

(d) The Parties shall have obtained all necessary governmental approvals relating to (i) termination of the Services by the Hospital, including but not limited to approval from the Office of Health Care Access of the Connecticut Department of Public Health of the certificate of need application filed by the Hospital with respect to such termination, (ii) the provision of Services by SWCHC, including but not limited to all required approvals from HRSA, including the Change in Scope for the activities described herein, and (iii) appropriate licensure from the Connecticut Department of Public Health, including an operating license issued to SWCHC for the Services to be provided at the Lindley Street Location.

(e) All proceedings in connection with the making of the Community Benefit Grant and the other transactions contemplated by this Agreement and the Master Agreement between the Parties of even date herewith, and all documents incidental thereto, shall be reasonably satisfactory to the Hospital.

2.9 On an annual basis, the Parties shall meet to review the Community Benefit Grant and the scope and availability of Services provided by SWCHC in the Service Area and to evaluate the impact of the Community Benefit Grant on SWCHC's operations (an "Evaluation") in accordance with Section 1.2 above; provided, however, that the Parties may conduct an Evaluation more frequently than annually upon a reasonable request by the Hospital or SWCHC. Such Evaluation shall be documented in writing by the Parties.

3. **Term of Agreement**. The effective date of this Agreement shall be the Effective Date and shall terminate on_____, 2022 (the "Term") unless sooner terminated as set forth below.

4. **Termination of Agreement**.

4.1 For Breach. Notwithstanding any of the provisions in this Agreement to the contrary, prior to the expiration of the Term, either Party may terminate this Agreement upon written notice to the other Party in the event of such other Party's breach of a material provision of this Agreement, which breach remains uncured for a period of thirty (30) days following receipt of written notice specifying the breach complained of.

4.2 Tax-Exempt or Medicare/Medicaid Status. Notwithstanding any of the provisions in this Agreement to the contrary, prior to the expiration of the Term, either Party may terminate this Agreement upon written notice to the other Party if the other Party loses its (i) tax-exempt status, (ii) eligibility status in a federal or state health care program, including but not limited to Medicare or Medicaid; or (iii) state facility licensure or, in the case of SWCHC, Federally Qualified Health Care status.

4.3 Bankruptcy. This Agreement shall immediately terminate upon: (i) the bankruptcy, insolvency, or cessation of operations of either Party, as applicable, or the filing of any voluntary petition for bankruptcy, dissolution, liquidation, or winding-up of the affairs of either Party, as applicable, or any assignment by either Party, as applicable, for the benefit

of creditors; or (ii) the filing of any involuntary petition for bankruptcy, dissolution, liquidation, or winding-up of the affairs of either Party, as applicable, which petition is not dismissed within ninety (90) days of the date upon which it is filed.

4.4 Hospital Termination Rights. The Hospital shall have the right to terminate this Agreement upon written notice to SWCHC upon the occurrence of any of the following events:

(a) SWCHC shall cease to operate the Lindley Street Clinic at the Lindley Street Location.

(b) SWCHC shall (i) merge or consolidate with another entity, including but not limited to another FQHC; (ii) become affiliated with, or sponsored by, another entity, including but not limited to another FQHC; (iii) sell or dispose of all or substantially all of its assets; or (iv) any entity shall have the authority to, directly or indirectly, manage or control the management, operations or governance of SWCHC, including but not limited to the ability to appoint any members of the board of directors of SWCHC; unless in each case the successor entity assumes the obligations of SWCHC under this Agreement and the other agreements entered into between SWCHC and the Hospital on the Effective Date.

(c) Any written agreement between the Hospital and SWCHC is not renewed or is terminated for any reason by either Party or SWCHC is in default under any written agreement between the Hospital and SWCHC.

Upon any termination of this Agreement by the Hospital, the Hospital shall have no further obligations under this Agreement, including the obligation to make any payment of Deficit Grant Funds after the date of termination.

4.5 Termination without Cause. Notwithstanding any of the provisions in this Agreement to the contrary, the Parties may mutually agree to terminate this Agreement at any time.

5. **Modification for Prospective Legal Events**. In the event any state, federal, or local laws or regulations, now existing or enacted, promulgated, or amended after the effective date of this Agreement, are interpreted by judicial decision, by a regulatory agency, or reasonably by either Party's legal counsel (which shall be a firm of recognized standing) in such a manner as to indicate that the structure of this Agreement may be in violation of such laws or regulations or may jeopardize the tax exempt status of either Party (an "Adverse Event"), the Parties hereto shall negotiate in good faith to amend this Agreement as necessary. To the maximum extent possible, any amendment to this Agreement effected shall preserve the underlying economic and financial arrangements between the Parties. Notwithstanding the foregoing, a Party shall not be obligated to agree to an amendment to this Agreement if that Party in good faith disagrees, in a writing delivered to the other Party, that an Adverse Event has occurred, or if the Parties cannot, using good faith efforts within sixty (60) days of either Party's notification in writing to the other Party that an Adverse Event has occurred, mutually agree upon amendments to this Agreement as necessary to cure such Adverse Event.

6. **Confidentiality.**

6.1 Each Party will require access to certain confidential and/or proprietary information relating to the business, financial, and strategic condition of the other Party, which may be in written, oral, or electronic format ("Confidential Information"). The term Confidential Information shall not include information that is or becomes publicly available through no fault of either Party.

6.2 Each Party acknowledges that the Confidential Information furnished by the other Party during the course of the negotiations and due diligence contemplated hereunder is a valuable, special, and unique asset of the Party furnishing such Confidential Information (hereinafter, the "Furnishing Party"). Accordingly, each Party agrees that, except as specifically provided herein, it will not disclose to any person, institution, entity, company, or any other third party, directly or indirectly, any Confidential Information, without the prior written consent of the Furnishing Party or as required by law.

(a) Each Party agrees that Confidential Information shall be disclosed to its corporate members, members of its Board, staff, contractors, or other agents, and in the case of the Hospital or potential successors-in-interest to the Hospital only: (i) on a need-to-know basis, and (ii) for the purpose of planning, negotiations and due diligence review contemplated by this Agreement or for the purpose of due diligence review by a potential successor-in-interest to the Hospital. Each Party shall require its Board members, staff, contractors, other agents and potential successors-in-interest who receive Confidential Information regarding the other Party to comply with the standards set forth in this Section.

(b) Each Party agrees that Confidential Information shall be disclosed to federal and state government bodies for the purpose of implementing this Agreement and obtaining applicable approvals relating thereto.

6.3 Nothing in this Agreement shall prohibit a Party from making any disclosure of Confidential Information that, in the good faith opinion of such Party making the disclosure, is required by law. If disclosure of the Confidential Information is required, the Party making the disclosure shall promptly notify the Furnishing Party, in order to permit the Furnishing Party an opportunity to object to such disclosure and/or to obtain a court order or other reliable assurance that confidential treatment shall be accorded to the disclosed Confidential Information.

6.4 Each Party warrants that, to its knowledge as of the date of this Agreement's execution and at the time of any subsequent disclosure, it is permitted to disclose to the other Party, as provided herein, its respective Confidential Information and that such disclosure does not, and will not, violate the rights of any third party.

6.5 Each Party shall retain title and all rights to the Confidential Information that has been disclosed to the other Party. Upon request, each Party agrees to return promptly to the other Party all Confidential Information and to not retain any copies, extracts, or other reproductions, in whole or in part, of such returned Confidential Information.

6.6 This Section 6 regarding the obligation of both Parties to keep confidential all Confidential Information, regardless of the manner of transmission, survives the expiration or termination of this Agreement.

7. **Notices.** Any and all notices, designations, consents, offers, acceptances or other communication required to be given under this Agreement shall be in writing and delivered in person or sent by registered or certified mail, return receipt requested, postage prepaid, to the following addresses:

If to SWCHC: Kathy Yacavone, President/CEO
Southwest Community Health Center, Inc.
Bridgeport, Connecticut 06606

If to Hospital: St. Vincent's Medical Center
2800 Main Street
Bridgeport, Connecticut 06606
Attention: President and Chief Executive Officer

The foregoing addresses may be changed and/or additional persons may be added thereto by notifying the other Party hereto in writing and in the manner hereinafter set forth. All notices shall be effective upon receipt.

8. **Independent Contractors.** The Parties shall remain separate and independent entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between or among the Parties other than that of independent contractors. Except as otherwise provided, neither of the Parties shall be construed to be the agent, partner, co-venturer, employee or representative of the other Party.

9. **Governing Law.** This Agreement is made pursuant to and shall be governed by the laws of the State of Connecticut, as well as all applicable Federal laws, regulations, and policies, including, but not limited to, all laws, rules, policies, and other terms applicable to SWCHC's Section 330 grant.

10. **Severability.** The provisions of this Agreement are not severable. In the event that any one or more provisions of this Agreement are deemed null, void, illegal, or unenforceable, the Parties shall renegotiate or terminate the remaining provisions of this Agreement unless the Parties mutually agree in writing that the invalidity, illegality, or unenforceability of said provision does not materially change the obligations of the Parties under this Agreement, in

which case this Agreement shall be construed in all respects as if such invalid or unenforceable provisions have been omitted.

11. **Third-Party Beneficiaries.** The Agreement is not intended to benefit, and shall not be construed to benefit, any person or entities other than the Parties hereto, or to create any third-party beneficiary right for any other person or entities.

12. **Assignment.** Neither Party may assign, delegate, or transfer this Agreement, or its rights and obligations hereunder, without the other Party's express, prior written consent except as expressly permitted in this Agreement. Hospital may assign this Agreement without such consent to (a) any entity that controls, is controlled by or is under common control with Hospital or (b) any successor-in-interest to the operations and assets of Hospital; provided, however, that Hospital shall remain liable for its obligations under this Agreement. Any assignment attempted without such consent shall be void. The provisions of this Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their duly authorized transferees, successors and assigns.

13. **Entire Agreement; Amendments.** This Agreement and its attachments represent the Parties' complete understanding regarding the subject matter herein. Any amendment to this Agreement shall be in writing and signed by both Parties. Except for any specific provision being amended, this Agreement shall remain in full force and effect after such amendment. This Agreement supersedes any other agreements or understandings between the Parties, whether oral or written, relating to the subject matter of this Agreement including, without limitation, that certain Letter of Intent between the Parties dated February 7, 2017. No such other agreements or understandings may be enforced by any Party nor may they be employed for interpretation purposes in any dispute involving this Agreement.

14. **Authority.** Each signatory to this Agreement represents and warrants that he or she possesses all necessary capacity and authority to act for, sign, and bind the respective entity on whose behalf he or she is signing.

15. **Government Access.** If Section 952 of the Medicare and Medicaid Amendments of 1980, 42 U.S.C. §1395x(v)(1)(I), is applicable to this Agreement, SWCHC agrees upon written request, to make available to the Secretary of DHHS, the Comptroller General or any of their duly authorized representatives, all contracts, books, documents and records of SWCHC necessary to certify the nature and extent of costs associated with the services furnished under this Agreement. All books and records described in this Section shall be maintained and made available for a period of four (4) years after the last date that services were rendered under this Agreement. The provisions of the Medicare and Medicaid Amendments of 1980, including Section 952 thereof, and the rules and regulations adopted from time to time thereunder, are incorporated herein by reference, and SWCHC agrees to be bound thereby. This Section shall survive the termination of this Agreement.

16. **Covenants of SWCHC.** During the term of this Agreement:

16.1 Medicaid Eligibility. SWCHC shall use reasonable efforts to determine eligibility of patients of the Lindley Street Clinic for the Medicaid Program and assist patients in obtaining Medicaid coverage.

16.2 Collections from Patients. SWCHC shall make reasonable efforts to collect payment from patients for Services provided by SWCHC at the Lindley Street Clinic within the limits of HRSA rules for FQHCs and SWCHC's then-current collections policy and procedures, as shall be provided to the Hospital upon request.

16.3 Reporting Requirements.

(a) SWCHC shall furnish to the Hospital upon request (i) unaudited financial statements, (ii) when due, annual audited financial statements, documents or reports that SWCHC is required to file with any federal agencies relating to its FQHC status, costs or reimbursement, and (iii) such other financial statements, reports, instruments and documents as the Hospital may reasonably request from time to time.

(b) SWCHC shall provide the Hospital, promptly after the commencement thereof, notice of each action, suit or proceeding before any court or other governmental authority or other regulatory body or any arbitrator in which SWCHC is a party, which may adversely affect its condition or operations, financial or otherwise.

(c) Maintenance of Permits. SWCHC shall maintain all permits, licenses, authorizations and approvals required for the lawful operation of its business, including without limitation, approval as an FQHC, and all such licenses and approvals as required under federal and state law.

(d) Conduct of Business/Insurance. SWCHC shall conduct its business in a commercially reasonable manner in accordance with all applicable laws, rules and regulations and maintain such insurance policies as are standard for a like organization located in the Service Area.

(d) Provision of Services. SWCHC shall operate the Lindley Street Clinic at the Lindley Street Location and provide the Services, including adult and pediatric primary care and primary care obstetrics and gynecology, including prenatal health services, to all residents of the Service Area, regardless of ability to pay.

17. **Ethical and Religious Directives.** The Parties acknowledge that the operations of the Hospital are in accordance with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor (the "Directives") and that the principles and beliefs of the Roman Catholic Church are a matter of conscience to the Hospital. The Directives are located at http://www.usccb.org/issues-and-action/human-life-and-

dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. It is the intent and agreement of the Parties that this Agreement shall not be construed to require the Hospital to violate said Directives in its operation and all parts of this Agreement must be interpreted in a manner that is consistent with said Directives.

18. **Corporate Responsibility.** The Hospital has a Corporate Responsibility Program (the "Program") which has as its goal to ensure that the Hospital complies with federal, state and local laws and regulations. The Program focuses on risk management, the promotion of good corporate citizenship, including the commitment to uphold a high standard of ethical and legal business practices, and the prevention of misconduct. SWCHC acknowledges the Hospital's commitment to the Program and agrees to ensure that its personnel comply and cooperate with, and participate in, the Program as applicable to the performance of business transactions under this Agreement.

[THE NEXT PAGE IS THE SIGNATURE PAGE.]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the date set forth above by their duly-authorized representatives.

Southwest Community Health Center, Inc.	St. Vincent's Medical Center
By: _____	By: _____
Its	Its
Date: _____	Date: _____

EXHIBIT A

FORM OF CERTIFICATION

Date:_____

Southwest Community Health Center, Inc. ("SWCHC") hereby certifies to St. Vincent's Medical Center, pursuant to the terms and conditions of the Community Benefit Grant Agreement dated as of _____, 2017, by and between SWCHC and St. Vincent's Medical Center (the "Agreement"), as follows:

1. All Deficit Grant Funds (as defined in the Agreement) received by SWCHC were used only for the Permitted Purpose (as defined in the Agreement) in accordance with the terms of the Agreement.

2. The representations and warranties contained in Section 6 of the Master Agreement (as defined in the Agreement) are true and correct as of the date of this Certification as though made on as and as of the date hereof; SWCHC is in compliance with all covenants set forth in Section 16 of the Agreement; and all conditions precedent to the making of a payment of Deficit Grant Funds set forth in Section 2.6 of the Agreement have been satisfied.

3. SWCHC hereby confirms that no default under the Agreement has occurred or is continuing as of the date of this Certification or would result from the next payment of Deficit Grant Funds to be paid by the Hospital to SWCHC pursuant to this Agreement.

4. The undersigned is duly authorized to make this certification on behalf of SWCHC.

SOUTHWEST COMMUNITY HEALTH CENTER, INC.

By:_____
Name:_____
Title:_____

Olejarz, Barbara

From: Riggott, Kaila
Sent: Wednesday, August 02, 2017 3:25 PM
To: Carney, Brian; Fernandes, David; Olejarz, Barbara
Cc: Hansted, Kevin; Martone, Kim
Subject: FW: Docket Number: 17 - 32165-CON
Attachments: CON Application.pdf

Please add to the record. Kim and Kevin, I followed up with Joan Feldman because we had not heard from her and they have decided not to request that some of the completeness responses be redacted/held confidential.

Kaila Riggott, MPA
Planning Specialist
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13-HCA
Hartford, CT 06134
phone: 860.418.7037
fax: 860.418.7053
http://www/ct.gov/ohca

From: Riggott, Kaila
Sent: Monday, July 31, 2017 11:47 AM
To: Carney, Brian <Brian.Carney@ct.gov>; Fernandes, David <David.Fernandes@ct.gov>
Subject: FW: Docket Number: 17 - 32165-CON

Completeness response for St. V's. They are requesting that certain information be kept confidential/redacted and are sending a separate email regarding that request (for Kevin's consideration), so please don't have anything posted until he decides on that matter. He is telecommuting today, so I will forward you his response once I hear from him. Please confirm with Joan that we received the responses. Thanks!

Kaila Riggott, MPA
Planning Specialist
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13-HCA
Hartford, CT 06134
phone: 860.418.7037
fax: 860.418.7053
http://www/ct.gov/ohca

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Monday, July 31, 2017 11:39 AM
To: User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Subject: Docket Number: 17 - 32165-CON

Kaila:
Attached for your consideration, you will find the responses to your letter dated June 1, 2017 in connection with St. Vincent's Medical Center's application to terminate its primary care clinic services.
Thank you.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

Privileged and confidential. If received in error, please notify me by e-mail and delete the message.

please consider the environment before printing this message

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

July 31, 2017

By email: OHCA@ct.gov

Mr. Brian A. Carney
Associate Research Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

Re: Certificate of Need Application: Docket Number: 17-32165-CON
Termination of Primary Care Clinical Services
Certificate of Need Completeness Letter

Dear Mr. Carney:

Reference is made to OHCA's letter to St. Vincent's Medical Center dated June 1, 2017. Set forth below are each of the questions included in the letter followed by our response.

1) In regard to the new specialty services planned for the Lindley Street location (page 14 of the application):

   a. provide the expected start date for each new service;

   The specialty services will no longer be located at the Lindley Street Location as previously planned and as represented in the above-referenced CON application. Instead, the St. Vincent's specialty clinics will be at a new medical office building leased by the St. Vincent's Medical Center located at 2979 Main Street, Bridgeport, Connecticut, approximately .4 tenths of a mile from the Lindley Street Location. Since submitting the above-referenced CON application, St. Vincent's Medical Center has had fully updated and furnished specialty space become available. This Main Street space is much larger, has ample parking, is on a bus route, and is beautifully built out. There will be a care coordinator stationed at the Lindley Street Location who will be responsible for scheduling the specialty visits at 2979 Main Street so the referral is seamless. The expense saved by St. Vincent's Medical Center in not having to renovate the Lindley Street Location will help finance the additional specialty services. The new schedule of services is planned to commence as follows:

Endocrinology - January 2018
Infectious Disease - January 2018
Gastroenterology - March 2018
Cardiology - January 2018
Podiatry - January 2018
General Surgery - January 2018
Ophthalmology - January 2018
Neurology - January 2018
Orthopedics - January 2018
Nephrology - January 2018
Rheumatology - March 2018
Pulmonology - March 2018
Nutritional Counseling - January 2018

b. explain whether additional physicians will need to be hired; and

To the extent that there is additional capacity for our physicians who are currently covering our specialty clinics, St. Vincent's Medical Center will use these same physicians to cover the specialty clinic hours by adding additional hours to their schedule. New Physicians will be hired to cover the pulmonology and rheumatology specialty clinics. In addition, additional cardiology and orthopedic physicians will be contracted to cover additional hours. Plans also call for including one full time gastroenterologist.

c. confirm that all specialty service physicians at this location will accept Medicaid.

All specialty physicians will accept Medicaid patients.

2) Page 12 of the application states the wait times for cardiology, endocrinology, neurology, gastroenterology and ophthalmology range from three to six months.

a. describe how the proposal will help reduce specialty care wait times;

Cardiology clinic offerings are increasing from 6 hours per month to 60 hours per month, endocrinology hours are doubling from 3 hour to 6 hours monthly, neurology clinic hours are doubling from 6 hours to 12 hours monthly, and ophthalmology clinic hours are doubling from 3 to 6 hours monthly. Gastroenterology hours are increasing dramatically from 9 hours monthly to 80 hours monthly. All of these additional hours will create ample new appointment slots which can be filled with these patients who would currently need to be put on a wait list.

Specialty	Now hours per Month	Proposed hours per Month
cardiology	6	60
endocrinology	3	6
neurology	6	12
ophthalmology	3	6
gastroenterology	9	80
rheumatology	0	6
infectious disease	6	8
general surgery	12	24
Neurology	6	12
orthopedics	3	48
nephrology	3	6
podiatry	6	12
nutritional counseling	8	32
pulmonary	0	16

b. explain the anticipated timeframe for accomplishing this goal;

We anticipate that we will start scheduling patients immediately and it is likely that by 4 to 6 months after the new specialty clinic schedule is implemented that the current wait lists will be significantly reduced and soon comparable to wait times for patients seeing specialists in private practice.

c. provide an estimate of future wait times anticipated for each specialty service, following adoption of the proposal.

Endocrinology - Less than 2 weeks
Infectious Disease - Approximately 2 weeks
Gastroenterology - Less than 2 weeks
Cardiology - Less than 1 week
Podiatry - Less than 2 weeks
General Surgery - Less than 2 weeks
Ophthalmology - Approximately 2 weeks
Neurology - Less than 2 weeks
Orthopedics - Less than 2 weeks
Nephrology - Approximately 2 weeks
Rheumatology - Approximately 2 weeks
Pulmonary- Less than 2 weeks
Nutritional Counseling - Approximately 2 weeks

3) Page 7 of the application states that the Applicant will enter into a five-year Community Benefit and Support Agreement with Southwest Community Health Center, Inc. ("SWCHC") to provide financial support to cover SWCHC's transition and other "ramp up" expenses at the Lindley Street service location.

   a. provide an estimate of the financial support dollar amount that will be committed in total and on a yearly basis;

      Financial support for the first year is up to $964,649.
      Financial support for the second year is up to $954,297.
      Financial support for the third year is up to $889,905.
      Financial support for the fourth year is up to $740,807.
      Financial support for the fifth year is up to $716,150.

   b. explain where the financial support commitment appears in the Financial Worksheet (if not included, revise worksheet to include the financial support commitment); and

      Financial Support is included in "Other Expenses". Please see revised Financial Worksheet (Attachment SVMC Table A.1)

   c. provide a copy of the proposed SWCHC Community Benefit and Support Agreement.

      Please see attached hereto.

4) Revise the FY 2020 "Projected Incremental" column on Financial Worksheet A (page 211) as it appears to be incorrect. Both "Net Patient Service Revenue" and "Total Operating Revenue" reflect $0, resulting in "Income from Operations" of $1,944,000.

Adjust the FY 2020 "Projected With CON" as necessary, based on your changes to the incremental column.

Please see revised Attachment SVMC Table A.1 to reflect adjusted operating income for 2020 at column "s", line 51.

5) Provide an explanation for the FY 2017 decline in Pediatric Care (-1.5%) and Specialty Care Clinic (-7.7%) visits (Table 5 on page 25 of the application).

Pediatrics had a physician unexpectedly out on FMLA for approximately two months which resulted in reduced hours for pediatric patients. Specialty clinics hours were reduced resulting in reduced clinic hours for nephrology 4 hours/month; cardiology 8 hours/month; and infectious disease 4 hours/month based upon reduced physician availability.

6) Please explain the basis for the projected Specialty Care Clinic visit increases of 26%, 22% and 7% respectively, for FY 2018, FY 2019 and FY 2020.

Specialty clinic hours will be increased dramatically from approximately 60 hours per month to over 300 hours per month. During the first two years, visits are projected to grow based on current wait list patients as well as new SWCHC patients. Such increase in visits will carry into year two as full clinic potential is realized and will eventually begin to level off in year three as we meet the specialty needs of area patients.

7) Revise Table 6 on page 26 of the application. "Current Year" should be based on the most recently completed fiscal year (FY 2016) - include projections through FY 2020.

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2016**		Projected							
			FY 2017**		FY 2018**		FY 2019**		FY 2020**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	2,225	10%	2,198	10%	523	10%	640	10%	685	10%
Medicaid*	14,239	64%	14,066	64%	3,344	64%	4,096	64%	4,384	64%
CHAMPUS & TriCare	0	0%	0	0%	0	0%	0	0%	0	0%
Total Government	**16,464**	**74%**	**16,264**	**74%**	**3,876**	**74%**	**4,736**	**74%**	**5,069**	**74%**
Commercial Insurers	445	2%	440	2%	95	2%	128	2%	137	2%
Uninsured	5,340	24%	5,274	24%	1,254	24%	1,536	24%	1,644	24%
Workers Compensation	0	0%	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**5,785**	**26%**	**5,714**	**26%**	**1,349**	**26%**	**1,664**	**26%**	**1,781**	**26%**
Total Payer Mix	**22,249**	**100%**	**21,978**	**100%**	**5,225**	**100%**	**6,400**	**100%**	**6,850**	**100%**

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

8) Provide SWCHC's projected FY 2018-FY 2020 patient volume and payer mix for Adult Primary Care and Pediatric Care services at the Lindley Street location. Will SWCHC be able to accommodate the entire SVMC primary care patient population currently served at the Lindley Street service location? - Yes

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2018**	FY 2019**	FY 2020**
Adult Primary Care	17,344	17,344	17,344
Pediatric Care	7,800	7,800	7,800
Total	25,144	25,144	25,144

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

SWCHC Projected Payer Mix

	Percentage 2018	Volume 2018	Percentage 2019	Volume 2019	Percentage 2020	Volume 2020
COMMERCIAL	4%	1006	5%	1258	5%	1258
SELF PAY	22%	5532	21%	5280	20%	5029
MEDICARE	10%	2514	10%	2514	10%	2514
MEDICAID	64%	16,092	64%	16,092	65%	16,343

SWCHC has committed to allowing the St. Vincent's Medical Center's internal medicine residents to continue to rotate through Lindley Street Location and SWCHC will staff the primary care and pediatric services to cover all the Lindley Street Location patients.

9) Will any new or additional facilities fees be imposed following the transition of primary care services to SWCHC?

No new fees or additional facility fees will be imposed as a result of this proposal.

If you have any questions regarding the above or the attached information, please contact the undersigned.

Very truly yours,

Joan Feldman, Esq.
Shipman & Goodwin LLP
On behalf of
Kurt Bassett
Director of Strategic Planning
St. Vincent's Medical Center

Cc: Kaila Riggott (Kaila.Riggott@ct.gov)

Enclosures

NON-PROFIT

Applicant: St. Vincent's Medical Center

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY16 Actual	(2) FY17 Projected	(3) FY17 Projected	(4) FY17 Projected	(5) FY18 Projected	(6) FY18 Projected	(7) FY18 Projected	(8) FY19 Projected	(9) FY19 Projected	(10) FY19 Projected	(11) FY20 Projected	(12) FY20 Projected	(13) FY20 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$1,548,392	$1,465,459		$1,465,459	1,427,000		$1,427,000	$1,469,810		$1,469,810	$1,513,904		$1,513,904
2	Less: Allowances	$1,040,692	$954,390		$954,390	928,300		$928,300	$956,149		$956,149	$984,833		$984,833
3	Less: Charity Care	$24,235	$25,000		$25,000	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
4	Less: Other Deductions	$0	$0		$0			$0	$0		$0			$0
	Net Patient Service Revenue	**$483,465**	**$486,069**	**$0**	**$486,069**	**$473,700**	**($350)**	**$473,350**	**$487,911**	**($700)**	**$487,211**	**$502,548**	**$0**	**$502,548**
5	Medicare	$186,816	$186,816		$186,816	$182,100	($10)	$182,090	$187,563	($20)	$187,543	$193,190	($20)	$193,170
6	Medicaid	$91,720	$91,720		$91,720	$89,400	($325)	$89,075	$92,082	($650)	$91,432	$94,844	($650)	$94,194
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$278,536**	**$278,536**	**$0**	**$278,536**	**$271,500**	**($335)**	**$271,165**	**$279,645**	**($670)**	**$278,975**	**$288,034**	**($670)**	**$287,364**
9	Commercial Insurers	$197,001	$197,001		$197,001	$192,000		$192,000	$197,760		$197,760	$203,693		$203,693
10	Uninsured	$25,649	$25,649		$25,649	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
11	Self Pay	$17,648	$17,648		$17,648	$17,200	($15)	$17,185	$17,716	($30)	$17,686	$18,247	($30)	$18,217
12	Workers Compensation				$0			$0			$0			$0
13	Other	($35,369)	($32,765)		($32,765)	($32,000)		($32,000)	($32,960)		($32,960)	($33,949)		($33,949)
	Total Non-Government	**$204,929**	**$207,533**	**$0**	**$207,533**	**$202,200**	**($15)**	**$202,185**	**$208,266**	**($30)**	**$208,236**	**$214,514**	**($30)**	**$214,484**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$483,465**	**$486,069**	**$0**	**$486,069**	**$473,700**	**($350)**	**$473,350**	**$487,911**	**($700)**	**$487,211**	**$502,548**	**($700)**	**$501,848**
14	Less: Provision for Bad Debts	$26,362	$26,362		**$26,362**	$25,700		**$25,700**	$26,471		**$26,471**	$27,265		**$27,265**
	Net Patient Service Revenue less provision for bad debts	**$457,103**	**$459,707**	**$0**	**$459,707**	**$448,000**	**($350)**	**$447,650**	**$461,440**	**($700)**	**$460,740**	**$475,283**	**($700)**	**$474,583**
15	Other Operating Revenue	$47,394	$46,475		**$46,475**	$45,000		**$45,000**	$46,350		**$46,350**	$47,741		**$47,741**
17	Net Assets Released from Restrictions	$1,961	$2,000		**$2,000**	$2,000		**$2,000**	$2,060		**$2,060**	$2,122		**$2,122**
	TOTAL OPERATING REVENUE	**$506,458**	**$508,182**	**$0**	**$508,182**	**$495,000**	**($350)**	**$494,650**	**$509,850**	**($700)**	**$509,150**	**$525,146**	**($700)**	**$524,446**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$218,910	$209,925		$209,925	$195,200	($719)	$194,481	$201,056	($1,438)	$199,618	$207,088	($1,438)	$205,650
2	Fringe Benefits	$53,186	$52,839		$52,839	$51,300	($232)	$51,068	$52,839	($464)	$52,375	$54,424	($464)	$53,960
3	Physicians Fees	$19,867	$19,867		$19,867	$19,300	($283)	$19,017	$19,879	($566)	$19,313	$20,475	($566)	$19,909
4	Supplies and Drugs	$58,754	$56,813		$56,813	$55,100	($29)	$55,071	$56,753	($58)	$56,695	$58,456	($58)	$58,398
5	Depreciation and Amortization	$27,221	$26,610		$26,610	$25,800	$45	$25,845	$26,574	$90	$26,664	$27,371	$90	$27,461
6	Provision for Bad Debts-Other[b]	$1,279	$1,279		$1,279	$1,200	$0	$1,200	$1,236	$0	$1,236	$1,273	$0	$1,273
7	Interest Expense	$1,800	$2,003		$2,003	$2,000	$0	$2,000	$2,060	$0	$2,060	$2,122	$0	$2,122
8	Malpractice Insurance Cost	$9,960	$9,960		$9,960	$10,200	$6	$10,206	$10,506	$12	$10,518	$10,821	$12	$10,833
9	Lease Expense	$8,025	$8,025		$8,025	$8,200	($92)	$8,108	$8,446	($184)	$8,262	$8,699	($184)	$8,515
10	Other Operating Expenses	$130,340	$129,861		$129,861	$119,500	$932	$120,432	$123,085	$959	$124,044	$126,778	$922	$127,700
	TOTAL OPERATING EXPENSES	**$529,342**	**$517,182**	**$0**	**$517,182**	**$487,800**	**($372)**	**$487,428**	**$502,434**	**($1,649)**	**$500,785**	**$517,507**	**($1,686)**	**$515,821**
	INCOME/(LOSS) FROM OPERATIONS	**($22,884)**	**($9,000)**	**$0**	**($9,000)**	**$7,200**	**$22**	**$7,222**	**$7,416**	**$949**	**$8,365**	**$7,639**	**$986**	**$8,625**
	NON-OPERATING REVENUE	**$6,940**	$6,940		**$6,940**	**$0**		**$0**	0		**$0**	0		**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**($15,944)**	**($2,060)**	**$0**	**($2,060)**	**$7,200**	**$22**	**$7,222**	**$7,416**	**$949**	**$8,365**	**$7,639**	**$986**	**$8,625**
	Principal Payments				**$0**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**-4.5%**	**-1.7%**	**0.0%**	**-1.7%**	**1.5%**	**-6.3%**	**1.5%**	**1.5%**	**-135.6%**	**1.6%**	**1.5%**	**-140.9%**	**1.6%**
2	Hospital Non Operating Margin	**1.4%**	**1.3%**	**0.0%**	**1.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-3.1%**	**-0.4%**	**0.0%**	**-0.4%**	**1.5%**	**-6.3%**	**1.5%**	**1.5%**	**-135.6%**	**1.6%**	**1.5%**	**-140.9%**	**1.6%**
D.	**FTEs**	**2,894**	**2,542**		**2,542**	2,470	(10)	**2,460**	2,470	(20)	**2,450**	2,470	(20)	**2,450**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	16,201	16,201		**16,201**	15,100	0	**15,100**	15,100		**15,100**	15,100		**15,100**
2	Outpatient Visits	602,810	602,810		**602,810**	614,870	(7,500)	**607,370**	627,170	(15,000)	**612,170**	639,710	(15,000)	**624,710**
	TOTAL VOLUME	**619,011**	**619,011**	**0**	**619,011**	**629,970**	**(7,500)**	**622,470**	**642,270**	**(15,000)**	**627,270**	**654,810**	**(15,000)**	**639,810**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

COMMUNITY BENEFIT GRANT AGREEMENT

This AGREEMENT (this "Agreement") is entered into as of _____ ____, 2017 (the "Effective Date"), by and between Southwest Community Health Center, Inc. ("SWCHC") and St. Vincent's Medical Center ("Hospital") (individually a "Party," and collectively the "Parties").

BACKGROUND

The Hospital is a charitable, nonprofit corporation pursuant to Section 501(c)(3) of the Internal Revenue Code and an acute care hospital and medical center located in Bridgeport, Connecticut.

In furtherance of its Mission, the Hospital has historically operated a primary care clinic located at 762 Lindley Street, Bridgeport, Connecticut (the "Lindley Street Location"), serving uninsured and underinsured patients (the "Lindley Street Clinic"). To date, the Lindley Street Clinic's focus has been on providing a medically underserved population of patients in the greater Bridgeport area (the "Service Area") with access to quality primary care services (the "Services"). The Hospital believes that the Services are important to the greater Bridgeport community (the "Community").

The Hospital has determined that the most efficient and effective way to ensure that individuals and families in the Service Area have increased access to such Services is to work with a provider with proven experience in providing primary care medical and other services to medically underserved populations and which is capable of assuming the responsibility of providing the Services to individuals and families in the Service Area.

SWCHC is a federally qualified health center ("FQHC") that receives federal grant support from the Health Resources and Services Administration ("HRSA") within the United States Department of Health and Human Services ("DHHS") pursuant to Section 330 of the Public Health Service Act, to provide, or arrange for the provision of, high quality, cost-effective, community-based comprehensive primary and preventive health care and related services (including, but not limited to, ancillary and enabling services) to medically underserved communities in the Service Area, regardless of the individual's or family's ability to pay for such services.

Because SWCHC is able to provide more comprehensive primary care services to the same patient population that utilizes the Lindley Street Clinic, the Hospital has proposed to SWCHC that SWCHC assume full responsibility for the Lindley Street Clinic. The Hospital, in turn, will allocate more of its resources to providing specialty medical services to the Community. Subject to state and federal regulatory approvals, SWCHC is desirous of assuming operational responsibility for the Lindley Street Clinic, as it would fully complement the other primary care services offered by SWCHC. To facilitate the transition of the Lindley

Street Clinic from the Hospital to SWCHC and support the availability of health care services for underserved persons in the Community, and in furtherance of the Hospital's Mission, and recognizing the interest of Service Area residents and governmental agencies in having a comprehensive primary care health center provide health care services in the Service Area, the Hospital intends to provide a community benefit grant ("Community Benefit Grant").

Simultaneously with the execution and delivery of this Agreement, the Parties are entering into a Master Agreement (the "Master Agreement"), and certain other agreements referenced in the Master Agreement, setting forth the terms and conditions on which SWCHC will assume full responsibility for the operation of the Lindley Street Clinic.

NOW, THEREFORE, in consideration of the covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually agreed as follows:

1. **Compliance**. It is the intention of the Parties hereto that this Agreement fully comply with the requirements of 42 U.S.C. 1320a-7b(b)(3)(I) and 42 C.F.R. §1001.952(w) and all other applicable laws and regulations. To the extent that it is determined by either Party's legal counsel or the Federal government that this Agreement is not fully compliant with any applicable law or regulation, the Parties agree to reform it to fully comply. Specifically,

1.1 The amount of the Community Benefit Grant will not be conditioned or varied based upon (or otherwise determined by taking into account in any way) the volume or value of any referrals or other business generated between SWCHC and the Hospital, which referrals or business are reimbursed, in whole or in part, under Medicare, Medicaid, CHIP, or any other federal health care program;

1.2 The amount of the Community Benefit Grant will contribute meaningfully to SWCHC's ability to maintain or increase the availability, or enhance the quality, of the services provided to the medically underserved populations at the Lindley Street Clinic. During the Term of this Agreement, and upon any renewals of this Agreement, the Parties will re-evaluate the Agreement annually to ensure that the Community Benefit Grant is satisfying, and is reasonably expected to continue satisfying, this standard, and will document such evaluation contemporaneously. The Parties will make such documentation available to the Secretary of DHHS upon request;

1.3 The Community Benefit Grant relates directly to services provided by SWCHC as part of the scope of SWCHC's Section 330 of the Public Health Service Act ("Section 330") grant, and SWCHC reasonably expects the arrangement to contribute meaningfully to SWCHC's ability to maintain or increase the access, or enhance the quality, of services provided to a medically underserved population;

1.4 SWCHC and the Hospital agree that each Party's health care professionals retain the right to refer patients to any providers they deem appropriate, based on their

professional judgment, and that all patients served by either Party retain the right to request referrals to any providers of their choosing. During the term of the Agreement, SWCHC shall provide its patients with notice, in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient, of their freedom to choose any willing provider or supplier. For the avoidance of doubt, the Parties understand and agree that SWCHC will retain the right to contract with other providers/suppliers;

1.5 SWCHC and Hospital agree to maintain a list of all agreements between the Parties. This list shall be centrally located, updated regularly, and maintained in a manner that preserves the historical record of arrangement, and made available for review by the Secretary of the DHHS upon request; and

1.6 All SWCHC patients shall be advised, upon request, of the existence and nature of this Agreement in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient

2. **Grant Funds**.

2.1 The Hospital shall provide funding to cover certain operational deficits and costs incurred by SWCHC relating to the Lindley Street Clinic for the period of _____, 2017 through_____, 2018 (the "First Period"), the period of _____, 2018 through _____, 2019 (the "Second Period"), the period of _____, 2019 through _____, 2020 (the "Third Period"), the period of _____, 2020 through _____, 2021 (the "Fourth Period"), and the period of _____, 2021 through September 30, 2022 (the "Fifth Period") (collectively, such funding is referred to as the "Grant Funds" and each such period is referred to as a "Period"). The Grant Funds are intended to contribute meaningfully to SWCHC's ability to maintain or increase the availability, or enhance the quality, of health care services provided to the medically underserved populations served by the Lindley Street Clinic (the "Permitted Purpose"). The amount of the Grant Funds paid by the Hospital to SWCHC for each quarter during the Term shall be based on a review of the Lindley Street Clinic's budgeted activities versus its actual activities as further described in this Section 2, subject to the maximum amounts set forth in Section 2.2 of this Agreement.

2.2 Notwithstanding anything to the contrary set forth in this Agreement:

(a) For the First Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $964,649, including a $150,000 contingency fund for unexpected expenses unrelated to clinical operations for such First Period;

(b) For the Second Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $954,297, including a $100,000 contingency fund for unexpected expenses unrelated to clinical operations for such Second Period;

(c) For the Third Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $889,905, including a $75,000 contingency fund for unexpected expenses unrelated to clinical operations for such Third Period;

(d) For the Fourth Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $740,807; and

(e) For the Fifth Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $716,150.

The term "Contingency Fund" shall refer to the contingency funds set forth above for each of the First, Second and Third Periods. The term "Maximum Community Benefit Grant" shall refer the maximum amounts set forth above for each Period.

2.3 The Parties shall meet on a quarterly basis to discuss the reasonableness of expenses during the previous quarter and to perform the reconciliation referred to below with respect to Grant Funds for the then-current quarter.

(a) With respect to the first quarter during the Term, the Hospital shall advance by no later than the first day of such first quarter, an amount equal to (i) twenty-five percent (25%) of the Maximum Community Benefit Grant for the First Period less (ii) the Contingency Amount for the First Period, or Two Hundred Three Thousand Six Hundred Sixty-Two and 25/100 Dollars ($203,662.25).

(b) After the first quarter during the Term, the Grant Funds will be paid to SWCHC in quarterly installments (each, a "Quarterly Installment") in an amount equal to (i) twenty-five percent (25%) of the difference between the Maximum Community Benefit Grant for the applicable Period less (ii) the Contingency Fund for the applicable Period, subject to the maximum amounts set forth in Section 2.5 and subject to the reconciliation process described in Section 2.3(c).

(c) After the first quarter during the Term, SWCHC shall provide the Hospital with a profit and loss statement for previous quarter with respect to the Lindley Street Clinic's teaching services (such services, as agreed by the Parties, are referred to as "Teaching Services") and non-teaching services (such services, as agreed by the Parties, are referred to as "Non-Teaching Services") (the "Quarterly P&L"). If the Quarterly P&L has a loss for the Teaching Services and Non-Teaching Services for such previous quarter as a result of lower than budgeted revenues or greater than budgeted expenses (so long as such expenses are of a type set forth in the Lindley Street Clinic budget or are otherwise approved by both Parties), then the Quarterly Installment will be increased by the amount of such loss; provided that in no event will the total Grant Funds for any Period exceed the maximum amount specified in Section 2.2 of this Agreement. If the Quarterly P&L has a profit for the Teaching Services and Non-Teaching Services for such previous quarter, the Quarterly Installment will be reduced by the amount of such profit or, if requested by the Hospital, shall be returned to the Hospital by SWCHC within 45 days.

(d) Payment of the Quarterly Installment will be due within forty-five (45) days of such reconciliation.

2.4 The Contingency Fund or any portion thereof will only be paid to SWCHC based on need and as agreed upon by SWCHC and the Hospital.

2.5 The Parties will meet at least annually to review the Lindley Street Clinic budget for the upcoming Period and the profit and loss statement for the Lindley Street Clinic's Teaching Services and Non-Teaching Services for the prior Period (the "Annual P&L"). If the Annual P&L has a profit with respect to such Teaching Services and Non-Teaching Services for such prior Period independent of any Grant Funds paid to SWCHC, then SWCHC shall return to the Hospital an amount of Grant Funds equal to the amount of such profit.

2.6 If, at any time during the term of this Agreement, the core financial assumptions prove faulty (e.g., material change in payer mix or patient volume) and/or other exigent circumstances occur such that SWCHC is unable to operate the Lindley Street Clinic in accordance with such core assumptions and/or there are unanticipated material deviations between the Lindley Street Clinic budget and actual financial performance, either Party may request a special meeting of the Parties to determine what reasonable options are available to address the circumstances, including but not limited to an adjustment in the Lindley Street Clinic budget and the Grant Funds amount; provided, however, that in no event will the Grant Funds amount exceed the applicable limit set forth in Section 2.5 of this Agreement.

2.7 SWCHC covenants and agrees that it will use the Grant Funds only for the Permitted Purpose and for no other purpose and further that the Grant Funds shall not be used for any activity that would violate the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor (the "Directives").

2.8 The obligation of the Hospital to pay any Deficit Grant Funds shall be subject to the fulfillment of the following conditions precedent:

(a) SWCHC shall provide to the Hospital an executed certification in the form of Exhibit A hereto, prior to the first day of each quarterly period during the Term of this Agreement.

(b) The representations and warranties contained in Section 6 of the Master Agreement shall be true and correct on and as of the date of each payment of Deficit Grant Funds as though made on and as of such date; SWCHC shall have complied with the covenants set forth in Section 16 of this Agreement; and no default under this Agreement shall have occurred or be continuing on the date of such payment or would result from the making of such payment.

(c) The payment of the Community Benefit Grant shall not contravene any federal, state of local law, rule or regulation applicable to the Hospital or SWCHC.

(d) The Parties shall have obtained all necessary governmental approvals relating to (i) termination of the Services by the Hospital, including but not limited to approval from the Office of Health Care Access of the Connecticut Department of Public Health of the certificate of need application filed by the Hospital with respect to such termination, (ii) the provision of Services by SWCHC, including but not limited to all required approvals from HRSA, including the Change in Scope for the activities described herein, and (iii) appropriate licensure from the Connecticut Department of Public Health, including an operating license issued to SWCHC for the Services to be provided at the Lindley Street Location.

(e) All proceedings in connection with the making of the Community Benefit Grant and the other transactions contemplated by this Agreement and the Master Agreement between the Parties of even date herewith, and all documents incidental thereto, shall be reasonably satisfactory to the Hospital.

2.9 On an annual basis, the Parties shall meet to review the Community Benefit Grant and the scope and availability of Services provided by SWCHC in the Service Area and to evaluate the impact of the Community Benefit Grant on SWCHC's operations (an "Evaluation") in accordance with Section 1.2 above; provided, however, that the Parties may conduct an Evaluation more frequently than annually upon a reasonable request by the Hospital or SWCHC. Such Evaluation shall be documented in writing by the Parties.

3. **Term of Agreement**. The effective date of this Agreement shall be the Effective Date and shall terminate on_____, 2022 (the "Term") unless sooner terminated as set forth below.

4. **Termination of Agreement**.

4.1 For Breach. Notwithstanding any of the provisions in this Agreement to the contrary, prior to the expiration of the Term, either Party may terminate this Agreement upon written notice to the other Party in the event of such other Party's breach of a material provision of this Agreement, which breach remains uncured for a period of thirty (30) days following receipt of written notice specifying the breach complained of.

4.2 Tax-Exempt or Medicare/Medicaid Status. Notwithstanding any of the provisions in this Agreement to the contrary, prior to the expiration of the Term, either Party may terminate this Agreement upon written notice to the other Party if the other Party loses its (i) tax-exempt status, (ii) eligibility status in a federal or state health care program, including but not limited to Medicare or Medicaid; or (iii) state facility licensure or, in the case of SWCHC, Federally Qualified Health Care status.

4.3 Bankruptcy. This Agreement shall immediately terminate upon: (i) the bankruptcy, insolvency, or cessation of operations of either Party, as applicable, or the filing of any voluntary petition for bankruptcy, dissolution, liquidation, or winding-up of the affairs of either Party, as applicable, or any assignment by either Party, as applicable, for the benefit

of creditors; or (ii) the filing of any involuntary petition for bankruptcy, dissolution, liquidation, or winding-up of the affairs of either Party, as applicable, which petition is not dismissed within ninety (90) days of the date upon which it is filed.

4.4 Hospital Termination Rights. The Hospital shall have the right to terminate this Agreement upon written notice to SWCHC upon the occurrence of any of the following events:

(a) SWCHC shall cease to operate the Lindley Street Clinic at the Lindley Street Location.

(b) SWCHC shall (i) merge or consolidate with another entity, including but not limited to another FQHC; (ii) become affiliated with, or sponsored by, another entity, including but not limited to another FQHC; (iii) sell or dispose of all or substantially all of its assets; or (iv) any entity shall have the authority to, directly or indirectly, manage or control the management, operations or governance of SWCHC, including but not limited to the ability to appoint any members of the board of directors of SWCHC; unless in each case the successor entity assumes the obligations of SWCHC under this Agreement and the other agreements entered into between SWCHC and the Hospital on the Effective Date.

(c) Any written agreement between the Hospital and SWCHC is not renewed or is terminated for any reason by either Party or SWCHC is in default under any written agreement between the Hospital and SWCHC.

Upon any termination of this Agreement by the Hospital, the Hospital shall have no further obligations under this Agreement, including the obligation to make any payment of Deficit Grant Funds after the date of termination.

4.5 Termination without Cause. Notwithstanding any of the provisions in this Agreement to the contrary, the Parties may mutually agree to terminate this Agreement at any time.

5. **Modification for Prospective Legal Events**. In the event any state, federal, or local laws or regulations, now existing or enacted, promulgated, or amended after the effective date of this Agreement, are interpreted by judicial decision, by a regulatory agency, or reasonably by either Party's legal counsel (which shall be a firm of recognized standing) in such a manner as to indicate that the structure of this Agreement may be in violation of such laws or regulations or may jeopardize the tax exempt status of either Party (an "Adverse Event"), the Parties hereto shall negotiate in good faith to amend this Agreement as necessary. To the maximum extent possible, any amendment to this Agreement effected shall preserve the underlying economic and financial arrangements between the Parties. Notwithstanding the foregoing, a Party shall not be obligated to agree to an amendment to this Agreement if that Party in good faith disagrees, in a writing delivered to the other Party, that an Adverse Event has occurred, or if the Parties cannot, using good faith efforts within sixty (60) days of either Party's notification in writing to the other Party that an Adverse Event has occurred, mutually agree upon amendments to this Agreement as necessary to cure such Adverse Event.

6. **Confidentiality.**

6.1 Each Party will require access to certain confidential and/or proprietary information relating to the business, financial, and strategic condition of the other Party, which may be in written, oral, or electronic format ("Confidential Information"). The term Confidential Information shall not include information that is or becomes publicly available through no fault of either Party.

6.2 Each Party acknowledges that the Confidential Information furnished by the other Party during the course of the negotiations and due diligence contemplated hereunder is a valuable, special, and unique asset of the Party furnishing such Confidential Information (hereinafter, the "Furnishing Party"). Accordingly, each Party agrees that, except as specifically provided herein, it will not disclose to any person, institution, entity, company, or any other third party, directly or indirectly, any Confidential Information, without the prior written consent of the Furnishing Party or as required by law.

(a) Each Party agrees that Confidential Information shall be disclosed to its corporate members, members of its Board, staff, contractors, or other agents, and in the case of the Hospital or potential successors-in-interest to the Hospital only: (i) on a need-to-know basis, and (ii) for the purpose of planning, negotiations and due diligence review contemplated by this Agreement or for the purpose of due diligence review by a potential successor-in-interest to the Hospital. Each Party shall require its Board members, staff, contractors, other agents and potential successors-in-interest who receive Confidential Information regarding the other Party to comply with the standards set forth in this Section.

(b) Each Party agrees that Confidential Information shall be disclosed to federal and state government bodies for the purpose of implementing this Agreement and obtaining applicable approvals relating thereto.

6.3 Nothing in this Agreement shall prohibit a Party from making any disclosure of Confidential Information that, in the good faith opinion of such Party making the disclosure, is required by law. If disclosure of the Confidential Information is required, the Party making the disclosure shall promptly notify the Furnishing Party, in order to permit the Furnishing Party an opportunity to object to such disclosure and/or to obtain a court order or other reliable assurance that confidential treatment shall be accorded to the disclosed Confidential Information.

6.4 Each Party warrants that, to its knowledge as of the date of this Agreement's execution and at the time of any subsequent disclosure, it is permitted to disclose to the other Party, as provided herein, its respective Confidential Information and that such disclosure does not, and will not, violate the rights of any third party.

6.5 Each Party shall retain title and all rights to the Confidential Information that has been disclosed to the other Party. Upon request, each Party agrees to return promptly to the other Party all Confidential Information and to not retain any copies, extracts, or other reproductions, in whole or in part, of such returned Confidential Information.

6.6 This Section 6 regarding the obligation of both Parties to keep confidential all Confidential Information, regardless of the manner of transmission, survives the expiration or termination of this Agreement.

7. **Notices.** Any and all notices, designations, consents, offers, acceptances or other communication required to be given under this Agreement shall be in writing and delivered in person or sent by registered or certified mail, return receipt requested, postage prepaid, to the following addresses:

If to SWCHC: Kathy Yacavone, President/CEO
Southwest Community Health Center, Inc.
Bridgeport, Connecticut 06606

If to Hospital: St. Vincent's Medical Center
2800 Main Street
Bridgeport, Connecticut 06606
Attention: President and Chief Executive Officer

The foregoing addresses may be changed and/or additional persons may be added thereto by notifying the other Party hereto in writing and in the manner hereinafter set forth. All notices shall be effective upon receipt.

8. **Independent Contractors.** The Parties shall remain separate and independent entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between or among the Parties other than that of independent contractors. Except as otherwise provided, neither of the Parties shall be construed to be the agent, partner, co-venturer, employee or representative of the other Party.

9. **Governing Law.** This Agreement is made pursuant to and shall be governed by the laws of the State of Connecticut, as well as all applicable Federal laws, regulations, and policies, including, but not limited to, all laws, rules, policies, and other terms applicable to SWCHC's Section 330 grant.

10. **Severability.** The provisions of this Agreement are not severable. In the event that any one or more provisions of this Agreement are deemed null, void, illegal, or unenforceable, the Parties shall renegotiate or terminate the remaining provisions of this Agreement unless the Parties mutually agree in writing that the invalidity, illegality, or unenforceability of said provision does not materially change the obligations of the Parties under this Agreement, in

which case this Agreement shall be construed in all respects as if such invalid or unenforceable provisions have been omitted.

11. **Third-Party Beneficiaries.** The Agreement is not intended to benefit, and shall not be construed to benefit, any person or entities other than the Parties hereto, or to create any third-party beneficiary right for any other person or entities.

12. **Assignment.** Neither Party may assign, delegate, or transfer this Agreement, or its rights and obligations hereunder, without the other Party's express, prior written consent except as expressly permitted in this Agreement. Hospital may assign this Agreement without such consent to (a) any entity that controls, is controlled by or is under common control with Hospital or (b) any successor-in-interest to the operations and assets of Hospital; provided, however, that Hospital shall remain liable for its obligations under this Agreement. Any assignment attempted without such consent shall be void. The provisions of this Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their duly authorized transferees, successors and assigns.

13. **Entire Agreement; Amendments.** This Agreement and its attachments represent the Parties' complete understanding regarding the subject matter herein. Any amendment to this Agreement shall be in writing and signed by both Parties. Except for any specific provision being amended, this Agreement shall remain in full force and effect after such amendment. This Agreement supersedes any other agreements or understandings between the Parties, whether oral or written, relating to the subject matter of this Agreement including, without limitation, that certain Letter of Intent between the Parties dated February 7, 2017. No such other agreements or understandings may be enforced by any Party nor may they be employed for interpretation purposes in any dispute involving this Agreement.

14. **Authority.** Each signatory to this Agreement represents and warrants that he or she possesses all necessary capacity and authority to act for, sign, and bind the respective entity on whose behalf he or she is signing.

15. **Government Access.** If Section 952 of the Medicare and Medicaid Amendments of 1980, 42 U.S.C. §1395x(v)(1)(I), is applicable to this Agreement, SWCHC agrees upon written request, to make available to the Secretary of DHHS, the Comptroller General or any of their duly authorized representatives, all contracts, books, documents and records of SWCHC necessary to certify the nature and extent of costs associated with the services furnished under this Agreement. All books and records described in this Section shall be maintained and made available for a period of four (4) years after the last date that services were rendered under this Agreement. The provisions of the Medicare and Medicaid Amendments of 1980, including Section 952 thereof, and the rules and regulations adopted from time to time thereunder, are incorporated herein by reference, and SWCHC agrees to be bound thereby. This Section shall survive the termination of this Agreement.

16. **Covenants of SWCHC.** During the term of this Agreement:

16.1 Medicaid Eligibility. SWCHC shall use reasonable efforts to determine eligibility of patients of the Lindley Street Clinic for the Medicaid Program and assist patients in obtaining Medicaid coverage.

16.2 Collections from Patients. SWCHC shall make reasonable efforts to collect payment from patients for Services provided by SWCHC at the Lindley Street Clinic within the limits of HRSA rules for FQHCs and SWCHC's then-current collections policy and procedures, as shall be provided to the Hospital upon request.

16.3 Reporting Requirements.

(a) SWCHC shall furnish to the Hospital upon request (i) unaudited financial statements, (ii) when due, annual audited financial statements, documents or reports that SWCHC is required to file with any federal agencies relating to its FQHC status, costs or reimbursement, and (iii) such other financial statements, reports, instruments and documents as the Hospital may reasonably request from time to time.

(b) SWCHC shall provide the Hospital, promptly after the commencement thereof, notice of each action, suit or proceeding before any court or other governmental authority or other regulatory body or any arbitrator in which SWCHC is a party, which may adversely affect its condition or operations, financial or otherwise.

(c) Maintenance of Permits. SWCHC shall maintain all permits, licenses, authorizations and approvals required for the lawful operation of its business, including without limitation, approval as an FQHC, and all such licenses and approvals as required under federal and state law.

(d) Conduct of Business/Insurance. SWCHC shall conduct its business in a commercially reasonable manner in accordance with all applicable laws, rules and regulations and maintain such insurance policies as are standard for a like organization located in the Service Area.

(d) Provision of Services. SWCHC shall operate the Lindley Street Clinic at the Lindley Street Location and provide the Services, including adult and pediatric primary care and primary care obstetrics and gynecology, including prenatal health services, to all residents of the Service Area, regardless of ability to pay.

17. **Ethical and Religious Directives.** The Parties acknowledge that the operations of the Hospital are in accordance with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor (the "Directives") and that the principles and beliefs of the Roman Catholic Church are a matter of conscience to the Hospital. The Directives are located at http://www.usccb.org/issues-and-action/human-life-and-

dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. It is the intent and agreement of the Parties that this Agreement shall not be construed to require the Hospital to violate said Directives in its operation and all parts of this Agreement must be interpreted in a manner that is consistent with said Directives.

18. **Corporate Responsibility.** The Hospital has a Corporate Responsibility Program (the "Program") which has as its goal to ensure that the Hospital complies with federal, state and local laws and regulations. The Program focuses on risk management, the promotion of good corporate citizenship, including the commitment to uphold a high standard of ethical and legal business practices, and the prevention of misconduct. SWCHC acknowledges the Hospital's commitment to the Program and agrees to ensure that its personnel comply and cooperate with, and participate in, the Program as applicable to the performance of business transactions under this Agreement.

[THE NEXT PAGE IS THE SIGNATURE PAGE.]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the date set forth above by their duly-authorized representatives.

Southwest Community Health Center, Inc.	St. Vincent's Medical Center
By: _____	By: _____
Its	Its
Date: _____	Date: _____

EXHIBIT A

FORM OF CERTIFICATION

Date:_____

Southwest Community Health Center, Inc. ("SWCHC") hereby certifies to St. Vincent's Medical Center, pursuant to the terms and conditions of the Community Benefit Grant Agreement dated as of _____, 2017, by and between SWCHC and St. Vincent's Medical Center (the "Agreement"), as follows:

1. All Deficit Grant Funds (as defined in the Agreement) received by SWCHC were used only for the Permitted Purpose (as defined in the Agreement) in accordance with the terms of the Agreement.

2. The representations and warranties contained in Section 6 of the Master Agreement (as defined in the Agreement) are true and correct as of the date of this Certification as though made on as and as of the date hereof; SWCHC is in compliance with all covenants set forth in Section 16 of the Agreement; and all conditions precedent to the making of a payment of Deficit Grant Funds set forth in Section 2.6 of the Agreement have been satisfied.

3. SWCHC hereby confirms that no default under the Agreement has occurred or is continuing as of the date of this Certification or would result from the next payment of Deficit Grant Funds to be paid by the Hospital to SWCHC pursuant to this Agreement.

4. The undersigned is duly authorized to make this certification on behalf of SWCHC.

SOUTHWEST COMMUNITY HEALTH CENTER, INC.

By:_____
Name:_____
Title:_____

User, OHCA

From: Fernandes, David
Sent: Wednesday, August 23, 2017 8:47 AM
To: Riggott, Kaila; User, OHCA
Subject: FW: Questions pertaining to 17-32165-CON

FYI

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

---

From: Bassett, Kurt [mailto:Kurt.Bassett@ascension.org]
Sent: Tuesday, August 22, 2017 2:06 PM
To: Fernandes, David <David.Fernandes@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Carney, Brian <Brian.Carney@ct.gov>
Subject: RE: Questions pertaining to 17-32165-CON

Thank you for the follow up email. I did receive your message and we are putting together a response and will follow up with you as soon as possible.

Thanks,

Kurt Bassett
Director – Strategic Planning
St. Vincent's Health Services
2800 Main Street
Bridgeport, CT 06606
Office: **475-210-6264**
(Please note new office number)

From: Fernandes, David [mailto:David.Fernandes@ct.gov]
Sent: Tuesday, August 22, 2017 2:03 PM
To: Bassett, Kurt
Cc: Martone, Kim; Carney, Brian
Subject: Questions pertaining to 17-32165-CON

*** Attention: This is an external email. Use caution responding, opening attachments or clicking on links. ***

Dear Mr. Bassett,

Following up on the message left on your voice mail on August 18th, OHCA is in the process of reviewing your completeness responses in the above referenced application. Pages 223-226 contain the "Community Benefit Grant Agreement" which outlines the proposal for SWCHC to assume full responsibility for the Lindley Street Clinic. Upon review of this draft agreement and the application, it is unclear what would happen if SWCHC was unable to continue to operate the clinic for the full length of the agreement.

Can you clarify whether SVMC would reassume provision of those services at the Lindley Street Clinic in the event SWCHC was unable to?

On an unrelated note, please indicate the actual months used to project the full fiscal year 2017 columns, found on financial worksheet A on page 222.

Please respond to this email at your earliest convenience.

David

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

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Olejarz, Barbara

From: Carney, Brian
Sent: Monday, August 28, 2017 2:56 PM
To: Olejarz, Barbara
Cc: Riggott, Kaila; Fernandes, David
Subject: FW: Questions pertaining to 17-32165-CON

Hi Barbara,

If you haven't already, can you please add this the Table of Record.

Thanks,

Brian

From: Bassett, Kurt [mailto:Kurt.Bassett@ascension.org]
Sent: Friday, August 25, 2017 10:38 AM
To: Fernandes, David <David.Fernandes@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Carney, Brian <Brian.Carney@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Subject: RE: Questions pertaining to 17-32165-CON

Mr. Fernandes,

The proposed Community Benefit and Support Agreement ("Agreement") between St. Vincent's and SWCHC is intended to be a transitional support agreement and both St. Vincent's and SWCHC have little expectation that the Agreement will be terminated before the planned five-year term ends. However, once SWCHC assumes responsibility for the clinic (subject to OHCA's approval), it is SWCHC's obligation and commitment to continue to operate the clinic with or without the Community Benefit and Support Agreement. If for some reason, SWCHC could not support the population, SWCHC would notify HRSA and the Federal government would likely assist SWCHC or open up the service area to other FQHCs. As stated in the Agreement, the parties plan to meet and discuss any ongoing commitments from St. Vincent's. As a FQHC, we believe that SWCHC has the necessary expertise and resources to effectively care for this population with much success. Notwithstanding, St. Vincent's is committed to providing specialty services to this population beyond the term of the Community Benefit and Support Agreement, and will continue to have its internal medicine residency program providing services at the Lindley Street Clinic Location.
I hope this is sufficiently responsive to OHCA's inquiry. If not, please let me know as soon as possible.

You asked that we indicate the actual months used to project the full fiscal year 2017 columns, as found on financial worksheet A on page 222. Actual data for the months of July through December 2016 were used, along with estimated numbers for January through June 2017.

Please let us know if you have any further questions.

Best,
Kurt

Kurt Bassett
Director – Strategic Planning

St. Vincent's Health Services
2800 Main Street
Bridgeport, CT 06606
Office: **475-210-6264**
(Please note new office number)

From: Fernandes, David [mailto:David.Fernandes@ct.gov]
Sent: Tuesday, August 22, 2017 2:03 PM
To: Bassett, Kurt
Cc: Martone, Kim; Carney, Brian
Subject: Questions pertaining to 17-32165-CON

*** Attention: This is an external email. Use caution responding, opening attachments or clicking on links. ***

Dear Mr. Bassett,

Following up on the message left on your voice mail on August 18th, OHCA is in the process of reviewing your completeness responses in the above referenced application. Pages 223-226 contain the "Community Benefit Grant Agreement" which outlines the proposal for SWCHC to assume full responsibility for the Lindley Street Clinic. Upon review of this draft agreement and the application, it is unclear what would happen if SWCHC was unable to continue to operate the clinic for the full length of the agreement.

Can you clarify whether SVMC would reassume provision of those services at the Lindley Street Clinic in the event SWCHC was unable to?

On an unrelated note, please indicate the actual months used to project the full fiscal year 2017 columns, found on financial worksheet A on page 222.

Please respond to this email at your earliest convenience.

David

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

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Olejarz, Barbara

From: Carney, Brian
Sent: Tuesday, August 29, 2017 10:53 AM
To: Kurt.Bassett@ascension.org
Cc: Riggott, Kaila; Fernandes, David; Olejarz, Barbara
Subject: Docket Number: 17-32165-CON - Deemed Complete
Attachments: 17-32165-CON Notification of Application Deemed Complete.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Mr. Bassett,

Please see the attached letter deeming the above-referenced application complete. Please confirm receipt of this email and corresponding attachment.

Sincerely,
Brian A. Carney

Brian Carney, MBA
Associate Research Analyst
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134-0308
Phone - 860-418-7014
brian.carney@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

Via Email Only

August 29, 2017

Kurt Bassett
Director of Strategic Planning
St. Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06606
Kurt.Bassett@ascension.org

RE: Certificate of Need Application: Docket Number: 17-32165-CON
Termination of Primary Care Clinic Services
Certificate of Need Completeness Letter

Dear Mr. Bassett:

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 August 29, 2017.

If you have any questions concerning this letter, please contact Kaila Riggott at (860) 418-7037.

Sincerely,

Brian A. Carney

Digitally signed by
Brian Carney
Date: 2017.08.29
10:39:45 -04'00'

Brian A. Carney
Associate Research Analyst

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Olejarz, Barbara

From: Carney, Brian
Sent: Tuesday, August 29, 2017 2:27 PM
To: Olejarz, Barbara
Subject: FW: Docket Number: 17 - 32165-CON
Attachments: CON Application.pdf

fyi

From: Riggott, Kaila
Sent: Wednesday, August 2, 2017 3:25 PM
To: Carney, Brian <Brian.Carney@ct.gov>; Fernandes, David <David.Fernandes@ct.gov>; Olejarz, Barbara <Barbara.Olejarz@ct.gov>
Cc: Hansted, Kevin <Kevin.Hansted@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: FW: Docket Number: 17 - 32165-CON

Please add to the record. Kim and Kevin, I followed up with Joan Feldman because we had not heard from her and they have decided not to request that some of the completeness responses be redacted/held confidential.

Kaila Riggott, MPA
Planning Specialist
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13-HCA
Hartford, CT 06134
phone: 860.418.7037
fax: 860.418.7053
http://www/ct.gov/ohca

From: Riggott, Kaila
Sent: Monday, July 31, 2017 11:47 AM
To: Carney, Brian <Brian.Carney@ct.gov>; Fernandes, David <David.Fernandes@ct.gov>
Subject: FW: Docket Number: 17 - 32165-CON

Completeness response for St. V's. They are requesting that certain information be kept confidential/redacted and are sending a separate email regarding that request (for Kevin's consideration), so please don't have anything posted until he decides on that matter. He is telecommuting today, so I will forward you his response once I hear from him. Please confirm with Joan that we received the responses. Thanks!

Kaila Riggott, MPA
Planning Specialist
State of Connecticut

Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13-HCA
Hartford, CT 06134
phone: 860.418.7037
fax: 860.418.7053
http://www/ct.gov/ohca

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Monday, July 31, 2017 11:39 AM
To: User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Subject: Docket Number: 17 - 32165-CON

Kaila:
Attached for your consideration, you will find the responses to your letter dated June 1, 2017 in connection with St. Vincent's Medical Center's application to terminate its primary care clinic services.
Thank you.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

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SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

July 31, 2017

By email: OHCA@ct.gov

Mr. Brian A. Carney
Associate Research Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

Re: Certificate of Need Application: Docket Number: 17-32165-CON
Termination of Primary Care Clinical Services
Certificate of Need Completeness Letter

Dear Mr. Carney:

Reference is made to OHCA's letter to St. Vincent's Medical Center dated June 1, 2017. Set forth below are each of the questions included in the letter followed by our response.

1) In regard to the new specialty services planned for the Lindley Street location (page 14 of the application):

   a. provide the expected start date for each new service;

      The specialty services will no longer be located at the Lindley Street Location as previously planned and as represented in the above-referenced CON application. Instead, the St. Vincent's specialty clinics will be at a new medical office building leased by the St. Vincent's Medical Center located at 2979 Main Street, Bridgeport, Connecticut, approximately .4 tenths of a mile from the Lindley Street Location. Since submitting the above-referenced CON application, St. Vincent's Medical Center has had fully updated and furnished specialty space become available. This Main Street space is much larger, has ample parking, is on a bus route, and is beautifully built out. There will be a care coordinator stationed at the Lindley Street Location who will be responsible for scheduling the specialty visits at 2979 Main Street so the referral is seamless. The expense saved by St. Vincent's Medical Center in not having to renovate the Lindley Street Location will help finance the additional specialty services. The new schedule of services is planned to commence as follows:

Endocrinology - January 2018
Infectious Disease - January 2018
Gastroenterology - March 2018
Cardiology - January 2018
Podiatry - January 2018
General Surgery - January 2018
Ophthalmology - January 2018
Neurology - January 2018
Orthopedics - January 2018
Nephrology - January 2018
Rheumatology - March 2018
Pulmonology - March 2018
Nutritional Counseling - January 2018

b. explain whether additional physicians will need to be hired; and

To the extent that there is additional capacity for our physicians who are currently covering our specialty clinics, St. Vincent's Medical Center will use these same physicians to cover the specialty clinic hours by adding additional hours to their schedule. New Physicians will be hired to cover the pulmonology and rheumatology specialty clinics. In addition, additional cardiology and orthopedic physicians will be contracted to cover additional hours. Plans also call for including one full time gastroenterologist.

c. confirm that all specialty service physicians at this location will accept Medicaid.

All specialty physicians will accept Medicaid patients.

2) Page 12 of the application states the wait times for cardiology, endocrinology, neurology, gastroenterology and ophthalmology range from three to six months.

a. describe how the proposal will help reduce specialty care wait times;

Cardiology clinic offerings are increasing from 6 hours per month to 60 hours per month, endocrinology hours are doubling from 3 hour to 6 hours monthly, neurology clinic hours are doubling from 6 hours to 12 hours monthly, and ophthalmology clinic hours are doubling from 3 to 6 hours monthly. Gastroenterology hours are increasing dramatically from 9 hours monthly to 80 hours monthly. All of these additional hours will create ample new appointment slots which can be filled with these patients who would currently need to be put on a wait list.

Specialty	Now hours per Month	Proposed hours per Month
cardiology	6	60
endocrinology	3	6
neurology	6	12
ophthalmology	3	6
gastroenterology	9	80
rheumatology	0	6
infectious disease	6	8
general surgery	12	24
Neurology	6	12
orthopedics	3	48
nephrology	3	6
podiatry	6	12
nutritional counseling	8	32
pulmonary	0	16

b. explain the anticipated timeframe for accomplishing this goal;

We anticipate that we will start scheduling patients immediately and it is likely that by 4 to 6 months after the new specialty clinic schedule is implemented that the current wait lists will be significantly reduced and soon comparable to wait times for patients seeing specialists in private practice.

c. provide an estimate of future wait times anticipated for each specialty service, following adoption of the proposal.

Endocrinology - Less than 2 weeks
Infectious Disease - Approximately 2 weeks
Gastroenterology - Less than 2 weeks
Cardiology - Less than 1 week
Podiatry - Less than 2 weeks
General Surgery - Less than 2 weeks
Ophthalmology - Approximately 2 weeks
Neurology - Less than 2 weeks
Orthopedics - Less than 2 weeks
Nephrology - Approximately 2 weeks
Rheumatology - Approximately 2 weeks
Pulmonary- Less than 2 weeks
Nutritional Counseling - Approximately 2 weeks

3) Page 7 of the application states that the Applicant will enter into a five-year Community Benefit and Support Agreement with Southwest Community Health Center, Inc. ("SWCHC") to provide financial support to cover SWCHC's transition and other "ramp up" expenses at the Lindley Street service location.

   a. provide an estimate of the financial support dollar amount that will be committed in total and on a yearly basis;

      Financial support for the first year is up to $964,649.
      Financial support for the second year is up to $954,297.
      Financial support for the third year is up to $889,905.
      Financial support for the fourth year is up to $740,807.
      Financial support for the fifth year is up to $716,150.

   b. explain where the financial support commitment appears in the Financial Worksheet (if not included, revise worksheet to include the financial support commitment); and

      Financial Support is included in "Other Expenses". Please see revised Financial Worksheet (Attachment SVMC Table A.1)

   c. provide a copy of the proposed SWCHC Community Benefit and Support Agreement.

      Please see attached hereto.

4) Revise the FY 2020 "Projected Incremental" column on Financial Worksheet A (page 211) as it appears to be incorrect. Both "Net Patient Service Revenue" and "Total Operating Revenue" reflect $0, resulting in "Income from Operations" of $1,944,000.

Adjust the FY 2020 "Projected With CON" as necessary, based on your changes to the incremental column.

Please see revised Attachment SVMC Table A.1 to reflect adjusted operating income for 2020 at column "s", line 51.

5) Provide an explanation for the FY 2017 decline in Pediatric Care (-1.5%) and Specialty Care Clinic (-7.7%) visits (Table 5 on page 25 of the application).

Pediatrics had a physician unexpectedly out on FMLA for approximately two months which resulted in reduced hours for pediatric patients. Specialty clinics hours were reduced resulting in reduced clinic hours for nephrology 4 hours/month; cardiology 8 hours/month; and infectious disease 4 hours/month based upon reduced physician availability.

6) Please explain the basis for the projected Specialty Care Clinic visit increases of 26%, 22% and 7% respectively, for FY 2018, FY 2019 and FY 2020.

Specialty clinic hours will be increased dramatically from approximately 60 hours per month to over 300 hours per month. During the first two years, visits are projected to grow based on current wait list patients as well as new SWCHC patients. Such increase in visits will carry into year two as full clinic potential is realized and will eventually begin to level off in year three as we meet the specialty needs of area patients.

7) Revise Table 6 on page 26 of the application. "Current Year" should be based on the most recently completed fiscal year (FY 2016) - include projections through FY 2020.

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2016**		Projected							
			FY 2017**		FY 2018**		FY 2019**		FY 2020**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	2,225	10%	2,198	10%	523	10%	640	10%	685	10%
Medicaid*	14,239	64%	14,066	64%	3,344	64%	4,096	64%	4,384	64%
CHAMPUS & TriCare	0	0%	0	0%	0	0%	0	0%	0	0%
Total Government	**16,464**	**74%**	**16,264**	**74%**	**3,876**	**74%**	**4,736**	**74%**	**5,069**	**74%**
Commercial Insurers	445	2%	440	2%	95	2%	128	2%	137	2%
Uninsured	5,340	24%	5,274	24%	1,254	24%	1,536	24%	1,644	24%
Workers Compensation	0	0%	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**5,785**	**26%**	**5,714**	**26%**	**1,349**	**26%**	**1,664**	**26%**	**1,781**	**26%**
Total Payer Mix	**22,249**	**100%**	**21,978**	**100%**	**5,225**	**100%**	**6,400**	**100%**	**6,850**	**100%**

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

8) Provide SWCHC's projected FY 2018-FY 2020 patient volume and payer mix for Adult Primary Care and Pediatric Care services at the Lindley Street location. Will SWCHC be able to accommodate the entire SVMC primary care patient population currently served at the Lindley Street service location? - Yes

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2018**	FY 2019**	FY 2020**
Adult Primary Care	17,344	17,344	17,344
Pediatric Care	7,800	7,800	7,800
Total	25,144	25,144	25,144

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

SWCHC Projected Payer Mix

	Percentage 2018	Volume 2018	Percentage 2019	Volume 2019	Percentage 2020	Volume 2020
COMMERCIAL	4%	1006	5%	1258	5%	1258
SELF PAY	22%	5532	21%	5280	20%	5029
MEDICARE	10%	2514	10%	2514	10%	2514
MEDICAID	64%	16,092	64%	16,092	65%	16,343

SWCHC has committed to allowing the St. Vincent's Medical Center's internal medicine residents to continue to rotate through Lindley Street Location and SWCHC will staff the primary care and pediatric services to cover all the Lindley Street Location patients.

9) Will any new or additional facilities fees be imposed following the transition of primary care services to SWCHC?

No new fees or additional facility fees will be imposed as a result of this proposal.

If you have any questions regarding the above or the attached information, please contact the undersigned.

Very truly yours,

Joan Feldman

Joan Feldman, Esq.
Shipman & Goodwin LLP
On behalf of
Kurt Bassett
Director of Strategic Planning
St. Vincent's Medical Center

Cc: Kaila Riggott (Kaila.Riggott@ct.gov)

Enclosures

NON-PROFIT

Applicant: St. Vincent's Medical Center

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY16 Actual	(2) FY17 Projected	(3) FY17 Projected	(4) FY17 Projected	(5) FY18 Projected	(6) FY18 Projected	(7) FY18 Projected	(8) FY19 Projected	(9) FY19 Projected	(10) FY19 Projected	(11) FY20 Projected	(12) FY20 Projected	(13) FY20 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$1,548,392	$1,465,459		$1,465,459	1,427,000		$1,427,000	$1,469,810		$1,469,810	$1,513,904		$1,513,904
2	Less: Allowances	$1,040,692	$954,390		$954,390	928,300		$928,300	$956,149		$956,149	$984,833		$984,833
3	Less: Charity Care	$24,235	$25,000		$25,000	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
4	Less: Other Deductions	$0	$0		$0			$0	$0		$0			$0
	Net Patient Service Revenue	**$483,465**	**$486,069**	**$0**	**$486,069**	**$473,700**	**($350)**	**$473,350**	**$487,911**	**($700)**	**$487,211**	**$502,548**	**$0**	**$502,548**
5	Medicare	$186,816	$186,816		$186,816	$182,100	($10)	$182,090	$187,563	($20)	$187,543	$193,190	($20)	$193,170
6	Medicaid	$91,720	$91,720		$91,720	$89,400	($325)	$89,075	$92,082	($650)	$91,432	$94,844	($650)	$94,194
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other				$0			$0			$0			$0
	Total Government	**$278,536**	**$278,536**	**$0**	**$278,536**	**$271,500**	**($335)**	**$271,165**	**$279,645**	**($670)**	**$278,975**	**$288,034**	**($670)**	**$287,364**
9	Commercial Insurers	$197,001	$197,001		$197,001	$192,000		$192,000	$197,760		$197,760	$203,693		$203,693
10	Uninsured	$25,649	$25,649		$25,649	$25,000		$25,000	$25,750		$25,750	$26,523		$26,523
11	Self Pay	$17,648	$17,648		$17,648	$17,200	($15)	$17,185	$17,716	($30)	$17,686	$18,247	($30)	$18,217
12	Workers Compensation				$0			$0			$0			$0
13	Other	($35,369)	($32,765)		($32,765)	($32,000)		($32,000)	($32,960)		($32,960)	($33,949)		($33,949)
	Total Non-Government	**$204,929**	**$207,533**	**$0**	**$207,533**	**$202,200**	**($15)**	**$202,185**	**$208,266**	**($30)**	**$208,236**	**$214,514**	**($30)**	**$214,484**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$483,465**	**$486,069**	**$0**	**$486,069**	**$473,700**	**($350)**	**$473,350**	**$487,911**	**($700)**	**$487,211**	**$502,548**	**($700)**	**$501,848**
14	Less: Provision for Bad Debts	$26,362	$26,362		$26,362	$25,700		$25,700	$26,471		$26,471	$27,265		$27,265
	Net Patient Service Revenue less provision for bad debts	**$457,103**	**$459,707**	**$0**	**$459,707**	**$448,000**	**($350)**	**$447,650**	**$461,440**	**($700)**	**$460,740**	**$475,283**	**($700)**	**$474,583**
15	Other Operating Revenue	$47,394	$46,475		$46,475	$45,000		$45,000	$46,350		$46,350	$47,741		$47,741
17	Net Assets Released from Restrictions	$1,961	$2,000		$2,000	$2,000		$2,000	$2,060		$2,060	$2,122		$2,122
	TOTAL OPERATING REVENUE	**$506,458**	**$508,182**	**$0**	**$508,182**	**$495,000**	**($350)**	**$494,650**	**$509,850**	**($700)**	**$509,150**	**$525,146**	**($700)**	**$524,446**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$218,910	$209,925		$209,925	$195,200	($719)	$194,481	$201,056	($1,438)	$199,618	$207,088	($1,438)	$205,650
2	Fringe Benefits	$53,186	$52,839		$52,839	$51,300	($232)	$51,068	$52,839	($464)	$52,375	$54,424	($464)	$53,960
3	Physicians Fees	$19,867	$19,867		$19,867	$19,300	($283)	$19,017	$19,879	($566)	$19,313	$20,475	($566)	$19,909
4	Supplies and Drugs	$58,754	$56,813		$56,813	$55,100	($29)	$55,071	$56,753	($58)	$56,695	$58,456	($58)	$58,398
5	Depreciation and Amortization	$27,221	$26,610		$26,610	$25,800	$45	$25,845	$26,574	$90	$26,664	$27,371	$90	$27,461
6	Provision for Bad Debts-Other[b]	$1,279	$1,279		$1,279	$1,200	$0	$1,200	$1,236	$0	$1,236	$1,273	$0	$1,273
7	Interest Expense	$1,800	$2,003		$2,003	$2,000	$0	$2,000	$2,060	$0	$2,060	$2,122	$0	$2,122
8	Malpractice Insurance Cost	$9,960	$9,960		$9,960	$10,200	$6	$10,206	$10,506	$12	$10,518	$10,821	$12	$10,833
9	Lease Expense	$8,025	$8,025		$8,025	$8,200	($92)	$8,108	$8,446	($184)	$8,262	$8,699	($184)	$8,515
10	Other Operating Expenses	$130,340	$129,861		$129,861	$119,500	$932	$120,432	$123,085	$959	$124,044	$126,778	$922	$127,700
	TOTAL OPERATING EXPENSES	**$529,342**	**$517,182**	**$0**	**$517,182**	**$487,800**	**($372)**	**$487,428**	**$502,434**	**($1,649)**	**$500,785**	**$517,507**	**($1,686)**	**$515,821**
	INCOME/(LOSS) FROM OPERATIONS	**($22,884)**	**($9,000)**	**$0**	**($9,000)**	**$7,200**	**$22**	**$7,222**	**$7,416**	**$949**	**$8,365**	**$7,639**	**$986**	**$8,625**
	NON-OPERATING REVENUE	**$6,940**	$6,940		**$6,940**	**$0**		**$0**	0		**$0**	0		**$0**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**($15,944)**	**($2,060)**	**$0**	**($2,060)**	**$7,200**	**$22**	**$7,222**	**$7,416**	**$949**	**$8,365**	**$7,639**	**$986**	**$8,625**
	Principal Payments				**$0**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**-4.5%**	**-1.7%**	**0.0%**	**-1.7%**	**1.5%**	**-6.3%**	**1.5%**	**1.5%**	**-135.6%**	**1.6%**	**1.5%**	**-140.9%**	**1.6%**
2	Hospital Non Operating Margin	**1.4%**	**1.3%**	**0.0%**	**1.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-3.1%**	**-0.4%**	**0.0%**	**-0.4%**	**1.5%**	**-6.3%**	**1.5%**	**1.5%**	**-135.6%**	**1.6%**	**1.5%**	**-140.9%**	**1.6%**
D.	**FTEs**	**2,894**	**2,542**		**2,542**	2,470	(10)	**2,460**	2,470	(20)	**2,450**	2,470	(20)	**2,450**
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	16,201	16,201		**16,201**	15,100	0	**15,100**	15,100		**15,100**	15,100		**15,100**
2	Outpatient Visits	602,810	602,810		**602,810**	614,870	(7,500)	**607,370**	627,170	(15,000)	**612,170**	639,710	(15,000)	**624,710**
	TOTAL VOLUME	**619,011**	**619,011**	**0**	**619,011**	**629,970**	**(7,500)**	**622,470**	**642,270**	**(15,000)**	**627,270**	**654,810**	**(15,000)**	**639,810**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

COMMUNITY BENEFIT GRANT AGREEMENT

This AGREEMENT (this "Agreement") is entered into as of _____ ____, 2017 (the "Effective Date"), by and between Southwest Community Health Center, Inc. ("SWCHC") and St. Vincent's Medical Center ("Hospital") (individually a "Party," and collectively the "Parties").

BACKGROUND

The Hospital is a charitable, nonprofit corporation pursuant to Section 501(c)(3) of the Internal Revenue Code and an acute care hospital and medical center located in Bridgeport, Connecticut.

In furtherance of its Mission, the Hospital has historically operated a primary care clinic located at 762 Lindley Street, Bridgeport, Connecticut (the "Lindley Street Location"), serving uninsured and underinsured patients (the "Lindley Street Clinic"). To date, the Lindley Street Clinic's focus has been on providing a medically underserved population of patients in the greater Bridgeport area (the "Service Area") with access to quality primary care services (the "Services"). The Hospital believes that the Services are important to the greater Bridgeport community (the "Community").

The Hospital has determined that the most efficient and effective way to ensure that individuals and families in the Service Area have increased access to such Services is to work with a provider with proven experience in providing primary care medical and other services to medically underserved populations and which is capable of assuming the responsibility of providing the Services to individuals and families in the Service Area.

SWCHC is a federally qualified health center ("FQHC") that receives federal grant support from the Health Resources and Services Administration ("HRSA") within the United States Department of Health and Human Services ("DHHS") pursuant to Section 330 of the Public Health Service Act, to provide, or arrange for the provision of, high quality, cost-effective, community-based comprehensive primary and preventive health care and related services (including, but not limited to, ancillary and enabling services) to medically underserved communities in the Service Area, regardless of the individual's or family's ability to pay for such services.

Because SWCHC is able to provide more comprehensive primary care services to the same patient population that utilizes the Lindley Street Clinic, the Hospital has proposed to SWCHC that SWCHC assume full responsibility for the Lindley Street Clinic. The Hospital, in turn, will allocate more of its resources to providing specialty medical services to the Community. Subject to state and federal regulatory approvals, SWCHC is desirous of assuming operational responsibility for the Lindley Street Clinic, as it would fully complement the other primary care services offered by SWCHC. To facilitate the transition of the Lindley

Street Clinic from the Hospital to SWCHC and support the availability of health care services for underserved persons in the Community, and in furtherance of the Hospital's Mission, and recognizing the interest of Service Area residents and governmental agencies in having a comprehensive primary care health center provide health care services in the Service Area, the Hospital intends to provide a community benefit grant ("Community Benefit Grant").

Simultaneously with the execution and delivery of this Agreement, the Parties are entering into a Master Agreement (the "Master Agreement"), and certain other agreements referenced in the Master Agreement, setting forth the terms and conditions on which SWCHC will assume full responsibility for the operation of the Lindley Street Clinic.

NOW, THEREFORE, in consideration of the covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually agreed as follows:

1. **Compliance**. It is the intention of the Parties hereto that this Agreement fully comply with the requirements of 42 U.S.C. 1320a-7b(b)(3)(I) and 42 C.F.R. §1001.952(w) and all other applicable laws and regulations. To the extent that it is determined by either Party's legal counsel or the Federal government that this Agreement is not fully compliant with any applicable law or regulation, the Parties agree to reform it to fully comply. Specifically,

1.1 The amount of the Community Benefit Grant will not be conditioned or varied based upon (or otherwise determined by taking into account in any way) the volume or value of any referrals or other business generated between SWCHC and the Hospital, which referrals or business are reimbursed, in whole or in part, under Medicare, Medicaid, CHIP, or any other federal health care program;

1.2 The amount of the Community Benefit Grant will contribute meaningfully to SWCHC's ability to maintain or increase the availability, or enhance the quality, of the services provided to the medically underserved populations at the Lindley Street Clinic. During the Term of this Agreement, and upon any renewals of this Agreement, the Parties will re-evaluate the Agreement annually to ensure that the Community Benefit Grant is satisfying, and is reasonably expected to continue satisfying, this standard, and will document such evaluation contemporaneously. The Parties will make such documentation available to the Secretary of DHHS upon request;

1.3 The Community Benefit Grant relates directly to services provided by SWCHC as part of the scope of SWCHC's Section 330 of the Public Health Service Act ("Section 330") grant, and SWCHC reasonably expects the arrangement to contribute meaningfully to SWCHC's ability to maintain or increase the access, or enhance the quality, of services provided to a medically underserved population;

1.4 SWCHC and the Hospital agree that each Party's health care professionals retain the right to refer patients to any providers they deem appropriate, based on their

professional judgment, and that all patients served by either Party retain the right to request referrals to any providers of their choosing. During the term of the Agreement, SWCHC shall provide its patients with notice, in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient, of their freedom to choose any willing provider or supplier. For the avoidance of doubt, the Parties understand and agree that SWCHC will retain the right to contract with other providers/suppliers;

1.5 SWCHC and Hospital agree to maintain a list of all agreements between the Parties. This list shall be centrally located, updated regularly, and maintained in a manner that preserves the historical record of arrangement, and made available for review by the Secretary of the DHHS upon request; and

1.6 All SWCHC patients shall be advised, upon request, of the existence and nature of this Agreement in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient

2. **Grant Funds**.

2.1 The Hospital shall provide funding to cover certain operational deficits and costs incurred by SWCHC relating to the Lindley Street Clinic for the period of _____, 2017 through_____, 2018 (the "First Period"), the period of _____, 2018 through _____, 2019 (the "Second Period"), the period of _____, 2019 through _____, 2020 (the "Third Period"), the period of _____, 2020 through _____, 2021 (the "Fourth Period"), and the period of _____, 2021 through September 30, 2022 (the "Fifth Period") (collectively, such funding is referred to as the "Grant Funds" and each such period is referred to as a "Period"). The Grant Funds are intended to contribute meaningfully to SWCHC's ability to maintain or increase the availability, or enhance the quality, of health care services provided to the medically underserved populations served by the Lindley Street Clinic (the "Permitted Purpose"). The amount of the Grant Funds paid by the Hospital to SWCHC for each quarter during the Term shall be based on a review of the Lindley Street Clinic's budgeted activities versus its actual activities as further described in this Section 2, subject to the maximum amounts set forth in Section 2.2 of this Agreement.

2.2 Notwithstanding anything to the contrary set forth in this Agreement:

(a) For the First Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $964,649, including a $150,000 contingency fund for unexpected expenses unrelated to clinical operations for such First Period;

(b) For the Second Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $954,297, including a $100,000 contingency fund for unexpected expenses unrelated to clinical operations for such Second Period;

(c) For the Third Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $889,905, including a $75,000 contingency fund for unexpected expenses unrelated to clinical operations for such Third Period;

(d) For the Fourth Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $740,807; and

(e) For the Fifth Period, the Grant Funds paid by the Hospital to SWCHC will not exceed $716,150.

The term "Contingency Fund" shall refer to the contingency funds set forth above for each of the First, Second and Third Periods. The term "Maximum Community Benefit Grant" shall refer the maximum amounts set forth above for each Period.

2.3 The Parties shall meet on a quarterly basis to discuss the reasonableness of expenses during the previous quarter and to perform the reconciliation referred to below with respect to Grant Funds for the then-current quarter.

(a) With respect to the first quarter during the Term, the Hospital shall advance by no later than the first day of such first quarter, an amount equal to (i) twenty-five percent (25%) of the Maximum Community Benefit Grant for the First Period less (ii) the Contingency Amount for the First Period, or Two Hundred Three Thousand Six Hundred Sixty-Two and 25/100 Dollars ($203,662.25).

(b) After the first quarter during the Term, the Grant Funds will be paid to SWCHC in quarterly installments (each, a "Quarterly Installment") in an amount equal to (i) twenty-five percent (25%) of the difference between the Maximum Community Benefit Grant for the applicable Period less (ii) the Contingency Fund for the applicable Period, subject to the maximum amounts set forth in Section 2.5 and subject to the reconciliation process described in Section 2.3(c).

(c) After the first quarter during the Term, SWCHC shall provide the Hospital with a profit and loss statement for previous quarter with respect to the Lindley Street Clinic's teaching services (such services, as agreed by the Parties, are referred to as "Teaching Services") and non-teaching services (such services, as agreed by the Parties, are referred to as "Non-Teaching Services") (the "Quarterly P&L"). If the Quarterly P&L has a loss for the Teaching Services and Non-Teaching Services for such previous quarter as a result of lower than budgeted revenues or greater than budgeted expenses (so long as such expenses are of a type set forth in the Lindley Street Clinic budget or are otherwise approved by both Parties), then the Quarterly Installment will be increased by the amount of such loss; provided that in no event will the total Grant Funds for any Period exceed the maximum amount specified in Section 2.2 of this Agreement. If the Quarterly P&L has a profit for the Teaching Services and Non-Teaching Services for such previous quarter, the Quarterly Installment will be reduced by the amount of such profit or, if requested by the Hospital, shall be returned to the Hospital by SWCHC within 45 days.

(d) Payment of the Quarterly Installment will be due within forty-five (45) days of such reconciliation.

2.4 The Contingency Fund or any portion thereof will only be paid to SWCHC based on need and as agreed upon by SWCHC and the Hospital.

2.5 The Parties will meet at least annually to review the Lindley Street Clinic budget for the upcoming Period and the profit and loss statement for the Lindley Street Clinic's Teaching Services and Non-Teaching Services for the prior Period (the "Annual P&L"). If the Annual P&L has a profit with respect to such Teaching Services and Non-Teaching Services for such prior Period independent of any Grant Funds paid to SWCHC, then SWCHC shall return to the Hospital an amount of Grant Funds equal to the amount of such profit.

2.6 If, at any time during the term of this Agreement, the core financial assumptions prove faulty (e.g., material change in payer mix or patient volume) and/or other exigent circumstances occur such that SWCHC is unable to operate the Lindley Street Clinic in accordance with such core assumptions and/or there are unanticipated material deviations between the Lindley Street Clinic budget and actual financial performance, either Party may request a special meeting of the Parties to determine what reasonable options are available to address the circumstances, including but not limited to an adjustment in the Lindley Street Clinic budget and the Grant Funds amount; provided, however, that in no event will the Grant Funds amount exceed the applicable limit set forth in Section 2.5 of this Agreement.

2.7 SWCHC covenants and agrees that it will use the Grant Funds only for the Permitted Purpose and for no other purpose and further that the Grant Funds shall not be used for any activity that would violate the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor (the "Directives").

2.8 The obligation of the Hospital to pay any Deficit Grant Funds shall be subject to the fulfillment of the following conditions precedent:

(a) SWCHC shall provide to the Hospital an executed certification in the form of Exhibit A hereto, prior to the first day of each quarterly period during the Term of this Agreement.

(b) The representations and warranties contained in Section 6 of the Master Agreement shall be true and correct on and as of the date of each payment of Deficit Grant Funds as though made on and as of such date; SWCHC shall have complied with the covenants set forth in Section 16 of this Agreement; and no default under this Agreement shall have occurred or be continuing on the date of such payment or would result from the making of such payment.

(c) The payment of the Community Benefit Grant shall not contravene any federal, state of local law, rule or regulation applicable to the Hospital or SWCHC.

(d) The Parties shall have obtained all necessary governmental approvals relating to (i) termination of the Services by the Hospital, including but not limited to approval from the Office of Health Care Access of the Connecticut Department of Public Health of the certificate of need application filed by the Hospital with respect to such termination, (ii) the provision of Services by SWCHC, including but not limited to all required approvals from HRSA, including the Change in Scope for the activities described herein, and (iii) appropriate licensure from the Connecticut Department of Public Health, including an operating license issued to SWCHC for the Services to be provided at the Lindley Street Location.

(e) All proceedings in connection with the making of the Community Benefit Grant and the other transactions contemplated by this Agreement and the Master Agreement between the Parties of even date herewith, and all documents incidental thereto, shall be reasonably satisfactory to the Hospital.

2.9 On an annual basis, the Parties shall meet to review the Community Benefit Grant and the scope and availability of Services provided by SWCHC in the Service Area and to evaluate the impact of the Community Benefit Grant on SWCHC's operations (an "Evaluation") in accordance with Section 1.2 above; provided, however, that the Parties may conduct an Evaluation more frequently than annually upon a reasonable request by the Hospital or SWCHC. Such Evaluation shall be documented in writing by the Parties.

3. **Term of Agreement**. The effective date of this Agreement shall be the Effective Date and shall terminate on_____, 2022 (the "Term") unless sooner terminated as set forth below.

4. **Termination of Agreement**.

4.1 For Breach. Notwithstanding any of the provisions in this Agreement to the contrary, prior to the expiration of the Term, either Party may terminate this Agreement upon written notice to the other Party in the event of such other Party's breach of a material provision of this Agreement, which breach remains uncured for a period of thirty (30) days following receipt of written notice specifying the breach complained of.

4.2 Tax-Exempt or Medicare/Medicaid Status. Notwithstanding any of the provisions in this Agreement to the contrary, prior to the expiration of the Term, either Party may terminate this Agreement upon written notice to the other Party if the other Party loses its (i) tax-exempt status, (ii) eligibility status in a federal or state health care program, including but not limited to Medicare or Medicaid; or (iii) state facility licensure or, in the case of SWCHC, Federally Qualified Health Care status.

4.3 Bankruptcy. This Agreement shall immediately terminate upon: (i) the bankruptcy, insolvency, or cessation of operations of either Party, as applicable, or the filing of any voluntary petition for bankruptcy, dissolution, liquidation, or winding-up of the affairs of either Party, as applicable, or any assignment by either Party, as applicable, for the benefit

of creditors; or (ii) the filing of any involuntary petition for bankruptcy, dissolution, liquidation, or winding-up of the affairs of either Party, as applicable, which petition is not dismissed within ninety (90) days of the date upon which it is filed.

4.4 Hospital Termination Rights. The Hospital shall have the right to terminate this Agreement upon written notice to SWCHC upon the occurrence of any of the following events:

(a) SWCHC shall cease to operate the Lindley Street Clinic at the Lindley Street Location.

(b) SWCHC shall (i) merge or consolidate with another entity, including but not limited to another FQHC; (ii) become affiliated with, or sponsored by, another entity, including but not limited to another FQHC; (iii) sell or dispose of all or substantially all of its assets; or (iv) any entity shall have the authority to, directly or indirectly, manage or control the management, operations or governance of SWCHC, including but not limited to the ability to appoint any members of the board of directors of SWCHC; unless in each case the successor entity assumes the obligations of SWCHC under this Agreement and the other agreements entered into between SWCHC and the Hospital on the Effective Date.

(c) Any written agreement between the Hospital and SWCHC is not renewed or is terminated for any reason by either Party or SWCHC is in default under any written agreement between the Hospital and SWCHC.

Upon any termination of this Agreement by the Hospital, the Hospital shall have no further obligations under this Agreement, including the obligation to make any payment of Deficit Grant Funds after the date of termination.

4.5 Termination without Cause. Notwithstanding any of the provisions in this Agreement to the contrary, the Parties may mutually agree to terminate this Agreement at any time.

5. **Modification for Prospective Legal Events**. In the event any state, federal, or local laws or regulations, now existing or enacted, promulgated, or amended after the effective date of this Agreement, are interpreted by judicial decision, by a regulatory agency, or reasonably by either Party's legal counsel (which shall be a firm of recognized standing) in such a manner as to indicate that the structure of this Agreement may be in violation of such laws or regulations or may jeopardize the tax exempt status of either Party (an "Adverse Event"), the Parties hereto shall negotiate in good faith to amend this Agreement as necessary. To the maximum extent possible, any amendment to this Agreement effected shall preserve the underlying economic and financial arrangements between the Parties. Notwithstanding the foregoing, a Party shall not be obligated to agree to an amendment to this Agreement if that Party in good faith disagrees, in a writing delivered to the other Party, that an Adverse Event has occurred, or if the Parties cannot, using good faith efforts within sixty (60) days of either Party's notification in writing to the other Party that an Adverse Event has occurred, mutually agree upon amendments to this Agreement as necessary to cure such Adverse Event.

6. **Confidentiality.**

6.1 Each Party will require access to certain confidential and/or proprietary information relating to the business, financial, and strategic condition of the other Party, which may be in written, oral, or electronic format ("Confidential Information"). The term Confidential Information shall not include information that is or becomes publicly available through no fault of either Party.

6.2 Each Party acknowledges that the Confidential Information furnished by the other Party during the course of the negotiations and due diligence contemplated hereunder is a valuable, special, and unique asset of the Party furnishing such Confidential Information (hereinafter, the "Furnishing Party"). Accordingly, each Party agrees that, except as specifically provided herein, it will not disclose to any person, institution, entity, company, or any other third party, directly or indirectly, any Confidential Information, without the prior written consent of the Furnishing Party or as required by law.

(a) Each Party agrees that Confidential Information shall be disclosed to its corporate members, members of its Board, staff, contractors, or other agents, and in the case of the Hospital or potential successors-in-interest to the Hospital only: (i) on a need-to-know basis, and (ii) for the purpose of planning, negotiations and due diligence review contemplated by this Agreement or for the purpose of due diligence review by a potential successor-in-interest to the Hospital. Each Party shall require its Board members, staff, contractors, other agents and potential successors-in-interest who receive Confidential Information regarding the other Party to comply with the standards set forth in this Section.

(b) Each Party agrees that Confidential Information shall be disclosed to federal and state government bodies for the purpose of implementing this Agreement and obtaining applicable approvals relating thereto.

6.3 Nothing in this Agreement shall prohibit a Party from making any disclosure of Confidential Information that, in the good faith opinion of such Party making the disclosure, is required by law. If disclosure of the Confidential Information is required, the Party making the disclosure shall promptly notify the Furnishing Party, in order to permit the Furnishing Party an opportunity to object to such disclosure and/or to obtain a court order or other reliable assurance that confidential treatment shall be accorded to the disclosed Confidential Information.

6.4 Each Party warrants that, to its knowledge as of the date of this Agreement's execution and at the time of any subsequent disclosure, it is permitted to disclose to the other Party, as provided herein, its respective Confidential Information and that such disclosure does not, and will not, violate the rights of any third party.

6.5 Each Party shall retain title and all rights to the Confidential Information that has been disclosed to the other Party. Upon request, each Party agrees to return promptly to the other Party all Confidential Information and to not retain any copies, extracts, or other reproductions, in whole or in part, of such returned Confidential Information.

6.6 This Section 6 regarding the obligation of both Parties to keep confidential all Confidential Information, regardless of the manner of transmission, survives the expiration or termination of this Agreement.

7. **Notices.** Any and all notices, designations, consents, offers, acceptances or other communication required to be given under this Agreement shall be in writing and delivered in person or sent by registered or certified mail, return receipt requested, postage prepaid, to the following addresses:

If to SWCHC: Kathy Yacavone, President/CEO
Southwest Community Health Center, Inc.
Bridgeport, Connecticut 06606

If to Hospital: St. Vincent's Medical Center
2800 Main Street
Bridgeport, Connecticut 06606
Attention: President and Chief Executive Officer

The foregoing addresses may be changed and/or additional persons may be added thereto by notifying the other Party hereto in writing and in the manner hereinafter set forth. All notices shall be effective upon receipt.

8. **Independent Contractors.** The Parties shall remain separate and independent entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between or among the Parties other than that of independent contractors. Except as otherwise provided, neither of the Parties shall be construed to be the agent, partner, co-venturer, employee or representative of the other Party.

9. **Governing Law.** This Agreement is made pursuant to and shall be governed by the laws of the State of Connecticut, as well as all applicable Federal laws, regulations, and policies, including, but not limited to, all laws, rules, policies, and other terms applicable to SWCHC's Section 330 grant.

10. **Severability.** The provisions of this Agreement are not severable. In the event that any one or more provisions of this Agreement are deemed null, void, illegal, or unenforceable, the Parties shall renegotiate or terminate the remaining provisions of this Agreement unless the Parties mutually agree in writing that the invalidity, illegality, or unenforceability of said provision does not materially change the obligations of the Parties under this Agreement, in

which case this Agreement shall be construed in all respects as if such invalid or unenforceable provisions have been omitted.

11. **Third-Party Beneficiaries.** The Agreement is not intended to benefit, and shall not be construed to benefit, any person or entities other than the Parties hereto, or to create any third-party beneficiary right for any other person or entities.

12. **Assignment.** Neither Party may assign, delegate, or transfer this Agreement, or its rights and obligations hereunder, without the other Party's express, prior written consent except as expressly permitted in this Agreement. Hospital may assign this Agreement without such consent to (a) any entity that controls, is controlled by or is under common control with Hospital or (b) any successor-in-interest to the operations and assets of Hospital; provided, however, that Hospital shall remain liable for its obligations under this Agreement. Any assignment attempted without such consent shall be void. The provisions of this Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their duly authorized transferees, successors and assigns.

13. **Entire Agreement; Amendments.** This Agreement and its attachments represent the Parties' complete understanding regarding the subject matter herein. Any amendment to this Agreement shall be in writing and signed by both Parties. Except for any specific provision being amended, this Agreement shall remain in full force and effect after such amendment. This Agreement supersedes any other agreements or understandings between the Parties, whether oral or written, relating to the subject matter of this Agreement including, without limitation, that certain Letter of Intent between the Parties dated February 7, 2017. No such other agreements or understandings may be enforced by any Party nor may they be employed for interpretation purposes in any dispute involving this Agreement.

14. **Authority.** Each signatory to this Agreement represents and warrants that he or she possesses all necessary capacity and authority to act for, sign, and bind the respective entity on whose behalf he or she is signing.

15. **Government Access.** If Section 952 of the Medicare and Medicaid Amendments of 1980, 42 U.S.C. §1395x(v)(1)(I), is applicable to this Agreement, SWCHC agrees upon written request, to make available to the Secretary of DHHS, the Comptroller General or any of their duly authorized representatives, all contracts, books, documents and records of SWCHC necessary to certify the nature and extent of costs associated with the services furnished under this Agreement. All books and records described in this Section shall be maintained and made available for a period of four (4) years after the last date that services were rendered under this Agreement. The provisions of the Medicare and Medicaid Amendments of 1980, including Section 952 thereof, and the rules and regulations adopted from time to time thereunder, are incorporated herein by reference, and SWCHC agrees to be bound thereby. This Section shall survive the termination of this Agreement.

16. **Covenants of SWCHC.** During the term of this Agreement:

16.1 Medicaid Eligibility. SWCHC shall use reasonable efforts to determine eligibility of patients of the Lindley Street Clinic for the Medicaid Program and assist patients in obtaining Medicaid coverage.

16.2 Collections from Patients. SWCHC shall make reasonable efforts to collect payment from patients for Services provided by SWCHC at the Lindley Street Clinic within the limits of HRSA rules for FQHCs and SWCHC's then-current collections policy and procedures, as shall be provided to the Hospital upon request.

16.3 Reporting Requirements.

(a) SWCHC shall furnish to the Hospital upon request (i) unaudited financial statements, (ii) when due, annual audited financial statements, documents or reports that SWCHC is required to file with any federal agencies relating to its FQHC status, costs or reimbursement, and (iii) such other financial statements, reports, instruments and documents as the Hospital may reasonably request from time to time.

(b) SWCHC shall provide the Hospital, promptly after the commencement thereof, notice of each action, suit or proceeding before any court or other governmental authority or other regulatory body or any arbitrator in which SWCHC is a party, which may adversely affect its condition or operations, financial or otherwise.

(c) Maintenance of Permits. SWCHC shall maintain all permits, licenses, authorizations and approvals required for the lawful operation of its business, including without limitation, approval as an FQHC, and all such licenses and approvals as required under federal and state law.

(d) Conduct of Business/Insurance. SWCHC shall conduct its business in a commercially reasonable manner in accordance with all applicable laws, rules and regulations and maintain such insurance policies as are standard for a like organization located in the Service Area.

(d) Provision of Services. SWCHC shall operate the Lindley Street Clinic at the Lindley Street Location and provide the Services, including adult and pediatric primary care and primary care obstetrics and gynecology, including prenatal health services, to all residents of the Service Area, regardless of ability to pay.

17. **Ethical and Religious Directives.** The Parties acknowledge that the operations of the Hospital are in accordance with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor (the "Directives") and that the principles and beliefs of the Roman Catholic Church are a matter of conscience to the Hospital. The Directives are located at http://www.usccb.org/issues-and-action/human-life-and-

dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. It is the intent and agreement of the Parties that this Agreement shall not be construed to require the Hospital to violate said Directives in its operation and all parts of this Agreement must be interpreted in a manner that is consistent with said Directives.

18. **Corporate Responsibility.** The Hospital has a Corporate Responsibility Program (the "Program") which has as its goal to ensure that the Hospital complies with federal, state and local laws and regulations. The Program focuses on risk management, the promotion of good corporate citizenship, including the commitment to uphold a high standard of ethical and legal business practices, and the prevention of misconduct. SWCHC acknowledges the Hospital's commitment to the Program and agrees to ensure that its personnel comply and cooperate with, and participate in, the Program as applicable to the performance of business transactions under this Agreement.

[THE NEXT PAGE IS THE SIGNATURE PAGE.]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the date set forth above by their duly-authorized representatives.

Southwest Community Health Center, Inc.	St. Vincent's Medical Center
By: _____	By: _____
Its	Its
Date: _____	Date: _____

EXHIBIT A

FORM OF CERTIFICATION

Date:_____

Southwest Community Health Center, Inc. ("SWCHC") hereby certifies to St. Vincent's Medical Center, pursuant to the terms and conditions of the Community Benefit Grant Agreement dated as of _____, 2017, by and between SWCHC and St. Vincent's Medical Center (the "Agreement"), as follows:

1. All Deficit Grant Funds (as defined in the Agreement) received by SWCHC were used only for the Permitted Purpose (as defined in the Agreement) in accordance with the terms of the Agreement.

2. The representations and warranties contained in Section 6 of the Master Agreement (as defined in the Agreement) are true and correct as of the date of this Certification as though made on as and as of the date hereof; SWCHC is in compliance with all covenants set forth in Section 16 of the Agreement; and all conditions precedent to the making of a payment of Deficit Grant Funds set forth in Section 2.6 of the Agreement have been satisfied.

3. SWCHC hereby confirms that no default under the Agreement has occurred or is continuing as of the date of this Certification or would result from the next payment of Deficit Grant Funds to be paid by the Hospital to SWCHC pursuant to this Agreement.

4. The undersigned is duly authorized to make this certification on behalf of SWCHC.

SOUTHWEST COMMUNITY HEALTH CENTER, INC.

By:_____
Name:_____
Title:_____

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Certificate of Need
Final Decision

Applicant: **St. Vincent's Medical Center**
2800 Main Street
Bridgeport, CT 06606

Docket Number: **17-32165-CON**

Project Title: **Termination of Primary Care Services**

Project Description: St. Vincent's Medical Center ("SVMC" or "Applicant"), seeks authorization to terminate outpatient primary care clinic services at the Family Health Center ("FHC").

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in the *Connecticut Post* (Bridgeport) on February 16, 17 and 19, 2017. On May 2, 2017, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on September 29, 2017. OHCA received no responses from the public concerning the proposal and no hearing requests were received from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.

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410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Findings of Fact and Conclusions of Law

1. SVMC is a 397-bed acute-care hospital located in Bridgeport, Connecticut. Ex. A, p. 5

2. FHC, located at 762 Lindley Street Bridgeport, Connecticut, has been operated by SVMC since 1996 and was established to provide primary care services to at-risk or vulnerable populations. FHC also provides limited specialty services[1] at the same location. Ex. A, pp. 5, 12

3. SVMC has experienced ongoing operating losses at FHC. These losses are primarily attributable to FHC's payer mix, which has a disproportionate level of medically uninsured and underinsured patients. Ex. A, pp. 5, 12

4. These FHC operating losses have limited SVMC's ability to provide specialty care at FHC and have contributed to extended wait times for patients seeking appointments: over three months for cardiology, endocrinology and neurology; over four months for gastroenterology and up to six months for ophthalmology. Ex. A, p. 12

5. To avoid further losses and address inadequate resources for specialty care, the Applicant proposes to terminate primary care services at FHC and to transition these same services to Southwest Community Health Center, Inc., ("SWCHC"). Ex. A, p. 6

6. SWCHC is a licensed Federally Qualified Health Center ("FQHC[2]") with five locations in the Bridgeport area. SWCHC provides primary care and supportive enabling services (e.g., education, translation and facilitation of transportation) to area residents. Ex. A, p. 6

7. SWCHC will begin providing primary care (including obstetrics and gynecology) and behavioral health services at FHC following OHCA approval. FHC patients will gain access to SWCHC's dental health services, provided at 968 Fairfield Avenue and 46 Albion Street, Bridgeport. Ex. A, pp. 6, 12; http://www.swchc.org/health-care-services/dental/

8. SWCHC will enter into a professional services agreement to maintain the same physician group providing obstetrics and gynecology at FHC. Ex. A, pp. 7, 12, 30

9. SVMC will continue to provide specialty services, but at a new location: 2979 Main Street in Bridgeport. The new location is only four tenths of a mile from FHC, is larger, has ample parking and is located on a bus route. Ex. A, p. 6; Ex. H, p. 215

10. The addition of behavioral health care services at the Lindley Street location will allow for collaboration between SVMC and SWCHC's behavioral health and primary care teams and integrated treatment plans. Ex. A, p. 14

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[1] Specialty services include: cardiology, endocrinology, neurology, ophthalmology, gastroenterology, infectious diseases, general surgery, orthopedics, nephrology, podiatry, nutritional counseling and pulmonary.
[2] FQHCs are community-based organizations that receive higher level reimbursement along with state and Federal support, such as U.S. Health Resources & Services Administration (HRSA) grants and 340B pricing discounts for pharmaceutical products to provide comprehensive primary and preventative care. Ex. A, pp. 1, 15.

11. SVMC and SWCHC will form an operating committee to monitor access, patient outcomes, and efficiency issues, and establish a committee for monitoring the quality and safety of services provided at the Lindley Street location. Ex. A, p. 16

12. SVMC will hire two new physicians to provide pulmonology and rheumatology specialty clinic services at the new location. In addition, specialty services in general surgery, infectious disease treatment, nephrology, nutritional counseling, orthopedics and podiatry will have expanded hours as a result of the proposal. Ex. C, pp. 216-217

13. In order to reduce significant wait times, SVMC plans to convert its part-time gastroenterologist to full-time and increase service hours available at its new location for cardiology, endocrinology, neurology, gastroenterology and ophthalmology (see table below).

TABLE 1
SVMC SPECIALTY SERVICE LINE HOURS

Specialty Service Line	Current Monthly Hours	Proposed Monthly Hours	% change
Cardiology	6	60	900%
Endocrinology	3	6	100%
Neurology	6	12	100%
Gastroenterology	9	80	789%
Ophthalmology	3	6	100%

Ex. A, p. 14; Ex. C, pp. 216-218

14. SWCHC will implement electronic health record technology at the Lindley Street location, allowing for data exchange between patients, providers, payers and health registries. Ex. A, p. 16; https://www.nextgen.com/electronic-health-records-ehr

15. To ensure there are no interruptions in services, the Applicant will transition Primary Care services to SWCHC over a 12-month period and provide notice to FHC patients explaining the transition. Ex. A, pp. 7, 30.

16. Historical utilization volume is shown in the table below:

TABLE 2
FHC HISTORICAL UTILIZATION BY SERVICE

	Actual Volume (cases)			
Service	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017[1]**
Pediatric and Adult Primary Care	12,936	15,583	17,756	17,832
Specialty Care	4,104	4,281	4,493	4,146[2]
Total	**17,040**	**19,864**	**22,249**	**21,978[2]**

[1]FY 2017 represents annualized volume based on 6 months (October 2016 through March 2017)
[2]Decrease in FY 2017 due to reduced hours at specialty clinic
Ex. A, pp. 20, 25; Ex. C, p. 219

17. Specialty care volumes are anticipated to grow as a result of hiring a pulmonologist and a rheumatologist as well as increasing specialty service hours substantially at the new location.

TABLE 3
SVMC PROJECTED SPECIALTY CARE UTILIZATION

	Projected Volume (cases)		
Service	**FY 2018**	**FY 2019**	**FY 2020**
Specialty Care	5,225	6,400	6,850

Ex. A, p. 25; Ex. C, pp. 219-220.

18. SVMC will enter into a five-year Community Benefit and Support Agreement, transitioning the operation of the Lindley Street location clinic to SWCHC and provide funding to help cover operational expenses through 2022.
Ex. A, pp. 7, 18; Ex. C, pp. 218, 225-228.

19. SVMC has experienced operating losses over the past two years and anticipates similar results in FY 2017 (see table below).

TABLE 4
SVMC HISTORICAL REVENUES AND EXPENSES

	FY 2015	**FY 2016**	**FY 2017[1]**
Revenue from Operations	$488,495	$506,458	$508,182
Total Operating Expenses[2]	$508,201	$529,342	$517,182
Gain/Loss from Operations	$(19,706)	$(22,884)	$(9,000)

[1]Annualized based on 6 months (July-December 2016)
[2]Significant expenses contributing to an overall operating loss are; salaries and wages, fringe benefits, supplies and drugs, depreciation and amortization and physician fees.
Ex. A, pp. 5, 15, 207; Ex. C, p. 222; Ex, F. p 1

20. SVMC anticipates incremental gains of $22,000, $949,000 and $986,000 in FY 2018 through FY 2020, respectively, due to its ability to offset the loss in revenue by reducing operating expenses associated with the proposal, including salaries and wages, fringe benefits, physician fees, supplies and drugs and lease expense. Ex. A, pp. 5, 12, 15, 207; Ex. C, p. 222.

21. The FHC service area includes the towns of Bridgeport, Stratford, Shelton, Fairfield, Easton, Trumbull and Monroe. Ex. A, p. 23.

22. The Applicant does not expect any changes to the patient population or payer mix. Medicaid recipients will continue to account for more than half (64%) of patients served.

TABLE 5
FHC HISTORICAL & SVMC PROJECTED SPECIALTY CARE PAYER MIX[1]

Payer	Actual		Current		Projected					
	FY 2016		FY 2017[2]		FY 2018		FY 2019		FY 2020	
	Visits	%	Visits	%	Visits	%	Visits	%	Visits	%
Medicare*	2,225	10%	2,198	10%	523	10%	640	10%	685	10%
Medicaid*	14,239	64%	14,066	64%	3,344	64%	4,096	64%	4,384	64%
CHAMPUS	0	0%	0	0%	0	0%	0	0%	0	0%
Total Government	**16,464**	**74%**	**16,264**	**74%**	**3,876**	**74%**	**4,736**	**74%**	**5,069**	**74%**
Commercial Insurers	445	2%	440	2%	95	2%	128	2%	137	2%
Uninsured	5,340	24%	5,274	24%	1,254	24%	1,536	24%	1,644	24%
Workers Compensation	0	0%	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**5,785**	**26%**	**5,714**	**26%**	**1,349**	**26%**	**1,664**	**26%**	**1,781**	**26%**
Total Payer Mix	**22,249**	**100%**	**21,978**	**100%**	**5,225**	**100%**	**6,400**	**100%**	**6,850**	**100%**

[1] FY 2016 and FY 2017 represent Lindley Street volume, while FY 2018-FY 2020 represent SVMC specialty care
[2] FY 2017 represents annualized volume based on 6 months (October 2016 through March 2017)
Ex. A, pp. 17, 19, 26, 87; Ex. C, p. 220

23. There will be no changes in SVMC's charity care policy. All SVMC specialty care physicians will accept Medicaid. Ex. A, p. 16; Ex. C, p. 216

24. SWCHC has a sliding fee scale payment policy that is based upon financial need and is consistent with federal guidelines for FQHCs. Ex. A, p. 16

25. There will be no new fees or additional facility fees imposed by SWCHC as a result of this proposal. Ex. C, p. 221

26. 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 regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

27. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2)) (Ex. A, pp. 10-11).

28. The Applicant has established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)) (Ex. A, pp. 11-13).

29. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)) (Ex. A, pp. 4, 15; Ex. C, p. 222).

30. The Applicant has satisfactorily demonstrated that the proposal will increase quality and accessibility and maintain the cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5)) (Ex. A, pp. 13-16).

31. The Applicant has shown that there would be no change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients. (Conn. Gen. Stat. § 19a-639(a)(6)) (Ex. A, pp. 17, 26).

32. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)) (Ex. A, pp. 11, 21).

33. The Applicant's historical provision of treatment in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)) (Ex. A, pp. 21-22).

34. The Applicant has satisfactorily demonstrated that the proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)) (Ex. A, p. 22).

35. The Applicant has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)) (Ex. A, p. 17).

36. The Applicant has demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11)) (Ex. A, p. 22).

37. The Applicant has satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or access to care. (Conn. Gen. Stat. § 19a-639(a)(12)) (Ex. A, p. 17).

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 Conn. Gen. § 19a-639(a). The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

Since 1996, SVMC has operated FHC, which provides primary and specialty care services to at-risk or vulnerable populations. SVMC has experienced ongoing operating losses at FHC, attributable to serving a high proportion of medically uninsured/ underinsured patients. FHC's payer mix has produced inadequate cost-of-care reimbursement, has limited the ability to provide specialty care at the Lindley Street location and contributed to lengthy patient wait times. As a result, SVMC proposes to terminate primary care services at FHC and to transition these same services to SWCHC. *FF2-FF5*

SWCHC will provide primary care (including obstetrics and gynecology) and behavioral health services at the Lindley Street location. Dental care will also be available at one of two SWCHC FQHC locations. SVMC will continue providing specialty services, but at a new location. The new facility is close to the Lindley Street location, is larger, provides ample parking and is on a bus route. SVMC will increase gastroenterologist coverage to full-time and hire two new specialty physicians to provide pulmonology and rheumatology services. Service hours will be expanded significantly. *FF7; FF9; FF12-FF13*

Adding behavioral health care will help create more integrated treatment plans to better coordinate the medical and behavioral health needs of patients. SVMC and SWCHC will form operating and quality committees to monitor access, efficiency, patient outcomes and review the quality and safety of services. Patients will benefit from new SVMC specialty offerings, expanded service hours and reduced wait times, with no additional cost to the patient. Finally, the proposal preserves access for Medicaid patients, which account for nearly two-thirds of FHC's payer mix. *FF10-FF13; FF22-FF25*

The proposal will allow SVMC to significantly reduce its expenses and realize incremental operating gains in excess of $940,000 in FY 2019 and FY 2020. Thus, the proposal is financially feasible. *FF19-FF20*

Based on the foregoing factors, the Applicant has satisfactorily demonstrated that quality and access to both primary and specialty care services in the region will be enhanced for all relevant patient populations, including Medicaid and indigent persons. These benefits are consistent with the Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application requesting authorization to terminate primary care services at SVMC'S Family Health Center in Bridgeport, Connecticut is hereby APPROVED.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

11/27/2017
Date

Yvonne T. Addo, MBA
Deputy Commissioner

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Tuesday, November 28, 2017 1:00 PM
To: 'Kurt.bassett@stvincents.org'; 'jfeldman@goodwin.com'
Subject: Final decision
Attachments: 32165 final decision.pdf

Tracking:

Recipient	Delivery	Read
'Kurt.bassett@stvincents.org'		
'jfeldman@goodwin.com'		
OHCA-DL All OHCA Users		
McLellan, Rose	Delivered: 11/28/2017 1:00 PM	Read: 11/28/2017 1:23 PM
Bruno, Anthony M.	Delivered: 11/28/2017 1:00 PM	
Johnson, Colleen M		
Foreman, Rebecca	Delivered: 11/28/2017 1:00 PM	
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Yvonne.Addo@ct.gov	Delivered: 11/28/2017 1:00 PM	
Carmen.Cotto@ct.gov	Delivered: 11/28/2017 1:00 PM	
Kimberly.Martone@ct.gov	Delivered: 11/28/2017 1:00 PM	
Chalikonda, Srinivasa		Read: 11/28/2017 1:00 PM
Carney, Brian		Read: 11/28/2017 1:01 PM

Recipient	Delivery	Read
Roberts, Karen		Read: 11/28/2017 1:02 PM
Ciesones, Ron		Read: 11/28/2017 1:11 PM
Cotto, Carmen		Read: 11/28/2017 1:56 PM

11/28/17

Please see attached final decision for Docket Number: 17-32165-CON, St. Vincent Medical Center's termination of primary care services.

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

Olejarz, Barbara

From: Microsoft Outlook
To: Kurt.bassett@stvincents.org; jfeldman@goodwin.com
Sent: Tuesday, November 28, 2017 1:00 PM
Subject: Relayed: Final decision

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

Kurt.bassett@stvincents.org (Kurt.bassett@stvincents.org)

jfeldman@goodwin.com (jfeldman@goodwin.com)

Subject: Final decision