STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH STRATEGY

NEWPORT ACADEMY
ESTABLISHMENT OF TWO HEALTH CARE FACILITIES
(MENTAL HEALTH RESIDENTIAL LIVING CENTERS)
IN FAIRFIELD, CONNECTICUT

DOCKET NO. 19-32305-CON

MARCH 4, 2020

1:00 P.M.

FAIRFIELD UNIVERSITY
200 BARLOW ROAD
FAIRFIELD, CONNECTICUT

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. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Strategy, in the matter of Newport Academy, Establishment of Two Health Care Facilities (Mental Health Residential Living Centers) in Fairfield, Connecticut, held at Fairfield University, 200 Barlow Road, Fairfield, Connecticut, on March 4, 2020 at 1:03 p.m. . . .

HEARING OFFICER MICHEALA MITCHELL: Good afternoon, everyone. We're going to go ahead and get started.

This public hearing before the Health Systems Planning Unit of the Office of Health Strategy, identified by Docket No. 19-32305-CON, is being held on today, March 4, 2020, to consider Newport Academy's application for the establishment of two mental health residential living centers in Fairfield, Connecticut.

This public hearing is being held pursuant to Connecticut General Statute, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General

Statutes.

My name is Micheala Mitchell. I have been designated by Victoria Veltri, who is the Executive Director of the Office of Health Strategy, to preside over today's hearing.

To my left and your right is Brian Carney, and to my right, and maybe most of your lefts, is Jessica Rival, and they are the staff from the Office, who are going to assist me today. The hearing is being recorded by Post Reporting Services.

At all times during the hearing today, references to the Health Systems Planning Unit is going to be referred to as HSP.

If the Applicant, witnesses and members of the public use acronyms, we just kindly ask that you define the acronym first. I will also direct anyone, who forgets to do so.

In making its decision, HSP will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

The Applicant, Newport Academy, has been designated as a party in this proceeding.

At this time, I'm going to ask Mr. Carney

to read into the record those documents already appearing in HSP's Table of Record in this case. All documents have been identified for referencing purposes.

MR. BRIAN CARNEY: Okay. At this time, I'd like to enter into the record Exhibits A through Y. A couple of additions, which will be Exhibit AA, motion for reconsideration and articulation, and Exhibit BB, the ruling on the motion for reconsideration and articulation.

HEARING OFFICER MITCHELL: I'm going to go to the Applicant's counsel and just ask that you identify yourself and, also, indicate whether or not you have any objection to the inclusion of the exhibits into the record.

MS. KIM RINEHART: Good morning, Hearing Officer Mitchell, and thank you, also, to Ms. Rival and Mr. Carney.

My name is Kim Rinehart from the law firm of Wiggin & Dana, and I'm here today representing the Applicant, Newport Academy. We have no objection to those exhibits going into the record.

My only question was that there was an objection to the motion for reconsideration, which was not listed, and, so, I just wanted to raise that.

HEARING OFFICER MITCHELL: I'm going to note that, and we will update the Table of Record. I believe that there may be some additional late files that we may ask for, so we'll make sure that everything is up-to-date once the Table of Record has been finalized, so duly noted.

MS. RINEHART: Thank you very much.

HEARING OFFICER MITCHELL: You're welcome. Anything additional?

MS. RINEHART: Hearing Officer, there was a motion that we had filed, asking for just some instruction and guidance, in terms of the scope of the hearing today, and we'd ask, obviously in your discretion, whether you'd like to give some guidance on those parameters.

HEARING OFFICER MITCHELL: So I will. I'll just go forward and give a few more instructions, and then I will rule on the motion for the setting of parameters for the hearing.

MS. RINEHART: Thank you.

HEARING OFFICER MITCHELL: You're welcome. So for the hearing today, the Applicant is going to present a 15-minute overview of the proposed project by way of Direct testimony.

HSP is then going to have the opportunity to question the Applicant. Following those questions, we are going to hear comments from the public.

Each person, who wishes to speak, should have written their name on the sign-up sheet that I believe is outside of the room. If you haven't signed up, just make sure that you sign up.

We're going to call legislators and municipal officials first, and then proceed to call members of the public from the sign-up sheets in the order in which they signed up.

I understand from reviewing the application and correspondence in the record that there is a disagreement between some residents of the town and the town Zoning Board about whether or not this proposal is appropriate for the neighborhood, and I just want to make clear that the Office of Health Strategy does not have jurisdiction to consider any zoning issues, so, accordingly, this is not the appropriate venue to raise those issues.

All testimony and comments should be limited to the guidelines that are set forth in Section 19a-639a of the General Statutes, and you'll find those guidelines on the back of the agenda that Ms. Greer

should have provided everyone with today. If you veer outside of those guidelines, I'll guide you back into the appropriate area.

With regard to the ruling on the motion, I'm going to make the ruling verbally. So looks like, on February 25th of 2020, the Applicant submitted a motion to OHS to establish parameters for the hearing, and my ruling is as follows.

The Applicants request that the Hearing Officer make an opening statement at the public hearing, explaining the importance of a respectful process, reiterating the purpose of the hearing and, also, the statutory criteria upon which the CON decision must be made as granted.

As stated just a few moments ago, this hearing is not about zoning. It's not about the proximity of the locations contained in the proposal to others in the community, and if OHS would try to weigh that, it would be inappropriate for us to do so.

This is not the venue to argue about the proposal's affect on traffic, crime, the residential nature of the location. It is not.

This hearing is about the guidelines that are set forth in 19a-639a, and they are as follows. We

consider whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Office of Health Strategy.

We consider the relationship of the proposed project to the Statewide Health Care Facilities and Services Plan.

We also consider whether there is clear public need for the health care facility or services proposed by the Applicant.

We consider 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.

We look at 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, the provision of or any change in the access to services for Medicaid recipients and indigent persons.

We look at the Applicant’s past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, again, access to services by Medicaid recipients and indigent persons.

We look at 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.

We look at the utilization of existing health care facilities and health care services in the service area of the Applicant.

We look at 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.

We analyze whether an Applicant, who has failed to provide or reduce 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.

We look at whether the Applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in a geographic region, and whether the Applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not

adversely affect health care costs or accessibility to health care.

Those are our factors.

Just one last thing on the first request that was made by the Applicants, and that is to reiterate that this is a regulatory proceeding.

My job as the presiding Officer is to manage these proceedings and to make sure that the record is complete.

Everyone, who wishes to speak, will have an opportunity to do so. We want to hear from you. However, I expect that everyone, who is in the room, will be respectful of one another during these proceedings.

Only one person speaks at a time. There will be no yelling, no calling out, no speaking out of turn. Anyone, who engages in improper conduct designed to interrupt the proceedings or who is speaking out of order during the proceedings, will be directed to leave.

The Applicant’s second request is denied, in part. I have no issue with persons, who are providing public comment, having a supportive person to be with them while they make their comments.

However, because I expect that everyone is going to adhere to my directions regarding the

appropriate conduct for these proceedings with regard to giving their public comments, I'm going to go in the order in which people have signed in, rather than have the Applicant's guests speak first.

At this time, I'm going to have the Applicant's witnesses raise their hand, so that they can be sworn in, and I will ask the hearing reporter to do the swearing in.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER MITCHELL: At this time, the Applicant may proceed with its testimony.

MS. RINEHART: Thank you. Our application will be presented by Joseph Procopio, the CEO of Newport Academy, Carter Barnhardt, the Chief Experience Officer of Newport, and Dr. Michel Mennesson, a long-time provider with Newport Academy. Joe, please go ahead.

MR. JOSEPH PROCOPIO: Thank you. Good afternoon, and thank you, Hearing Officer Mitchell, for providing us an opportunity to discuss our program to provide residential mental health services to young adults ages 18 to 26 here in the Town of Fairfield.

My name is Joe Procopio. I am the Chief Executive Officer for Newport Academy, and I ask that my

pre-filed testimony be adopted.

Newport Academy is an experienced, high-quality provider of primary mental health treatment. We were founded on the principle of treating the underlying disease, as opposed to the maladaptive behaviors that sometimes accompany those diseases.

Our mission was launched in Southern California in a single-family residence early in 2009, and something remarkable happened at that singular house. Young people came to treatment and they got healthy.

Since that time, Newport has grown to over 20 programs, including a residential program for adolescents and young adults ages 14 to 20 in Bethlehem, Connecticut, and an outpatient program in Darien. We are nationally recognized for high quality, effective life-changing care.

Today, we stand before you with a simple request. Allow a decade-old experienced high-quality provider to expand access for care to young adults with primary mental health diagnosis by opening our program here in Fairfield.

The need for these services are profound. According to SAMHSA, 8.2 percent of young adults in Connecticut have reported seriously considering suicide

in the last 12 months. As a parent, that should be shocking to most and frightening. 6.2 percent have a serious mental illness.

The Community Needs Assessments of every local hospital have confirmed that mental health services are lacking. DMHAS specifically has identified young adults as a, quote, “special population of concern,” and noted that residential services specifically are lacking. Moreover, 53 percent of adults with mental illness here in Southwest Connecticut receive no help. The need is real, the need is growing, and it cuts across all socioeconomic statuses.

On the topic of quality, Newport Academy is a result-driven organization, so much so we have that terminology built right into our mission statement.

All of our programs are certified by the Joint Commission, widely known as the Gold Seal in health care. For calendar years 2017 and 2018, we engaged Vanderbilt University to review our outcomes data, which we collected using well-accepted tools, PHQ-9, the GAD-7 and the WHO-5, which are a depression scale, an anxiety scale and overall wellness, and, as will be discussed further by Dr. Mennesson, this study showed significant improvement in all measures.

Also, on quality here in Bethlehem, 76 percent of the clients, who came to us for care last year, were referred by professional reference.

In 2019, nationally, over 1,300 unique professional reference sent us clients. Professionals in this community and others clearly have confidence in what we do.

We surveyed those professional references well, and, in last year's surveys, they rated us a 9.1 on a scale of one to 10, in terms of overall satisfaction, and 96 percent of them will continue to refer to Newport.

Additionally, we survey our families, our customers. Our residential clients, who receive services here in Connecticut, scored us a 94 when asked the question would you refer another family in need to Newport Academy?

And, finally, as a statement of quality, there's a reason, we went to bed last night, there were 147 individuals on a Newport Academy wait list. Here in Connecticut, that list had 65 as of last evening.

On the topic of access and who will pay for our service and will we adversely affect other providers in the area, it is clear that we have generated enough interest in Newport, as defined by our utilization

of our current capacity and by our wait list, that we don't need to pull clients from other providers.

Last year in Bethlehem, we admitted 55 clients between the ages of 18 and 20, and we also had 300 clients hit our wait list in that same age cohort, who eventually fell off the wait list, because of lack of access to care.

Unlike how our opposers frame us, we are an insurance-based health care provider. Ninety-seven percent of our revenues in 2019 came from third party payers.

Average out-of-pocket costs for families in 2019 was $3,200, and for our families, who can't afford their portion of the subscriber responsibilities, we offer financial hardship relief. Only 1.5 percent of all of our admissions in Bethlehem were cash pay clients.

In my experience, this commitment to working with insurance companies is crucial in providing access to care.

Additionally, in 2019, Newport provided over $3 million in uncompensated care, 1.1 million here in the State of Connecticut. Notably, this does not include the hardship waivers that I previously mentioned.

Finally, to further relieve the fiscal

burden of families, who cannot afford to pay, Newport has committed a $100,000 scholarship fund annually for the purpose of the proposed programs to support local clients, who cannot access care otherwise.

In conclusion, we are excited about the opportunity to provide much needed care, high quality mental health services to young adults here in this community and the surrounding communities.

I'll allow the rest of my time to Dr. Mennesson, who is the interim Medical Director for Newport's Fairfield project.

DR. MICHEL MENNESSON: Good afternoon. My name is Michel Mennesson, and I'm a psychiatrist at Newport Academy Bethlehem program and the interim Medical Director for the proposed youth adult program in Fairfield. As I discussed -- I adopt my pre-filed testimony.

As I discuss in my pre-filed testimony, there's a need, a specific need for services for this young population, young adult.

The emerging adulthood delay in development is increasingly recognized, as it can incapacitate young adults for years; dropped out of college, not working, dependent financially to their

parents, not emotionally responsible, or not active in society.

The challenges and concern of young adults are sufficiently different that they are best served with programs that focus on their specific challenges, as they are no longer adolescent, not yet adults.

While young adults need treatment, they do not access readily outpatient treatment, IOP or PHP, due to their patterns of poor functioning, lack of responsibility or denial, along with depression and anxiety.

They refuse to attend, and, because they are legally adults, parents cannot make them go. As a result, they can be stagnant for years.

It can be difficult for parents to get withdrawn young adults to say yes to treatment every day, as it is required for PHP and IOP program, rendering outpatient treatment ineffective.

With residential services, parents can capitalize on moments of acceptance and clarity, in which a young adult agrees to treatment.

As long as a program has availability, the parents and these young adults only need one yes. Once in treatment, support from staff and peers helps reduce

the risk of the resident leaving the program and dropping out of treatment.

Additionally, residential treatment allows for more intensive engagement. We provide at least four hours of clinical program daily, using evidence-based intervention, addressing their mental health needs. We also provide training in much-needed life skills.

The significant support from staff prevents residents from retreating to their preferred maladaptive coping strategies.

They also have the opportunity to develop supportive relationships with peers and a sense of community that these often isolated young adults desperately need.

Furthermore, family members are integrally involved in treatment, which helps address painful enabling behaviors and conflictive relationships.

Through this intensive residential experience, failure to launch is transforming to a successful launch into adulthood, where these young adults can move to college, live independently in their own apartments, working and not returning to mom and dad.

To monitor quality and effectiveness of this treatment, Newport Academy measured its outcome

measures and commissioned a third party physician to analyze the data.

We provided the entire study to you as Appendix D to our responses to the first set of completeness questions.

The statistician found that the results were highly statistically significant, as well as showing a high degree of clinical improvement.

Generally, an improvement of 10 percent or more is considered clinically significant. Newport Academy's outcome showed 45 percent improvement in resident well-being, 47 percent decrease in anxiety index and 53 percent decrease in depression index in practice.

This translates into residents feeling better, less anxious, less depressed, and with a sense of well-being noticeable by residents and family. They become ready to move into adulthood.

A Connecticut young adult population will be well-served by a residential treatment program specifically designed for the age group that brings that kind of improvement, as documented by validated measures.

MS. CARTER BARNHARDT: Good afternoon. My name is Carter Barnhardt, and I'm the Chief Experience Officer at Newport Academy. I adopt my pre-filed

testimony.

Thank you for allowing me the opportunity to speak today. I'm extremely passionate about the needs for young adult services, specifically for individuals struggling with primary mental health diagnoses and needing to utilize insurance.

I've worked for Newport Academy for the last eight years, and I've served in a variety of roles. Among other things, I developed the Discharge Planning Department and the Alumni Program at Newport Academy.

I have also been integrally involved in developing a referral program. As a result, I've personally visited over 300 other programs across the country.

We routinely refer to these other programs when an individual does not meet Newport's clinical criteria, it's outside of the age range we serve, or when we have a lengthy wait list.

As a result of my experiences, I'm acutely aware of the struggles that young people face in finding treatment.

Just last Friday, I received a call from a 23-year-old girl, who grew up in Fairfield County and lost her mom when she was 16 years old. A few months

ago, she found out that her dad is terminally ill and is also in debt.

As a teenager, she struggled with depression after the loss of her mom, and finding out about her dad's illness, she told me that she just feels totally hopeless. She can't get out of bed, has lost her job, and feels lost. She reached out to me for support and asked for a solution.

She sent me her insurance card and explained that she cannot pay out of pocket for a residential stay and would like to stay on the east coast, in case something happened quickly with her dad.

I called every program I know. Turnbridge, Mountainside and Rushford all require a primary substance use disorder diagnosis, and she has not touched drugs or alcohol in months.

She did not qualify for Silver Hill's inpatient, as she was not acutely suicidal, and their residential program is $46,000 with her insurance coverage, and no additional scholarshipping is available.

Angelus House with a scholarship would still be about $390 per day, and, finally, I called Institute of Living. They explained that she was not acute enough for their three to seven-day inpatient

program. Desperate, I asked if they had any other suggestions. The woman said I wish I did.

This is a huge reoccurring issue in the State of Connecticut. If clients have money, we send them to Florida or California. Otherwise, we have no options for primary mental health residential treatment.

Ultimately, I was unable to find a single program on the east coast that would treat her trauma, anxiety and depression and accept her insurance.

She is now paralyzed with fear, trying to decide if she should fly to California to the one program that takes her insurance and delivers evidence-based care or not.

If she were 20 years old, Newport Academy in Bethlehem would be able to work with her and accept her insurance. Unfortunately, she is outside of our age range for that program, and she is not alone.

Every week, I personally receive many calls similar to this one. Newport Academy as a company receives even more. We have a dedicated referral relations specialist, whose whole job is finding appropriate placement for people, who are not able to be served by Newport’s existing programs.

Our goal is for every person that calls

Newport to find an appropriate treatment option, and we aim to provide three referrals to any person that calls.

On average, we provide recommendations to about 85 people a week. As a result, I'm highly knowledgeable about the options for treatment and, specifically, about the lack of adequate options for young adults requiring residential treatment.

It is my hope that OHS will approve Newport's application to open the two homes in Fairfield, so that we can help address at least a small part of this need.

I would also like to take a moment to highlight two other aspects of Newport's programming that I believe are very unique; our focus on discharge planning and family involvement.

We believe that, for long-term success, individuals must have tailored treatment plans after they leave Newport Academy's residential program, and they must have family support. Family involvement is integral to our programming.

In addition, we begin discharge planning from the beginning of treatment, and every Newport client leaves with a thorough after care plan.

We also contact individuals and their

families weekly after discharge for the first month to offer support, then monthly for at least a year, often longer.

We also have a parent and alumni app, which allows our community to support one another in their recovery, and many alumni attend our events for years after they leave our program. In fact, this past year, we had over 300 alumni and their families attend our event.

As you have seen from the letters from alumni and their families I submitted with my pre-filed testimony and as you will hear from the alumni and families, who courageously want to share their stories here with you today, the need is crushing. These testimonials also demonstrate the high quality services Newport Academy provides.

I am hopeful that Newport Academy’s application is approved, so that we can continue to be a part of the solution for the young adults struggling with mental health conditions.

I am happy to answer any questions. Thank you.

MS. RINEHART: Thank you.

HEARING OFFICER MITCHELL: Nothing

further?

MS. RINEHART: Nothing further.

HEARING OFFICER MITCHELL: Okay. I'm going to go out of order a little bit. Are there any elected officials? I think we have a list for the elected officials that are here that wanted to speak.

I know I saw Senator Hwang. I don't know if he's still here. Senator Hwang, did you want to come and give your public comment?

Is Representative Devlin here?

(APPLAUSE)

FIRST SELECTWOMAN BRENDA KUPCHICK: Good afternoon. My name is Brenda Kupchick. I am the First Selectwoman of the Town of Fairfield.

I submitted a letter from myself and, also, the Board of Selectmen to you a couple of weeks ago.

I looked at the criteria that you established for testimony today, and I'm going to try to fit into that criteria the best I can.

I'd like to just give you a little history. As a State Representative before I took this office for nine years, I was probably one of the biggest leaders on mental health services and expanding access to

mental health in the state legislature. I take that issue very seriously.

I met with the CEO of Newport Academy, and I think that their services are important and valuable and needed.

I offered the CEO the opportunity to work with us at the Town of Fairfield to locate space in our town in a commercial zone, because I view this medical facility, while very important, as being a medical facility, a business, and I don't believe businesses should be operating in residential areas in our town, like any other business.

I am willing to work, as the leader of the Town of Fairfield, to assist Newport Academy in finding a location in a commercial zone to provide services that I believe are desperately needed for our state for people with addiction and with mental health, but I don't believe it is appropriate in a residential neighborhood, and I'm here to speak about that.

So that is all I wanted to say, that I am willing to work diligently with Newport. We do have a lot of locations that are prime opportunities for this facility, because I have had many family members myself, who have suffered from drug addiction, and the treatment

that they received was about what was happening inside the facility, not where it was located.

It was the staff, it was the services, it was the treatment that helped them, not where it was located, so I still have that invitation open, and I hope that you will take me up on it. Thank you for the time.

(APPLAUSE)

HEARING OFFICER MITCHELL: So let me just -- let me just make a brief statement about the content of the statements that are going to be presented to us through public comment.

I do understand that there is an ongoing issue of whether or not this proposal is appropriate in a residential area. That is not something that we can decide. I didn't want to interrupt you at all, because I want to give you deference, because of your position.

I respect your position, but OHS has no authority to make decisions about where this Applicant can put their program.

We have authority to decide the criteria, based upon the criteria that I read to everyone that's here just a few moments ago, and we're bound by that.

So I'm just going to ask, if there's anything that you're going to say that is regarding the

appropriateness of this proposal in this specific area that relates to zoning, that you hold it. Don't say it.

MS. LAURA DEVLIN: So your rules do make this a little bit of a challenge. I'm Laura Devlin, State Representative for the 134th District, which includes parts of the community of both Fairfield and Trumbull.

Because I think we can all agree the issue of mental illness, the issue of drug addiction is vast, it is widespread, it has been growing, it is serious, and probably I would guess every single one of you and everybody in this room, if they haven't dealt with those issues personally, directly, has a friend or family member who has, so I don't think there's any question related to that.

You do make it a bit challenging with the rules to be able to comment further, because -- and I do believe that Newport Academy has a positive reputation.

I don't think it's unique that other facilities that are private pay at $1,000-plus a day, near $100,000 for a round of treatment that already exists within our state, also include family involvement, also include planning for discharge when that patient comes in.

And patient is probably a key word, because, while we won't talk about zoning, Newport Academy has been very unclear and misrepresents itself, depending on which body it has been in front of, so, you know, a treatment facility like Newport would like to operate in a home-like setting, will discharge its patients much like a hospital will, and then they will return to their home. That's quite a distinct difference from a group home that we're not discussing here today.

There's been a lot of talk about NIMBY issues and all of that. There is no desire to want to limit opportunities for people in protected classes to live and exist in our communities. I want to make that perfectly clear, but there absolutely is opposition to corporations trying to exploit group home protections.

(APPLAUSE)

MS. DEVLIN: So I will turn it over to Senator Hwang.

MR. TONY HWANG: First, thank the Office of Health Strategy. I'm going to acronym you as OHS as we begin this conversation, and I do understand the purview and the cognizance that you have in this hearing.

It is unfortunate that we have gotten to this point and the frustration that you will sense. And

I appreciate the emotions that you're feeling and the asking of the participants in the audience to respect the process, but we've gotten to this point, because of concerns on how the process has been undertaken, so indulge me, if I may, if you may, and let me share with you.

I'm State Senator Tony Hwang. I represent the 28th District in the Connecticut General Assembly, which encompasses Fairfield, Southport, Westport, Weston, Easton, Newtown and Sandy Hook.

I'm also the ranking minority leader in the Housing Committee, which recently held a public hearing regarding and considering the definition of group homes under Section 8-3e, and it was important to review that process, which articulated the state law exempting group homes in a protected population --

MS. RINEHART: I'm just going to make an objection on the record.

MR. HWANG: -- so my testimony will focus on the statutory process.

HEARING OFFICER MITCHELL: I'm going to note the objection. I'll still let him make his point.

MR. HWANG: Thank you.

HEARING OFFICER MITCHELL: But I'm just

going to ask, if there's any distinction about whether or not a group home belongs in a residential area, this is not the appropriate venue for that, and I don't want people to follow you and believe that that is the case and then start going down that road.

I have to be able to control this hearing. I have to be able to make sure that we have all the information that is pertinent to the criteria in the record, and, when I'm not able to do that, it makes our job very difficult, and our job is very distinct from what the Zoning Board does. We are not the Zoning Board.

MR. HWANG: Ma'am, I fully appreciate that, and I fully appreciate the concern, and I appreciate the latitude, but it is important, because what came out of the statutory hearing was an insightful conversation in regards to 8-3e.

And the reason I offer that is the basic premise of why I am objecting to this application, because this application, from its onset, was made under the premise of the protection afforded under 8-3e.

You can refer back to your notes, and I would encourage your body to take that examination to understand that the premise of this entire application up to this point has been based on a premise of protection

in its application under 8-3e, and I will be happy to share with this Committee or this hearing body testimony and feedback that was part of the legislative process that truly articulated, in almost a unified voice, whether you supported it or you were opposed to the statute, the definition of group homes precludes Newport Academy's application.

So if you're basing it on this --

HEARING OFFICER MITCHELL: We are not.

MR. HWANG: Then it's unfortunate, but allow me, and I appreciate the latitude. If you are basing a foundation of this application on a false premise --

HEARING OFFICER MITCHELL: We are not.

MR. HWANG: But I would offer and like to enter into the record that it is, that if you were to look at the process and look at the definition in which these initial applications were made, they were made under the premise of 8-3e. If that is incorrect --

HEARING OFFICER MITCHELL: Senator Hwang, you're not listening to me when I talk about the criteria, and I don't mean to be disrespectful to you, but, in order to keep this process focused on what we have jurisdiction to look at, I'm going to ask you if you

can focus on our statutory criteria. That would be helpful.

MR. HWANG: Ms. Mitchell, if I may, I will share with you a premise of an application, based on a false premise, has no foundation at all.

(APPLAUSE)

MR. HWANG: And it is important that the initial application was based on a false premise and based on a statutory exclusion of Newport Academy.

Now for me and I would propose the solution moving forward, because, make no mistake about it, there are people that I know, there are people that we all know that struggle from the challenges and the emotions of substance abuse and mental health supportive services. There is no denying that.

The articulation by Newport Academy was quite telling, quite emotionally pulling. Nevertheless, there is not a problem with me or with any other people in addressing the critical need. There's no doubt of it, but what I have a struggle with this is, and I'll repeat again, the foundation of this original application does not apply under 8-3e.

And when you are on a base of a false premise, everything you do after that is tainted by that

inaccuracy. I am challenged to think that you will not, under an open process and a, I hope, a proceeding to evaluate this, the foundation in which you're going to make your decision on and which you tell me you're bound by, if it is based on a false premise, the entire process is flawed.

(APPLAUSE)

MR. HWANG: So are you going to tell me that if you found that out to be a complete mislead or a misunderstanding, that you're going to approve something, because everything else, based on a, quote, "misrepresentation or non-applicability" is going to be okay?

I think, from your legal background or whatever your background is in evaluating that, you cannot ignore the fact that the foundation of this premise, where we are right now, was based upon a false premise.

In my testimony, you will see the timeline to that process. You will look at the application process. You know, as I review this process, I look at the initial application in which there were multiple names being used, and, as I looked at the application on its original approval by the Town body, it was

represented as a group home.

I have the Chairman of the Housing Committee, I have participants in a public testimony, bound by statute in evaluating 8-3e, that uniformly said Newport Academy, however important their mission is, however important the need is, does not qualify under 8-3e. They support the services.

So my solution to this, ma'am, and to your body is I support their access to services, I support their efforts to come to Fairfield and to provide critical services to our community and throughout the country. I simply ask them to begin the process under the proper context and make the application to our town and to any other town.

HEARING OFFICER MITCHELL: We don't have jurisdiction over where they can make their application to the town. You're asking the wrong people to help you with that.

MR. HWANG: But you raise a very interesting point. The approval process that led to here --

HEARING OFFICER MITCHELL: Is for a Certificate of Need, not for to decide where to go.

MR. HWANG: Madam, Madam, I think you will

see my presentation in my testimony.

MS. RINEHART: I'm going to object at this point.

HEARING OFFICER MITCHELL: We have to move on.

(Public disruption)

MR. HWANG: I think it's a frustration point, if I may.

HEARING OFFICER MITCHELL: I'm going to give you a few more minutes, and then we're going to take a break, and then I'm going to come back, and we will talk about it again, but I can't have people yelling out.

This is not how this is going to proceed. This is not a zoning hearing, it's not, and you're making it something that it's not.

MR. HWANG: Well I would ask that the body evaluate the testimony written, and I will repeat again, you know, as you have charged under OHS, that grounds for denial of said licensure included if the resident furnishes or make any false or misleading statement to the Department of Health, in order to obtain --

HEARING OFFICER MITCHELL: We are not the Department of Health. We're not the Department of Health.

MR. HWANG: So what you're saying, also, again, is, if there was a false statement made to the Department of Health and it was brought up in this meeting --

HEARING OFFICER MITCHELL: You would need to go to the Department of Health. We can only look at what is before us. We are not the Department of Health. I cannot make a determination on the part of the Department of Health.

MR. HWANG: Well allow me to be on the record to say that, if the foundation of this application, of which you're only considering, is based on a house of cards and lack the foundation, as provided under statutory requirements, that there are grounds for people to pursue alternative action to ensure that this process is proper and that it is correct.

All I'm asking for is that people follow the law and respect the process of the application.

HEARING OFFICER MITCHELL: We will ensure it.

MR. HWANG: And this is not just for Fairfield.

HEARING OFFICER MITCHELL: Right.

MR. HWANG: It is for the entire State of

Connecticut, and it is an important separation. Let us make no mistake about this premise. I think everyone standing up here and the people out in the audience support that there is a critical need to provide for loved ones and individuals impacted by addiction and mental health services.

There is no doubt, but what I am deeply troubled and deeply disappointed is the fact that we have gotten here to this meeting with many a voice, with one hand tied behind their back, in not being able to have the due process afforded to them. It's disappointing. It's frustrating.

HEARING OFFICER MITCHELL: Is this not due process? Is this hearing not due process?

MR. HWANG: Ma'am, you have just hamstrung the entire proceeding --

HEARING OFFICER MITCHELL: I have not.

MR. HWANG: -- with regulations. We may agree to disagree, but the guidelines that you offered is, and I appreciate the latitude that you've given me, but, nevertheless, I provided written testimony, and I hope it's a basis for us to continue further conversations.

HEARING OFFICER MITCHELL: Thank you.

MR. HWANG: Thank you.

(APPLAUSE)

HEARING OFFICER MITCHELL: I'm going to make another comment before we take a break. I want the people in this room to know that the Office of Health Strategy does not not empathize with you regarding whatever you may feel about zoning.

We do not have jurisdiction over zoning matters. We do not. This is not the proper venue for that. I'm sorry. I have to control this hearing. I have to.

We're going to take a 10-minute break. We're going to come back, and then OHS is going to ask some questions.

(Off the record)

HEARING OFFICER MITCHELL: We're going to go back on the record. So we're back on the record, and I just wanted to talk a little bit about the Office of Health Strategy and what we look at when we look at an application, because what I did earlier was I read the criteria that's in the statute, and it's quite wordy, so I just want to make sure that I try to bring it into focus, in terms of what we do have jurisdiction over, and, when I say jurisdiction, I mean power to make a

decision.

So we have power to make a decision over whether or not this Applicant establishes need for the program, whether or not it's cost effective, whether or not it's a quality program, and whether or not they can demonstrate that they will provide access to all people of Connecticut, including those who are indigent or those who receive Medicaid. That's our criteria that we look at.

And now I'm going to just turn it over to my colleague, Jessica Rival. She's going to ask our questions of the Applicant, then we'll go back to public comment.

MS. RINEHART: Hearing Officer Mitchell, may I briefly address the prior comment before we go to questions?

HEARING OFFICER MITCHELL: Which one?

MS. RINEHART: The comment made by Senator Hwang.

HEARING OFFICER MITCHELL: I'm going to ask that you do so briefly.

MS. RINEHART: Very briefly. We just want to set the record straight that there was absolutely no misrepresentation made by Newport Academy in connection

with our application, and, indeed, the reference to 8-3 - -

(Public disruption)

HEARING OFFICER MITCHELL: Let me just say that, in order for us to proceed with the hearing, that everyone needs to make sure that they exhibit proper decorum.

Doing that doesn't facilitate the hearing. It doesn't help in the decision, so I just ask that everybody is respectful, even if you disagree with what's being said. You're going to have the opportunity to talk. I'm going to give it to you. I want to listen to what you have to say. Thank you.

MS. RINEHART: So I just wanted to make very clear that there was absolutely no misrepresentations made in the applications, and, in fact, this reference to 8-3, there is no reference to that in the application, whatsoever, so I wanted to correct any confusion with that on the record.

It is not relevant, as the Hearing Officer has already noted, but we wanted to be very clear in that regard, and I would also request that the Hearing Officer issue an order that there be no clapping, cheering, booing, or other things, because the hearing is already

in a very emotional place.

HEARING OFFICER MITCHELL: So I do note your concern, counsel. I do also note that there are a lot of people in here that are emotionally vested in the outcome of this decision, so I don't mind if people clap.

I just don't want you to disrupt the hearing. It's okay if you clap, it's okay if you cheer, but coughing while someone is speaking, yelling out, those are things that are disruptive to the orderly, you know, flow of the proceedings, and I have to control that. Is that understood, everybody? I heard a couple of yeses. Thank you. Thank you.

All right, so, we'll move on. Thank you, counselor. We're going to -- I'm going to turn it over to my colleague, Jessica Rival, who is going to ask our questions.

MS. JESSICA RIVAL: Good afternoon. On page 61 of the pre-filed testimony that was submitted by Ms. Barnhardt, you discuss managing the wait lists for patients needing services.

Could you please speak to these wait lists, specifically, the approximate number of patients that are currently wait listed and the number of wait listed potential clients that could be appropriate for

the proposed program in Fairfield?

MS. BARNHARDT: I think you shared the exact numbers, as of this morning, so do you mind if I have Mr. Procopio answer, in terms of numbers?

MS. RIVAL: Sure.

MR. PROCOPIO: So, as of this morning, as of last night, we had 147 clients on our wait list nationally, and 65 of those clients were waiting for a bed here in Connecticut.

MS. RIVAL: Okay and how many of those do you feel would be appropriate for the proposed program?

MR. PROCOPIO: For the proposed program, there's minimally a handful of those clients that would be available to access care here in Fairfield.

MS. RIVAL: Okay.

MR. PROCOPIO: We had 11 specific clients, who were from Connecticut, on our wait list as of today.

MS. RIVAL: And for each fiscal year that Newport Academy in Bethlehem has been open, what percentage of those patients have been Connecticut residents?

MR. PROCOPIO: It's approximately 20 percent.

MS. RIVAL: Twenty percent?

MR. PROCOPIO: And we think, by providing greater access, more capacity here, we'll be able to accept more Connecticut residents to our program.

MS. RIVAL: Great. Thank you. Could you describe how your proposal would help improve the continuum of care for behavioral health services in the area, including how clients would be referred into the program, the program, itself, and post-discharge care?

MS. BARNHARDT: Yeah, so, as Mr. Procopio had noted, the majority of our referrals do come from professional referral sources. I think he said 76 percent of our referrals come from professional reference.

What that typically means is a therapist, a member of the community. Actually, the programs that I cited, that I had called for this young 24-year-old, are some of our biggest referral sources in the area, so we work with a lot of Connecticut programs and get referrals directly from them; Silver Hill Hospital, Rushford, IOL, things like that.

Currently, as I had addressed, there's no primary mental health residential treatment center that's able to work with insurance, and, so, that's really in terms of continuum of care. That's where we see

ourselves fitting in.

Discharge planning is something that we think about from the very beginning of treatment. How are we going to support the client afterwards? What's the home environment going to look like? Will they stay locally? What does that exactly look like? And we really try to make that plan as thorough as possible. Does that answer your question?

MS. RIVAL: Yes. Thank you.

MR. CARNEY: Can I just follow-up? What percentage of patients, who complete your program, are referred for post-discharge care, like on an outpatient basis?

MS. BARNHARDT: At one of our programs or just in general, an intensive outpatient or a partial hospitalization?

MR. CARNEY: In general.

MS. BARNHARDT: Most of our clients are recommended to transition to a lower level of care once completing residential treatment. That could be an IOP. It also could just be outpatient providers. We do also offer a virtual care program, continuing connections. It depends on what's most appropriate.

MR. CARNEY: And you have an outpatient

program already established in is it Darien?

MS. BARNHARDT: Yes.

MS. RIVAL: Could you identify any agreements that you have with other providers within the state to coordinate step-downs from residential to the next appropriate level of care?

MR. PROCOPIO: There are no formal agreements between ourselves and other providers. We do business associate agreements with local hospitals, as we have in the Bethlehem community. We're seeking one with Norwalk in reference to this particular program.

In terms of referring professionals, it is really the majority of clients who come to us, you know, through the professional network, go back to the same referent when they are discharged from care.

And just to follow-up on one of the comments that Carter made, all of our clients leave with a discharge plan, a step down to a lower level of care.

Typically, from a residential setting, no one goes directly unsupported back to home without a plan of treatment. That continues while they're at home.

MS. RIVAL: Can you identify the components in a discharge plan?

MS. BARNHARDT: Yes. So we do something

called attachment-based family therapy while our clients are with us in treatment, so we're looking at the family relationship. We do a family session at the end that's really spelling out what after care is going to look like, so will there be weekly family dinners, things like that, social activities?

What's the client passionate about? We really want to make sure that the kids and young adults that come to our program are getting reconnected to their passion, so tapping into their creative outlets, tapping into what they're passionate about, different activities, and then, also, putting in that therapeutic component, as well, so that could be an IOP, PHP, outpatient, really looking at all the different needs that a client has, as well as educational needs.

MS. RIVAL: Could either of you provide an estimate percentage of each of the primary diagnoses to be treated at the proposed locations in Fairfield?

MR. PROCOPIO: That may be difficult to predict, but, if we look at our history, this past year 69 percent of the clients, who were admitted to a Newport program, had major depressive disorder, was the primary diagnosis.

Second on our list was anxiety disorder,

which I believe was nine percent.

MS. RIVAL: And are there other residential programs within the service area that provide similar treatment to young adults?

MS. BARNHARDT: There's programs that provide primary substance use disorder treatment, so Mountainside is a great example, good program here in Connecticut that provides primary substance use disorder treatment, and then Silver Hill Hospital provides inpatient care. They do also have a residential program. The residential does not, however, work with insurance.

MR. PROCOPIO: And Center for Discovery does eating disorders, specifically, here in Fairfield.

MS. BARNHARDT: Turnbridge also is an example of a program locally that provides. They have a residential component, where they take the clients to an IOP, but you have to have a primary substance use disorder diagnosis.

MR. CARNEY: And none of those other programs are treating the same age population that you're proposing in this matter?

MS. BARNHARDT: Turnbridge's program is young adult, however, they go down to age 16.

MR. CARNEY: Okay.

MS. BARNHARDT: But, again, it's primary substance use disorder, and it's not a licensed residential treatment center.

MS. RIVAL: Could you tell me what the average daily cost of treatment for a client in the program would be?

MR. PROCOPIO: Our average cost nationally for services at the residential level of care run about $800.

MS. RIVAL: Per day?

MR. PROCOPIO: Per day. Per day, yeah. Per patient day. Some, obviously, are more expensive, depending on the geographic setting. Others are a little bit less.

MR. CARNEY: So how would that compare here in Connecticut? What do you estimate the cost to be? The same? Higher or lower?

MR. PROCOPIO: I would estimate that it would be very similar.

MR. CARNEY: Could you provide us any further evidence to support your assertion about average cost of your service? That's part of our criteria, is to evaluate the cost of care.

MR. PROCOPIO: Sure.

MR. CARNEY: It's highly important to our Executive Director.

MR. PROCOPIO: Certainly. I mean we can provide -- I guess, when you asked the question about cost of care, I'm assuming you were asking the cost that we incur or the cost for a client?

MR. CARNEY: Cost for the patient, for the client.

MR. PROCOPIO: Sorry. I misunderstood your question. So, in our application, in the financials, it was around $1,100 per day.

MR. CARNEY: Okay. Okay, so, for the patient, 1,100. Your cost, 800. Is that what you're saying, basically, generally speaking?

MR. PROCOPIO: Yeah, so, again, I will say the cost is typically reimbursed by insurance companies, 97 percent of the cases this past year.

MR. CARNEY: Thank you.

MS. RIVAL: On page 104 of the pre-filed responses to the public hearing issues, it states that Newport Academy is ineligible for both DMHAS grants and Medicaid participation. Will Newport Academy continue to actively reach out to both DSS and DMHAS to explore Medicaid eligibility and potential DMHAS funding in the

future?

MR. PROCOPIO: Yes.

MS. RIVAL: And could you talk to us a little bit about single case agreements and how those work?

MR. PROCOPIO: Sure. So, in many cases, we have relationships with third party payers, Anthem Blue Cross here in Connecticut, for instance, Aetna, Optimum, and, because of those relationships, we, through the utilization review process and the admission process, contact the payer, and we sign single case agreements, which basically allow the subscriber almost the same benefit as being in in-network payment, in terms of co-pays and deductibles.

And, so, we establish those on a patient-by-patient basis with the payers, and, here in Connecticut, that represented 44 percent of our business last year.

MS. RIVAL: And will Newport Academy be willing to enter into single case agreements with DSS or DMHAS in the event of a client referral?

MR. PROCOPIO: Yes. We have in the past, in our history.

MS. RIVAL: Okay. Given the stated

scholarship level of $100,000 annually, how many patients would that treat in a given year?

MR. PROCOPIO: It's dependent on length of stay, but it will be two to three clients per year. Again, though, I would reference you back to, you know, Newport has I think been a good community partner, in that we've provided significant free care, and this would be in addition to that free care.

Here in Connecticut last year, it was about a million dollars.

MS. RIVAL: Would you be willing to consider offering additional scholarship dollars to help serve clients without adequate means to afford the services?

MR. PROCOPIO: I'd welcome that discussion.

MS. RIVAL: And have you ever considered establishing a priority bed for Medicaid recipients or indigent clients?

MR. PROCOPIO: We have not.

MS. RIVAL: Is that something that Newport Academy would ever consider?

MR. PROCOPIO: Again, we'll welcome that discussion for sure.

MS. RIVAL: Page 106 of the pre-filed response to public hearing issues states that Newport Academy continues to work to become an in-network provider with commercial payers in Connecticut.

Aside from single case agreements, have any agreements been formalized to become an in-network provider with any of the major insurers in Connecticut?

MR. PROCOPIO: We have a multi-plan agreement, which covers Connecticut, and we have a first choice agreement that also gives coverage to Connecticut, although, again, to be fully transparent, most of those patients are in the northwest part of the country. It's a national agreement that we have in place.

We strategically have come to the conclusion that we want to be in-network. We've been working diligently over the past two years to gain more in-network agreements, and we have some on the west coast, you know, in some of our other programs.

We've also employed a Chief Payer Officer with whom her sole responsibility is to gain in-network agreements on our behalf.

We've had long conversations with many payers here on the east coast. We just haven't gotten to a place that we've been able to get a signature on the

bottom line yet. I do suspect we will be successful before the end of the year.

HEARING OFFICER MITCHELL: Can you tell me if you're able to -- why is it taking so long to come to an agreement with these payers?

MR. PROCOPIO: You know, it's, as any business arrangement, it's a give and take with the other side, and, you know, again, as someone who has worked in health care for 30-some-odd years, it does take months literally to get an agreement in place with a third party payer.

Now a lot of that is situated around pricing, and a lot of that is situated around if you have a vehicle in place already to give access, like a single case agreement. There isn't always the initiative to get an in-network agreement in place.

MR. CARNEY: Just for curiosity, how long does it take to complete one of the single payer agreements?

MR. PROCOPIO: They are happening literally in a matter of hours now. Again, those relationships with Optimum, Aetna, you know, our folks in our admissions call center know who to speak with, and we are typically able to get those in a matter of hours.

HEARING OFFICER MITCHELL: I have to ask this question.

MR. PROCOPIO: I hope I have an answer.

HEARING OFFICER MITCHELL: Are the single case payer agreements more lucrative than becoming an in-network provider?

MR. PROCOPIO: Today, they are slightly more. Again, they are slightly more profitable than our in-network agreements, but it’s not substantially different.

HEARING OFFICER MITCHELL: Can you give me an idea what you mean by substantially?

MR. PROCOPIO: Ten percent.

MS. RIVAL: Page 106 notes that 97 percent of the reimbursement received by Newport Academy was from commercial payers. What percentage of the reimbursement from commercial payers represents in-network agreements?

MR. PROCOPIO: Twenty-four percent.

MS. RIVAL: Thank you.

HEARING OFFICER MITCHELL: I have a question for the doctor. Is it Dr. --

DR. MENNESSON: Mennesson.

HEARING OFFICER MITCHELL: Mennesson. Got it. Dr. Mennesson, you were talking about it only takes

one yes to have a patient enter treatment with Newport Academy. How do you reduce the risk of them dropping out? Can you talk about the mechanism for that?

DR. MENNESSON: Sure.

HEARING OFFICER MITCHELL: How that works?

DR. MENNESSON: Sure. It's really a relational model. We believe strongly that people, who are feeling connected to the staff they work with and with the other peers that are in the program, have more chance of remaining in treatment.

They see themselves as identical, similar, having commonality with them, and that has reduced drastically any tendency to want to go away. They belong. They have a sense of belonging.

Remember, a lot of them are isolated in their room. They don't go much. Some of them, many of them are depressed, isolating, not leaving their room. They are now beginning to belong to a place, and they don't have to do that choice every single day.

Even if they don't feel like getting up that morning, the staff is there present to them, and they help them engage in treatment. It's been very, very -- yeah, it's been very helpful to do it that way.

HEARING OFFICER MITCHELL: How often, if

any, do your patients or clients, I want to make sure I'm saying it correctly, how often do they drop out or leave?

DR. MENNESSON: So it tends to be usually around critical events; a phone call that doesn't go the way they may have wished, a rupture in an outside relationship, then they all of the sudden say, you know, I want to leave, and then usually, with people talking and reasoning them, they just settle down and come back and stay in treatment, so it's managing the struggles of daily life, and most of them try to rely on avoidance, so working with the engagement and the sense of connection they settle down.

HEARING OFFICER MITCHELL: How often do people leave?

MR. PROCOPIO: I may be able to answer that. So, here in Connecticut, our treatment completion rate is greater than 80 percent, so the inverse of that, obviously, are someone who leaves treatment prematurely, and that's a combination of those who we feel can't comply with the program and, also, parents or individuals who self-select leave, or those who need a higher level of care.

And I apologize. I don't have the statistics for each one of those discharges available.

HEARING OFFICER MITCHELL: I have another question, and it's regarding financial hardship relief. You said that, in terms of financial hardship relief, you have spent 1.1 million in Connecticut. Did I get that right?

MR. PROCOPIO: No, that's not correct.

HEARING OFFICER MITCHELL: Okay.

MR. PROCOPIO: We did provide $1.1 million of free care, uncompensated care, and that would be a combination of scholarships and/or keeping someone in treatment after their insurance ceases to pay for insurance.

The financial hardship, so if a family has a, you know, a large co-pay that they cannot afford, we have a process, where they can fill out an application.

We look at the cost of care versus their adjusted gross income, we look at their total income as a comparison to the poverty level, and then we make a judgment, as to whether or not we can forego their co-pays or deductibles, and that is not included in the $1.1 million.

MR. CARNEY: Is the 1.1 million for Connecticut only?

MR. PROCOPIO: Yes, that's correct.

That's a combination of Bethlehem and Darien.

HEARING OFFICER MITCHELL: I want to ask a couple of questions about continuum of care, after care, and I heard that there are calls that happen weekly, then monthly. What's discussed during those calls, and, if there is an issue that's raised, how is that issue then resolved?

MS. BARNHARDT: So it depends on where that client is in their transition, right? So we do have parent alumni coordinators, as well as alumni coordinators, so those are individuals that reach out to alumni and reach out to parents.

If there's any sort of an issue that arises on that phone call, they will reach out. We generally have consents for the local provider that they're seeing. We'll reach out to the local provider, collaborate with that local provider to help make sure that the client is safe.

HEARING OFFICER MITCHELL: And one thing I heard during the public comment is that the discharge process would be to discharge a patient like a hospital would. Can you speak to that?

MS. BARNHARDT: Yeah, so, I don't really know what it means to discharge a patient like a hospital

would, but I think our process is pretty different, just that clients are with us for a longer length of stay, so we're really able to address all the different emotional issues that's going on with the client; the behavioral issues, the educational issues.

My understanding of hospital discharge planning is just that it refers you to a program, maybe gives the name of two programs that you could go to next, but doesn't actually do that family work, the family contracting, the family agreement, as to what's going to happen next.

It doesn't always look at the educational needs. We're really thorough about what that client is going to be returning to and what exactly that looks like and working with the family and establishing plans.

HEARING OFFICER MITCHELL: And then one other question about the cost of care. So, in the application, it looks like there was going to be $100,000 in kind of, and I'm not saying it the way that you put it in the application, but kind of like a grant that would be given year-over-year that would carry over to the next year to help people, who may be unable to afford for care.

In one of the questions, we asked is how

many patients or clients that would cover in any given year, so the answer was two to three, and I'm just wondering if you can expand upon that and break that down, given the average cost of care is $1,100 per day.

How does that, you know, in terms of the length of stay, how does that kind of pan out?

MR. PROCOPIO: Again, we intend that to be at our cost, our cost, so we would actually apply that against our, you know, potential $800 a day in cost for services, and, so, we would provide services.

Our average length of stay is typically --

HEARING OFFICER MITCHELL: Hold on one moment. Thanks. Okay. Go ahead.

MR. PROCOPIO: All right, so, let me try again. So our intentions with that $100,000 are to provide access to indigent clients. We would apply it against our cost, not our typical reimbursement, and over an average length of stay of 45 days, and that's where I came up with the estimate of, you know, two to three clients per year.

HEARING OFFICER MITCHELL: So that was at the $800 rate that you were talking about?

MR. PROCOPIO: And, again, we don't know. I mean we've created a budget. We don't know

intentionally today what all of our costs will be, but that's just an estimate, based on our history in other markets.

MR. CARNEY: And your average length of stay for the program is 60 days?

MR. PROCOPIO: That would be our hope. I mean that's what we calculated, was I think in the mid fifties, actually, in the application that we submitted. Our average length of stay nationally it varies. In Connecticut last month it was 50 days for our Bethlehem campus.

HEARING OFFICER MITCHELL: All right, so, OHS has concluded with its questions. We are going to take another 10-minute break, then we're going to come back for public comment. Thanks. We're off the record.

(Off the record)

HEARING OFFICER MITCHELL: Public comment. I just want to mention that each person that wishes to speak should have written their name on the sign-up sheet with Leslie Greer, who is standing over to my right and most of your left.

We're going to be calling people in the order in which they signed up to speak, and we're going to give you three minutes each to make your comments.

I just want to reiterate that what we do have the power to consider is whether or not there's a need for this service, whether or not it's cost effective, whether or not it's a quality program, and whether or not it creates access to all Connecticut residents to those services.

I know that some of you want to talk about zoning. I know that this is really dear to your heart. I know that some of you live in the area. I do empathize with you. I empathize with everyone, who has an opinion.

I can't show any preference to either side, but I want to reiterate that we really don't have the jurisdiction or the power to make a decision about zoning issues and whether or not this group home that many are referring to it as whether or not it's appropriate for it to be where it is. We can only consider need, quality, access and cost.

I'm going to go ahead and turn it over to Ms. Greer. She's going to call up the first five commenters.

(Whereupon, public comment was given.)

HEARING OFFICER MITCHELL: All right, so, we have a few additional questions for the Applicant. We're just going to convene for about 10 minutes to get

those questions together, and then we'll come back on the record, so it will be 5:12 when we come back.

MS. RINEHART: May we ask for 15 minutes?

HEARING OFFICER MITCHELL: Yeah, I have no problem with that. So we'll come back at 5:17.

(Off the record)

HEARING OFFICER MITCHELL: Back on the record. All right. Based on the public comment that I heard, I just have a couple of follow-up questions, and then I will let you give closing remarks, and we may have a late file or two.

The first question that I have, based upon what I heard from the public, are questions surrounding the amount of the scholarship that you plan to give to people, who are unable to afford services for whatever reason, and then, also, an assertion that you don't want to serve Medicaid. Can you talk about those two things? Can you respond to those two issues?

MR. PROCOPIO: Sure. First, I mean, service of Medicaid would require a change in policy by DSS and/or DMHAS, in terms of how they reimburse for-profit entities that provide the same level of care that Newport is intending to do.

HEARING OFFICER MITCHELL: When you say

change in policy, what do you mean by that?

MR. PROCOPIO: So we've contacted DSS, and we asked whether or not there is reimbursement available for our level of care and were told that that is not available to us at this time, and our understanding of DMHAS is that they will do grant funding for not-for-profits.

We have, in the past, as I mentioned earlier, worked with DCF to do single case agreements, again, and there have been few, but we've done some with them.

HEARING OFFICER MITCHELL: And I think we asked this before, but is it possible that you could also do that with people, who are covered under Medicaid?

MR. PROCOPIO: Sure. Absolutely.

HEARING OFFICER MITCHELL: Are you willing to do that?

MR. PROCOPIO: Yes.

HEARING OFFICER MITCHELL: And then what about the amount of the scholarship? I don't want to mischaracterize what I heard, but somebody, and this is not my statement, but someone said that it basically was a token, but can you respond to that, please?

MR. PROCOPIO: Sure. I think, for all the

folks, who took the deep dive into our application, you can see our operating margins, based on our budget, are fairly narrow, and, so, we dedicated a piece of that margin back to the community, and we would do that in addition to the free care that we traditionally give at all of our Newport campuses, whether they be scholarships and/or extending stays, when insurance runs out.

(Public disruption)

HEARING OFFICER MITCHELL: Everyone should be quiet in the audience. Thanks.

MR. PROCOPIO: We also have hardship waivers, so, when a family can't afford their co-pay or deductible, there's a process where they can appeal financial relief for those co-pays and deductibles.

There's been a lot of conversation about affordability of our program, and I think I said in my opening remarks our average out-of-pocket for a family in 2019 was $3,200.

HEARING OFFICER MITCHELL: Do you have any proof of that?

MR. PROCOPIO: Sure. I mean what type of proof would you like? Again, I could provide you with the spreadsheet that I got from my finance office. Would that suffice?

HEARING OFFICER MITCHELL: What's on the spreadsheet?

MR. PROCOPIO: It just basically shows I asked the question of our revenue team what is the average out-of-pocket our clients have paid in the past year?

HEARING OFFICER MITCHELL: Can you give it to me for the past three years?

MR. PROCOPIO: I think I can. I don't want to commit to something, again, that we don't financially have and maybe potentially tracked, but I can provide that to you. I would just ask, and it is somewhat proprietary information, if there's a way to do that privately.

HEARING OFFICER MITCHELL: I don't know. Let me just ask a -- let me think about that.

MR. PROCOPIO: Okay.

HEARING OFFICER MITCHELL: Let me just ask another follow-up question. That amount that you're talking about, the $3,200, that is for which programs?

MR. PROCOPIO: That is for across the country. Across the country, all of our programs.

HEARING OFFICER MITCHELL: So I heard someone talk about being -- someone purchasing their own

insurance, that they were, you know, buying it directly, and they would have the inability to pay.

In a situation like that, where someone is having problems meeting, you know, the premiums and would probably not be able to pay a deductible, how do you work with them?

MR. PROCOPIO: So, again, I'll lean back to our financial hardship policy. So our admissions office would work with that individual family, and we would have them fill out that hardship policy and see where it landed, in terms of financial relief.

We look at 300 times the poverty level, and we look at I think it's eight, it's eight percent, 8.1, 8.2 percent of adjusted gross income, and then we also take a look at whether or not there's an immediate crisis in the family.

HEARING OFFICER MITCHELL: Do you ever turn people away, who would otherwise meet the criteria for admission, because they can't pay?

MR. PROCOPIO: We have turned away -- I can tell you that nine percent of our inquiries were excluded from treatment, because of financial limitations. 9.5 last year.

HEARING OFFICER MITCHELL: And then what

happens when they're turned away?

MR. PROCOPIO: Carter's team jumps into play and helps find an adequate resource for them.

HEARING OFFICER MITCHELL: There was also an assertion that you're targeting affluent populations and that you're not interested in assisting kids who are involved in the juvenile justice system, maybe kids who are involved with child welfare. Can you speak to that?

MR. PROCOPIO: Sure. I mean we've done single case agreements with other states that include those types of individuals. We are not targeting the affluent.

I think I, again, earlier in my testimony, we treated only seven clients in the Bethlehem campus, who are pure cash pay, and that's of 473 admissions last year, and I think across all of Newport there were a total of 15 clients that were pure cash pay, and we've done 1,524 admissions last year.

HEARING OFFICER MITCHELL: You addressed this a little bit in your application, but can you talk about why you're not seeking licensure from the Department of Public Health to serve or provide services to people specifically with substance use disorders?

MR. PROCOPIO: Sure. We have that

capability at our Bethlehem campus today. You know, again, nationally, I apologize, I don't have it specifically for Connecticut, but about six percent of our clients, who come to us for care, are primary substance use clients. Another 21 percent are secondary co-occurring substance use disorders.

We have that capability in our Bethlehem campus. We decided that we were specifically going to focus on mental health diagnosis here in Fairfield, but that doesn't eliminate someone, who has a co-occurring condition for substance use.

HEARING OFFICER MITCHELL: Is it your opinion that you can serve them as well without the DPH licensure?

MR. PROCOPIO: I think we can, yes.

HEARING OFFICER MITCHELL: On what basis?

MR. PROCOPIO: Based on our experience. As I think I mentioned earlier, 69 percent of the folks, who come to us for care, are a primary diagnosis of major depressive disorder. Nine percent of them are anxiety disorders.

HEARING OFFICER MITCHELL: Have you had discussions with DPH Facilities Licensing & Investigations Unit to determine whether or not that's

the case?

MR. PROCOPIO: We have not, no.

HEARING OFFICER MITCHELL: There were questions, as well, about regulatory oversight. You talked about the Bethlehem location being subject to oversight by the Department of Children and Families.

Are there any other agencies that would be providing oversight of the programs, both of them?

MR. PROCOPIO: Sure. So DPH, the Department of Public Health, also will be licensing this individual facility, and we will obviously seek Joint Commission accreditation, as well.

In addition to those outside regulatory bodies that license us and supervise the care that we deliver routinely on an annual basis, sometimes every six months, we also have internally significant assets dedicated to compliance.

We have a compliance office that looks at how we are living up to our standards that we set in our own policies and procedures.

We have our Chief Clinical Officer works under the model of fidelity to the model. We ensure that the treatment program is being delivered as it's designed. She looks at all of our programs on a

quarterly basis, and, again, if there's any opportunities for improvement, we act on those.

We have Carter, who is sitting to my left, as our Chief Experience Officer, and her job is to ensure that the client experience and the family experience meets the expectations that we set for ourselves, so we have a robust internal process, and then, of course, we're regulated by all the licensing bodies, and, on top of that, we have Joint Commission oversight, as well.

HEARING OFFICER MITCHELL: Someone also pointed out that your use of the wait list at the Bethlehem location was irrelevant, because of the fact that the age difference between that program and the proposed program is different. The age range, not the age difference.

The age range is different, and then, in addition, they pointed out that a lot of them aren't Connecticut residents, so I'm talking kind of about two things when it comes to how you're going to fill the proposed program and kind of meet the requirement that you're serving Connecticut residents. If you could address that?

MR. PROCOPIO: Sure. So, first, on the wait list, the wait list someone described that, if we

initially put in 20, 17 to 20, it has literally ballooned in the back half of last year and continues to rise.

The highest our wait list has ever been is 150, and that literally was about two or three days ago, and, again, that's company wide.

Our wait list in Connecticut for our Bethlehem campus was 65 last night, and there were 11 clients on that or potential clients on that wait list from the state of Connecticut.

Access is really an interesting topic, in terms of who we provide access to, so, typically, when a young person goes on our wait list, it's just systematic.

The next person moves up. We contact the family. We have a bed, you know, here in Connecticut. We have a bed in California. We have a bed in Washington State.

This is what we think your insurance, you know, your co-pays and deductibles will be, based on where you choose to go, and you can accept that bed or not, and, so, we don't discriminate, based on where someone comes from, in terms of providing access to treatment.

I was having a conversation with a neighbor, and she said, well, can't you just give

Connecticut folks priority access to treatment, and I think that's a little bit of a slippery slope, in that, you know, if you have a kid, who is from, you know, 26 miles away in New York and he's sitting on the wait list for two weeks and he has suicidal ideations and you want to bump him with somebody who is new, because they're from Connecticut, that's a really difficult clinical decision for us to make.

If everything were equal, we would provide access to Connecticut folks first, but we have to take into consideration the acuity of the folks, who are coming to treatment for us, and how long they've been sitting on a wait list waiting for a bed.

HEARING OFFICER MITCHELL: So the next thing I want to talk about is need, so people have been raising issues surrounding need.

They say that there are already other places in Connecticut that can serve this population. Can you talk about why you feel like the proposed program is needed in Connecticut?

MS. BARNHARDT: So, as I spoke about this morning, really what we get a ton of calls for are local Connecticut families that are looking for primary mental health services.

In order to qualify for the treatment centers that do exist currently in the state, either you have to have a primary eating disorder diagnosis, a primary substance use disorder diagnosis, which many of our patients, even if they're smoking weed, they may not meet criteria for an SUD diagnosis, have true levels of dependence, or it has to be someone whose -- the primary mental health facilities all require out-of-pocket payments, so there's no availability right now within the state.

Even Institute of Living, one of the biggest programs here in Connecticut, said that this is a problem that they're facing every single day, is that they cannot find residential treatment centers that are able to treat clients from Connecticut using their insurance that have a primary mental health diagnosis.

HEARING OFFICER MITCHELL: And then I think --

MS. BARNHARDT: And I can go through all the -- I have all the programs here in Connecticut. I'm happy to go through all of them and kind of highlight which one does which, if you would like, if that would be helpful.

HEARING OFFICER MITCHELL: Can we talk

about the ones in your service area?

MS. BARNHARDT: Yeah. Yes.

HEARING OFFICER MITCHELL: Then I would.

MS. BARNHARDT: So like Silver Hill Hospital?

HEARING OFFICER MITCHELL: Yes.

MS. BARNHARDT: Okay, so, Silver Hill Hospital has an inpatient program. It's a three to seven-day program. They're actually one of our largest referral sources in our Bethlehem campus, because they often treat clients for three to seven days, and then are in need of a step-down program to a residential treatment center.

The only programs that they offer are all out-of-pocket for an average of about $50,000. With insurance benefits, it goes down to about $47,000 per month for the residential.

They are a non-profit, but, in order to qualify for a scholarship in their program, you have to be in their program, and then you can maybe get a scholarship for another week or two once you're there, so we get a lot of referrals from Silver Hill for residential treatment, because we're able to work with those clients and with their insurance.

Rushford, Rushford requires a primary substance use disorder diagnosis. Mountainside we work with well. We love Mountainside. They also require a primary substance use diagnosis. And many of the clients that we treat that are ages 18 to 20 just don't meet criteria for that SUD diagnosis.

They don't require detox. They're people, who are maybe at home smoking weed, but don't reach true levels of dependence.

Turnbridge is another one that's come up a couple of times today, so Turnbridge also requires a primary SUD diagnosis. They only provide IOP level of care.

They do have a transitional living facility, so you're able to live there, but the transitional living facility is an out-of-pocket cost to families, typically around $10,000 per month, and that's a 12-month program, so around $100,000 to $120,000.

HEARING OFFICER MITCHELL: Okay, so, just a couple more questions.

MS. BARNHARDT: Oh, sorry. Angelus House. Angelus House is another big one, another great program. They're a non-profit. They're part of Wellspring. They treat primary mental health clients, however, they do not

accept insurance, so it's $390. Eli's House, $390 per day.

There's Eli's House, which is a part of IOL, and you have to get a referral from the State, from the Department of Mental, I believe. DCF into DMHAS into Eli's House.

HEARING OFFICER MITCHELL: So just a couple of questions on the quality, and, so, I heard a comment about one of the pieces of -- one of the studies that you provided us that basically says that six to 12 months is the, I guess, the best amount of time I want to say.

I might be mischaracterizing it, but six to 12 months is kind of the necessary amount of time for someone to receive benefit from a residential facility. Did you hear that comment?

MS. BARNHARDT: I heard the comment, but I thought they said it was up to six to 12 months. I'm not sure which article it points to.

HEARING OFFICER MITCHELL: Maybe you can -- I was going to say, Doctor, maybe you can kind of respond to the number of days that your organization recommends and how that works, in terms of -- or how that falls in with this study that was provided in the

application.

DR. MENNESSON: Sure. I don't have it in front of my eyes, but I'm pretty sure it's a study that at least is 15 years old, or something like that.

HEARING OFFICER MITCHELL: Okay.

DR. MENNESSON: Where, at that time, all treatment were much longer, and they trend as being both from inpatient to residential to shortening the length of stay driven by the pressure put by insurance to have the treatment done faster and faster, so there's this tension where, clinically, you know, it would be clear that some -- there will be some benefit to continuing to treat residents in all programs around the country, not just in Newport, but there is not a commitment from a society to provide that kind of work and that kind of coverage.

Now, so, the moral shifted from doing work from six to 12 months in a residential. A lot of it is engaging the person into treatment within this 45 to 60 days engaging them in treatment, so imagine you have someone, who doesn't want treatment, doesn't think there's anything wrong with them, and, within 45 to 60 days, can you get them motivated to really take on the work of doing the, you know, taking care of themselves, definitely.

That's the work that is done, and then there's a continuation of care with PHP, IOP, or outpatient treatment, and then, also, engaging the family in a different dynamic, because a lot of mental health gets reinforced by those constant conflicts at home, fighting and parents misunderstanding, and if we are a relational model, to the extent that there's constant fighting going on in the background, it's contributing to the worsening of depression, anxiety, substance use, etcetera.

So by trying to do a fair amount of work upfront, the hope is that the improvement will continue over the months when they are in the less restrictive environment.

MS. BARNHARDT: As a program, we do believe in a continuum of care for all of our clients. For local Fairfield County clients, we do have a PHP and IOP for young adults in Darien.

We do believe that a continuum of care is very important. We try to have that for all of our clients, regardless of where they're discharging to, setting up after care resources, a thorough after care plan that includes clinical, as well as educational, emotional needs and fun activities to keep them

motivated.

HEARING OFFICER MITCHELL: Okay and can you also talk about your quality initiatives? Can you talk about some of the assertions that you haven't met the threshold to establish that your program is a quality program, that the information that was provided was self-serving?

MR. PROCOPIO: It's a little bit difficult to respond to. I mean the quality of the information is from our clients, themselves, and, so, those three outcome studies that we've done that measure depression, anxiety and wellness are by self-report, and that's how they're intended to be, by self-report.

I'm not a statistician that can debate. You know, we had Vanderbilt University look at that study, and the opposers had someone from Columbia. I guess we can get their resumes together and figure out which of the two are smarter, but what I do know with absolute certainty is that the number of clients, who completed the outcome study, over 700 of them, measured significant wellness.

And, so, if we can impact the quality of 700 young people over the course of two years, I think that that's pretty impressive from my perspective.

So, in addition to measuring quality with the customers, themselves, we measure quality with our reference, we asked them for feedback about their clients' treatment stay, and the majority of our business comes from professional reference in the community.

We measure family surveys. We do client satisfaction surveys to measure quality. We look at, you know, we have key performance indicators, where we look at, you know, the number of incidents that may occur on a particular location.

We use our national database to determine how to make those -- our facilities safer and to improve care. We look at discharge rates, in terms of how many of our clients successfully complete treatment, so there's a whole myriad of statistical indicators that we follow with the purpose of, you know, again, finding opportunities to do better and improve care.

And, so, we study quality very seriously, and then, overarching all of it, we got the State DPH, DCF, and we've got Joint Commission, and they all look at, you know, quality factors and determine whether or not we're a viable program, and, today, all of our licenses across the country are in good standing.

We're fully certified at all of our

programs by the Joint Commission, so I think we have a lot on the quality side that I would hope that OHS would appreciate.

DR. MENNESSON: There was a question about why we use self-report. Self-reports is different than just asking a person how they're doing, because it's not always standardized.

In a self-report, there are very standard questions that have been tested, over 1,000 answers, and we have -- we note by that that that person reporting that improvement is somewhat significantly better or not, so it's a way of standardizing the subjective impression of the person, so that person ultimately saying I'm less depressed, I'm less anxious, and I'm feeling better. That's what self-report does.

Now you could argue that maybe it should be done by an outsider, but then you will have the argument that the outsider has advised full, good outcome, and, ultimately, it's somewhat better to rely on that person's subjective experience, who say I'm feeling less depressed.

HEARING OFFICER MITCHELL: Okay.

DR. MENNESSON: Those PHQ-9 and GAD-7 and all that are very well standardized around the world. I

would say it's very well-established as measures of anxiety and depression.

MS. BARNHARDT: Joe touched on, too, the client survey, in terms of the client experience and the family experience, so we survey our clients throughout the treatment experience, so when they first get there, during the middle of their stay, I think it's at day 21 of day 45, and then at day of discharge.

HEARING OFFICER MITCHELL: And these are all standardized?

MS. BARNHARDT: Yeah.

HEARING OFFICER MITCHELL: Okay.

MS. BARNHARDT: Yeah, and we're tracking client satisfaction and family satisfaction and are able to make really immediate changes if we need to. Luckily, we normally score pretty high. Our kids complain about no sugar, but, other than that --

HEARING OFFICER MITCHELL: All right. We do not have any additional questions, but I'm going to actually turn it over to counsel for the Applicants, in case there's anything that she wants to add to the record, or any closing remarks that she wants to make.

MS. RINEHART: Thank you very much. We really appreciate the opportunity to have a chance to

speak to you today about this important program.

I think we've heard a lot of comments that were raised on speculation, but those people, who have had a direct experience with this program, have come in here to tell you the amazing life-changing impact that this had.

The data on need is overwhelming, and the HUD report indicated that the need is even more severe among patients who have commercial insurance than it is in many cases among those who are on Medicaid for DMHAS, because there are special programs for them, whereas many programs, as we've heard, do not take any commercial insurance, so there is a huge need for people with insurance, and this program is very unique in the way that it works with insurance.

So we do believe that the need is overwhelming. The quality data is overwhelming. There has been no contrary evidence.

There is just an overwhelming and crushing need for this type of service that's transformative to the lives of those that it touches, and we really appreciate the opportunity to present the program and hope that you will grant the CON application.

HEARING OFFICER MITCHELL: Thanks. I just

have possibly two late files for you. I just want ask, when you guys keep track of your wait list, do you track age, gender, those types of things?

MR. PROCOPIO: Yeah. Yes, we do. We do both.

HEARING OFFICER MITCHELL: So for your current wait list, you said, I believe, there are 65?

MR. PROCOPIO: Yes. For Bethlehem today?

HEARING OFFICER MITCHELL: Yeah.

MR. PROCOPIO: Yeah.

HEARING OFFICER MITCHELL: So can you provide us with information regarding the gender, town of residence and age for that wait list?

MR. PROCOPIO: Yes, we can.

HEARING OFFICER MITCHELL: All right and then, additionally, we're looking for some evidence over the last three years of the average out-of-pocket cost.

MR. PROCOPIO: Okay.

HEARING OFFICER MITCHELL: I know that you raised some issues with regard to competitive information. Let me ask counsel. Do you have any concerns about that? Is there any way that you think that you can get us that information without --

MS. RINEHART: I think we need to see what

data exists and what form it's in, and we can certainly do something like an affidavit from the CFO, confirming the average out-of-pocket cost.

HEARING OFFICER MITCHELL: All right. I really want to see how that is derived. I don't want to put you at risk for any type of confidential, private, competitive information, but this is something that we're interested in, because this has been raised multiple times throughout the hearing, and it's a huge issue that I know that I have to be able to justify to the Executive Director if she's going to sign a decision related to that, so I will leave the record open for seven days, so that you can provide information, both on the wait list and then, also, on the out-of-pocket cost, so we're looking for a three-year trend.

Any questions that you have about that?

MS. RINEHART: No. I guess just one question, in terms of the wait list.

HEARING OFFICER MITCHELL: Yes.

MS. RINEHART: One thing that is helpful to understand is that, if these programs were allowed to open, because, currently, there is a small overlap in the age groups served, it's not just the wait list that matters. It would allow rebalancing of the ages served,

so, potentially, folks that are currently in the program, not on a wait list, would be able to move, you know what I mean?

HEARING OFFICER MITCHELL: Forward to the new program, if it was open?

MS. RINEHART: You have more focus on the 14 to 18 year olds in Darien, taking some of the 18 to 20 year olds that may not be on a wait list, but may be currently served out of that population and moving them over.

I'm not saying, obviously, current people would be moved, but, in the future, it would allow them to focus more and to serve more of the folks that are on the wait list in both age groups.

MS. BARNHARDT: I also think it's important to note that the clients that we're serving right now professionals in the community know us as treating clients up to age 20.

HEARING OFFICER MITCHELL: Right.

MS. BARNHARDT: So they're not sending us clients that are 21 to 26 years old. We would have more people.

HEARING OFFICER MITCHELL: I think we're interested in a couple of things, so one of the things is

how many of the people on the wait list are actually from Connecticut, because that was raised, so we're looking at that, and then, you know, while we're talking about it, I'm kind of backtracking, I know that we were talking about late files, but this is one thing that I think I forgot when I was asking questions, so I just want to make sure that I ask you this.

So it was brought up that a lot of your advertisement, you know, kind of would appeal to people, who are out of state, and, so, is there anything that you can say about that, because the overarching concern is that your program might be tailored, according to some people's opinions, to people, who are not in Connecticut, so, you know, I think that this is something that we want to make sure that we cover.

MR. PROCOPIO: Sure. So, on that same website where that information was derived, in that back of that, you'll see a map that shows where all of our clients came from. It's like a map of the United States, and you'll see there's a significant density around our facilities.

Typically, the majority of our clients come from a three-hour radius of where we are.

MS. BARNHARDT: We do make parents, also -

- parent participation is mandatory in treatment, so, if they're closer, they're able to participate in a more meaningful way.

HEARING OFFICER MITCHELL: Okay. All right. I don't have any additional questions. Anything additional from the Applicant?

MR. PROCOPIO: I just would like to make one comment to our families, and I know most of them have left who came, just the, again, and I think others have said this and not to sound redundant, but the courage that they showed to come and talk about their personal experience and share what little part Newport had in their treatment, because, really, the young people are doing all the work.

We get them started on the right path, but those young people, who came in and spoke about their treatment experience with us and how it has helped them in their life, I just wanted to thank them for standing up in a really difficult circumstance and talking about the care they received.

MS. RINEHART: Thank you very much.

HEARING OFFICER MITCHELL: Thank you. So the hearing is now adjourned. We're going to keep the record open for seven calendar days, that would be March

11, for the production of late files. Thanks, everybody.

(Whereupon, the hearing adjourned at 5:51 p.m.)

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify and attest that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinto set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness, whereof I have hereunto set my hand and do so attest to the above, this 10th day of March, 2020.

Paul Landman
President

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