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STATE OF CONNECTICUT

OFFICE OF HEALTH STRATEGY

DOCKET NO. 24-32699-CON

UCONN JOHN DEMPSEY HOSPITAL

APPLICATION FOR INCREASE IN LICENSED-BED CAPACITY

BEFORE HEARING OFFICERS:

W. BOYD JACKSON, OHS DIRECTOR OF LEGISLATION AND REGULATION

DANIEL J. CSUKA, ESQ., OHS STAFF ATTORNEY

DATE: July 11, 2024
TIME: 9:00 a.m.
VIA: In Person/Zoom

REPORTER: ALEXA A. BUDIHAS, RPR/CRR

A P P E A R A N C E S

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IN ATTENDANCE:

ANNALIESE FAIELLA, CON TEAM LEAD
NICOLE TOMCZUK, HEALTHCARE ANALYST
FAYE FENTIS, OHS PARALEGAL AND SUPPORT

I N D E X

WITNESSES:

ANDREW AGWUNOBI
KURT BARWIS
CHAD BIANCHI
BRIAN GIBBS
CHRIS HYERS
CARYL RYAN
THOMAS STRATMANN

E X H I B I T S

*** Original exhibits retained by OHS ***

(The proceedings began at 9:04 a.m.)

MR. CSUKA: Good morning, everybody. The University of Connecticut John Dempsey Hospital has filed a Certificate of Need Application seeking to increase its Licensed Bed Capacity by 23 medical-surgical beds.

In its application, the Hospital represents that it is filing this application in response to a sustained increase in overall patient volume resulting in the medical-surgical census being over the 80% threshold 7 times in the past 12 months. The anticipated capital expenditure for the project is $1,100,000.

Today is July 11th, 2024. My name is Daniel Csuka. It is 9:05 a.m. I am a staff attorney with the Office of Health Strategy. To my side is the hearing officer, who I will invite to introduce himself now.

HEARING OFFICER JACKSON: Good morning. I am W. Boyd Jackson. I'm the Director of Legislation and Regulation at the Office of Health Strategy.

For clarity, based on what I've seen in the prefile testimony, I am a member of the District of Columbia Bar. I am in the application process with the Connecticut Bar. So, since we're sitting in Connecticut, please stick with Mr. Jackson rather than

Attorney Jackson.

MR. CSUKA: Thank you. So, although I am here to assist and provide legal counsel, Hearing Officer Jackson will be presiding over this matter. He will rule on all motions and will issue a decision that includes findings of fact and conclusions of law upon completion of the hearing.

This is a hybrid hearing. By that, I mean it is being held both in person and electronically via Zoom in accordance with Section 1-225a of the Connecticut General Statutes.

Any person who is participating orally via the electronic component of this meeting shall make a good-faith effort to state his or her or their name and title at the outset of each occasion that such person participates orally during an uninterrupted dialogue or series of questions and answers.

I don't believe we have any witnesses testifying through the Zoom. Is that correct?

MS. FELDMAN: Correct.

MR. CSUKA: Okay. Sign-up for public comment will be from 11:00 a.m. to 12:00 p.m. If you would like to supply commentary, please sign up either in person or in the Zoom chat box at the designated time. You can also submit written comments to

CONComment@CT.gov for up to seven days from today.

Please note that the time set for commencement of public comment, 12:00 p.m., is advisory only. The public comment portion of the hearing shall not commence until after the technical portion of the hearing is concluded, provided, however, that an allowance of up to one hour may be made for the received comments from public officials or members and any other entity with status of the hearing and clinicians only.

For anyone attending remotely, unless you are actively participating in the hearing, either as one of the Applicant's or Intervenor's witnesses or as a member of the public providing comment at the designated time, please mute the device that you are using to access the hearing and silence any additional devices that are around you. I would ask that everyone in this room also make sure that their devices are also silenced.

This public hearing is held pursuant to Connecticut General Statutes Section 19a-639a(e). As such, this matter constitutes a contested case under the Uniform Administrative Procedure Act and will be conducted in accordance therewith, along with the regulations of Connecticut General Statute -- excuse

me -- regulations of the Connecticut State Agencies beginning at Section 19a-9-24.

Mr. Jackson will be asking the bulk of OHS' questions. Other OHS staff and members are also here to assist us related to the gathering of facts in the application and may also be asking Applicant witnesses questions. We may also have some questions for the Intervenor as well.

At this time, I am going to ask each staff person up here to identify themselves with their names, spelling of their last name, and their OHS title.

MS. FAIELLA: Good morning. My name is Annie Faiella, F-A-I-E-L-L-A, and I am the CON team lead.

MS. TOMCZUK: Good morning. My name is Nicole Tomczuk, T-O-M-C-Z-U-K. I'm a healthcare analyst.

MR. CSUKA: Thank you. And also present over there in the corner is Faye Fentis. She is a paralegal and a staff member of the -- of OHS. She will be assisting us with hearing logistics, gathering of names for public comment, and providing miscellaneous other support.

The Certificate of Need process is a regulatory process; and as such, the highest level of respect will be afforded to the Applicant, the

Intervenor, members of the public, and our staff. Our priority is the integrity and transparency of this process. Accordingly, decorum must be maintained by all present during these proceedings.

This hearing is being transcribed and recorded, and the video will also be made available on the OHS website and its YouTube accounts. All documents related to this hearing that have been or will be submitted to OHS are available to review through our Certificate of Need portal, which is accessible on the OHS CON website.

In making a decision, Hearing Officer Jackson will consider and make written findings in accordance with Section 19a-639 of the Connecticut General Statutes.

Lastly, I wish to point out that by appearing on camera in this hybrid hearing, you are consenting to being filmed. If you wish to revoke your consent, please do so at this time by exiting the Zoom meeting or this hearing room.

I'm going to start by going over the exhibits and the items of which we are taking administrative notice. And then I will -- I will ask whether there are any objections. The CON portal contains the prehearing Table of Record in this case. At the time

of its filing two days ago, exhibits were identified in the table from A to Z. Yesterday, a public comment was received from one of the UConn unions, which is Exhibit AA.

Does anyone from OHS have any additional exhibits that they would like to enter into the record at this time?

MS. FAIELLA: Not at this time. Thank you.

MR. CSUKA: Counsel for Applicant, can you please identify yourself for the record. And be sure to unmute yourself on the mic. Sorry. The gray -- the standing mic. The gray button.

MS. FELDMAN: Good morning. My name is Joan Feldman, and I am with the law firm of Shipman & Goodwin.

MR. CSUKA: You might want to bend it a little towards you.

MS. FELDMAN: How's that? Better?

MR. CSUKA: That's better. Thank you.

Counsel for the Intervenor, can you please identify yourself for the record?

MR. VOZZA: Good morning. David Vozza with the law firm of Norris McLaughlin.

MS. JARVA WEISS: Also Sandra Jarva Weiss with Norris McLaughlin.

MR. CSUKA: Thank you. Attorney Feldman, are there any objections to the exhibits we have just gone over?

MS. FELDMAN: No objections to the exhibits we just went over. However, I would like to add some exhibits.

MR. CSUKA: Attorney Feldman, just make sure that your mic is on.

MS. FELDMAN: It's on.

MR. CSUKA: Is it lit up green?

MS. FELDMAN: Yes. I'll make sure I'll speak into it.

MR. CSUKA: I'm not sure what's going on, but I'm being told that you guys are -- they're not picking up your voices.

MS. FELDMAN: Can you hear me now?

MR. CSUKA: Okay. Yes.

MS. FELDMAN: Okay.

MR. CSUKA: Sorry about that. So, we'll get into those exhibits in a moment. The ones that we have identified and marked as exhibits are all entered as full exhibits at this time.

(Exhibits A through Z and Exhibit AA admitted into evidence.)

MR. CSUKA: Attorney Feldman, you indicated

that you have some additional exhibits that you wanted to enter. Can you run us through those?

MS. FELDMAN: Yes. The first exhibit is the Statewide Healthcare Facilities and Services Plan for -- issued in June of 2024 by OHS.

MR. CSUKA: Do you happen to have copies of that for the Intervenor as well?

MS. FELDMAN: No. It's publicly available on the OHS web page.

MR. CSUKA: Okay. So, if you're going to be referencing specific pages from that, we would ask that they be provided --

MS. FELDMAN: I will make sure --

MR. CSUKA: -- either copied or we can take a break and they can pull it up on their computers.

MS. FELDMAN: Okay. I don't think I'll be referencing specific pages.

MR. CSUKA: Okay.

MS. FELDMAN: Okay. The second --

MR. CSUKA: That will be Exhibit BB, as in boy.

(Exhibit BB admitted into evidence.)

MS. CSUKA: You can continue. I apologize.

MS. FELDMAN: Thank you. The next exhibit is the Annual Report on the Financial Status of

Connecticut Short-Term Acute Care Hospitals for Fiscal Year 2022. I do not have copies. Again, this is available, publicly available on the OHS website. And I believe it's the source for statements made by the Intervenor.

MR. CSUKA: Okay. And do you anticipate asking specific questions about -- from specific pages within that document?

MS. FELDMAN: Yes.

MR. CSUKA: Okay. So, we'll have to make sure that they have a copy of that. It sounds like they may have submitted that as part of their prefile submissions or at least --

MS. FELDMAN: I believe so.

MR. CSUKA: Okay. So, that will be Exhibit CC.

(Exhibit CC admitted into evidence.)

MR. CSUKA: Continue.

MS. FELDMAN: My next exhibit would be a document that I have shared. It is information from the RAND Corporation website. The link is on that page along with the authors of the study. It was issued in May of 2024, and it reflects 2022 payer data.

MR. CSUKA: Okay. That will be Exhibit DD.

(Exhibit DD admitted into evidence.)

MS. FELDMAN: My last additional exhibit for today is -- has been shared with the Intervenor and OHS staff. And it is a document that the Applicant has created based on CHIMEData. And it reflects the CMI for several hospitals, including John Dempsey Hospital and Bristol Hospital. And CMI stands for Case Mix Index.

MR. CSUKA: Okay. That will be Exhibit EE.

(Exhibit EE marked for identification.)

MR. CSUKA: And thank you for identifying what the acronym stood for. For anyone in this room testifying today, please try to your best ability to identify any acronyms as you may use.

Do you have any other exhibits that you wanted to enter?

MS. FELDMAN: No, I don't at this time.

MR. CSUKA: Okay. Thank you.

And Attorney -- was it Vozza? Vozza?

MR. VOZZA: Vozza.

MR. CSUKA: Vozza. I apologize. Do you have any additional exhibits you would like to enter at this time?

MR. VOZZA: Not at this time.

MR. CSUKA: Okay. Thank you.

The parties are hereby advised that we are

also taking administrative notice of the following: The Statewide Healthcare Facilities and Services Plan and its supplements. The Facilities and Services Inventory. The OHS Acute Care Hospital Discharge Database. The All-Payor Claims Database Claims Data. Hospital Reporting, that is HRS, Financial and Utilization Data. And the Hospital's Community Health Needs Assessments.

We are also taking administrative notice of the following CON dockets. Docket Number 20-32392-CON, in which Encompass Health Rehabilitation Hospital of Danbury sought to establish a 40-bed chronic-disease hospital providing inpatient physical rehabilitation care.

Docket Number 22-32533-CON, in which Connecticut Children's Medical Center sought to increase its Licensed Bed Capacity for purposes of building a medical and psychiatric inpatient unit.

Docket Number 22-32554-CON, in which Connecticut Children's Medical Center sought to increase its Licensed Bed Capacity for purposes of expanding its NICU services. And I should say that the -- that's an acronym for neo -- I think it's Neonatal Intensive Care Unit? Is that correct?

HEARING OFFICER JACKSON: Right.

MR. CSUKA: Thank you. And then Docket Number 23-32657-CON, in which MidState Medical Center sought to increase its Licensed Bed Capacity for purposes of adding 16 medical-surgical beds.

Attorney Feldman, are there any objections to the administratively noticed documents or dockets?

MS. FELDMAN: No objection.

(Administrative Notice Taken of the Preceding.)

MR. CSUKA: Thank you. As the hearing progresses, we may also take administrative notice of other information, including prior OHS decisions, agreed settlements, and determinations that may be relevant but which have not yet been identified.

We will proceed in the order established in the agenda for today's hearing. I would like to advise the parties that we may ask questions related to your prehearing submissions that you feel may have already been addressed. We will do this to ensure the public has knowledge about your proposal and for purpose of clarification. I want to reassure you that we have reviewed the docket and we will do so again before issuing a decision.

As this hearing is being held in hybrid fashion, we ask that all participants attending via Zoom enable the use of video cameras when testifying or

commenting remotely during these proceedings.

All participants and the public shall mute their devices and should disable their cameras when we go off the record or take a break. Please be advised that although we will try our best to shut off the hearing recording during breaks, it may still continue. If the technology continues to run, any video and audio that has not been disabled will be accessible to all participants.

As I said earlier, public comment taken during the hearing will likely go in the order established by OHS during the registration process; however, we may allow public officials to testify out of order. Registration, again, for public comment will begin at 11:00 a.m. If the technical portion of the hearing has not been completed by 12:00 p.m., public comment may be postponed until the technical portion is completed.

The Applicant's and the Intervenor's witnesses must be available after public comment, as OHS may have additional questions based on the public comment.

Attorney Feldman, are there any other housekeeping matters or procedural issues you would like to address before we start?

MS. FELDMAN: No.

MR. CSUKA: Thank you. And Attorney Vozza, do you have anything else that you would like to address before we start?

MR. VOZZA: Only that I don't believe we filed a copy of Exhibit CC, so if you do have pages which are relevant to questions, if you can provide those, I'd appreciate it.

MS. FELDMAN: I'm sorry. I didn't understand the comment.

MR. CSUKA: Exhibit CC was not filed by Bristol Hospital as an actual exhibit. So, to the extent that you're referring to specific pages in the course of questioning, he would just ask that we make those available to them.

MS. FELDMAN: Exhibit C?

MR. CSUKA: CC, the Annual Report on Financial Status --

MS. FELDMAN: Oh, okay.

MR. CSUKA: -- excuse me -- for fiscal year --

MS. FELDMAN: Okay. Okay. Sure. No problem.

MR. VOZZA: Thank you.

MR. CSUKA: Let's see. So, I believe we are

ready to begin the technical portion, then. The way this will work is we will start with the Applicant, an opening statement.

Attorney Feldman, if you have any direct questions for your witnesses at that time, you can ask those. Then we'll allow cross-examination and then redirect if there's any redirect.

We will then turn our attention to the Intervenor's case-in-chief, and then you'll have an opportunity to cross-examine, and then you will also have an opportunity for redirect.

And then OHS will have their own questions tacked onto the end of that. Attorney -- excuse me -- Mr. Jackson may have some questions that he asks in the course of your own questioning. Those may just be made as interjections or interruptions. But we will try not to derail things too much with that line of questioning.

So, Attorney Feldman, can you please identify all the individuals by name and title who are planning to provide opening remarks?

MS. FELDMAN: Absolutely. I'm going to make opening remarks. My name is Attorney Joan Feldman. And I am with the law firm of Shipman & Goodwin. And I am Counsel for John Dempsey Hospital. With me today is

the CEO of UConn Health, Dr. Andrew Agwunobi, to my left. And he will be the first to provide his prefile testimony.

Also with me is Caryl Ryan, who is the Chief Operating Officer for JDH, Chief Nursing Officer, and Vice President of Patient Services and Quality. And she will be providing her prefile testimony after Dr. Agwunobi.

And then third, we will be receiving expert testimony from Doctor -- Professor Stratmann, who is a Distinguished Professor in Economics at George Mason University. Those are our three witnesses.

MR. CSUKA: Thank you. And to the extent that you call upon anyone else behind you to make statements, we will swear them in if necessary.

So, I'm going to ask that the three individuals who you just identified please raise their right hand.

(ANDREW AGWUNOBI, CARYL RYAN, AND THOMAS STRATMANN, having first been duly sworn by Daniel J. Csuka, Esq., OHS Staff Attorney, were examined and testified as follows:)

DR. AGWUNOBI: I do.

MS. RYAN: I do.

MR. STRATMANN: I do.

MR. CSUKA: Let the record reflect that they all affirmed their agreement with that.

So, the Applicant may now proceed with its testimony. When giving testimony, make sure you state your full name and adopt any written testimony you have submitted on the record prior to testifying today.

And Attorney Feldman, you can begin. I apologize for that.

MS. FELDMAN: Thank you. Good morning, Hearing Officer Jackson and OHS staff. Thank you for the opportunity to make opening comments.

As you stated, the purpose of today's hearing or proposal before you is for JDH, or John Dempsey Hospital -- and I will refer to it as JDH throughout -- to add 23 medical-surgical beds, less than 10% of its licensed beds, all of which are currently staffed.

This application is not about thwarting competition or JDH attempting to gain market share from other providers. It's also not about JDH's failure to implement operational improvements that facilitate throughput throughout the hospital. It's also not about seeking approval to reallocate its beds from other much-needed service lines. We need all of our beds.

It is about serving the needs of the patients

who choose with their feet John Dempsey Hospital. It is also about keeping patients safe and reducing emergency department boarding.

You'll hear from two clinicians today regarding the dangers of extended boarding in an emergency department, which has been recognized by way of the Joint Commission, which has set the standards with respect to permissible time in an ED.

I'd like to start with just a brief history of the current OHS Bed Need Methodology. I'm probably the only one here who is -- well, other than maybe Kurt -- 13 years ago, OHS Staff Member Brian Carney was instrumental in helping the State of Connecticut develop its OHS bed need, the methodology. It did so by turning to other states and finding common elements in those other states.

What Brian Carney found and reported back to the subcommittee was that most states allow hospitals to increase their bed capacity without a CON, allowing for the hospital to self-correct in response to surges in volume. He also found that a Bed Need Methodology should not be subject to precipitous elimination of beds in an arbitrary manner or politicalization, meaning -- what I mean, and what I think they meant, was one hospital opposes another hospital obtaining

beds that are demonstrably needed, not to split-the-baby-in-half approach.

The Bed Need Methodology should consider the Affordable Care Act. So, this was implemented in 2011. As you know, the Affordable Care Act was adopted in 2010. Incorporated in the Affordable Care Act is the concept of value-based care, which reverses the incentives for hospitals to control utilization with things such as value-based care, DRGs, risk-based contracts.

Most importantly, it was conclusive that additional factors should be considered when evaluating bed need, the specific needs of the hospital. Unfortunately, and this is obviously my observation and my opinion, the current OHS Bed Need Methodology shows little evidence that these dynamic factors are incorporated into the analysis. Instead, what we see is a total reliance on numbers.

Also, the Bed Need Methodology was to be reviewed every five years with updates to make objective changes based on the dynamic changes in the industry. It's clear to me that at the inception of this Bed Need Methodology, which was barred from other states, the intentions of OHCA, now OHS, were to be more responsive and less formulaic to the needs of the

hospitals.

In fact, most recently, Illinois, the State of Illinois, one of the states that was referenced to in addition to North Carolina and South Carolina, the State of Illinois passed a law in 2014 that no CON is needed for the addition of beds beyond 20 beds, or 10% of the facility's bed capacity, whichever is greater, over a two-year period. So, every two years, if the hospital had a need, they could increase their beds.

So, the key question for OHS with respect to the proposal before you for 23 additional medical-surgical beds is not whether Bed Occupancy Rates are too high or too low in one particular region or county but whether we have the right array of healthcare services that the patients in our communities need and want at each hospital.

Raw hospital Bed Occupancy Rates do not tell the whole story about the value of a particular hospital to a particular community. Hospitals such as John Dempsey Hospital need more flexibility in recognition of the following factors.

As I previously mentioned, and as considered by OHCA back in 2011, the impact of the Affordable Care Act. More individuals in the state are covered by Medicaid. Connecticut, as you'll hear from Professor

Stratmann, adopted the Affordable Care Act for Medicaid I believe in 2014. More Connecticut residents are insured. And as a result of both of those factors, there's an increased demand for hospital services from these newly insured individuals.

There's also the fact that there is an aging population, that there are 76 million baby boomers right now, I'm being one of them, and as they age, their healthcare needs will grow. And you'll hear more about that from Professor Stratmann.

I believe that the idea of patient choice is a premise that we will all value and respect and that is which built into our healthcare culture and system. There is a reason for it. Patients vote with their feet.

In addition, there are -- there are more new services being offered by John Dempsey Hospital. Interestingly, before I came today, I read in "The New York Times" today that hospitals in Houston, Texas, Nevada, Utah, and Arizona, where it's hot, are having a real problem and backlog in terms of being able to discharge their patients because many of their patients cannot be discharged to an un-air-conditioned home.

These kind of issues should be recognized because they're real. What I'm basically saying is

when this Bed Need Methodology was developed in many states across the country, which it seems OHS modeled after, it was a different time, a different dynamic. It started in the '90s.

We're now in 2024, where the economics and the dynamics of healthcare are greatly different and the reasons for curtailing bed capacity are no longer as important.

So, as I stated previously, you'll hear from our three witnesses today. Dr. Agwunobi, who will speak to the importance of these beds to John Dempsey Hospital's future, he'll explain to you, as an academic medical center and a core component of such academic medical center, why JDH is so unique. And most importantly, he will speak to the value of patient choice and some of the risks of ED boarding as it relates to outcomes nationally recognized.

Ms. Caryl Ryan, our C.O.O., will discuss realtime, boots-on-the-ground capacity issues and trends that impact our patients and our staff every single day.

And then you will hear from Professor Thomas Stratmann, who will discuss his review and assessment of the current OHS Bed Need Methodology.

I do plan on having cross-examination for

Mr. Barwis and making closing remarks. Thank you.

MR. CSUKA: Thank you. Mr. Agwunobi, you can proceed whenever you're ready.

DR. AGWUNOBI: Thank you very much. Good morning, Mr. Jackson and the staff of the Office of Health Strategy. My name is Andrew Agwunobi. I'm the Executive Vice President for Health Affairs and the Chief Executive Officer of UConn Health. I'm a pediatrician by training, but I spent my career managing health systems that deliver care.

This -- today is -- there's one simple reason why we're here today. We're here because, since 2016, the -- we have -- John Dempsey Hospital, which is a pre-eminent academic medical center, one of two in the state of Connecticut, has seen a steady and sustained increase in its Average Daily Census, particularly with respect to its medical and surgical beds, patient beds.

And for that reason, we are out of capacity and we are unable to serve the patients the way we believe they deserve to be served in Connecticut. And it has led to bottlenecks in our emergency department, where we have patients boarding in the emergency department.

Of course, there's -- this is in contrast to what the 2012 OHS Bed Need Methodology states that our

need is. But the reason we're here is because we are in the hospital, and we are experiencing a lack of capacity for our patients. We're out of beds.

I want to emphasize something here. UConn Health is an academic medical center. A bed is not a bed. Community hospitals are extremely important. And I think we have demonstrated that we support all the community hospitals in our region and beyond.

So -- but we are not a community hospital. We are an academic, research, teaching, high-end-of-care hospital. We are a center of excellence that attracts patients from every single county in Connecticut. So, we're in North Central Connecticut, but we get patients from every county in the state. And the reason is that we -- we offer a level of care that is to be expected from an academic medical center.

And perhaps that's why for the third consecutive year "Newsweek" has named John Dempsey Hospital as one of five hospitals in the state of Connecticut which is named -- has been named as the world's best hospital. And in terms of our safety rating, we have seven consecutive awards in a row.

So, we're an extremely important teaching and research hospital. And we think we bring great value,

particularly as a public health system, to the State of Connecticut. And there's why we're here. We're here to ask for 23 medical-surgical beds for one simple reason -- to be able to serve our patients, not have patients boarding in the emergency department, not be -- not have to divert and turn patients away when they need our care. And this is what's really important when we talk about patient choice.

So, I would go on to say that our belief and opinion is that our patients are deliberately choosing John Dempsey Hospital for the following reasons.

They desire a teaching hospital that has a diverse team, a very deep bench of medical experts representing a broad spectrum of specialties. And we're able to attract those experts because we are a university, we're part of a university. We train doctors. We train dentists. We do research. So, we get world-class faculty that come to us that would not go to -- would not necessarily go to a community hospital.

The quality and standard of care, which I mentioned already, is exemplary at John Dempsey Hospital. The patient satisfaction is outstanding. And when we talk about the costs to payers, so the costs that people and organizations pay for the care at

John Dempsey Hospital, is among the lowest in the state of Connecticut.

So, put simply, our patient census is up at John Dempsey Hospital. We're happy about that because we want to serve, and that's what we're here for. We were created to serve the people of Connecticut. And it's because of patient choice. People are coming to us because they choose the care.

Every time we wake up in the morning, if we're sick, if I'm sick or my mother's sick or someone I know is sick, like everyone else, you make a decision about where you want to go. Sometimes you bypass your local hospital. Sometimes you don't. But it's a patient-choice decision a lot of times based on what you believe the health system you're going to offers.

So, all of us as patients and family members have the freedom and right to choose where we or our family members receive medical care. We're out of capacity because more patients than projected by the OHS methodology need and desire our -- access to our care.

So, it's a simple situation of yes, there was an estimation, a projection of what we should need in terms of beds. But that's not what has happened. And we -- we understand this because it has happened over

time, and we've been responding to need by putting on new services and growing our staff, et cetera.

I would just add that we have the physical space to cost effectively add 23 additional medical-surgical beds without incurring any construction costs, because we already have a building that we can put those beds in.

If the 23 medical-surgical beds are not approved, there will, in our minds, continue to be an unacceptable bottleneck in our emergency department. Now, Caryl Ryan's going to talk about all the numerous interventions, which I think many hospitals do, to try to prevent unnecessary admissions, readmissions, and to take care of people in an outpatient basis. And we are doing the same. But we still have a bottleneck in the John Dempsey Hospital Emergency Department, which is caused by an insufficient number of inpatient beds.

And I want to say here that the interim report from the Connecticut Emergency Department Boarding and Crowding Work Group, I'm quoting, said -- well, actually said emergency department crowding is not due to patients who are treated and discharged home but rather due to an inadequate number of hospital beds for patients who need inpatient admission. We are living that right now.

And one of the other points that was made in the report is that it's not people who need low acuity care that are making -- causing the bottleneck in the emergency departments. People who have -- who are not that sick are quite quickly triaged out of the emergency departments. They're treated and triaged and leave the emergency departments. We're talking about people who are very sick, who need admission to the hospital, and because of a lack of beds, they end up boarding in the emergency department.

If we had enough beds, we wouldn't be here. We're here because we're responding as a public institution, an academic medical center, to the needs of the people of Connecticut that come to our -- our hospital for admission. And by the way, 60% of our admissions come in through the emergency department, so that's why I'm emphasizing the emergency department.

And we know that the emergency department crowding and delays in care due to that can cause -- now, we work the hardest we can to make sure that our care is at the best it can be -- but can cause an increased exposure to medical errors and even increased mortality. The American College of Emergency Physicians have called the boarding of patients in emergency departments as a public health concern. So,

we really need to address this.

So, in summary, we're simply saying -- we're simply here saying we understand the projections and the projections that have said, you know, we don't need beds. But we do need beds. And if you look at the data that we have that shows the trajectory of our growth, this isn't something that happened yesterday or two months ago. For years, we have been having an increase in our occupancy, and we're now at a point where we're out of beds. And we believe that 23 beds, which is about 10% of our beds that we have, is the reasonable way forward.

So, again, I just want to thank you all. Before I end, I'd like to adopt my prefiled testimony -- make sure I get the language right -- as my own. Thank you very much.

MR. CSUKA: Thank you. And I believe I referred to you as Mr. Agwunobi earlier. I apologize. Dr. Agwunobi.

DR. AGWUNOBI: That's fine. No problem.

MR. CSUKA: I apologize. So, next on the list will be Caryl Ryan. If you can come up to the podium.

MS. RYAN: Good morning.

MR. CSUKA: Good morning. Can you please

just spell your name for the record? I should have had Dr. Agwunobi do the same.

MS. RYAN: Sure. Would you like him to do that?

MR. CSUKA: No. I can take care of that with the court reporter off the record.

MS. RYAN: Okay. My name is Caryl Ryan, C-A-R-Y-L R-Y-A-N.

MR. CSUKA: Thank you.

MS. RYAN: Again, good morning, Hearing Officer Jackson and OHS staff. I appreciate the opportunity to provide my prefile testimony to you today. Again, my testimony will focus on the need for and the importance for 23 additional med-surg beds for JDH and the ramifications for patients. Before I begin, I would also like to adopt my prefile testimony as my own.

I have been with UConn Health for over 30 years. I began as an adult ICU Staff Nurse and then progressed through administration as Assistant Nurse Manager of the ICU, Intensive Care Unit, through a manager role for medicine, then actually Director and worked with BRG Assessment Group on Workforce, primarily workforce, became a Senior Director, and then assumed the CNO responsibilities in 2019, and then two

years later accepted the C.O.O. responsibilities.

I truly understand our organization and its needs. My job is to make sure and insure that we deliver timely, safe, and high quality healthcare services to our constituents in the state of Connecticut.

As detailed in the CON application, our volume, as stated by Dr. Agwunobi, has significantly increased over the past decade, particularly post-pandemic. With this application, again, we seek to increase med-surg capacity by 23 beds.

Five years ago, our emergency department visits averaged in a day in the low 90s. For the last year, we have averaged more than 150. That's at pretty much a 63% increase. There are days we have seen as many as 206 patient visits per day and admitting anywhere from 18% to about 23% of those patients, despite the growth of urgent care and walk-in options in the surrounding communities and our efforts to prevent avoidable ED visits.

As Dr. Agwunobi alluded to, many of our patients are being sent from urgent cares to John Dempsey Hospital. Our ESI rates that -- our severity index for ED patients, ED Severity Index, ESI, are patients that come in that really don't meet criteria

to be in the urgent care. They need to be in the hospital emergency department.

With ED providing again around 60%, as Dr. Agwunobi alluded to, of all hospital admissions, it's not hard to see why we are presently stretched. It's not just the ED. I would say about ten years ago there were less than 500 babies that were born and delivered at JDH. For our fiscal year this year, concluding on June 30th, we actually had 1,309 deliveries at John Dempsey Hospital. That is also a credit to our maternal fetal medicine that is doing an extraordinary job. And I believe they also actually lend a hand to Bristol Hospital in services.

So, with the growth in JDH surgical medical staff, opening up new programs and procedures available to everyone in Connecticut, regardless of the ability to pay, the result has been a 33% overall increase in discharges.

In every way, reputationally and delivering results, we are a very different place than we were before Vital Signs Connecticut made our campus a destination for healthcare.

Dr. Agwunobi put a lot of emphasis on why patients choose UConn Health. And I am very proud that we deliver really great patient satisfaction results.

Today, if you look on Hospital Compare website, where results are publicly available, you find two generally accepted summary measure results that we are very proud of: One, with respect to the patient rating, JDH is an IR10. We're at 75%, 4 points above the national average, ten points above the average for all Connecticut hospitals. As stated, we also are in the 91st percentile this year for recommending John Dempsey Hospital.

With respect to the patients who would recommend our hospital, again, JDH is at 78%, about 10 points higher than the national average, 12 points higher than Connecticut. And as I said, we actually were in the 91st percentile for this year.

We also have incredible STEMI and stroke response. So, for the last -- for many years, I would say probably for the last 8 years, we have been the gold standard for STEMI and probably 10 years and probably 6 for stroke. Oh, I'm sorry. This is -- myocardial infarction, and it is actually quick acute care for a myocardial infarction that is brought into the emergency department, and there is a swift response. You need to get an EKG within ten minutes. And you also need to be able to do door -- door-to-balloon time that is within 90 minutes. We

achieve that, and that is why we have been at a gold -- with the guidelines, gold-plus standard for many years.

Along with that, our stroke program, we have the ability to do thrombectomy -- is also -- we have many accolades you get with the guidelines stroke program with the gold-plus award. And this is really door-to-CAT-Scan within 25 minutes and door-to-natal within 60. And that is why we are presently awarded that gold standard.

We do extraordinary care in neurosurgery. Our intensive care unit is a 28-bed intensive care unit where we do all disciplines and services, and we excel in cancer and also cardiology, CHF. We've done a tremendous job on it. We've had -- some of these areas we've actually made, like, infusions, cardiac infusions, so that we can keep patients out of the emergency room with heart failure patients.

I understand, and Dr. Stratmann will address, how the 2012 OHS Bed Need Methodology has issues shortly. But I want to address now the impact on bed capacity issues on family, patients, and staff. Again, observation beds, something that really wasn't -- we didn't have a lot of in 2012, it really wasn't added to our licensure but now is.

So, often patients experience what is

boarding in the ED. And as Dr. Agwunobi referred to, these patients, you know, they want to come to John Dempsey Hospital. Many of them have to be admitted. And when they are admitted and we don't have any beds, you know, that are available to admit inpatients for observation patients, we do board in the ED.

That becomes difficult on staff and on patients. As mentioned, I believe by Attorney Feldman, the research shows that, you know, there are delays in care, there's an increase in adverse events. But really, it's not good care. We're taking up, you know, whatever that number is -- 5, 10, 15, 20 emergency room bays. We have 42, plus a 4-bed locked psych unit down in ED, that is operated by the ED.

And when that happens, you know, there are, you know, less people than you can really bring into the ED. It hurts the ED flow time. It delays our door-to-down time, our doc-to-decision time, our decision-to-discharge time, all within the ED.

And our -- on our admitted patients that are boarded, you know, they are in a -- you know, they're not in a unit. They're still in the emergency room. They're still in a stretcher. We do have our staff nurses for the inpatient taking care of them, but they've come down from units. They're not in their

home area.

So, it is really -- it decreases patient satisfaction. It decreases staff engagement. And really, as far as patient safety, it's not safe for patients to be in the emergency room.

JDH absolutely has the physical space, as Dr. Agwunobi alluded to, to add 23 med-surg beds in the University Tower really without incurring any construction costs. And we are at this point staffed for 234 beds.

If the 23 med-surg beds are not approved, there will continue to be unacceptable bottlenecks in JDH Emergency Department despite the numerous interventions. And that also includes our ambulances that actually come into the UConn, Storrs, assisting us in nonurgent transports along with the rest of -- along with the rest of our colleagues and agencies that we use for ambulance transport.

We have no reserve of beds. And it really is unacceptable and inappropriate to use our other service lying beds as a substitute because they are also vital and needed. As we talked about our deliveries, our MFM service, which is Maternal Fetal Medicine service, we are seeing increased acuities down in our -- in our L&D and OB, so much so that really many of them now need a

monitor in L&D. I'm talking about the cardiac monitor that shows the EKG.

Our efforts to curtail avoidable ED visits, reduce admissions, and facilitate -- facilitate medically ready discharges continues as set forth in my prefile testimony.

If UConn is going to continue its trajectory of becoming a world-class teaching hospital, it will need additional scale to serve its patients. We've examined all options and bring you the most efficient use of resources to meet a growing demand. Patients should have the freedom and the right to choose where they receive care, and in growing numbers, for the reasons I give, they choose us as was defined by both Attorney Feldman and Dr. Agwunobi.

In closing, the average occupancy rates exceed 80% for 11 distinct periods of 30 days within the most recent 12-month period. Discharge shows, you know, there are charts within weekly occupancy rate. And that is -- I'm not sure what number that is, but it is in my testimony -- that the occupancy is higher than 80%, which is the red line most always. Regardless of the statistics with boots on the ground, I can attest to the fact that the need is real and sustained and not going away.

And just one other point: Diversion. So, when our capacity is nearing our licensed beds, one thing to enact is diversion. And that is a decision made from hospital administration and the emergency department. When that happens, calls are made to around the state. And many times our calls are -- basically it is stated by area hospitals that they have no room in their beds, including Bristol hospital. And there have been calls made to CHA to help us in that journey. And then they will call certain members of local institutions. And one diversion was to St. Vincent's.

Now, if your family member who lives in Farmington, New Britain, Hartford, anywhere around us, Simsbury, Avon, and they were told that they needed to go to St. Vincent's, how would your family member really feel?

So, that's what we're up against. And it's 23 beds.

Thank you for the opportunity to explain our clear need and the challenges we face each and every day by not having enough medical-surgical bed capacity. Thank you.

MR. CSUKA: Thank you, Ms. Ryan.

Dr. Stratmann? Do you prefer professor or

doctor?

DR. STRATMANN: Professor or -- doesn't really matter to me.

MR. CSUKA: Okay.

DR. STRATMANN: Mister works too.

MR. CSUKA: Okay. Thank you.

THE COURT REPORTER: I'm sorry. Would you spell your name for me, please?

MR. STRATMANN: Thomas Stratmann, T-H-O-M-A-S. Stratmann is S-T-R-A-T-M-A-N-N.

THE COURT REPORTER: Thank you.

DR. STRATMANN: Thank you.

MR. CSUKA: I think we're -- can you move a little closer to the mic?

MR. STRATMANN: Sorry.

MS. FELDMAN: That's okay.

MR. STRATMANN: Okay. Is this a little bit better?

MR. CSUKA: Yes.

MR. STRATMANN: Okay. All set. So, good morning, Mr. Jackson and OHS staff. Thank you for the opportunity to provide testimony today. Before I begin, I would like to adopt my prefile testimony as my own.

I am a Distinguished University Professor at

George Mason University. There I hold an appointment as Professor of Economics, and I have the courtesy of an appointment at the law school.

In this testimony I will focus on the arbitrariness of the OHS methodology, its many errors, and its failure to address the real needs of John Dempsey Hospital, or I refer to it as Dempsey or JDH.

OHS views a method to compute bed needs that was developed in 2012. This 2012 Bed Need Methodology is outdated and has many faults. I won't go into each fault in this oral presentation, but I'd like to make clear that the OHS method to compute bed needs is arbitrary, statistically invalid, and fails to reflect the reality that JDH faces. The results produced by the OHS method are biased and false.

Now, I would like to give you a few examples of the methodological faults in the OHS methodology.

MR. CSUKA: Dr. Stratmann, I'm sorry. Is there a way to move the mic a little bit -- does it come out? No. It doesn't seem like it does.

MR. STRATMANN: Would you like me to -- this is better. Would you like me to repeat anything?

MR. CSUKA: I don't think so. I think you can just continue. The recording said they could hear you but you were really low. So, I just want to make

sure.

MR. STRATMANN: Now I can better hear myself.

MR. CSUKA: Okay.

MR. STRATMANN: So, I left off with one problem with the OHS methodology is that it's using arbitrary weighting of the Average Daily Census over the previous three years. The weighting they use has no scientific basis, and it is basics. There is no justification, scientific justification, for applying these weights.

With their method, OHS gives a positive weight to old data. Specifically, it puts weight on the first two of the previous three years. This skews the results. And why are the results skewed? Because the OHS approach fails to fully capture the most recent increases in patient volume at Dempsey, thereby underestimating the current bed needs.

Another example of the methodological fault is its outdated regional analysis. That is because the OHS calculations fail to reflect the current healthcare demands, that is, the demands in the 2024 fiscal year.

The OHS method does not consider the unique healthcare needs in each region or county and does not consider the regional changes in demand for medical services.

Here is an example. Since 2012, Hartford County has seen a significant increase in the baby boomer population. Today, 25 -- 26% of people aged 65 and above reside -- who reside in Connecticut live in Hartford County. So, Hartford County is the residence of a quarter of all baby boomers and earlier generations living in Connecticut.

What does it mean? What does this fact mean for the demand for medical services, medical care, and medical care in Hartford County? Well, we know that older people -- so, people like me -- have more healthcare needs than younger folks. And not to count a county of a large size for all individuals in Hartford County and by not considering that this population has been growing in the Hartford region, OHS underestimates Dempsey's hospital bed needs -- Dempsey's hospital bed needs, thus freezing the regional beds in time and not considering the demographics -- that demographics have changed since 2012 creates a bias in the methodology, and it makes this methodology from 2012 arbitrary and static.

Let me touch on one other methodological shortcoming, which is the use of statewide averages. The use of statewide averages for making predictions about bed needs and the use of statewide averages is

not the specific demand faced by JDH. Dempsey faces specific demand, as evidenced by its higher proportion of complex cases and specialized services provided.

And Dempsey's high quality of medical care attracts patients from all over Connecticut and beyond. Dempsey attracts patients who have complex cases and need Dempsey's specialized services, and these patients often are at longer days of stay. Longer days of stay. All this is not accounted for in the OHS methodology.

Here are a few examples of the specific demand by Dempsey that is not accounted for in the Bed Need Methodology.

One, JDH offers unique specialized services, such as advanced neurosurgery, comprehensive cancer care, high-risk obstetrics, which are unavailable in many regional Connecticut hospitals.

Further, JDH's reputation for handling complex pregnancies and neonatal care has resulted in a significant increase in high-risk obstetrics cases with a rise in Medicaid deliveries and newborn admissions. The OHS methodology has not accounted for this patient demand for Dempsey's specific services, resulting in additional underestimation of bed need by Dempsey.

Further, OLS -- OHS does not consider that Dempsey handles a higher proportion of medically

complex patients who require a more extended stay and more intensive care. These patients often cannot be adequately served by smaller community hospitals like Bristol Hospital, which lacks -- which -- hospitals which lack the infrastructure and the specialized staff required for such high acuity cases.

Summarizing what I said so far, the OHS method uses arbitrary rates, it ignores changing demographics, it bases projections on statewide averages, and does not reflect Dempsey Hospital's specific demand. The result of this method make the bed need predictions -- the result is that the method of bed need predictions comes nothing close to reality. Using the arbitrary method results in a gross underestimation of actual bed need, and this underestimation of bed needs puts immense pressure on hospital resources and compromises patient care.

I would like to point out another flaw in OHS -- in the OHS method. This flaw documents -- by pointing out this flaw, it shows that OHS does not -- or the OHS method does not consider or understand how hospitals are managed and run, which results in false predictions about Dempsey's bed needs.

One aspect for OHS is that Dempsey has ten licensed beds from the Department of Corrections, so it

has ten Department of Corrections beds. Dempsey has no control over these beds, and OHS does not account for this fact in a spreadsheet in computing bed needs. OHS includes department of correction beds in their calculations and thereby uses the wrong denominator in computing occupancy rates. The result, again, is biased estimates and underestimating full needs. The Department of Correction beds inflated earlier by Dempsey's occupancy standards is the wrong approach for determining Dempsey's bed needs.

As with any improper method, including the OHS method, when a methodology does not account for the institutions and when a methodology does not account for rules that govern the topic analyzed, then that method produces unreliable results. When a method is not informed by reality, it becomes arbitrary, and that is the case with the OHS methodology.

Now, let me move to another serious flaw in the OHS methodology. This flaw is that the OHS spreadsheet computations do not account for the outpatient use of Dempsey's hospital beds. Despite their own regulations stating that outpatient use should be considered, which is in the OHS rules, OHS fails to incorporate outpatient use of hospital beds in their spreadsheet calculations.

This is an important point. It's an important point because JDH has seen a significant increase in the use of outpatients, as we just heard. And hospital use by outpatients increases hospital Bed Occupancy Rates. To get a sense of the magnitude of the error by OHS by not considering outpatient use of hospital beds, I took the data from the current 2024 fiscal year and analyzed the first 11 months of the 2024 fiscal year, so the most recent data available for that fiscal year.

I found that the inpatient Bed Occupancy Rate was 80 -- 68.4% but that the occupancy rate jumps to 82 -- 84.2% when outpatient use of the beds is considered. Therefore, omitting outpatient use of hospital beds, OHS underestimates actual bed needs at Dempsey. It underestimates it by almost 16 percentage points.

And note, and it's important to say, that an 84.2% occupancy rate of course is just an average between higher and lower rates, with the average being so high there are going to be days that the occupancy rate is 100% and JDH must go on diversion, as you just heard. And this is very likely to result in patient harm, as diversion causes delay in serving the patient. Failure to account for outpatient use of hospital beds is another example that shows that the OHS method

doesn't -- does not consider the realities on the hospital floor.

I took the OHS methodology and made three small changes to it, thereby assessing some of the magnitude of its most obvious mistakes. However, I retain the basic and misguided OHS methodology, including the use of statewide averages for these projections. All these three changes I made are informed and motivated by the facts on the ground.

One change is it doesn't account for the Department of Correction beds, because they are just simply not under Dempsey's control. These are beds for the use of the Department of Corrections.

The second change is that instead of using the arbitrary weighting I mentioned before that considers only the last -- that considers the last three years of bed use, I analyzed the most recent 12 months of patient visits. This change shows to accurately account for the increased recent patient demand at Dempsey.

Third, I added the standard hospital industry measure to compute hospital Bed Occupancy Rates by including outpatient use of these beds. Again, this change -- this change reflects the reality that many outpatients, after a procedure, spend some time in the

hospital beds so that they can be observed, assuring that they are stable when they are being discharged. So, obviously, a very important function of hospital beds.

So, when making these few adjustments, what do you think the results were? Lo and behold, the analysis shows that Dempsey has a shortage, not a surplus, in hospitals. It has a shortage of 17 beds. This is a very different assessment than the OHS assessment, which claims that JDH has a surplus of 17 beds. My calculation show that the OHS calculations are off by 87 beds, 87 beds, or more than half of Dempsey's 147 licensed med-surg beds. That's quite a miscalculation.

This miscalculation tells us that the OHS method is out of touch with reality and that its method is arbitrary and fails to predict true hospital needs, true hospital bed needs at Dempsey. And the size of this error, the size of this miscalculation, is even more impressive when considering that I only made three fact-based tweaks to the methods. My estimates ignored the other shortcomings of the OHS methodology, those other flaws that I mentioned before and will mention next.

Any computation of bed needs that would

address -- address these faults, these other faults, would come up with a larger shortage number than 17 beds. This is because these other flaws tend to further underestimate Dempsey's true bed need.

There's another issue or problem with the OHS method I haven't mentioned yet. OHS computes bed capacity needed based on licensed beds in the region. But just having a licensed bed does not imply that a hospital also has patients in it. In fact, many hospitals in Connecticut do not staff all their beds because they have no use for it. In fact, some hospitals have more than 200 beds that are unstaffed.

So, why is this a problem? Because actual Bed Occupancy Rate is the only sensible measure -- measure, and that means using staffed beds in the denominator when computing occupancy rates. It is not sensible to use all licensed beds to compute occupancy rates when some of them are not being staffed.

Making the bed occupancy calculations using licensed beds, not staffed beds, adds fictional beds to the denominator. They are fictional because no patient uses understaffed -- no patient used the unstaffed beds. By computing needs based on fictional beds, beds that are not staffed, OHS ignores reality and will necessarily underestimate bed need demand in the

region.

So, what are the reasons that the OHS methodology is so often flawed? The evidence suggests that the methodology does not capture how hospitals are managed; that is, regulators do not have expertise in the hospital industry and the management and administration of hospitals. Even if there's -- even if a medical doctor is on the medical -- regulator staff, medical doctors are trained to be experts in the medical field but not to be experts in hospital administration and how hospitals are run.

Next, I would like to present the shortcomings of OHS in the broader context of the marketplace in which hospitals such as Dempsey operates.

Healthcare demand is not static. It evolves rapidly due to various factors, such as demographic shifts, something I already mentioned. It evolves due to rapidly changing technological progress and changes in healthcare policies. These factors are causing a rapidly evolving demand for healthcare and a rapidly changing hospital industry, both of which are ignored by the OHS method. The method accounts -- fails to account for the dynamic nature of the healthcare market and secular increase in the demand for healthcare

services.

And here are some examples that illustrate these failures in the OHS methodology.

Let's start with technological advances. These advances in the past many years and recent years make the healthcare industry very dynamic, outstanding. Advances in medical technology have led to an increase in overall volume and of patients seeking care, also minimally invasive surgeries, improved anesthesia techniques, advanced diagnostics. All these made it possible for patients, including those with complex conditions, to undergo procedures that were not possible before. And patients with complex procedures often require more intensive postoperative care and monitoring, contributing to a higher bed occupancy at Dempsey.

Another big change that has happened is that -- is the policy changes that Attorney Feldman referred to a few minutes ago. For example, the Affordable Care Act has increased the insured -- number of insured individuals, leading to a surge in healthcare demand. The Affordable Care Act went fully into effect in Connecticut in 2014. And the 2012 OHS method does not account for the increased enrollment in Medicaid and subsequent -- and subsequent increases in

the demand for Dempsey's services.

And this number of -- this increase in the number of insured individuals has been substantial. In Connecticut, the Medicaid population increased from about 500,000 individuals in 2012 to more than 900,000, so almost double, in January 2024, an increase of 80% made up by more than 420,000 individuals now being newly on Medicare. By not accounting for these changes, the static model used by OHS spits out the wrong results, not surprisingly.

Another example of the innovation in healthcare is the reintroduction of managed care, the use of fixed payments based on the diagnosis, the absence of contracts that make providers financially liable. All these changes incentivize hospitals to be more efficient, to control cost, and to reduce hospital stays.

Today, in 2024, hospitals no longer have incentives to overutilize beds. Instead, newer reimbursements model -- new reimbursement models, fixed payments, value-based care, risk-based contracts, and other factors provide hospitals with financial carrots and sticks to provide the most efficient care available and no unnecessary care. In this dynamic healthcare environment, the static methodology of OHS, which does

not account for this dynamism, is misguided and arbitrary, and the concern of overutilization of beds and resources is misplaced.

Let's talk about how actually the OHS method is likely to cause harm to patients. One goal that is shared among medical providers and payers, such as Medicare and insurance companies, is to reduce readmissions. However, lowering readmissions requires resources. One such resource is the availability of beds.

To ensure that patients are stable before they're being discharged, a hospital wants to be 100% sure that the patient is really ready to be discharged, and the only way to do this might be to have the patient stay another day at the hospital.

Dempsey has successfully reduced readmission rates by providing comprehensive inpatient care. These efforts required additional resources, meaning increased Bed Occupancy Rates. We do not want that JDH finds itself in a position of having to cut patients' stays short just because occupancy rates are getting too high or because there are no beds available.

When a hospital shortens bed use of patients because its capacity is maxed out, its bed capacity is maxed out, then readmissions are likely to increase,

but -- and nobody wants this. And the way to ensure readmissions will stay low at Dempsey or get even lower is to approve Dempsey's request for 23 med-surg beds.

However, contrary to the facts, OHS believes that Dempsey has a surplus of med-surg beds. The reality is the opposite. JDH has a deficit. By not acknowledging this deficit, OHS is likely to be a contributor to future higher readmission rates, more patient harm, and increased healthcare costs as CMS penalizes hospitals when CMS deems that the hospital readmission rates are too high. Adding beds to JDH's current bed capacity would benefit patient health and ensure readmission rates remain low.

Let me talk for just a minute about Bristol's opposition, Bristol Hospital's opposition to Dempsey's request for additional med-surg beds.

So, here, a competitor to Dempsey, which has seen a decline in patient visits and possibly lost patients to the high quality medical services provided by Dempsey, wants to restrict Dempsey's ability to admit patients. Patients may -- patients may choose -- may have chosen to obtain treatment at JDH over Bristol because of Dempsey's excellent medical services. If the Bristol intervention is granted, in all likelihood, it would harm these patients.

To give an analogy, Bristol Hospital's opposition to Dempsey's bed expansion is akin to a small bookstore opposing the expansion of the public library. The library serves a broader community. The library serves broader community needs beyond what this local store can offer, just very much like JDH addresses unique healthcare demands that neighboring hospitals cannot fully meet. There is no good reason to look favorably upon Bristol's opposition to Dempsey's bed requests.

So, coming to the end, what would be a -- possibly better way for OHS to assess bed need in Connecticut? One suggestion -- one suggestion is to move from arbitrary methodology to simple rules. Here is my idea.

We know that from 2012 to 2022, the most recent data available for this, the average growth rate in spending for hospitals was 4.4%. A 4.4% increase each year amounts to a compounded growth rate of 10% over two years. This suggests that's OHS should automatically grant a 10% increase to the number of its beds every two years if needed. And importantly, this idea is not new or untested. As you heard, (indiscernible) has adopted a very similar rule as I'm describing here.

In 2012, OHS determined to give Dempsey 147 licenses -- licenses for med-surg beds. 12 years later, this number has not been adjusted. The number of licensed beds has not changed since then. It just defies commonsense to think that the 214 beds in -- 147 med-surg beds staffed in 2012 would be adequate 12 years later, in 2024.

Since 2012, demand for healthcare services has significantly increased. And unlike many other hospitals in Connecticut, Dempsey staffers -- staffs all licensed beds. Dempsey has no slack in bed use as other hospitals in Connecticut who can convert licensed, unstaffed beds into staffed beds.

When OHS developed this methodology, they said they would plan to revisit the method every five years. I see no evidence that this has happened. Dempsey still has the same number of licensed beds as in 2012, despite increasing demand.

The hospitals -- the hospital industry's dynamic nature necessitates a flexible and adaptive bed-planning model. However, the static and outdated 2012 OHS Bed Need Methodology does not consider the current healthcare environment. The OHS methodology is arbitrary, has many faults, and makes inaccurate predictions.

JDH's application for additional beds is a testament to its commitment to meeting the evolving needs of its patient population. A methodology that accurately captures patient care demand would support this application. Thank you.

MR. CSUKA: Thank you, Dr. Stratmann.

Attorney Feldman, did you have any direct questions for any of your witnesses?

MS. FELDMAN: Dr. Stratmann, I do have one redirect.

When you mentioned -- used the term outpatient, you -- outpatients using or occupying beds, were you referring to what is commonly referred to also as observation beds and extended stays for surgeries?

MR. STRATMANN: Yes. When I referred to outpatient -- outpatients using hospital beds, I referred to observation beds or extended stays.

MS. FELDMAN: Okay. Thank you.

No further redirect.

MR. CSUKA: Thank you. We're going to take a ten-minute break. Let's come back at 10:50.

And just a reminder to everybody, if you're in the room, the recording -- or the audio and visual may pick up what you're doing.

(Recess from 10:38 a.m. until 11:52 a.m.)

MR. CSUKA: Welcome back, everybody. This is a hearing regarding UConn John Dempsey Hospital's Application for an Increase in Licensed Bed Capacity, Docket Number 24-32699-CON.

We had the Applicant's preliminary remarks earlier, and then we took a ten-minute break. And now we are back on the record. We're going to proceed to cross-examination by the Intervenor of the Applicant's witnesses.

So, Attorney Weiss or Attorney Vozza, whoever would prefer to begin? It's up to you how you want to do this. If you want to do it witness by witness, that's fine. If you want to just sort of present your questions on whoever is most appropriate --

MR. VOZZA: I think it's probably easiest to go witness by witness. But I don't have a lot of questions. It will be quick.

MS. FELDMAN: Okay. Great. Thank you.

MR. VOZZA: Good morning, Doctor. I am the Attorney for the Intervenor, Bristol Hospital, here. I just have a few questions for you.

You had indicated in your testimony that you're aware of the community hospitals in the area and their reduced capacity; is that correct?

DR. AGWUNOBI: I didn't -- I didn't indicate

that in my testimony. No.

MR. VOZZA: Okay. You had mentioned the community hospitals in the area?

DR. AGWUNOBI: Yeah. I said we are supportive of the community hospitals in the area and beyond.

MR. VOZZA: Okay. And are you aware of what community hospitals are within the UConn JDH primary service area?

DR. AGWUNOBI: I'm aware -- I tapped -- I wanted to make sure to be accurate and I would have to ask to check, but I know that -- I know that Bristol, for example, is in our area.

MR. VOZZA: Okay. So, you wouldn't be surprised that Bristol is in the primary service area?

DR. AGWUNOBI: No.

MR. VOZZA: Okay. You had mentioned in your prefile testimony at the very end that --

MS. FELDMAN: May -- it's not necessarily an objection, but when we refer to "primary service area," that's not necessarily a defined term. Each hospital defines it by itself.

This is Joan Feldman speaking, by the way. I'm sorry for not announcing myself.

But I also note that in OHS' 2024 Statewide

Health Facilities and Services Plan there's a new approach that OHS has adopted with regard to moving from regions to counties. Am I correct?

Well, I think I am correct. So, I just want to clarify that -- that -- that are we talking about the county or are we talking about service area? What exactly are you focused on?

MR. VOZZA: I think -- let's just -- point taken. My point is that in your prefile testimony you indicate, and I'll quote, "Unfortunately, unlike some hospitals in the region, JDH does not have a reserve of beds to draw from." Is that your statement?

DR. AGWUNOBI: That was not my specific statement.

MR. VOZZA: I'm reading verbatim from your prefile testimony.

DR. AGWUNOBI: Oh, my prefile testimony.

MR. VOZZA: Yes.

DR. AGWUNOBI: I'm sorry. I thought you were talking about --

MS. FELDMAN: Do you want to look at it?

DR. AGWUNOBI: No. It is in my prefile testimony. I thought you were talking about my statement today.

MR. VOZZA: That's okay. My question is,

what formed the basis for your statement, that statement?

DR. AGWUNOBI: Could you repeat the statement?

MR. VOZZA: Sure. It's the last line of your -- it's the last line of your prefile testimony. "Unfortunately, unlike some hospitals in its region, JDH does not have a reserve of beds to draw from."

DR. AGWUNOBI: Yeah. That was a reference to the difference between staffed beds and licensed beds, that some organizations have -- they don't staff up to their -- some hospitals do not staff up to their fully licensed beds so they can draw from their unused capacity, whereas we -- we have both staffed -- our staffed beds and our licensed beds are the same.

MR. VOZZA: As far as you know, has JDH ever considered any sort of lease arrangements or utilization arrangements with hospitals in the region?

DR. AGWUNOBI: Not to my knowledge, no.

MR. VOZZA: That's all.

MR. CSUKA: Attorney Vozza, do you have questions for any of the other witnesses?

MR. VOZZA: Yes. Ms. Ryan.

MS. FELDMAN: Okay.

MR. VOZZA: Good morning, Ms. Ryan.

MS. RYAN: Good morning.

MR. VOZZA: Hi. Just very quickly, in your prefile testimony, did you define what the primary service area of UConn JDH is?

MS. RYAN: There are references to the primary service area I believe in the graph, and we could have that interpreted with graphs of primary service area.

MR. VOZZA: Very simply, is Bristol part of the primary service area according to your prefile testimony?

MS. RYAN: Yes, it is.

MR. VOZZA: Okay. I just want to bring you to Footnotes 2 and 3 in your prefile testimony. I didn't see any citation for those footnotes. Would you be able to provide us with those?

MS. FELDMAN: Let us -- yeah.

MS. RYAN: What page are you on?

MS. FELDMAN: Did you say two and three?

MR. VOZZA: Two and three. I think it's page 3. There's no page numbers.

MS. FELDMAN: Absolutely. We can provide that as a late file.

MR. VOZZA: Okay. Attorney Jackson, I have just a procedural question. Earlier there was a list

of who the participants were on the screen here. Can we put that back up?

MS. FELDMAN: Those are people that I think are watching through Zoom; right?

MR. CSUKA: Correct. Yeah. Those are the Zoom participants.

MS. FELDMAN: And that's -- that's not static either. People have joined --

MR. CSUKA: Right. Yeah. People have come and gone.

MS. FENTIS: I have it on the laptop.

MR. CSUKA: It was on the screen earlier. Are you able to bring it back up?

MS. FENTIS: I just took it off because of the chat function. People were sending me messages on there. I don't know if we want that or anything.

MR. CSUKA: Attorney Vozza, can I just ask why you want that up?

MR. VOZZA: It was a request of the Intervenor. It's not absolutely necessary. If you can't do it, it's fine.

MR. CSUKA: All right.

MS. FENTIS: It's up to you.

MR. CSUKA: You can bring it up. It's fine.

MS. FENTIS: Sure.

MR. CSUKA: In the video recording that is uploaded, I don't think that will be present. There may be -- I'm unaware of the capabilities of Zoom, so I don't know whether that is something that we'll be able to generate after the fact or not.

MR. VOZZA: I appreciate your willingness.

Ms. Ryan, I wanted also to bring you to page 4 of your prefile testimony. You have a chart there that is entitled "Weekday Occupancy Rate Percentage." Do you see that?

MS. RYAN: Mm-hmm. I do.

MR. VOZZA: And can you tell us why -- why weekday as opposed to the full week?

MS. RYAN: So, as many know that we discharge on the weekends. Once everything picks up on Monday, Monday through Friday or Saturday morning is our highest occupancy rate.

MR. VOZZA: Okay. Would you agree that utilizing the weekday occupancy rate as opposed to the full week would necessarily increase the capacity number?

MS. RYAN: I think in some weekends, but it is the standard in the industry to document like that. But I think that there are times where it stays the same and there are times when it's slightly decreased.

But it is the standard.

MR. VOZZA: There are times where what stays the same? I'm sorry.

MS. RYAN: The census. That's what you're referring to, isn't it?

MR. VOZZA: Yes. I just wasn't clear what you said. You had said that's what's used in the industry.

MS. RYAN: Mm-hmm.

MR. VOZZA: Is there a set of standards that you can refer to that you would find the weekday occupancy rate used?

MS. FELDMAN: There -- I may be able to have someone else answer your question.

MR. VOZZA: Dr. Stratmann? Sorry.

MS. FELDMAN: Mr. Gibbs, who's our analyst. You may want to swear in folks or -- if that's okay with you.

MR. VOZZA: I -- I don't have a problem with that. But maybe it's not necessary. Just let me ask this next question.

MS. FELDMAN: Okay.

MR. VOZZA: Are you -- are you utilizing this standard because it is part and parcel of the 2012 bed methodology?

MS. FELDMAN: Yeah.

MS. RYAN: Yes.

MR. VOZZA: Okay. Is that the methodology that Dr. Stratmann had indicated is statistically invalid?

MS. FELDMAN: I -- I don't know that Ms. Ryan has the answer, but there are other people here that do, if you're looking for the answer.

MR. VOZZA: Okay. I'll move on.

MS. FELDMAN: Go ahead. She would like to --

MR. VOZZA: Sure.

MS. RYAN: I can say that -- I can say that we use this in our data just as a review. It's not that it is -- you know, this is data that we review on weekends and weekdays, so --

MR. VOZZA: So, is the chart -- sorry.

MS. RYAN: -- data --

MR. VOZZA: Is the weekday occupancy rate percentage, was that utilized in the actual CON application?

MS. FELDMAN: Yes.

MS. RYAN: Yes.

MR. VOZZA: Okay. And, again, I just wanted to reiterate, that's -- that's from the methodology which Dr. Stratmann has indicated is statistically

invalid?

MS. RYAN: I would have to validate that. I would have to validate that.

MR. VOZZA: Okay.

MS. RYAN: Because our overall Average Daily Census, as you can see, is pretty high.

MR. VOZZA: I think I'll ask Dr. Stratmann some questions about that as well.

But you had indicated in your prefile testimony also that the costs are limited to, what was it, just equipment for the project?

MS. RYAN: For the project of 23 beds?

MR. VOZZA: 23 beds. Yes.

MS. RYAN: 23 beds. Yes. It would be equipment and staffing. I think staffing was also mentioned in that.

MR. VOZZA: I don't think staffing was. So, I think only construction was in your prefile testimony.

MS. RYAN: Okay.

MR. VOZZA: So, what is your estimate of what the construction costs are?

MS. RYAN: So, the construction -- so, right now, if we were to add 23 beds, there is no construction cost except for some minimal cosmetic

revamping, so -- yeah -- and the physical beds, some of the physical beds that are needed.

MR. VOZZA: So, what about equipment?

MS. RYAN: If they are monitored, they actually -- that unit is already monitored, currently monitored.

MR. CSUKA: Attorney Feldman, try not to give her information. You can do that through redirect if you'd like.

MS. FELDMAN: Mm-hmm.

MR. CSUKA: I just want to make sure that whatever you're using is on the record.

MS. RYAN: Mm-hmm. So, usually when equipment is stated, it is usually monitoring equipment, pump equipment, beds. And we do have -- because we have been housing an emergency department, we do have additional equipment available.

MR. VOZZA: All right. And what about staffing? Are -- are all the beds fully staffed as we sit here today?

MS. RYAN: They are.

MR. VOZZA: And so, that would require additional staffing if the CON was -- application was granted?

MS. RYAN: So, it wouldn't be -- it would not

be fully 23-bed staffing, but it would be -- we have partial staffing for that. So, it would be half of that.

MR. VOZZA: Are you -- you said that "we have partial staffing for that." Does that mean that those staff are already hired and -- and employees?

MS. RYAN: In the flow pool, correct.

MR. VOZZA: It would have to be reallocated from a different department, you're saying?

MS. RYAN: Some would be reallocated from the flow pool, and some additional because we have a contract. And it would be -- if you're looking at 24, it would be divided over three weekends. So, 23 -- 23 additional beds, you can use 21, and that would be that you would have to divide that up and do a staffing plan for that. Is that what you're asking me?

MR. VOZZA: It's a little confusing what you're saying, but I guess my point is --

MS. RYAN: The staffing --

MR. VOZZA: -- what is -- what is the cost that is associated with the staffing that would be necessary for this?

MS. RYAN: So, the total cost would actually be -- you're asking me for the staffing?

MR. VOZZA: Yes.

MS. RYAN: Mm-hmm? Okay. So, it would approximately be dependent on the FTEs that were needed. Say that there would be approximately 12 FTEs needed on each shift. That's 24, at -- at approximately $125,000.

MR. VOZZA: $125,000 total or per?

MS. FELDMAN: I'm going to -- this -- I'm going to object because this information is in the financial Worksheet A. It's the projections with the CON, and it includes the additional FTEs. All that information is available in the application.

MR. VOZZA: Counsel, do you -- do you recall what page that would be on?

MR. CSUKA: One moment, Attorney Vozza.

MS. FELDMAN: Oh, I actually have copies here.

HEARING OFFICER JACKSON: So, we'll sustain the objection to the question for now. Can you provide the worksheet, and then we can proceed with questions about the worksheet to the extent they exist?

MR. VOZZA: Thank you. Actually, while I take a look, I have another question.

You had indicated in your -- in your testimony that there's an issue at JDH with boarding in the ED; is that correct?

MS. RYAN: I did in my prefile testimony.

MR. VOZZA: Okay. And can you just talk about what different types of factors might contribute to that?

MS. RYAN: Boarding in the ED?

MR. VOZZA: Yes.

MS. RYAN: So, I believe that what I said to you was, you know, right now patient satisfaction, if you have -- whether it's 5, 10, 15 taking up ED spaces, so there's less room to basically admit ED patients at that time. So, it's longer waits, whether that's door to doc, doc to decision, decision to admit or discharge. It affects staff and it affects staff engagement. It affects patient satisfaction.

I also indicated that there are delays, whether that's delays in radiology -- you have boarded patients down there. So, it's just not good care. They're not in their own room. They're not in their own unit. They don't have their own nursing staff. It's poor care.

MR. VOZZA: I think you had indicated also that you've looked into or considered all options to confront the issue of boarding in the ED; is that correct?

MS. RYAN: Within our institution, yes.

MR. VOZZA: Okay. What about outside the institution? Has there been any collaboration with any of the hospitals in the primary service area?

MS. RYAN: As Dr. Agwunobi alluded to, no.

MR. VOZZA: Okay. I have nothing further.

MS. FELDMAN: I do have some redirect.

MR. CSUKA: Let's hold that until we've gotten through your three witnesses.

MS. FELDMAN: Oh, I'm sorry.

MR. VOZZA: It's entirely up to you. It doesn't matter to me either way.

MR. CSUKA: Okay. We can do redirect -- or did you have redirect of -- I'm sorry, Attorney Feldman. Did you have redirect of Dr. Agwunobi too?

MS. FELDMAN: Yeah. I can wait. I can wait until after Dr. Stratmann.

MR. CSUKA: Okay. Okay. Okay. Let's just proceed through the witnesses then.

MR. VOZZA: Good morning, Dr. Stratmann.

MR. STRATMANN: Good morning.

MR. VOZZA: Just -- you might have heard some of the discussion before regarding the 2012 bed methodology?

MR. STRATMANN: I'm not sure what you're referring -- you mean the testimony right now?

MR. VOZZA: No. Just now, when I was speaking with Ms. Ryan and the weekday occupancy rate percentage report.

MR. STRATMANN: Yeah. I heard your question about the weekday occupancy rate.

MR. VOZZA: Yes. So, are you aware if that weekday occupancy report methodology is part of or a standard set forth in the 2012 bed methodology?

MR. STRATMANN: I do not know.

MR. VOZZA: Okay. So, if there is somebody who knows that, we're going to have to --

MS. FELDMAN: Mm-hmm.

MR. VOZZA: I wanted to just point out, in your testimony earlier, your verbal testimony, you had indicated that your findings resulted in a need for 17 beds; is that correct?

MR. STRATMANN: That's correct.

MR. VOZZA: So, not 23?

MR. STRATMANN: Not 23.

MR. VOZZA: Okay.

MR. STRATMANN: But that was also -- there I mentioned I already made three small changes to the method. And the testimony that I provided, I mentioned that I had not considered -- at least a few of the changes, I did not consider many of the other faults in

the methodology which tends to underestimate bed need.

MR. VOZZA: Would you agree that -- I understand trying to predict bed capacity. That's one thing.

Is actual historical data important in trying to determine or predict bed capacity?

MR. STRATMANN: I think it depends on the question that's being asked. And right now, for the current purposes, I think historical data are irrelevant because we're looking at at least, you know -- you're looking at the situation that Dempsey is facing right now, and that is current data; that is not data from some years ago.

MR. VOZZA: Okay. Can I refer you to Exhibit V if you don't mind?

MR. STRATMANN: V?

MS. FELDMAN: In the Table of Record or --

MR. VOZZA: The Table of Record. It's the collection of Report 400, the --

MS. FELDMAN: Okay. That was just uploaded yesterday?

MR. VOZZA: Yes. A couple days ago.

MS. FELDMAN: Okay.

MR. STRATMANN: So, what am I looking at here?

MR. VOZZA: Well, there's actually several reports here. And I'd ask you to take a look at the one for John Dempsey Hospital. I think it's the third page, third or fourth.

MR. STRATMANN: Okay.

MR. VOZZA: So, you know, we're specifically talking about the med-surg beds; correct?

MR. STRATMANN: Correct.

MR. VOZZA: Okay. If you take a look at the 2022 and 2023 data, which I think you would agree is recent, what does it indicate the bed capacity as?

MR. STRATMANN: I do not agree it's recent. Recent is the last 11 months of the current fiscal year, number one. And your bed capacity, it says -- med-surg -- oh, here -- is 63%.

MR. VOZZA: Okay. Is that below the 80% threshold?

MR. STRATMANN: I think so.

MR. VOZZA: Okay. So, again, I would ask you, isn't -- well, strike that.

Do you know where this information comes from?

MR. STRATMANN: Yes. I mean, from the -- CHIMs or CHIMEs data.

MR. VOZZA: No. What I mean is would you

agree that this data is submitted to the OHS? Will you accept my representation that it is?

MS. FELDMAN: I'm -- I'm going to object on the form of your question. It's unclear.

MR. VOZZA: Does JDH submit this information to create this -- this report?

MS. FELDMAN: Again, what information are you asking? I have to object to the question because it's impossible to answer.

MR. VOZZA: How about this.

MR. CSUKA: One second.

HEARING OFFICER JACKSON: I think part of the confusion is perhaps Dr. Stratmann is not the best person to answer this question. So, I'll ask JDH generally to confirm that the information as presented in this exhibit is reported by the Hospital to OHS. I am seeing nodding. So, if someone can state for the record that --

MS. FELDMAN: Yes. You want to come up here, please?

MR. CSUKA: So, we're going to have to swear him in --

MS. FELDMAN: Right.

MR. CSUKA: -- even if it's just for this one --

MS. FELDMAN: Yeah. One of the issues -- this is not our document. I just want to be clear.

HEARING OFFICER JACKSON: Right.

MS. FELDMAN: Okay.

MR. BIANCHI: Good morning. I'm Chad Bianchi, Comptroller for UConn Health. Yes, my staff submitted this data.

MR. CSUKA: And before you restate that question, we'll need you to raise your hand.

Before you do that, can you just spell your name?

THE WITNESS: Sure. Chad, C-H-A-D, Bianchi, B-I-A-N-C-H-I.

(CHAD BIANCHI, having first been duly sworn by Daniel J. Csuka, Esq., OHS Staff Attorney, was examined and testified as follows:)

MR. BIANCHI: So, yes, we submit that to OHS. It's my staff.

MR. VOZZA: Thank you. I don't have any other questions for you. I apologize, but I really appreciate it.

Just the one issue, if you don't mind. If the individual who is able to discuss the bed methodology and the weekday occupancy percentage, if there's someone who can answer that question, that

would be -- that would be great.

MR. CSUKA: In hindsight, perhaps I should have sworn everybody in, but I apologize for that. Can you just state your name for the record, please?

MR. GIBBS: Brian Gibbs, B-R-I-A-N G-I-B-B-S.

MR. CSUKA: And your title or affiliation with --

MR. GIBBS: Strategic Planner. I work for John Dempsey and UConn Health Center.

MR. CSUKA: Thank you.

(BRIAN GIBBS, having first been duly sworn by Daniel J. Csuka, Esq., OHS Staff Attorney, was examined and testified as follows:)

MR. VOZZA: Good morning, Dr. Gibbs. I appreciate it.

MR. GIBBS: I'm not a doctor, but thank you.

MR. VOZZA: Force of habit. So, just very quickly, the Weekday Occupancy Rate Percentage Report that was submitted by JDH and testified to by Ms. Ryan, are you aware of that report?

MR. GIBBS: Yes.

MR. VOZZA: Okay. And are you aware of where the standard for utilizing that report comes from?

MR. GIBBS: Yes. There was a part in the

2012 document, the OHS, that methodology was outlined. And the part about the weekday average was sort of a consideration that they offered combined with the consideration of observation beds.

MR. VOZZA: So, I'm going to paraphrase how I read it, and you can maybe tell me if you agree.

I read that to indicate that utilization of the weekday percentage rate is just -- is one of the factors you can use in trying to determine bed capacity in a particular institution; is that correct?

MR. GIBBS: I would agree with that, yeah.

MR. VOZZA: That's how I read it.

So, my question is, is this is the same bed methodology that Dr. Stratmann is indicating is statistically invalid; is that correct?

MR. GIBBS: Sure. Yeah.

MR. VOZZA: That's all I have.

MR. CSUKA: Did you have any further questions for Dr. Stratmann?

MR. VOZZA: I don't.

MR. CSUKA: Okay. Attorney Feldman, would you like to begin redirect?

MS. FELDMAN: I would.

MR. CSUKA: Okay.

MS. FELDMAN: Ms. Ryan?

Is it true that if you did include the weekend days, that the number might be even higher? In other words, the weekend patient census, if you include that, the Average Daily Census number could go up? Is that possible?

MS. RYAN: That is possible. My Average Daily Census total is 183.1, including weekends.

MS. FELDMAN: With respect to the concept of perhaps leasing beds at a hospital that's approximately 12 miles away, as a clinician, what is your opinion in terms of the potential fragmentation and cost associated with having JDH have 23 beds at Bristol Hospital?

MS. RYAN: I'm going to go back to what Dr. Agwunobi stated. Dr. Agwunobi stated that patients are coming to UConn because we have a great brand, we have a great reputation, we have a great quality, we have great patient safety, we have great subspecialties. And that's why they're coming here. It would be very difficult to have 23 beds at a hospital that does not have the same level of such specialties.

MS. FELDMAN: Ms. Ryan, with respect to your prefile testimony -- could you take a look at that? Specifically Footnote 2 and 3.

Are those footnotes referring to the chart below? Two and three. Right here.

MS. RYAN: Yes.

MS. FELDMAN: You can answer.

MS. RYAN: Yes. All right. It refers to the maternal health beds. Yes, it does.

MS. FELDMAN: And the source for that graph, does that data come from your own internal utilization and reported to CHIME?

MS. RYAN: Yes.

MS. FELDMAN: Okay. Thank you.

HEARING OFFICER JACKSON: And just for clarity, we've marked as a Late File Request Number 1 to refile the prefile testimony with the appropriate footnotes, because they're just missing. So, we'll --

MS. FELDMAN: They're erroneously there.

HEARING OFFICER JACKSON: Okay.

MS. FELDMAN: But I can footnote the chart.

HEARING OFFICER JACKSON: If we can just clean that up. Thank you.

(Late File Request Number 1.)

MS. FELDMAN: I have redirect of Chad, please?

With respect to this exhibit here that was uploaded yesterday, Report 400, are you responsible for

calculating the percentages or just reporting the data?

MR. BIANCHI: I am uncertain. I think OHS may calculate the percentage based on the raw data.

MS. FELDMAN: Okay. Thank you. I have no further redirect.

MR. CSUKA: Okay. Let's take a five-minute break. Let's take a five-minute break. We'll come back --

MS. FELDMAN: I have one more redirect of Dr. Stratmann.

MR. CSUKA: Okay. Sure.

MS. FELDMAN: Dr. Stratmann, you've heard some questions regarding JDH's use of the midweek occupancy rates for medical-surgical beds, or all beds, for that matter.

Is consideration or use of weekday census the reason why the 2012 method is unreliable?

MR. STRATMANN: No, it is not. I believe I have never mentioned the weekday census during my testimony, oral testimony or during my written testimony.

MS. FELDMAN: Thank you.

MR. CSUKA: All right. So, now we will take a five-minute break. Let's plan to come back at 11:32, and we can start with the Intervenor's case-in-chief.

And just as a reminder to the public, public comment sign-up is currently happening. It will go until 12:00. I have no expectation that public comment will begin at 12:00, though.

So, off the record we'll need to discuss whether there are any individuals who need to provide public comment from the Intervenor or the Applicant, whether they be clinicians or executives who have specifically blocked that time, or public officials.

So, let's come back at -- actually, let's say 11:33 now. And we will see you momentarily.

(Recess from 11:27 a.m. to 11:35 a.m.)

MR. CSUKA: All right. So, we are ready. Welcome back. This is the CON hearing in UConn John Dempsey Hospital's Application for an Increase in Licensed Bed Capacity, Docket Number 24-32699-CON.

We have gone through the Applicant's case as well as the cross-examination and redirect. We're now going to transition over to the Intervenor's case as well as cross-exam, if there is any, and any redirect following that.

The plan is to get through all of the Intervenor's technical component, excluding OHS' questions and taking public comment immediately after, then breaking for lunch. And then we'll come back and

we'll do OHS' questions for the Applicant and for the Intervenor.

So, as I stated earlier, public comment is ongoing. It'll end -- excuse me. Public comment sign-up is ongoing. It will end at 12:00. And we will find out whether there is anyone who wishes to make a comment at that time.

So, right now, I am going to turn it over to Attorney Vozza, and you can make any preliminary remarks you have and present your witness.

MR. VOZZA: That's not necessary. I just wanted to introduce Mr. Barwis to testify on behalf of the Intervenor.

THE WITNESS: Thank you.

MR. CSUKA: Thank you. Mr. Barwis, can you please state your name and title?

MR. BARWIS: I am Kurt Barwis, K-U-R-T B-A-R-W-I-S, and I am the President and CEO of Bristol Health and the President and C.O.O. of Bristol Hospital.

(KURT BARWIS, having first been duly sworn by Daniel J. Csuka, Esq., OHS Staff Attorney, was examined and testified as follows:)

MR. BARWIS: Thank you. First, I'd just like to adopt my prefile testimony.

MR. CSUKA: Thank you.

MR. BARWIS: Just a little bit of history about me. I started in the late '70s in healthcare. I worked at a hospital. And my undergrad is from Orton School in accounting. My graduate degree is from La Salle. It's an MBA with a Concentration in Finance.

I practiced as a CPA for a while, working for Coopers & Lybrand. I was fortunate enough to work on a specialized reimbursement team in Philadelphia under the direction of the past Director of Reimbursement Policy for the Centers for Medicare and Medicaid Services, Mike Barr. I provided reimbursement opinion letters. I did audits of hospitals. Actually, I had about 32 hospital clients where I did the -- the analytics for their hospital reports and their financial statements.

And I've actually worked on the nursing side of the world for a while as a nonclinical director. Worked as -- always in the healthcare industry, medical device companies, sales and distribution companies, manufacturing companies, at medical start-up, and ended up back in a hospital in Bristol, Connecticut, as the CEO, which was like coming home for me, because I grew up at a small hospital in Philly. So, a lot of -- a lot of extensive background on all sides of the

business.

I'm currently on the Board of the American Hospital Association, and I happen to be the Chair of their Regional Policy Board for all of New England. And I am a Fellow of the American College of Healthcare Executives. That's our credentialing organization for hospital executives. I just came off the board of the American College of Healthcare Executives as a governor, and I was the actual Governor of all of Canada for the time that I was on that board. So, very fortunate to have a lot of healthcare experience.

And one of the kind of interesting things I would say about my background is I'm probably one of the few people that can actually say they did a cost report on a Morrow calculator on 17-column paper. So, people would probably understand how amazingly difficult that can be.

Bristol Hospital -- you know, and let me say this. You know, I'm very impressed with the testimony that I heard from UConn Health Center. I have a tremendous amount of respect for their leadership team, Ms. Ryan's testimony and all that she's done to try to improve the flow and throughput at her facility, you know, and all of the aspects of what that team has done. And we do, in fact, collaborate with them, you

know, and mentioned the current technology relationship we have.

A big part of the increase in referrals is because they changed the definitions of high risk for women. So, naturally, you would see an increased referral base to a high-risk specialty hospital like the UConn Health Center. And they should be very proud of what they do.

But I would say this. Two days ago at 4:00 in the morning, we had a woman show up in our ER and had to deliver a baby breech in under ten minutes. So, the need for a community hospital like Bristol Hospital is very important. We do not, in fact, have all of the things that they have, and we do rely on them for those things. So, again, I appreciate the collaboration.

The other thing I would say about Bristol Hospital -- and I -- and I really love the sense of pride that I heard from Ms. Ryan about their quality and their outcomes. And she pointed to two of the really very difficult measures to score well on.

But I point out that in terms of patient experience, in terms of quality and outcomes, there are actually ten questions that are asked, right. And those ten questions, you could say this is an important one for me or it's an important one for another

hospital. And we all work really hard on our patient experience, right.

There's ten questions that compile up into an overall star rating for patient survey rating. And what's really interesting is we all get there in a different way, but we all strive for excellence. The star rating gives one through five. And we are -- just as proud as them, we are four stars, just like them, in patient experience.

We also, in terms of quality and outcome measures -- and I -- and I rely on the CMS Quality Rating System. It has 45 objective measures. And it encompasses everything -- quality, safety, readmissions, patient experience. And they weight those things in a bunch of different ways. I'm proud to say that we're a four-star hospital in terms of the overall rating from the Centers for Medicare & Medicaid Services.

The other thing I would say is we're one of the few hospitals in hospital that are a Magnet status. Literally in this country, there's only about 8% of the hospitals in the country, in the world, that actually can achieve that rating. And it has to do with your nursing quality and outcomes.

We are also the only hospital in Connecticut

that has ever achieved any level of status with the Baldrige Quality Award. We've now since been awarded twice on a regional level for our quality and outcomes.

In terms of high reliability, as I sit here today, I'm going to knock on wood, it's been 899 days since we had our last serious safety -- 899 days. That just demonstrates an extraordinary culture of safety and focus on quality. And it does a lot more than just that, right. So, it actually contributes to patients' outcomes, but it also contributes to the cost of delivering care in the organization. So, right now I think I only have two active malpractice cases on the hospital side. And we have had nothing in the last five years that was material in terms of a settlement.

So, as an accountant and a CPA, I always look for the return on investment. I can tell you, aside from patient outcomes, those things are very, very important to us.

All this to say, you know, Bristol Hospital is a very important aspect of the community, and the community, which in our -- we call it our primary service area, they call it their primary service area, one that treats 38% of our patients coming through the ER are actually Medicaid patients, and about 2% are uninsured patients.

So -- so, just like, as you heard from UConn, very proud, very proud of our systems, the way we've really focused on throughput and outcome and all of those things.

I really -- our objection or our intervening in this process has to do with our desire for more collaboration. You know, that's about as simple as I can say. We don't have the resources that the UConn Health center has. We would love to be able to work with them and achieve together a much better cost outcome for the State and also a much better health access outcome for the State.

We are literally less than 12 miles away. I see that there's a variety of definitions of how far we are from them. The shortest -- there's actually many different routes you can take. The shortest distance is about ten miles driving by car.

In my testimony, we used eight miles, and that has to do with the way you define your recruitment objectives for the federal government, and it's as the crow flies. So, literally you wouldn't get there in eight miles, but if you took a plane or a helicopter, you would.

So, you know, I just want to be clear up front, we are not here to, you know, to say anything

derogatory or bad about anything. We appreciate and value that relationship and the team that we work with on a pretty continual basis.

So, the first thing that I'd point out, and I think it became very clear, is that the data does not support the need for 23 beds. So, that -- that to me is very clear. It's -- if, you know, if you look at the OHS definition of it -- and by the way, I'm also on the Governor's Healthcare Cabinet and have been on that cabinet since before OHS actually came into existence. And I have a lot of respect for OHS. I think they do a great job. They work very hard at their definitions and their reporting. So, the reports that we see go through a lot of work and evolution over time. So, I'm sure they're going to appreciate some of the feedback they got today.

The thing about the weekday census clearly skews the need for the beds, right. That to me is a very important factor in this, and that's why I can say authoritatively that there is no need for these 23 beds based on the occupancy.

The OHS 400 Report correctly reflects that she has a much lower occupancy than what's in this application. And as I stated, we're really close.

An important thing, and I really came by this

in terms of the process that we went through to actually build that health center, to rebuild that extension, that wing, I was very intimately involved in it. It was back in 2010. I am a registered lobbyist in the State of Connecticut. So, I was very familiar with the grand bargain that occurred, because there were a lot of objections from other hospitals at that time.

And as I was preparing for this, I remembered when Governor Rell signed the bill, she actually turned around and handed me a signed copy of it. I couldn't find it, but I was able to go online and get the bill.

And I think one of the things that I don't understand and I think has to be examined as part of this process is that -- that in participating in that legislative process and actually being very familiar with the language in the bill, having read it several times, the PA, PA 10-104, that provided for the construction of the new bed tower at John Dempsey Hospital, in the current statutes, in Connecticut Statutes, Statute CGS 10a-109c(33), provides that JDH's Licensed Bed Capacity will increase from 224 beds between a number not to exceed 234 beds.

So, I'm curious about that, because -- and I'm not aware of it, I don't understand the actual

process, but it would seem to me that in order to do this you would need to go through a legislative process to actually increase the beds above 234 beds. That's -- and I'm not sure -- I'm way out of my bounds, but I'm just -- I'm quoting what the current state statute says. Okay?

The next part of this is the CON unnecessarily increases the cost of healthcare in the state of Connecticut. I preceded the edition of this Exhibit AD, which defines cost in a way that looks at what -- what a -- you know, what a -- employer plans would pay for the services at John Dempsey versus Bristol Hospital.

MR. VOZZA: Just for the record I think you mean AA; correct?

MR. BARWIS: I have AD. AD.

MR. VOZZA: Sorry.

MR. BARWIS: AD. Thank you. So, it looks at the prices that people actually pay, so the commercial health plans.

MR. CSUKA: Just one moment. Sorry.

HEARING OFFICER JACKSON: For clarity, I think it's DD. It's okay. It's okay. You're referencing the RAND 2022 payer data --

THE WITNESS: Yes, I am.

HEARING OFFICER JACKSON: -- and your report published 2024.

MR. BARWIS: Yes, I am. So, if you consider -- if you define cost as what a commercial plan would pay, then that's great. I mean, you know, that's a reasonable way to do it. And when you look at that, you can see that there are costs -- their prices that the plans would pay through their negotiations are pretty close to ours. They're a little bit more than what we are, right.

But the other thing that I would point out, being a finance person, is that when you look at the overall -- and I'll go back to my testimony -- if you go back to the actual reimbursement-to-cost ratio, the commercial reimbursement-to-cost ratio -- so this is commercial in the exhibit -- and you look at what the OHS report says and what I've included in my testimony, the reimbursement-to-cost ratio for commercial payers for John Dempsey is 1.02. For Bristol Hospital, it's 1.56.

So, as an accountant, as a CPA, as someone who did cost reports, what that tells me is that these prices are almost exactly what it's costing them to provide the service.

And in the scheme of things, in the scheme of

hospital finance, right, government payers pay less than cost, substantially less than cost. Medicare on average is paying about 82 cents on a dollar cost. And Medicaid in the state, depending on how you want to calculate it, is 69 cents on the dollar cost. Medicare Advantage, to the extent you have Medicare Advantage, is almost 11% to 12% less than traditional Medicare.

So, what it really drives is where is this money being made up? So, if commercial payers are paying what it costs them to deliver the service and governmental payers are paying less than what it costs them to deliver services, somebody's making up that cost. And that somebody is the State of Connecticut. It's the taxpayers in the state of Connecticut.

And so, from my perspective, the issue is that these additional beds generate more cost or put -- put services into a place that is more costly than the alternatives in the communities around them and their primary service area.

Now, we've heard a lot about this issue of they're not doing this to compete with us, they're doing this to deal with patient preference. We, too, have community preference surveys almost exactly the same time frame, I think demonstrate almost the exact same kind of growth and choice perception or the choice

from the community growing stronger and stronger for Bristol Health over time, almost the exact same time periods.

But the bottom line is we don't have the benefit of the government support, the State of Connecticut. We are a fragile -- we just defaulted on our bonds on -- well, I'm at break-even right now in our operation. My balance sheet was destroyed during the pandemic. Coming out of this pandemic, I have literally -- I work to make payroll every other week.

So, for me it's real. And what I look at is -- and from a community perspective, from a broader perspective, I take care of 10% more of the Medicaid population than John Dempsey Hospital does. Those patients are in my community. Those Medicaid patients are in my community. I have a 73% government payer mix. I wish I had their payer mix, but I don't, because I don't have those specialty services.

And so, part of my concern is if we don't find a way to collaborate, what is going to happen to all those patients, those patients who do not have the economic ability to go to another hospital?

And furthermore, if you were to take our 30-plus-thousand visits in our ED, because we are virtually in the cross-hairs of not being able to

exist, who's going to take care of those patients? Are they going to be able to get to John Dempsey Hospital and their ER? Are they going to be able to get the care? Is the woman who came through the door at 4:00 a.m. in the morning that had no prenatal care, had a pretty serious history of substance abuse, going to be able to -- going to be able to deliver that baby alive? I don't think so.

So -- so, the harm -- and the harm that was actually identified, the issues with building the health center in the first place, has really kind of played out over time. We have lost market share to them. My EMS took 653 patients to them last year from my community, which they define as their primary service area.

So -- so, there are true consequences to growing and keeping, you know, this investment and the subsidy of that health center without some collaboration and really paying attention to access to care in the communities that are being served. How do we make it right for patients so that it's -- it's -- patients everywhere can get that access?

You know, I point to, you know, a simple fact. At any point in time, we have had 32 beds available. So, we could easily accommodate that bed

capacity.

I point to the fact that the Yale-New Haven health system ran out of capacity, which everyone's well aware of, and they leased a floor from Milford Hospital, and it worked very, very well, because they couldn't build that bed capacity on their campus.

I'd also point to what I see as the biggest issue with ER overcrowding. And I know that they have done extraordinary work to resolve the overcrowding issue. But as Mr. Stratmann pointed out, Professor Stratmann pointed out, Connecticut has the lion's share of the senior population. We have -- and specifically Hartford County does.

So, one of the factors in ER overcrowding is the prior authorization process. When I look in my ER and understand what's blocking it up, it's because the vast majority of -- more than 50 -- almost 60% of the Medicare patients in the state of Connecticut are Medicare Advantage.

And that means, unlike traditional Medicare, where you can -- you have to have a three-day qualifying and acute-care stay before they can go to a skilled nursing facility, under Medicare Advantage, they can go directly from the ER to the skilled nursing facility -- which means that on the weekends, on

holidays, and things like that -- and often, there is nobody there to give a patient a prior authorization.

So, they sit in your ER for three or four days waiting to be authorized, waiting to go to a skilled nursing facility. That to me is the number-one factor blocking up my hospital beds, because at the same time they're waiting in the ER to go to a skilled nursing facility and there's a delay in getting that prior authorization, I have the same number -- during the pandemic, there was one night I had 12 patients in my acute-care beds waiting for a prior authorization to go to a skilled nursing facility, while I had an equal number in my ER waiting for admission.

And the only reason they weren't able to move to the beds that they needed -- because I agree wholeheartedly that it is not safe to keep somebody that needs to be an inpatient in your ER -- was because they couldn't get an authorization from their insurance company to go to a skilled nursing facility. That is a big problem in our states and towns across our country.

But I would point this out to you. In 2024, January 2024, this is on the radar for CMS, Centers for Medicare & Medicaid services, they released about a thousand pages of regulations to improve and reduce the prior authorization delays. We have another thousand

pages of regulations that are going to be coming out on January 1st of 2026 which will make all prior authorizations electronic.

You have a recent announcement from the Office of the Inspector General investigating all these insurance companies for all these delays and denials related to moving patients from acute-care settings to post-acute settings.

When I look into the future -- and we heard testimony that talked about sometimes the historical data on census does not accurately give you a picture of what's coming in the future -- when I think about the future, I think about a national focus -- because this is a federal focus, and it's also a state focus -- we have prior language in the current -- the current legislative session that just ended that's going to focus on this and get us back to where we were when we didn't have all these delays, when this wasn't a factor. And so, that also, to me, plays into this -- this concept of what do I need in terms of beds? You have to factor that in because those numbers are real.

And the other thing that's really important to understand is you've got a trend from inpatient to outpatient which is national. And you can easily see it because orthopedic joint surgery just six years ago

was an inpatient admission. Now it's an outpatient procedure. And it's an outpatient procedure 80%, 90% of the time now, so you don't need those beds.

So -- and beds are expensive, right. If you go back and do the math on the health center, it was $600 million, something like that, for 234 beds? That's over $2.5 million a bed.

So, the idea or the notion that you can just put the beds where you think you need them or in the facilities you need them and just ignore what you invested in another facility doesn't make a lot of sense, right. You have to weigh in those cost factors into the equation.

So -- so, look, I -- I would -- I'm not here to hurt the health center in any way, shape, or form. It is a phenomenal organization. It does an incredible job. And -- and I respect them, and I love collaborating with them.

I just think we're sitting within however you define it -- 12 miles, 11 miles, 13 miles, whatever it is -- we are in close proximity. We need to work together to create a construct that improves access in our communities, because, look, their Medicaid percentage is really low. Why? Because they don't have it in Farmington.

So, how about take some of that incredible talent, that knowledge, and all those specialists, 650 or whatever it is I read in that Cain Brothers report, and extend it out into the communities like we did under perinatology, and let's build a construct that lowers the cost of healthcare in the state of Connecticut, Executive or Governor's Executive Order Number 5; right?

How do we get the cost of healthcare down in the state of Connecticut, all of the costs, not just the costs of the commercial plans but the total taxpayer burden in terms of healthcare, and make it better for everybody?

So, that's my testimony. Thank you for the opportunity.

MR. CSUKA: Thank you.

Attorney Vozza, did you have any questions for Mr. Barwis?

MR. VOZZA: Just a couple.

Mr. Barwis, you heard Dr. Stratmann earlier testify regarding the infrastructure and the ability for Bristol Hospital to take on some of these patients. Can you speak to that?

MR. BARWIS: Sure. You know, so, we have -- we have renovated our floors internally because we

really couldn't afford to do it externally. So, we have 32 beds available. We have the infrastructure. We have -- you know, we have an incredible support system, you know, all of the, you know, brand-new monitors, the incode monitors, telemetry monitors throughout the organization. We have an incredible radiology department. Our pathology department is extremely well positioned to do additional volume. We have incredible capacity in our ORs.

You know, we could easily allocate two ORs, and we have capacity to build out more ORs. And our ambulatory center is incredibly efficient in terms of its staging of patients. Patients can literally park outside the hospital and walk in, so parking and accessibility is there.

So, while we have an old infrastructure, we've maintained it, we've invested in it, and it's in a great place to do this.

MR. VOZZA: One more question in the same vein. I also heard Ms. Ryan testify earlier that Bristol Hospital was too busy to take on patients. Can you speak to that?

MR. BARWIS: I can't -- I can't speak to the exact instance that she's talking about. But I'd point out that there's 365 days in the year, and we all --

depending on what's going on in our communities, there could be some kind of an emergency or a problem -- go on diversion. I mean, we had an unfortunate event a year and a half ago where we had two police officers ambushed and we had to shut down our facility.

So, without noting the specific day and time to be able to respond, I can't respond to that -- that specific time. But I can say this. At any point in time, we have 32 beds available in our hospital.

MR. VOZZA: That's all I have.

MR. CSUKA: Thank you.

Attorney Feldman, you can proceed with cross-examination.

MS. FELDMAN: Thank you.

Mr. Barwis, in your prefile testimony, you stated that Bristol Hospital has a maximum capacity of 140 beds. But on your website, Bristol Health states that you have 154 licensed beds.

So, do you know which one it is?

MR. BARWIS: We're licensed for 154 beds.

MS. FELDMAN: Okay. Thank you. So, with 154 beds, based on the data that we were able to obtain from CHIME, it seems as if you're filling about a third of your licensed beds?

MR. BARWIS: I'd have to -- I'd have to look

exactly at the data, but --

MS. FELDMAN: Well, just roughly speaking, as the CEO of the Hospital, do you have a sense generally what your percentage of utilization is or capacity --

MR. BARWIS: So, we typically run in a 70-to-80 range Average Daily Census.

MS. FELDMAN: Okay, because --

MR. BARWIS: So, and if you're utilizing the Licensed Bed Capacity, that's pretty easy.

MS. FELDMAN: Okay. So, I'm talking about your prefile testimony. And in your prefile testimony, I'll refer you to your tables, it looked like your Average Daily Census for inpatient admissions ran around 42. Is that correct? On average? It's your Table 1.

MR. BARWIS: It excludes observation status. And it's -- so, that's just med-surg, and it excludes observation patients. That may be -- so, it's not heads in beds. And it's specifically med-surg.

MS. FELDMAN: Okay. So, just with respect to med-surg, so, what would you say your percentage of beds that are on average being occupied?

MR. BARWIS: So --

MS. FELDMAN: How many med-surg beds do you have?

MR. BARWIS: I would have to look. 47 right now.

MS. FELDMAN: Is that -- is that staffed or licensed med-surg beds? How many licensed med-surg beds do you have?

MR. BARWIS: 47 are staffed. I'd have to look at the breakdown. This is my testimony; right? Hold on a second. So, let me go through --

MS. FELDMAN: Now, I will point out that your Table 1 doesn't say it's med-surg, does it?

MR. BARWIS: Yeah. It's using G-South and G-Extension. That is our med-surg force. That's how I know it. Sorry. I apologize for that.

MS. FELDMAN: Oh, okay.

MR. BARWIS: GX and GS is G-South and G-Extension. So, I have -- so, I have 95 med-surgical beds, 14 ICU. Yeah.

MS. FELDMAN: So, about 50% of your med-surg beds are being occupied; is that correct?

MR. BARWIS: Correct. Yes. A little more.

MS. FELDMAN: Okay. And the same with 140 beds; right? Is that your -- these are your staffed beds? 50% of your staffed beds are being occupied?

MR. BARWIS: I believe that's correct, yes.

MS. FELDMAN: Okay. You mentioned just now

that you just defaulted on your bonds.

MR. BARWIS: Yep.

MS. FELDMAN: Are you financially solvent right now?

MR. BARWIS: Can you define that for me?

MS. FELDMAN: You're the accountant.

MR. BARWIS: No. I mean, when you ask that question, it's a complex question.

MS. FELDMAN: How many days of cash on hand do you have right now?

MR. BARWIS: So, right now we run at about 16 to 17 days cash on hand.

MS. FELDMAN: Okay. Has your health system or the hospital ever received any sort of subsidies, financial subsidies, from the State or Federal Government? Let's just start with the State.

MR. BARWIS: Yeah. Absolutely.

MS. FELDMAN: Okay. In the last five years, have you received any --

MR. BARWIS: Yes.

MS. FELDMAN: -- money? How much?

MR. BARWIS: So, just in the last session, so two sessions ago, $7 million over two years.

MS. FELDMAN: Okay. And would you say -- so, that money comes from the State of Connecticut? RAND.

MR. BARWIS: RAND. Right.

MS. FELDMAN: And how is that money funded? Would we be able to say the taxpayers fund that money?

MR. BARWIS: Yes. That would be -- would be correct.

MS. FELDMAN: Okay. Looking at your Table 3 in your prefile -- I have to admit it was hard to read some of these tables. I'll just try to read it now.

But since 2019, let's call that the pre-Covid period, in 2019, am I correct when I say you were about 4,300 discharges for your primary service area?

MR. BARWIS: Correct. 4,357.

MS. FELDMAN: Okay. And now, in looking at 2023 -- and I'm happy to look at 2024 too -- am I right in saying that you're at 3,300, roughly?

MR. BARWIS: Yeah. That's correct.

MS. FELDMAN: So, you haven't rebounded after Covid like most other hospitals in the country?

MR. BARWIS: So, I wouldn't agree with that statement. And the reason I wouldn't agree with it is because when you look at our programs, as I pointed out to you earlier, you know, take orthopedic joint surgery, that was all inpatient. All of that volume transferred out.

And then more recently, we ended our

bariatric surgery program because of the move to GLP-1s and being able to sustain that. So, there have been -- and you take a look at the shift in maternity. We've maintained our -- our volumes while at the same time transferring out more patients to UConn because they're high risk. So, it's a multifactorial issue.

MS. FELDMAN: Okay. With respect to your data that's reported in these tables, is that full-week occupancy or similarly reflects midweek?

MR. BARWIS: Full week.

MS. FELDMAN: Okay. Have you looked at John Dempsey Hospital's CHIMEData? Because seven days they're at -- they're above the 80%, including all seven days. Have you looked at that?

MR. BARWIS: No, not specifically.

MS. FELDMAN: Okay. All right. In Your Table 2 in your prefile, you state that it reflects ED discharges. Let me show you what I mean. But when we checked that data with CHIME -- I believe there's an error, because I believe those numbers reflect all of your discharges, not your ED discharges. Is that something --

MR. BARWIS: No. I mean, if you go back in time and history, you report your ED visits as a statistic, which includes those patients that are

admitted to the hospital and patients that are discharged out to the community, right. So, that's a combined metric. And then you also separate and look at ED visits that are, you know, discharged to the community and separately those that are admitted. So, the staff simply combined -- and they reported all ED visits.

MS. FELDMAN: I don't think you understood my question.

Table 2 is titled "ED Discharges." Okay? Do you agree with that title?

MR. BARWIS: Yeah.

MS. FELDMAN: Okay. Those numbers, when you check it on CHIME, reflect all discharges from Bristol Hospital, inclusive of ED discharges.

MR. BARWIS: So -- so your --

MS. FELDMAN: My point is that I don't think this is accurate data.

MR. BARWIS: So, can I ask for a clarification? So, your point is the word "discharges." That's what you're focused on. You're saying the data is not discharges, because you're saying that -- you're defining discharges as just those patients that go from the ED to the community.

MS. FELDMAN: Correct.

MR. BARWIS: Okay. So -- so, the definition -- we should have changed that, so I apologize for that. It should have included all ED visits, both inpatient discharged and outpatient discharged.

MS. FELDMAN: Perhaps that could be a late file to correct the data.

So, in the 2024 Statewide Facilities Report, and I might be butchering the full name of the report, I believe it states, OHS states that ED visits statewide have decreased.

Is it fair to say that John Dempsey Hospital's growth of ED visits far exceeds those of Bristol Hospital's ED decline if you look at --

MR. BARWIS: Yeah.

MS. FELDMAN: Yeah?

MR. BARWIS: Yeah. And I would also say -- like, I would point out to you that our EMS crew, if you go back just five years, STEMIs were coming to Bristol and then determined where they were going to go. We now bypass Bristol Hospital's ED and take them directly to your cath lab.

MS. FELDMAN: Who's "we"?

MR. BARWIS: My EMS. I have my own ambulance company that serves the area. Yes.

MS. FELDMAN: Okay. And the reason for doing that?

MR. BARWIS: Because that's best practice.

MS. FELDMAN: Okay. That's door-to-cath-lab time. Thank you. Sure.

MR. BARWIS: Correct.

MS. FELDMAN: If you look at Ms. Caryl's prefile testimony, there's a chart there that shows the inpatient discharge trend for both John Dempsey Hospital and Bristol Hospital. I'll give you a second to look.

MR. BARWIS: I just -- can I -- is it okay if I just make one more clarification to your last question?

MS. FELDMAN: Of course.

MR. BARWIS: So, let's take stroke and let's take neurological and neurosurgery coverage. So, there have been times we had two neurosurgeons -- neurologists, I'm sorry, and so we were able to keep all our stroke patients, you know? And then there was a time when we lost them, and we had to divert those patients directly to John Dempsey Hospital.

We're now recruiting those neurosurgical coverages back and going through the neurosurgical telehealth program so we'll be able to take those

patients and keep them at Bristol Hospital and manage them to a great extent unless they need interventional neurosurgery.

So -- so, I wouldn't characterize it as, you know, we've -- you know, people aren't preferring to come to us. We're also triaging them appropriately and getting them to the place they need to go. And it has to do with the coverage that we have. We are not -- we are not an academic medical center, so recruiting physicians is often difficult and -- and it changes.

MS. FELDMAN: Mr. Barwis, I'm really just focusing on the data in Ms. Caryl's prefile testimony.

And if you look at the chart with respect to inpatient discharge trends -- can you look at that chart, please?

MR. BARWIS: Yep.

HEARING OFFICER JACKSON: Could you identify which section of this you're --

MS. FELDMAN: Absolutely. In the prefile. I -- unfortunately, I don't have numbered pages, but --

HEARING OFFICER JACKSON: But the sections are numbered?

MS. FELDMAN: Yes. Right before Section 2.

HEARING OFFICER JACKSON: Okay. Thank you.

MS. FELDMAN: Right before Section 2, there's

a chart which shows the inpatient discharge trend for both Bristol Hospital and John Dempsey Hospital.

Is it fair to say, when you look at that trend back from 2014 up through 2024, that Bristol Hospital's inpatient discharge trend has been on a steady downward decline based on --

MR. BARWIS: Yeah. Yeah.

MS. FELDMAN: Okay. Thank you.

Are you attributing your decline exclusively to patients going to John Dempsey Hospital?

MR. BARWIS: No.

MS. FELDMAN: Okay. Are you aware that some of your volume that you've lost are going to other hospitals?

MR. BARWIS: Yes.

MS. FELDMAN: Okay. In your prefile testimony, Mr. Barwis, you state that Bristol Hospital is a lower-cost provider than John Dempsey Hospital. I think that's your Table 8 in your prefile. Are you familiar with that Table 8?

MR. BARWIS: I am. I am.

MS. FELDMAN: Okay. So, how did you -- how did you calculate those numbers? Where did you get those numbers from?

MR. BARWIS: So, the -- the -- the op

expenses, the overall op expenses from the OHCA reports.

MS. FELDMAN: Which one?

MR. BARWIS: The Fiscal Stability Report.

MS. FELDMAN: Was that 2022?

MR. BARWIS: '22. Correct. Yep.

MS. FELDMAN: Okay. Thank you. So, I'm trying to understand how you calculated that number in your table.

Did you -- am I correct in saying that you took the total operating expense for Bristol Hospital and divided it by the number of discharges?

MR. BARWIS: That's correct.

MS. FELDMAN: And you did the same for John Dempsey Hospital?

MR. BARWIS: That's correct.

MS. FELDMAN: Is that the same as the cost to the patient, operating expense per discharge?

MR. BARWIS: So, reimbursement and what patients pay --

MS. FELDMAN: Correct.

MR. BARWIS: -- is different.

MS. FELDMAN: Okay.

MR. BARWIS: But somebody pays for that cost.

MS. FELDMAN: Okay. Yes. And you just

mentioned that the State was helping pay for some of your costs; correct?

MR. BARWIS: A little bit of our cost.

MS. FELDMAN: Okay. So, when I do the same methodology that you've done with respect to John Dempsey Hospital and I look at the other academic medical center, the only other academic medical center in the state, which is Yale, I see that their operating expense per discharge is roughly $57,000.

And when I look at JDH's Financial Worksheet A, which you have, for 2024, the operating expense per discharge for the other academic medical center, which JDH is part of, is $59,000; is that correct? I mean, I don't know if you've done the math.

MR. BARWIS: I have not.

MS. FELDMAN: But you have the exhibit that I have added to -- is it correct? Maybe I haven't added this one.

MR. BARWIS: I don't know.

MS. FELDMAN: But I could introduce it as a late file, if that would be something --

MR. VOZZA: I'll just object to the last question. I mean, it was more testifying, and it's really difficult for us to come up with that answer right now.

MS. FELDMAN: Okay. So --

MR. CSUKA: One moment.

HEARING OFFICER JACKSON: Just a second. I will sustain the objection. And if you can rephrase.

MS. FELDMAN: Sure. I'm going to basically take you to the Financial Stability Report. Do you have that?

MR. BARWIS: I do not.

MS. FELDMAN: Probably you do not. Well, it's hard to speak and -- but I'll give you numbers.

Let's start with looking at Yale, which is on page 75.

MR. VOZZA: Page 75 of -- of what exhibit?

MS. FELDMAN: This is the financial -- this is the calculation that you used in your prefile testimony in Table 8.

MR. VOZZA: But it's not -- not a current exhibit, is it?

MS. FELDMAN: It's -- we just added it to the Table of Records.

MR. CSUKA: Yeah. A copy hasn't been provided to you. This is the document that she referenced earlier where we said if we were going to be referencing specific pages, they would need a copy. So --

MS. FELDMAN: I -- well, okay. So, they can have my copy. I will get up and walk it over.

MR. CSUKA: Okay. It's either that or we can take a break and we can pull it up from the Internet.

MS. FELDMAN: No. It's fine.

MR. CSUKA: Whichever is.

MS. FELDMAN: It's fine.

MR. CSUKA: Okay.

MS. FELDMAN: If you look at page 75, you'll see the financial information for Yale. And if you look at their operating expenses, I believe it's $3,747,000, roughly. And the number of discharges are 65,695.

MR. BARWIS: That's actually incorrect.

MS. FELDMAN: Okay. So, go ahead.

MR. BARWIS: Their operating expenses are 3.97.

MS. FELDMAN: Okay. So, there -- that would probably yield an even higher number.

MR. BARWIS: I've never done the math for them, so I wouldn't know.

MS. FELDMAN: Okay. I'm just stating this methodology because it's one you used in your prefile testimony to say that JDH is a more expensive hospital. And I'm trying to just point you to the numbers for

some other hospitals.

MR. VOZZA: I would just object to the relevancy.

MS. FELDMAN: The relevancy is because it's in your prefile testimony that you use these numbers in Table 8, Mr. Barwis. There's a reference to Table 8 in your prefile testimony. Am I correct?

MR. VOZZA: Object to the relevancy concerning other institutions other than Bristol or John Dempsey.

MS. FELDMAN: Okay. It's relevant because -- look, I want to continue with my questioning because we are -- all right.

Would you agree that John Dempsey Hospital --

HEARING OFFICER JACKSON: Hold on. Hold on.

MS. FELDMAN: Sure.

HEARING OFFICER JACKSON: We've had a couple of objections, so let's --

MS. FELDMAN: Yeah. Sorry.

HEARING OFFICER JACKSON: Okay. We'll overrule that objection and say that the comparison between academic medical centers, which is my understanding of where we're going, is relevant enough. But let's try to --

MS. FELDMAN: Okay. We'll move on.

HEARING OFFICER JACKSON: Let's just get to that -- to that comparison.

MS. FELDMAN: Okay. So, would you agree, Mr. Barwis, that it's a well-known fact that academic medical centers tend to be more expensive institutions because of the academics, the teaching, and the research that goes on 24/7?

MR. BARWIS: Sure. Yeah.

MS. FELDMAN: Okay. So, you're comparing John Dempsey Hospital, which is part of an academic medical center, with Bristol Hospital? Is that correct?

MR. BARWIS: Yes.

MS. FELDMAN: So, you're treating them as the same type of hospitals?

MR. BARWIS: No. That wasn't my --

MS. FELDMAN: So, what is the significance of the calculation or the statement in your prefile testimony that John Dempsey Hospital is a more expensive hospital?

MR. BARWIS: That's a great question. So, we're in a fragile state. We provide extraordinary care, and we do it at a lower cost. And to the extent that we rationalize care as a state to a place where you can get it at a lower cost and at the same quality

and outcome, it's better for the State of Connecticut. If I go down and all these visits go somewhere else, you're going to exponentially increase the cost of healthcare in Hartford County.

MS. FELDMAN: Mr. Barwis, are you suggesting that we rationalize care in Connecticut?

MR. BARWIS: I'm suggesting that you should literally try to create access points that enable people to go to those access points and achieve a really good health outcome for the lowest cost possible.

MS. FELDMAN: Okay. Lowest cost possible. Okay. So, let's talk about that.

Are you familiar with the RAND study 5.0 for 2024? I've provided that exhibit.

MR. BARWIS: Yes. I actually referred to it in my opening comments.

MS. FELDMAN: Okay. And as you might have mentioned about the prices for the patient, the standardized prices in the state for inpatient facility services for JDH is $20,621; is that correct? Based on the exhibit? It's on the second page.

MR. BARWIS: Yeah. But I'd point out that's not for all patients. The RAND study says it's for what employer health plans pay.

MS. FELDMAN: Okay. So, do you negotiate your Medicaid rates with the Medicaid payer?

MR. BARWIS: Mm-hmm.

MS. FELDMAN: Do you negotiate your Medicare rates with Medicare --

MR. BARWIS: We do with Medicare Advantage.

MS. FELDMAN: I'm not talking about Medicare Advantage. I'm talking about --

MR. BARWIS: That's 60% of our Medicare population.

MS. FELDMAN: Okay. So, but would you agree that the employer costs for healthcare for the employees is relatively the same for Bristol Hospital and John Dempsey Hospital based on this RAND report?

MR. BARWIS: It's close. It is close, yes.

MS. FELDMAN: What's the difference?

MR. BARWIS: It's hard to follow across because --

MS. FELDMAN: I know. I'm sorry about that.

MR. BARWIS: So, we're at 17,510 and you are at 19,432 in 2020. And if I follow across, we were at 20,341 in 2022. But right now we're down about 13% from that point.

MS. FELDMAN: So, if you look at standardized price for inpatient services for 2022 -- and that's the

latest data that RAND provided -- this is what this May 2024 report is based on, data as of 2022 -- I see the cost for Bristol Hospital at 20,341; is that correct?

MR. BARWIS: Yep.

MS. FELDMAN: And I see the cost for JDH at 20,621; is that correct?

MR. BARWIS: That's correct for what employers pay for their employees.

MS. FELDMAN: Right. Okay.

MR. BARWIS: Not for the entire universe.

MS. FELDMAN: Okay. And what's the price differential there between those two rates?

MR. BARWIS: It's about 300 bucks.

MS. FELDMAN: Okay. So, about the same.

MR. BARWIS: For what employers pay for their patients --

MS. FELDMAN: Right. Okay. I also would like to take you -- a second for you to pull the exhibit that reflects the Case Mix Index that we provided to you.

MR. BARWIS: What exhibit would that be?

MS. FELDMAN: EE. EE.

MR. BARWIS: Is this the one?

MS. FELDMAN: Yes.

MR. BARWIS: Go ahead.

MS. FELDMAN: In 2024, can you tell me what JDH's case mix was?

MR. BARWIS: So, is this the overall case mix, or is this just Medicare case mix? What Case Mix Index is this?

MS. FELDMAN: The overall.

MR. BARWIS: So, you're looking for what year?

MS. FELDMAN: 2024. You -- you can give me the total or 2024 or whatever you want, but 2024 or the total.

MR. BARWIS: So, that's -- I can't tell. Is that year to date? Is that -- what is that? Because 2024 fiscal year is not over yet.

MS. FELDMAN: That would be year to date.

MR. BARWIS: Okay. So, we're at 1.4374, according to your chart, and you are at 1.745.

MS. FELDMAN: Okay. So, would you agree that a higher CMI generally means that the patient has a higher acuity?

MR. BARWIS: That's an interesting question, because CMI is the intensity of service, not necessarily reflective of the acuity of the patient.

MS. FELDMAN: Do you believe that Bristol Hospital patients have the same acuity level as John

Dempsey Hospital patients?

MR. BARWIS: That's a difficult question to answer, to be honest with you. You do things that are higher intensity, but the acuity of the patient, as your nurse executive will tell you, has to do with a lot of factors other than what's captured in a CMI. It could be they have extensive -- they're diabetic, they're COPD, they have heart conditions, they have all these other things that aren't necessarily captured in a CMI.

MS. FELDMAN: Okay. So, you're disputing the validity of the CMI index?

MR. BARWIS: I'm just saying that the definition of CMI versus acuity are two different things.

MS. FELDMAN: Okay. So, what is -- what is the significance of CMI?

MR. BARWIS: It's the intensity of services you're delivering.

MS. FELDMAN: Okay. And is it --

MR. BARWIS: And I would agree that the intensity of services that you're delivering is higher than that of Bristol Hospital's.

MS. FELDMAN: Okay.

MR. BARWIS: Based on your information.

MS. FELDMAN: Okay. Thank you.

Did you have a partnership with UConn Health that started in 2019 where UConn Health provided to you perinatologists to conduct a clinic at Bristol Hospital supporting your Bristol OB/GYN providers and making access to high-risk care to pregnant women in Bristol?

MR. BARWIS: Yes.

MS. FELDMAN: Is that still ongoing?

MR. BARWIS: Yes.

MS. FELDMAN: Is it true that in the summer of 2022 you were facing a shortage of -- "you," meaning Bristol Hospital -- a shortage of neurologists because of physician departures, and since then UConn Health neurologists have been reading EEGs for Bristol Health?

MR. BARWIS: I believe that's correct.

MS. FELDMAN: Okay. And with respect to the services that UConn Health has continued to provide in terms of perinatology and neurology, have you been billing for those services?

MR. BARWIS: I don't know the billing arrangement for those services.

MS. FELDMAN: Do you typically bill for services that you provide at Bristol Hospital?

MR. BARWIS: Yes. But under contract, it could be a very different thing.

MS. FELDMAN: Okay. Are you -- has your account payable been fulfilled for UConn Health or --

MR. BARWIS: I have no idea.

MS. FELDMAN: Are you aware that there's an outstanding -- that Bristol Hospital owes UConn Health 250,000 for services performed in connection with perinatology and neurology?

MR. BARWIS: I'm not specifically aware of that.

MS. FELDMAN: Okay. But we contend that UConn is continuing to provide the service; is that correct?

MR. BARWIS: I believe that's correct.

MS. FELDMAN: Okay. Is it also true that in late 2022 Bristol Hospital reached out for help with respect to covering your ICU on weekends for about 9 to 12 months?

MR. BARWIS: I am not familiar with that.

MS. FELDMAN: Okay. Mr. Barwis, you've spoken a lot about collaboration today, even though this is really about JDH needing 23 more beds.

But despite that, since you brought it up several times, is it true that in 2022 Bristol Health engaged Cain Brothers?

MR. BARWIS: We have had Cain Brothers

engaged in a variety of activities since I can remember 18 years ago.

MS. FELDMAN: Okay. But in 2022, through Cain Brothers, had you solicited RFPs for -- with respect to what you referred to generally as collaborations?

MR. BARWIS: Yeah.

MS. FELDMAN: And did UConn Health submit a response, a proposal?

MR. BARWIS: They -- they submitted a response.

MS. FELDMAN: And were there negotiations?

MR. BARWIS: There were discussions. We never got to a negotiation.

MS. FELDMAN: Okay. As a result of that, is it true -- well, let me -- let me -- strike that.

Is it true that UConn Health was exploring opening a multispecialty clinic in Bristol to really meet the need of the shortage of specialists at Bristol Health and that when Bristol Health learned of that possibility you implored UConn Health not to pursue it?

MR. BARWIS: So, to be clear, the response that I got from UConn Health was they thought we were going to become part of Yale and therefore they needed to open a clinic in our community. That was the

conversation.

And we were not going to become part of Yale. And we were also very fragile at that point in time, and so -- and we were building -- we had just opened our multispecialty group, and I had developers all over the community calling me saying, What is going on here? Why are they looking for something in close proximity to your medical center, like, literally, across the street?

MS. FELDMAN: Are there other hospital systems that have facilities in Bristol and --

MR. BARWIS: Hartford -- Hartford has one facility, yeah.

MS. FELDMAN: Okay. And was the request that you made of UConn, for whatever the reason that you state, which I have no way of knowing whether that's a fact, did the -- did your request not to open a facility in Bristol -- was that honored by UConn Health?

MR. BARWIS: Yeah.

MS. FELDMAN: Is it also true that very recently UConn Health reached out to Bristol Hospital to extend interventional pulmonary and thoracic surgery services to you?

MR. BARWIS: Yep.

MS. FELDMAN: Okay. And I believe -- and if you said this already, I apologize for asking the question again. But does Bristol Health have a shortage of specialists?

MR. BARWIS: At any given time, we have a shortage of some specialists.

MS. FELDMAN: And do you have a medical staff development plan?

MR. BARWIS: We do.

MS. FELDMAN: And how many vacancies do you have in that plan currently for physicians?

MR. BARWIS: I couldn't tell you off the top of my head.

MS. FELDMAN: Significant number?

MR. BARWIS: It depends on what the specialty is.

MS. FELDMAN: Okay.

MR. BARWIS: And specifically, you know, we've always tried to work on neurology. ENT has been an issue with ProHealth taking on ENT and then letting it go in the community. So, we are always looking at primary care and creating access points in our community.

But we have an extensive, extensive, broad spectrum of specialists. I mean, for a small community

hospital, we have two endocrinologists, two rheumatologists. I probably have -- I have a plastic surgeon that's incredibly qualified who takes Medicaid. I have a hand surgeon who takes Medicaid. So, I'm seeing patients from all over the state on an ambulatory basis, outpatient surgeries. So -- so, we have extensive, extensive -- in our group, we have extensive specialists, but we always will have weaknesses.

And I think the important thing that I would point out to you is you're asking specifically about relationships and arrangements. Having neurology means that patients can stay at Bristol Hospital. Having some of these specialties means they can stay at Bristol Hospital. And so, that collaboration is exactly what I'm talking about.

MS. FELDMAN: Mr. Barwis, have you reviewed the 2024 Statewide Healthcare Facilities and Services Plan that was just published in June by OHS?

MR. BARWIS: I got it in my inbox last week. I printed it, and I have not read it.

MS. FELDMAN: Okay. Are you aware that Bristol Hospital or Bristol Health is no longer in JDH's planning area and that JDH is in the Capitol Region and Bristol Health or Hospital is in the

Naugatuck planning region?

MR. BARWIS: I had no idea that that happened.

MS. FELDMAN: Okay.

MR. BARWIS: It will come to the healthcare cabinet. We'll go through it. But I haven't had a chance to digest.

MS. FELDMAN: Also in your prefile, as you previously mentioned, Mr. Barwis, you mentioned something about Bristol Hospital being roughly eight miles away. Is it possible that you're wrong? Because when we Google Mapped it via 184 and 72 West, we see it's 12.9 miles.

MR. BARWIS: Yeah. As I explained in my opening comments, so, from a -- when -- we do a lot of recruitment through the J-1 waiver program, and you had to always define your service area as a crow's fly. And that's also the definition that you use for restrictive covenants, not driving distances.

So, I'm not sure how we ended up with eight miles in there other than that's probably where it came from. But if you Google search and you look for, you know, routes to UConn, if you go down Route 6, it could be ten miles, if you go 84, it could be 12 miles.

MS. FELDMAN: Okay. But that eight miles is

not an accurate number with respect to how long it would take or the distance location to travel or EMS to travel from Bristol to UConn. Eight miles is not --

MR. BARWIS: I'm not sure that question is fully --

MS. FELDMAN: Is that true?

MR. BARWIS: No, I don't -- no, because if you take a helicopter from Bristol Hospital to UConn, it's eight miles. It's as the crow flies.

MS. FELDMAN: Okay. But --

MR. BARWIS: So, it's not that eight miles is wrong. It's just -- it's how you -- what method of transportation you're going.

MS. FELDMAN: But in your prefile testimony, what was the point you were trying to make by saying that the two hospitals are so close to each other?

MR. BARWIS: They are.

MS. FELDMAN: Eight miles?

MR. BARWIS: No.

MS. FELDMAN: Okay.

MR. BARWIS: If you fly there, it's eight miles. We transport patients by helicopter all the time to trauma centers and things like that. My point is that we're still close at 12 miles.

MS. FELDMAN: Okay. I have no further

questions.

MR. CSUKA: Thank you. Just one moment, please.

Attorney Vozza? Attorney Vozza, do you have any redirect?

MR. VOZZA: One question.

MR. CSUKA: Okay. I was going to ask how long you expected, but that's -- okay. So, yeah, we can proceed with that, or if you want to take, like, a two-minute break just to discuss something, that's fine.

MR. VOZZA: No. We can do this now.

MR. CSUKA: Okay.

MR. VOZZA: Mr. Barwis, Counsel had discussed with you a recent report that came out, and specifically with regards to the service area, Bristol planning area. Can you speak to that?

MR. BARWIS: Yeah. I'm not sure -- I think what I heard was "planning area," and I'm not sure that that's the same as "service area." And I'm not sure that -- there's a bunch of different definitions.

So, you can look at, for example, how your wage index is set. And, in fact, I think UConn's wage index is set in a different area to reflect the wages that you pay.

So, I'm not sure the point that was trying to be made, but I really think the definition of what they were looking -- it could just be the planning area as opposed to any other implication that -- that you're trying to make from pointing that out. I'd have to read it.

MR. VOZZA: That's all.

MR. CSUKA: Okay. Thank you. So, as far as public comment goes, we've had no one sign up. And I don't believe there's anyone here who plans to make public comment. So, we're not going to take in any public comment verbally today. Anyone who does want to make public comment can submit it in writing through our email address, which is CONcomment@ct.gov.

We're going to take a lunch break now. And when we come back, we will proceed with OHS questions. And let's come back at -- plan to restart at 2:00. So, that will give us a little bit over an hour. I'm not sure what's in the area, to be completely honest. So, we are going to have to do some investigation of our own.

And as a reminder to everyone who is in this room, if you say anything or do anything, you will probably be visible, even if we're not recording. So just be careful of that. And we will see you back at

2:00.

(Recess from 12:48 p.m. to 2:00 p.m.)

MR. CSUKA: Good afternoon. Welcome back. For those just joining us, this is the second portion of today's hearing regarding the UConn John Dempsey Hospital's CON application docketed as 24-32699-CON.

Hospital is seeking to increase its Licensed Bed Capacity by 23 med-surg beds. We had the technical -- we had a lot of the technical portion earlier. We also concluded the public portion as well. No one provided verbal public comment.

We are going to turn now to the questions by OHS. But before I get into that, I did just want to ask the two attorneys, are there any housekeeping matters that you needed to address before we got into the questions?

MS. FELDMAN: No.

MR. CSUKA: Okay. No.

MR. VOZZA: Nothing here.

MR. CSUKA: Okay. Thank you. So, I am going to give the floor to Mr. Jackson, and we'll go from there.

HEARING OFFICER JACKSON: Thank you. Attorney Feldman, Bristol Hospital raised a concern about Public Act 10-104. I'm going to ask for late

files to address that issue. This is the issue that they argued. It raises a concern that the statute limits the Licensed Bed Capacity to 234, including bassinets.

I don't know -- do you have any remarks to make on that at this point, or do you just want to leave it to late files?

MS. FELDMAN: Late file, please.

HEARING OFFICER JACKSON: Great. And then I'm going to ask for another late file regarding Exhibit EE. These are the charts and map. I'll lay it out in more detail in the order for late files, but just some explanation of what we're looking at and explaining the source and citations, explaining what CMI means, how it's calculated. We had a back-and-forth about the definition. So, if you can brief that in your late files.

Also some explanation of the map. We only see one route presented. Google often presents multiple routes and a time of day, but this was calculated as -- the travel time is going to fluctuate throughout the day. So, some of those clarifying details. But as I said, we'll provide more context in the order for late files.

Any remarks on that one?

MS. FELDMAN: No.

HEARING OFFICER JACKSON: Great. I'm going to try to go by theme, so hopefully there will not have to be too much shuffling around. And there may be an occasion where I bounce to Intervenor for a question in the middle of asking questions for the Applicant. So, apologizing for any jumping around if it happens.

MR. CSUKA: I will say that you'll have an opportunity to do redirect with the witnesses based on any questions that he -- and that goes for the Intervenor as well. That's it.

HEARING OFFICER JACKSON: I'm going to start with a couple questions about the kind of argument presented in the testimony.

The application and prefile testimony makes -- places substantial weight on argument for patient preference.

Is there a limiting principle to patient preference driving the beds available? And what I mean is, if everyone in the state preferred to go to one location, is that hospital allowed to grow to the maximum extent to serve the entire state?

MS. FELDMAN: You're asking the question right now?

HEARING OFFICER JACKSON: Yes.

MS. FELDMAN: Okay. I'm going to ask Dr. Agwunobi to take that.

DR. AGWUNOBI: I think our -- our premise there is that we're really talking about locally more than anything. But what we're saying is that patients make a decision to go to a hospital based on a multitude of factors, multifactorial, which will include things like, how far is it from me? What -- what level of services does it have?

And many patients -- we talk about patient preference, but in some cases, patients don't necessarily -- you know, they're coming in through the emergency department, so it might be how -- you know, can this emergency department support the level of illness that I have? And so, they go to a certain emergency department.

And so, I think we're -- I think you could stretch it and say, well, we get patients from 169 towns in Connecticut, so every single county we get patients, you know, some of them might be Medicaid specialty patients. So, you could stretch it and say, yes, if -- if we are going to be the ones doing Medicaid operations or procedures, then you're going to have people coming from all over the state. And we should accommodate those patients because we're the

ones that are saying, yes, we take all comers with no regard of, you know, their ability to pay.

So, I guess I'm -- what I'm trying to say is, yes, at a stretch, if a hospital provides -- in my opinion, if a hospital provides the type of care that the whole state needs and, therefore, the whole state -- people from across the state are coming to that hospital, we should factor that in in terms of their capacity to serve those patients.

But I think that -- I think more commonly we're talking about any geographic region, people making a choice about which hospital they want to go to in that region as opposed to maybe driving four hours to go somewhere else.

HEARING OFFICER JACKSON: So, in a region -- and did anyone else want to -- if in a region there's one hospital that's preferred, so then everyone wanted to go there, should that hospital be allowed to grow as large as they want to be to serve everyone in that region with -- without regard to other hospitals in that region and the effect that that would have on them?

DR. AGWUNOBI: I mean, you're asking my opinion on this.

HEARING OFFICER JACKSON: Well, I'm asking

how to interpret your argument here that --

DR. AGWUNOBI: Right.

HEARING OFFICER JACKSON: -- patients' preference -- your argument is that patients prefer to go to John Dempsey.

DR. AGWUNOBI: Right. Right.

HEARING OFFICER JACKSON: And that's why you have elevated utilization, and therefore you should be allowed --

DR. AGWUNOBI: I think it get to definition of "prefer." When we say "prefer," it sounds as if we're saying they just, you know, woke up one morning and decided, oh, I prefer John Dempsey, I'm going to go there.

What's in that word "prefer" includes the fact that we are providing the services they need. So, if a hospital provides the scope of services and the depth of services and the level of care and the tertiary level of care that an academic medical center provides and, therefore, people need to go to that facility to get that care and believe that that's the best place for their care, that should be respected, both from a quality of care perspective but also from a patient choice perspective. So, it's not a casual prefer. It's they need that care, that level of care

for the conditions that they have.

And so, with that regards, I would say yes, that, you know, if -- there's two academic medical centers in Connecticut. There are a certain number of patients that are going to go to academic medical centers, and we should make sure that those centers have the access they need.

HEARING OFFICER JACKSON: And with regard to unique services, I think we heard testimony earlier about specific services that John Dempsey might offer that Bristol does not offer.

Are there services that John Dempsey offers that no other hospital in the primary service area provides?

DR. AGWUNOBI: I'd have to think about the other hospitals.

MS. RYAN: Sickle cell.

DR. AGWUNOBI: Yeah. So, there are some, for example, sickle cell, so we provide care for sickle cell patients. We have a sickle cell center. I think Huntington's as well?

MS. RYAN: Huntington's and I think high-risk maternal fetal.

DR. AGWUNOBI: High-risk maternal fetal. So, yes, there are some. But the other thing is that when

we provide services that others provide, a lot of times the depth of services that we provide or the level of -- the number of specialists, the types of procedures they can do within those specialties are often above what you might see in a regular community hospital.

HEARING OFFICER JACKSON: So, I want to clarify something that was inherent in my question that there was some confusion about earlier, and that's the definition of primary service area. And it relates to the 2012 plan and the preliminary 2024. And when I say "plan," I mean the statewide facilities -- Statewide Healthcare Facilities and Services Plan released June 30th/July 1st.

The plan evaluates the need. And in the 2012 it looks at need at the county level. In 2024, it doesn't propose to make a switch to the planning regions.

But when we're talking about a CON application, the bedding methodology looks at the need within a PSA for the hospital applying. And the PSA, the primary service area, is calculated based on the towns that make up 75% of that hospital's inpatient discharges. Inpatient.

So, when we talk about the primary service

area, we're talking about John Dempsey's primary service area. And there was some debate about the hospitals that are included in that. Manchester Hospital and Charlotte Hungerford.

And does John Dempsey take issue with those hospitals being included in the PSA under the bedding methodology?

DR. AGWUNOBI: Mm-hmm.

MS. FELDMAN: Can I redirect to another --

HEARING OFFICER JACKSON: Oh, yes. These are thematic questions, not intended to --

MS. FELDMAN: Okay. Chris, do you want to come up?

HEARING OFFICER JACKSON: Although I don't think that Mr. Hyers has been sworn in.

MR. HYERS: Howdy.

HEARING OFFICER JACKSON: Could you identify yourself and role for the record?

MR. HYERS: I can. Chris Hyers, C-H-R-I-S H-Y-E-R-S. Vice President of Strategy and Business Development for UConn Health.

HEARING OFFICER JACKSON: Thank you. Could you please raise your right hand?

(CHRIS HYERS, having first been duly sworn by W. Boyd Jackson, OHS Hearing Officer, was examined and

testified as follows:)

MR. HYERS: So, when we do the math to get to that 75%, because we get so much from Hartford proper and they're so densely populated, towns like Torrington, the Charlotte market, and the Manchester market tend to fall outside of that. The real concentrated core for us is the area that includes New Britain, Newington, Hartford, and the Farmington Valley. So, we do not look at Charlotte and Manchester as in our primary service area.

HEARING OFFICER JACKSON: Are you saying that in calculating the 75% that they do not fall into the 75%, or are you just saying that for the purposes of John Dempsey's plan --

MR. HYERS: I don't think that they do, but if I can consult our list real quick, the application.

MS. FELDMAN: Yeah.

HEARING OFFICER JACKSON: Yeah. Manchester and Torrington were listed in the application as falling under the 75%. And actually, the -- John Dempsey included these towns in the PSA but attempted to make an argument that we should not consider the hospitals in those towns as being in the PSA.

MR. HYERS: Understood. So, mathematically, they fall in. They're, like, 1% of our business. So,

to get to the 75%, yeah, technically, if you want to talk about towns that have hospitals that get us to 75%, then they're in.

But the way we look at that, we're not in those markets. We are in Torrington, but the vast majority -- if you look at our primary service area, you can take the Farmington Valley, Hartford, Bristol, New Britain, Newington, and you're going to get to about 69%, 70%. So, then -- does that answer your question? I'm sorry.

HEARING OFFICER JACKSON: Yes. So, I just wanted to establish for everyone to be on the same page the difference in a primary service area and a planning region. While both are discussed in the plan, they're used for different purposes. The plan serves many functions. That's why it's 250 pages. It -- you have a plan looking broadly, and then you have definition of primary service area, 75% of discharges. And so, that's what we're specifically talking about when we're looking at the bedding methodology.

MR. HYERS: Understand. To clarify why we don't think about those hospitals in our primary service area, because there's a large number of other hospitals between us and them. I think there's four closer to Manchester than us. There's four or five

from Torrington. So, when you think back to that behavior question, it seems like we're not in that circle.

HEARING OFFICER JACKSON: Okay. There was -- and this is not necessarily for you, just continuing on this theme.

There's been discussion about the higher acuity of patients, and you discussed one factor of patient preference being expected higher levels of care needed.

If John Dempsey is providing care to these highest acuity patients, could lower acuity patients -- are all patients treated at John Dempsey of this higher acuity, or are there lower acuity patients who could be treated at other hospitals?

DR. AGWUNOBI: So, yes. As I was mentioning in my testimony, the -- if you think about -- so, let's take the emergency department where 60% of admissions come in. There are a lot of patients that come to the emergency department that are not high acuity. But those are not the patients that are causing the problem with the boarding in the emergency department and the lack of bed capacity because those patients are being triaged very quickly out of the emergency department. They're being treated and sent out and sent home.

One of the things to know in sort of the emergency department care is when a patient shows up, you have to, by law, the EMTALA, as you know, the EMTALA law --

HEARING OFFICER JACKSON: Could we specify that? Sorry.

DR. AGWUNOBI: Emergency --

MS. FELDMAN: Medical --

HEARING OFFICER JACKSON: That was unfair of me. I can rattle it off, but Emergency Medical Treatment --

DR. AGWUNOBI: Right.

MS. FELDMAN: Medical Treatment and Labor Act.

HEARING OFFICER JACKSON: Thank you.

DR. AGWUNOBI: So, that act requires that you screen, medically screen and stabilize patients. So, you can imagine someone who comes in who is not a high acuity patient, by the time they're medically screened and stabilized, you're basically treating them or have treated them, and then they go home.

So -- so, yes, we see patients who are lower acuity. But it's the higher acuity patients, the sicker patients, who are the ones who need the inpatient beds and the observation beds who are causing

the backlog in the organization.

HEARING OFFICER JACKSON: So, if a lower acuity patient who needs inpatient -- so, you still are at the inpatient level, you need inpatient care but a lower level of inpatient care. Could those people be transferred to another hospital? That's part one.

And for nonemergency department inpatients, admissions, could some of those referrals incoming for inpatient care be transferred to a lower intensity hospital?

DR. AGWUNOBI: Yeah. I'm going to ask Caryl to speak about transfers and what's involved in that.

MS. RYAN: So, I'm just going to ask you to just restate.

HEARING OFFICER JACKSON: Sure. Now I'm going to have to recall.

MS. RYAN: Yeah. Okay.

HEARING OFFICER JACKSON: So, that was unfair because there was a transition.

MS. RYAN: Okay. Sorry. Okay.

HEARING OFFICER JACKSON: So, I'll start with just the first part. A patient who is lower acuity who needs inpatient level of care but on the lower end of inpatient level of care, could those people be transferred to another area hospital for the inpatient

care?

MS. RYAN: So, what's difficult about that is that they would have to agree to transfer. They would have to agree that they wanted to transfer. And the majority of that population will not transfer. Actually, I've never asked anyone that's said yes, go ahead. And we ran into that situation when I could not have anybody -- no one would accept diversion. So, we were going to transfer. We were looking to transfer some patients out. But no one wanted to move.

HEARING OFFICER JACKSON: Okay. I have a follow-up on the diversion piece. But on the first part, people not wanting to move, how frequently does John Dempsey inquire as to whether someone is willing to be transferred?

MS. RYAN: Only when we get to that diversion level.

HEARING OFFICER JACKSON: And you talked about the diversion. I can't remember where I had my note.

You -- you said that during -- when you needed to go on diversion, you made calls to other hospitals and they said no.

MS. RYAN: Their emergency departments.

HEARING OFFICER JACKSON: Right. That's --

do you have documentation of when these times were -- the outreach that was done, their response? Do you have documentation of any of that?

MS. RYAN: I have some documentation of who accepted. I'd have to validate that as far as who -- who basically said no. But I do know because I get called on every one of them. And there are times that we edge up and we attempt to divert, but no one will accept.

Then we basically reinforce with the patients and the docs, let's see how fast we can discharge, let's see -- you know, are we going to cancel any -- any surgeries that are elective, you know? That's the road that we've gone down with the Department of Public Health.

HEARING OFFICER JACKSON: Right. So, I'm going to ask for a late file, if you can just provide additional information on when you've gone on diversion --

MS. RYAN: Mm-hmm.

HEARING OFFICER JACKSON: -- to whom outreach was made --

MS. RYAN: Mm-hmm.

HEARING OFFICER JACKSON: -- and we'll specify the details that we're looking for there.

MS. RYAN: Mm-hmm.

HEARING OFFICER JACKSON: When you've had these issues -- and you just mentioned working with the Department of Public Health -- what -- can you provide a little more context about the measures that are undertaken to discharge people or to change the scheduling of elective surgeries?

MS. RYAN: So, basically, when we're getting closer to our licensed beds -- I'm sorry. I thought you put your hand up.

MR. VOZZA: Nope.

MS. RYAN: Okay. When we're getting to that number of increased licensed beds, we do a variety of things, and that is to look at who's going to be -- you know, how many pending discharges do we have throughout -- throughout the hospital, who's got a ride, who needs an ambulance, who needs a -- you know, who needs a nonurgent transfer. At that point, we will double up on ambulance utilization for nonurgent transfers from UConn Paramedics.

We also will go every two hours rounding, get the doctors, interdisciplinary, case management to make sure that we can discharge, discharge safely, and if we can call their rides in.

Many patients -- and that's why we're looking

at right now in the formation of a discharge lounge, because many patients don't want to be picked up until 5:00. This would alleviate -- we could put them in a discharge lounge, keep them there until their transportation arrives.

So, all of those measures we're utilizing right now in order to be able to discharge quickly, you know. And these are patients that were identified the day before, they have -- you know, they have -- we've been -- we try to get their testing done, their consults done in the morning so we can discharge.

So, there's a population that there's an issue with transportation. There's a population that is delayed because of consultation or additional radiology efforts, like in stroke patients. And all of that is formulated to begin very early in the morning so we can discharge.

So, we have -- we have quite a few things that we do. Sometimes it works better than others. We do this on a daily basis. This isn't something that's just done when we start to reach 230. This is something that's done every day on interdisciplinary rounds. When we start to increase and get to that level, it's -- it's basically more hands on deck and calling everybody in, including the docs.

Does that help you?

HEARING OFFICER JACKSON: Yeah. So, everything that's done in these extreme times that have been described are done all the time.

Is there anything done during those times, aside from intensity level -- so -- but --

MS. RYAN: Yes.

HEARING OFFICER JACKSON: -- are there things done during that time aside from diversion that are used to expedite discharges, for example?

MS. RYAN: Well, like I said, we're looking at diagnostic testing. We're looking at medical consults. We're looking at our discharge planning and making sure that we have their follow-up appointment done. We're making sure that if they have a -- a LACE score -- that is actually length of stay, acuity, comorbid condition, and recent ED visit -- greater than 75, we put them on a special virtual remote discharge consultation.

So, we're doing all that in effect to make sure that we have a daily run of throughput, you know, between the ambulances, between the discharge clinic, between medication management, between discharge education, the discharge lounge, and collaborating with our community providers and our -- out of -- out of

UConn and also within UConn primary care. If they have physicians within UConn primary care, they go into a transition process. But if they're outside, they have to be discharged with an appointment.

HEARING OFFICER JACKSON: And those are all the things that you do all the time?

MS. RYAN: Mm-hmm.

HEARING OFFICER JACKSON: Are there any things done during these intense times that are not done as standard procedure that -- and why could those things not be incorporated all the time?

MS. RYAN: Well, because I wouldn't want to cancel an elective surgery if we didn't have to. You know, people wait weeks, months for elective surgery. But they're put on a -- basically if we come through -- into that 220 range, 225 range -- you can't stop deliveries; right? One night, we had three sets of twins born. So, that's six more patients. And, you know, you're already at 224, so now you're at 230 -- now you're at 224, 230.

So, these are the things that happen. Some of them you can't help. Some of them you can. So, when it gets to that point, we'll talk to the OR, we'll talk to the surgeons. We'll say, okay, let's just look at a priority list. That is what the Department of

Health would like us to do.

And then we would also -- we got to the point at two different levels that we asked patients, you know, would you consider going to a certain hospital. We had talked to that hospital, and that hospital would accept patients into their emergency department.

But out of the patients asked, they did not want to go. So, we kept them in the emergency room. They were not admitted patients. And then your length of stay gets a little bit longer until they're discharged, and then they were --

HEARING OFFICER JACKSON: On the issue of discharges, are you aware how many Patient Days in Fiscal Year 2023 were due to an inability to discharge?

MS. RYAN: Can you ask that again?

HEARING OFFICER JACKSON: Are you aware how many Patient Days in the last fiscal year were due to the inability to discharge?

MS. RYAN: I don't have that number readily at my fingertips, no.

MS. FELDMAN: May I ask for some clarification? Are you asking the patient is medically ready for discharge, is going to an aftercare facility -- right? Is that what we're talking -- maybe --

HEARING OFFICER JACKSON: Or -- and one of my questions is on the reasons that people have not been able to be discharged. I know -- I think you made reference in your prefile testimony and just brought up transportation challenges.

So, are there Patient Days that are due to an inability to discharge a patient who is medically ready to be discharged?

MS. RYAN: There are. I don't -- I'm sorry. I thought you wanted the exact number of days.

HEARING OFFICER JACKSON: Well, I would like that and recognize that you may not have that at your fingertips. And so, is that something you could provide in follow-up to this hearing, or is that not tracked?

MS. RYAN: I think that is something that I will have to look at. It's tracked by case management, so I could go back to see how many, you know -- how many -- what days were difficult in discharges. We also have a contract with several different long acute -- acute-care facilities for rehab that we will discharge to without the authorization and be responsible for the payment.

HEARING OFFICER JACKSON: Okay. So, we'll ask for the information in late files to understand the

scope -- the scale of challenges that may have occurred due to inability to discharge a patient ready to be discharged.

I'm going to come to you. I just want to check -- the TVs just went off in the room. So, I just want to make sure that we're still live on Zoom and haven't encountered any other technical difficulties. That's fine. I don't think we need to see ourselves. But I just want to make sure that we're still in the public. Faye, can you confirm?

MS. FENTIS: Yes.

HEARING OFFICER JACKSON: Okay. We're still good publicly. So, does anyone have a concern about proceeding while the TVs are off? Okay. Sorry. Go ahead.

MS. FELDMAN: I'm -- I'm -- your question raises an issue that I would assume all hospitals face, you know, on different levels. And -- okay. That's all I want -- that's all I want to say for now.

MS. FENTIS: Can I get a break to get I.T. in here? We're still live on Zoom. I'm just not sure what's going on.

MR. CSUKA: We're having some annoyances in the hearing room. I don't know if people can hear that. But it's going to disrupt our ability to

proceed. So, we're going to take a few minutes to try to figure out what's going on. So, we'll probably be back within I'd say five minutes? But stay tuned.

MS. FELDMAN: It definitely sounds like a connection, Internet connection.

MR. CSUKA: Yeah. So, are you able to stop the recording?

(Off the record 2:31 p.m. to 2:34 p.m.)

MS. RYAN: So, I just wanted to clarify a couple things. One was that I thought you were referring to just ED patients, transferring out ED patients. Or were you referring to transferring out inpatients also?

HEARING OFFICER JACKSON: That was my two-parter question.

MS. RYAN: Oh, okay. So, inpatient transfers we really would not do. Transfers from the ED is what I was referring to. But you have to be really careful with that because the payers are not going to pay for someone that is not going to a higher level of care.

Say we didn't have cardiothoracic surgery and they needed cardiothoracic surgery, we could transfer them to Hartford. But if we're transferring them for pneumonia, payers are very apt to say we're not going to pay for that because it's not transferring to a

higher level of care.

HEARING OFFICER JACKSON: For the transfer itself. Is that what you -- when you say "pay" for it --

MS. RYAN: For the hospitalization.

HEARING OFFICER JACKSON: Oh, okay. Thank you. And the other part -- rather than transferring inpatients, my question -- I'm coming back to my original question -- was when -- when patients are being referred to the hospital for inpatient care, such as for elective procedures --

MS. RYAN: Mm-hmm.

HEARING OFFICER JACKSON: -- is there any consideration given to this patient is a lower acuity patient who may need a lower intensity of care and they might be able to receive care at a lower intensity, as it's been described, hospital?

MS. RYAN: Not if they're requiring surgery. Is that what you're -- a surgical patient, you mean?

HEARING OFFICER JACKSON: If someone is going to be referred for inpatient care, would John Dempsey consider this person doesn't need what has been described as vastly different and elevated level of care? They could receive this lower acuity inpatient care at a -- at a different hospital in the region?

MS. RYAN: So, there are times when we have gotten referrals from other hospitals around the state of Connecticut to accept another patient at the time. If our numbers are too high, we have stated we cannot accept that patient at that time. We don't say yes, come on into our ED. I basically say, we're too high right now, our numbers are too high. We cannot accept calls in the morning when we still haven't transferred that patient.

HEARING OFFICER JACKSON: Okay. So, I'm going to ask a couple questions about relationship to the Facilities and Services Plan.

The application makes reference to a portion that says OHS should consider when a hospital has averaged weekday occupancy rates at or about 80% of total licensed beds for two separate periods of at least 30 calendar days within the last 12 months.

The information that's presented in the application to say that John Dempsey meets that threshold and that should be considered is only for medical-surgical beds, when the criterion in the plan says total licensed beds.

So, has John Dempsey hospital consistently exceeded the 80% recommended capacity for total licensed beds?

MS. RYAN: I'm going to defer to --

HEARING OFFICER JACKSON: And I'll refer to page 18 in the application. It says in the first six months of physical year 2024 overall occupancy rate was approximately 72%. But have there been stretches under this argument where it has exceeded 80% consistently for 30 days?

MR. HYERS: I have to read small off the phone, so I apologize, because when we were having the discussion about weekday versus total, we asked people to run the numbers both ways. So, we can certainly verify this with a late file.

But what I was provided while we were in here is total JDH occupancy rate, all beds, so the most recent month May was 79%; back up to April, 85.7; back up to March, 81.1; back up to February, 81.3; January, 81.4. So, yeah, I would say four, five six months of the last seven, eight, nine, total occupancy would meet that number.

HEARING OFFICER JACKSON: So, we'll ask in late file.

MR. HYERS: I appreciate the question. That's 100% in --

HEARING OFFICER JACKSON: Thank you. This next question may require a couple of people to opine,

so apologies, because it references expert testimony and the application.

The expert testimony says that the -- argues that the Connecticut bedding methodology is not statistically sound for a number of reasons, including not accounting for patient acuity, not using predictive analyses, not accounting for variability and uncertainty, socioeconomic factors, sample size and data quality.

The application itself on page 26 points to Maryland as a superior bed-need calculation. Under Maryland law, licensed beds are allocated annually by multiplying the prior year's, ADC, Average Daily Census, by 140%.

Does the Maryland model tick the boxes that were raised as concerns for why this is statistically invalid? And if not, why are we -- or is John Dempsey saying that we should use this statistically invalid model?

DR. STRATMANN: Unfortunately, I didn't write the application and I'm not familiar with the Maryland law.

HEARING OFFICER JACKSON: And does anyone from John Dempsey want to speak about why Maryland was pointed to as a superior model?

MS. FELDMAN: Can I --

MR. STRATMANN: I think it's --

MS. FELDMAN: You want to go?

MR. STRATMANN: From what you described of the Maryland model, it sounds like they are following a simple rule, like what I proposed at the end of my testimony or like what Illinois is doing.

So, my -- my best guess from, again, understanding how you described the Maryland model is that it's superior because it's less arbitrary.

MR. CSUKA: If you have more to add, Attorney Feldman, you can. Just keep in mind whatever you say will not be used as evidence.

MS. FELDMAN: Okay. Well, I'll say it again in closing. But we looked at multiple states and their methodologies, and they're all very different. South Carolina says when you're at 70% capacity. North Carolina says 75% capacity. And they don't have all of the same elements.

As I pointed out in my opening remarks, it was the intention to update the methodology on a regular basis, and there does not appear to have -- there doesn't appear to be evidence that the methodology has evolved since 2012 as some of the other states have, including Maryland, New York. And, you

know, they're apples and oranges.

So, our focus is really on the Connecticut methodology and the -- the faults that Professor Stratmann pointed out in his prefile testimony.

I don't know if that answers your question, but I think our focus on our testimony is about what OHS seems to be focusing on with respect to weighted numbers and what it doesn't include. I think that's primarily -- and also grouping hospitals together as opposed to looking at individual needs of hospitals.

Hospitals in the state of Connecticut operate very independently, even if they're part of a large system. They're separately licensed, and their beds are not interchangeable.

I'll stop right there. Thank you for indulging me.

HEARING OFFICER JACKSON: Regarding the weighting, I want to clarify something from Dr. Stratmann's testimony. I believe he stated -- you stated -- that years further in the past are positively weighted over the most recent year. Was that -- is that --

MR. STRATMANN: I did not say they're more positively. It's changing the weight over time.

HEARING OFFICER JACKSON: And you -- do you

agree that the most recent year is the most heavily weighted?

MR. STRATMANN: Yes.

HEARING OFFICER JACKSON: Okay. Just wanted to clarify it. Perhaps that was just a misunderstanding of your argument.

And so, your concern is considering two years and three years ago at all in this calculation?

MR. STRATMANN: Exactly. That's what I meant to say.

HEARING OFFICER JACKSON: Okay. Thank you.

MR. STRATMANN: Thanks.

HEARING OFFICER JACKSON: For John Dempsey itself, when -- when John Dempsey is planning future services, do you look to past utilization to plan future needs?

DR. AGWUNOBI: It depends on the service, but we mostly look at recent utilization to plan for future. So, recent can be -- can differ. It can be the last year, last 12 months. It could be the last 24 months. It just depends on the service.

So, I'll give you an example. Like maternal fetal health, when we're looking at deliveries and planning for deliveries, if we go back to several years, we had relatively low delivery count. Now we've

been -- for -- at least the last two or three years, we've been quite high in our deliveries. And so, when we look into the future, we look back maybe a year, year and a half. So, it just depends.

HEARING OFFICER JACKSON: And sometimes there are fluctuations that may mean that you want to consider more than just the last -- the current year that you're in; you may want to consider a longer time horizon to better understand and account for fluctuations year to year?

DR. AGWUNOBI: Yes. That's -- that's sometimes true.

HEARING OFFICER JACKSON: Thank you.

DR. AGWUNOBI: If I could just clarify. But I would say one thing. In our -- our sort of history, if you look at most of -- many of our specialties, of our key specialties, have had a continually increasing -- except for the pandemic, so when there's a blip in the pandemic. So, we don't -- the fluctuations are not -- they're not typically as significant or material that we would incorporate them in our -- in our planning. But certainly when they do occur, we would incorporate them.

HEARING OFFICER JACKSON: Okay. How did John Dempsey calculate 23 as the number of beds needed?

MR. CSUKA: We're doing a lot of musical chairs, so when you come up to the podium, if you can just remind the court reporter who you are, that would be helpful, I think, for the court reporter.

MR. HYERS: I can do that. So, Chris Hyers again. So, going back to the -- the same rule that you cited about the 80% benchmark that we made -- that we thought we were doing on med-surg beds we were talking about a minute ago, in that same thing it says when a hospital exceeds -- that's up to 10%, or 23 beds.

So, seeing that number, seeing some of the -- mostly around the ER projections, everywhere else it was going and huddling with the operators, it was saying where do we have physical capacity today? Right? Because we didn't want to build anything. We wanted to know what we had. And all those numbers coalesced around that 20 to 27 number regularly, so we opted for the 10% number that was part of that rule.

MR. JACKSON: So, the 80% was applied to just medical-surgical to meet the threshold, but the 10% was multiplied times total beds?

MR. HYERS: Correct.

HEARING OFFICER JACKSON: Okay. Thank you.

MR. HYERS: Because most of our -- can I just clarify -- because most of our growth has been in

medical-surgical -- in surgical -- in surgeons in wider procedures, so that's where most of our growth would be anyhow.

HEARING OFFICER JACKSON: Okay. So, I have a quick clarification question for Dr. Stratmann before asking a question -- so, I apologize for these musical chairs.

Can you restate -- so, I thought I heard when you performed your own calculation, making the three changes that you proposed, not counting the Department of Corrections, using the most recent 12 months of patient use, and including observation stays -- did I get those correct?

MR. STRATMANN: This is Thomas Stratmann. Yes. That's correct.

HEARING OFFICER JACKSON: And can you remind us what you said the actual number bed increase you needed was?

MR. STRATMANN: 17.

HEARING OFFICER JACKSON: 17?

MR. STRATMANN: Yeah. 17.

HEARING OFFICER JACKSON: All right. Thank you. I misheard. Thank you.

So, some questions about staffing.

MS. FELDMAN: That would be Caryl.

MS. RYAN: Hi. Caryl Ryan.

HEARING OFFICER JACKSON: And looking at the HRS, health reporting -- Hospital Reporting System filing that we had, that we entered into the record, exhibit --

MS. FELDMAN: Form 400.

HEARING OFFICER JACKSON: Yes. Looking only at medical-surgical beds over the last couple of years, John Dempsey staffed 118 and 164 allocated beds in fiscal year -- excuse me -- 118 of 164 beds in fiscal year -- fiscal 2022, 132 of 151 allocated beds in fiscal year '21. Occupancy rates were in the range of 72 to 78.5 range of available -- of staffed beds, and occupancy of available beds allocated to medical-surgical was 56.3% to 63.24%.

Why has there been such a big jump from the numbers reported in 2023 to the first half of Fiscal Year '24?

MS. RYAN: We added two more permanent units. So, we added a 28-bed med-surg unit that was actually an outpatient clinic. It was on the University Tower 4.

And a -- do you have a quick question? Okay. And as of January of this year, we added another additional 18 beds to CT, Connecticut Tower 7.

HEARING OFFICER JACKSON: So, the number of allocated beds has gone down from 164 to 151, and now to 147 as reported in the prefile testimony.

What has accounted for that decrease in beds allocated to medical-surgical over the last 2 1/2 years?

MS. FELDMAN: Do you understand --

MS. RYAN: No. I think --

HEARING OFFICER JACKSON: Do you have the --

MS. FELDMAN: We do.

HEARING OFFICER JACKSON: Okay.

MS. FELDMAN: I think we need some clarification regarding the difference between available beds and staffed beds, because it's unclear.

HEARING OFFICER JACKSON: So, I will explain and look to my colleagues to correct me if I misstate anything.

My understanding is that the hospitals report to OHS. So, available beds are the total licensed beds. And the hospital is reporting how those are allocated across the total beds available and the staffed beds. And the number of beds allocated to medical-surgical has decreased over those two years reported and has further decreased to 147 as reported in your prefile.

MS. FELDMAN: We may need to ask Brian --

MR. BIANCHI: I'm looking at --

MS. FELDMAN: Oh, you don't have the information. We may need to clarify that with a late file. We just don't have the ability to answer. We would have to look at the data that was reported and reconcile.

HEARING OFFICER JACKSON: Okay.

MS. FELDMAN: Again, you just said that -- at the beginning that -- I just want to make sure I understand what we're reporting. That available beds are licensed beds? Because I've seen -- I've seen three categories, staffed --

HEARING OFFICER JACKSON: Physically set up.

MS. FELDMAN: Physically set up.

HEARING OFFICER JACKSON: Beds available to be staffed and used.

MS. FELDMAN: Okay. So, it might be less than licensed; correct? Correct?

HEARING OFFICER JACKSON: It could be.

MS. FELDMAN: Okay. But it is not -- is it -- well, you answer.

MS. RYAN: Well, I think we're still going to have to look at the data backup, so it's going to have to be a late file.

HEARING OFFICER JACKSON: Okay. To clarify what I'm asking and what I'm trying to understand, there has been a reported decrease in the number of beds allocated to medical-surgical over time. It started at 164 in the Fiscal Year 2022 report. It's 151 reported in Fiscal Year 2023. And in your prefile testimony, it states there are 147 allocated to medical-surgical.

MS. FELDMAN: I think we'll do a late file --

HEARING OFFICER JACKSON: Okay.

MS. FELDMAN: -- as requested by OHS.

HEARING OFFICER JACKSON: And in the prefile testimony, how did John Dempsey calculate its staffed and available beds for Fiscal Year 2024?

MS. FELDMAN: That may have to be a late file too. For 2024, you're asking --

HEARING OFFICER JACKSON: The prefile testimony, I believe it's Caryl's, but I can -- there is a table that shows Fiscal Year 2024 beds available and staffed. It's showing 100% staffed. I'm trying to understand what's being stated here.

MS. RYAN: Yeah. So, we are going to have to go back to the data. It's internal finance that this came from. I think that there were staffed beds, there were -- we had temporary staffed in certain areas, and

then we opened up others. So, I just need to really go back. We are at 147 right now staffed.

HEARING OFFICER JACKSON: Have you been staffed at 100% consistently this entire beginning of Fiscal Year 2024?

MS. RYAN: Only for six months. So, when we opened up CT 7, then we were staffed to 230 --

HEARING OFFICER JACKSON: Consistently? Thank you.

MS. RYAN: January of 2024.

HEARING OFFICER JACKSON: Nicole, did you get the late file, how they calculated the staffing --

MS. TOMCZUK: Yes.

HEARING OFFICER JACKSON: And we'll include in that expanding that table to the prior years.

Given widely reported challenges that hospitals have said that they're having staffing up beds --

MS. RYAN: Mm-hmm.

HEARING OFFICER JACKSON: -- could you describe John Dempsey's plan for staffing the proposed additional beds?

MS. RYAN: Right. So, during the pandemic, we had up to probably 120, 130 nursing vacancies across the house, across the hospital inpatient areas. We did

really well with basically new grads from UConn, Storrs, that we put into place. Every year we -- actually, during the pandemic had students -- the students were still doing rotations at John Dempsey when other house -- when other institutions were not sending their students, UConn did send students to UConn Health and -- during the pandemic. So, they were able to be trained.

We did take quite a few students every year. We took them in the spring. We took them in August with the baccalaureates. And then we took our other students that already had a previous degree, and then they went into an accelerated nursing program and they graduated in March. So, we had two different times where we took nurses.

We were also -- we were also able to recruit nurses. You know, there was a lot of movement between each -- as there were -- as there was movement with travelers across the state of Connecticut, there was movement of staff throughout the state of Connecticut.

I had nurses going to Hartford Hospital. I had nurses going to Yale. I had nurses that were going to surgery centers. Surgery centers at one point, you -- it required you to be critical-care certified. Now they're taking new grads into surgery centers. So,

we lost a lot to surgery centers and both Hartford and Yale that were paying more, that had -- that were paying -- you know, and people coming out of school wanted cash. So, their salaries were higher.

And so, we were able through being -- we went to recruitment. We really brought home the academic institution. We had open houses. We did experiences where RNs could shadow for a day.

And I think that the academic environment along with the education, you know -- education enhancement to academic environment and the engagement of staff being in a teaching hospital and being able to take part in rounds, take part in grand rounds, take part where there was a hole, there was just a lot of specialty and learning, and we were able to recruit. Right now, I'm not having really any problems recruiting.

HEARING OFFICER JACKSON: Something that was mentioned earlier was an idea, an argument that medical advances have led to more inpatient utilization and longer stays.

Has John Dempsey experienced that medical advances have also led to a number of procedures that used to be provided in the inpatient setting that are now available in the outpatient setting?

MS. RYAN: Yes. I think we do more orthopedic -- a lot more orthopedic surgeries that were mentioned before in the outpatient setting. We do some more pulmonary procedures that are in the outpatient setting. Many of our cath lab patients go home, and they used to stay over. So, there are many more procedural areas and procedures that are being done and patients are going home.

HEARING OFFICER JACKSON: And so, can you just kind of describe those countervailing trends and how you have -- you simultaneously are saying we have more inpatient utilization and need more beds.

MS. RYAN: Mm-hmm. Mm-hmm.

HEARING OFFICER JACKSON: And we're moving a lot of what used to be inpatient to outpatient.

MS. RYAN: Mm-hmm.

HEARING OFFICER JACKSON: So, can you just describe how those affect John Dempsey's need on balance and kind of the magnitude of those shifts?

MS. RYAN: I think we're just seeing more patients in general. So, what was here three years ago is now, you know, increased, whether that is in the ambulatory setting, in the procedural setting, in the inpatient setting. We have got more patients that are meeting inpatient criteria, not observation criteria,

but inpatient criteria, even postsurgical, that need to be admitted. And that's a much greater number.

As you may know, you know, based on the payers, you know, we -- you have to have medical necessity to be admitted, right, whether it's an observation or inpatient. And we use middlemen. We have to meet that criteria. It's not our hunch. You know, we have to meet the criteria or else it's rejected.

HEARING OFFICER JACKSON: And as far as incoming patients go, John Dempsey noted in the application that there's been increased emergency department use.

Has the rate of admissions as a percentage of patients presenting at the emergency department, has that rate of admission to inpatient remained constant over time?

MS. RYAN: I believe it's increased over time. It has not remained --

HEARING OFFICER JACKSON: The percentage of patients presenting at the emergency department who are admitted, you believe that that's increased over time?

MS. RYAN: Correct.

HEARING OFFICER JACKSON: Okay. Do you have those numbers? Would you be able to provide those

numbers?

MS. RYAN: Yes.

HEARING OFFICER JACKSON: Earlier, there was reference to the number of emergency department visits. Now, I'm finding your -- okay. So, this is just before Section 5 of your pretrial testimony. Total ED visits.

And so, this is -- this is going to get to the question of discharges and visits, because I -- I have self-reported discharges as 43,000 and it looks like approximately 49,000.

Can you just clarify the number of ED visits versus discharges versus admissions? And that can be part of that same late file that I just asked for --

MS. RYAN: Yeah.

HEARING OFFICER JACKSON: -- clarifying over time the percentage of patients who are in the ED who are being admitted to inpatient versus outpatient and total number of visits. I think that these numbers are kind of sprinkled throughout, but I don't have them in one place to see them clearly.

This was referenced earlier, and I would just like a little more information about the change in observation stays over time.

MS. RYAN: I may not be the total expert on that.

MS. FELDMAN: I think we need some clarification on that. This is Joan Feldman speaking. Are you asking for us to report to you our observation stay trends over a period of time?

HEARING OFFICER JACKSON: I'm asking for a narrative description right now.

MS. FELDMAN: Okay.

MS. RYAN: Yeah.

HEARING OFFICER JACKSON: There's an argument that observation stays should be included --

MS. RYAN: Yes.

HEARING OFFICER JACKSON: -- here. Have those changed over time such that there's a more pressing need due to observation stays now because are observation stays different today than they were last year, than they were three years ago?

MS. RYAN: Yes. They're increasing. So, years ago, 2012 -- and I think I mentioned this when I was talking earlier -- we had very few observation -- and at that time, observation people, you know, hospitals wanted to run observation units because it was over and above your licensed beds. Now it is included in your licensed beds as part of the number.

MR. JACKSON: And to follow up on a question that I said I would circle back to earlier, can you

provide a little more information on the specific challenges that have arisen, acknowledging that these challenges face a number of hospitals, the specific challenges to discharge?

I know one reference was made to transportation sometimes to prior authorization. Can you just describe kind of the primary reasons that people are not being discharged when medically appropriate?

MS. RYAN: The primary reasons are that the discharge -- we have problems with ambulances. So, problems with ambulances have been pretty -- pretty problematic during the pandemic, slightly after -- and also after the pandemic because many of the -- many of the staff had left. The schools weren't open during that time. So, we had a real decrease in the number of people that were actually paramedics and running ambulances.

At that time, we actually -- slightly after that time -- and we had been utilizing many ambulances, including Bristol's ambulances, to transport our patients. The problem with discharge is you need to transport nonurgent patients.

Storrs has a fleet of -- UConn, Storrs, has a fleet of paramedics and vehicles. We have one vehicle

at UConn for -- and they take 911 calls out of Farmington. But we did employ another vehicle there for nonurgent transfers so that we could get patients out to facilities faster. So, that was one issue.

We also wanted to make sure that consults and -- consults and other -- consults and other radiologic -- particularly radiology scans were being done first thing in the morning for patients that were being discharged. So, that was an interdisciplinary approach. The discharge lounge was another approach. And medication management, making sure -- and, you know, that patients would be discharged, know their medications. And we made sure that if they fit the LACE criteria, which I had gone over earlier, of 75 or above, that we employed them into our discharge virtual clinic to really look at and address readmissions.

HEARING OFFICER JACKSON: To follow up on your very last point there, there's been discussion back and forth in the filings with OHS regarding more-than-expected readmissions in Fiscal Year 2020, 2021, and 2023. You talked about some steps.

Are there other steps that you would like to discuss that John Dempsey has taken to prevent readmissions? And is that a problem that is still plaguing John Dempsey in Fiscal Year '24?

MS. RYAN: Mm-hmm. So, I think that our most current data suggests that we have -- eight is our number, maybe, with readmissions. So, as I said, we have a transitional care management program for any of our patients that are -- have docs, primary docs, at UConn. And our population health really looks at, you know, calling them, making sure, following up, that they follow their primary care appointment.

We have our postdischarge call nurses that have -- we actually have employed a couple more so that we can cover all of our postdischarge patients' phone calls within 48 hours and make sure that any problem they're having in addition to the discharge remote clinic -- which looks at the LACE score patients that are increased.

Now, it could be that, you know, one of the patients is a, you know, heart failure patient. So, if you were called 24 hours postdischarge, we can bring that patient in if we feel that her wait is up, she's having trouble breathing, shortness of breath, and we can put her in for heart failure outpatient infusion. They have medication management on the virtual outpatient clinic. They can have a physician remote visit and then also be brought in for that visit outpatient.

We also have -- you know, a lot of the medication follow-up, we also have a pharmacist on that remote discharge. As I said, our Lasix infusions for heart failure. We have much more community resource, also coordination through population health.

HEARING OFFICER JACKSON: I don't know if this question is appropriately formed, so you may need to rotate again.

If more beds were approved and John Dempsey increased its admissions further -- let me back up.

If additional beds are approved, does John Dempsey anticipate further increases in its inpatient admissions?

MS. RYAN: I would say -- I mean, it would basically operate like we are right now. I mean, I don't -- I think we anticipate that the EDs are still going to be busy, and that's 60% of our population, unless I misunderstood your question. Go ahead. Ask it again, please.

HEARING OFFICER JACKSON: Does John Dempsey anticipate that with an increase in beds there would similarly be an increase in the Average Daily Census?

MS. RYAN: I think it -- it would remain constant at the moment. I think we're -- we're seeing -- we have been consistent. We have been -- we

have had a slight increase, but we have been consistent on that Average Daily Census. It is staying in the 180 range.

MS. FELDMAN: You want to --

MR. HYERS: Can I --

MS. RYAN: Sure.

MR. HYERS: Chris Hyers again. Caryl and I spent a lot of time working on this stuff.

So, I think the answer to your question is when we looked at the need for those 23 beds, would we fill them. And the primary factor for us when you look at an ED visit rate, total volume, it's gone up, like, 56% over four years and has not slowed down at all from all over the service area.

If that continues even at, like, a third of its current growth rate, the number of admissions that would naturally push through -- because that rate you asked about earlier is pretty steady at about 18% of the people who show up. You know, some months it's 20. Some months it's 17. So, yeah, the census would go up a little.

And part of the magic of that 23 was not only to get us over the hurdle today, where we feel we're short, but to look at that short-term -- short-term window of the 18 months. Nobody can predict what their

volume is going do forever.

HEARING OFFICER JACKSON: Right.

MR. HYERS: But there's nothing we could find to say that it's going to slow down so we're okay.

HEARING OFFICER JACKSON: And leading that with the argument about patient choice, does John Dempsey believe that in that increase some of those are likely to come from what would have gone to Bristol Hospital? As John Dempsey increases its admissions, do you believe that some of those would have gone to Bristol Hospital?

MR. HYERS: So, it's impossible to know, because, just like Bristol will talk about patients that may come our direction, we have patients that live across the street from us in Farmington and go downtown to Hartford. So, patient movement, the market is really hard to say.

What we know is that the volume continues to go up from all of those ZIP codes we talked about earlier around us, our direction. And where -- how they're making those choices other than what we know -- and I think, you know, Caryl pointed to it earlier, which is patient satisfaction is high. And as a consumerist, I know that when a customer is happy, they come back, and they tell a friend. There's no reason

for us to think they won't keep coming. From where and to the gain or detriment of other hospitals we wouldn't be able to say.

HEARING OFFICER JACKSON: In prefile testimony, John Dempsey said that it refuted -- that was a quote -- Bristol's prefile testimony because Bristol had lost more volume than John Dempsey gained.

But does John Dempsey think that adding additional census would further contribute to harm to other hospitals in the region?

MR. HYERS: Can I have just a moment? So, that statement is based on just looking at the CHA data that we all look at, where our patients go and what they do. And what we've seen, especially after reading Bristol's prefiles, we went and looked at our patterns, what's going on here.

The -- more patients leave the Bristol service area for the hospital in Central Connecticut than they do for us. So, if we believe trends continue, they're headed, by whole number, which is what I took your question to mean, more towards Hartford facilities than to UConn Health as a -- as a whole number.

The percentages, you know, by and large -- I mean, when you look at a market, you take the ZIP codes

that's their primary -- patient origin, where are they going. Right? And they're going first to Bristol, then they're going to hospitals in Central Connecticut, then they're coming to us.

HEARING OFFICER JACKSON: Okay. Thank you for that clarification.

Financial stability. I don't know who's the most appropriate person.

MS. FELDMAN: Chris. Or --

HEARING OFFICER JACKSON: And I can go ahead and ask a question if that helps.

DR. AGWUNOBI: Yeah. You can ask, and then we can clarify.

MS. FELDMAN: Yeah.

HEARING OFFICER JACKSON: Attorney Feldman asked earlier of Bristol Hospital about the State stepping in for financial assistance.

Aside from standard appropriations of the State, has the State had to step in to close funding gaps at John Dempsey or -- which would include increasing the appropriation due to a need to fill a gap?

DR. AGWUNOBI: If you could clarify "a gap." And we get different types of funding from the State. So, we get our block grant, which is basically an

investment from the State for being an academic medical center and having students and research. So, we get a block grant.

We also get -- we get capital funds from the State as well for deferred maintenance and things like that.

And to a certain extent, each year we have to determine what our needs are, justifiable needs are, from the State versus what we are paying for ourselves. You know, for example, in some years, we were responsible for legacy costs or pension costs. That has changed. And now -- so, there's a lot of ins and outs. It's a little bit, you know, complicated.

But I would say that each year we go to the -- each biennium, we go to the State, we tell them, you know, what we are going to cover ourselves from a clinical care perspective, and our net revenues have tripled over the last ten years or so. But sometimes there's some adjustment back and forth depending on what the State has available versus what our needs are.

HEARING OFFICER JACKSON: So, I'll highlight, the difficulty in comparing the conversation --

DR. AGWUNOBI: Right.

HEARING OFFICER JACKSON: -- is Attorney Feldman asked directly have you received State aid.

DR. AGWUNOBI: Right. Right.

HEARING OFFICER JACKSON: And the answer was affirmative. And here there are lots of State funds flowing.

So, analogous to that type of aid as a result of financial need, has there been additional aid from the State in that kind of analogous method?

DR. AGWUNOBI: Well, I -- I wouldn't say totally analogous in the sense that I think -- I won't speak for Attorney Feldman, but I think it was in reaction to the idea that we receive State funds, you know, called a subsidy, which we consider to be an investment. And I think it was just -- been pointed out that Bristol has also received State funds.

But in terms of analogous, it's a little bit different because, you know, we are -- we are an academic medical center that is a public/state institution, and we therefore receive funding in order to support the tripartite mission that we do for State of Connecticut.

So, it's a little -- it's a little bit different than going to the State, for example, to -- to bail you out when you're not a State organization. We're actually a part of the State, so it's a little bit different -- it's difficult to draw that analogy.

HEARING OFFICER JACKSON: Okay. And UConn Health's state appropriation was $340 million in Fiscal Year 2023. What was John Dempsey's state appropriation?

DR. AGWUNOBI: Ask our finance person to help us with that allocation.

MR. BIANCHI: Chad Bianchi. I have the '23 statements here with me, so just bear with me.

MS. FELDMAN: He always travels with those.

MR. BIANCHI: So, it's -- as Dr. Andrew said, the funds are to the health center, they're commingled, so we don't have a specific single number. What we have are transfers in and out of different entities. So, we have transfers in roughly a net of maybe $50 million.

HEARING OFFICER JACKSON: A transfer into the hospital --

MR. BIANCHI: Into the hospital, right, which is typically the fringe benefit match that -- or -- that in-kind fringe benefit.

So, the 340 you mentioned includes two components. It is our block grant, and then it is the fringe benefit that we charge along with the State. So, the money that was back in the hospital was fringe-benefit related.

HEARING OFFICER JACKSON: Okay. And can you -- can you differentiate the size of those two things?

MR. BIANCHI: They're roughly equal.

HEARING OFFICER JACKSON: Okay. So, approximately half goes to the fringe benefits, approximately half to the --

MR. BIANCHI: Of The 340. Yes.

HEARING OFFICER JACKSON: Yes. And the part that goes to the hospital is fringe benefits primarily.

MR. BIANCHI: Yes.

HEARING OFFICER JACKSON: Okay. Thank you.

Can you provide additional information about how John Dempsey calculated the estimates provided in Worksheet A, specifically as far as how the beds will contribute to increasing the operating margin?

MR. BIANCHI: I did not put them together, so I could not give you the details. In high-level theory, obviously, more beds, we're expecting more surgical patients to come through.

And then -- so, I'll -- you know, based on our standard patient mix, we would estimate the net revenue expected to come in. And then the expenses follow any number of paths. So, some of our expenses remain flat, some of them go up in a stepwise fashion,

and some of them are directly correlated to the patient coming through the door.

So, if we do a surgical case and there was an implant, obviously our medical-surgical supplies are going to go up directly with the number of cases we do.

HEARING OFFICER JACKSON: So, I -- my understanding, then, is that you're taking a basic per-patient type of figure and multiplying it by what's expected to happen or a per-bed calculation and then multiplying it by what would be an increase?

MR. BIANCHI: Yes, but also factoring in -- you know, we have our standard bargaining unit increases.

HEARING OFFICER JACKSON: Thank you.

MR. BIANCHI: And those were modeled in as well.

HEARING OFFICER JACKSON: Thank you. So, there's been a big change that was cited in various pieces of testimony and the application, improvement at John Dempsey of the operating margin.

What have been the big contributors to the improvement of that operating margin? And what's driving the continued improvement that we see in Worksheet A? What's driving that expected increase?

DR. AGWUNOBI: Well, I think there are two

main components, and it goes back several years, you know, seven, eight years, where we started to operate John Dempsey Hospital and the clinical enterprise in a much more, let me say -- well, let me back up.

You know, John Dempsey is part -- is an integrated part of a teaching, research, and clinical enterprise. It's often the same physicians who are doing research who are doing teaching who are also doing clinical care.

And so, I think when you go back seven or eight years, there was a lot more weight put towards investing sort of resources and time and strategy and business operations into the schools as opposed to focused on the clinical enterprise. And so, there was a realization at that time that, to be able to serve our patients well clinically, we needed to invest the resources, plan strategically to be able to improve our delivery of care.

And so, that involved things such as increasing the -- the bench strength of our different specialties; equipment, you know, making sure that we have the latest equipment; infrastructure. There's Bioscience Connecticut, which was an $800 million investment in that campus. Opening the new teaching hospital. Opening an outpatient pavilion. It also

included education as well. Research building. New building for the medical school pavilion. Et cetera.

But there's a lot invested in that campus, both in terms of equipment, buildings, specialty growth, cutting -- being cutting-edge when it comes to equipment and diagnostics and technology, and then, of course, bringing in more -- we already had very high-caliber faculty, but bringing in more faculty into those different specialties. And then at the same time, also, applying some of the -- just the typical industry principles around, you know, how you manage a high-performing clinical enterprise.

And all of those things came together, making sure, as well, that we were investing in patient satisfaction, making sure that we're taking care of our patients and our providers as well.

I think, so, it's a multifactorial component but a real focus on the clinical enterprise as a part of that integrated tripartite mission. And I think -- now, again, we can't say which one of those things or all of those, you know, made -- gave success that we've seen over the last seven years. But it certainly has served our patients well.

And one of our goals, of course, is we're a public institution. So, why were we doing all of that?

We were doing all of that to best serve the patients in Connecticut. That's what our goal is. And it seems to be working.

HEARING OFFICER JACKSON: And to circle back to my previous question, I just want to make sure that I am understanding how the math works as far as increased beds go.

Are there assumptions about economies of scale or, you know, by bringing in these beds we're going to increase our operating margin other than just we have a margin per bed and we will have more beds and therefore multiply that through and that's a higher number?

DR. AGWUNOBI: Yeah. Yeah. I'm happy for anyone to correct me, but our focus -- this is how I started the discussion today. Our focus has been 100% on we do not have the capacity to serve the patients we have today, and we're continuing to grow. And so, it's always been about how do we get more beds for our patients.

I have not been part of any conversation where we're sitting down and saying, oh, if we could get 23 beds, we could generate this much more margin. That's simply -- that's simply a factor of when you put beds -- when you have more beds and you have more

patients and you bill as you have been billing for those patients and you have the costs.

Now, we do think there are some economies of scale in the sense that we don't have to build a whole new hospital or a whole new unit. So, there's some inherent economies of scale. But really, it's about patient capacity.

HEARING OFFICER JACKSON: Thank you. I just want to draw attention to the fact we've been going for an hour and a half. Anyone needs a break at any time, please let me know. But I'm trying to desperately make sure that we can get out our cars out of the garage on time because it locks at 5:45. So, I'm going to keep going. I'm about 60% -- no, I'm more than that done. 75% done.

MS. FELDMAN: Promise?

HEARING OFFICER JACKSON: Yeah. So, I'm going to keep going. But if anyone needs to take a break at any time --

MS. FELDMAN: Please keep going.

HEARING OFFICER JACKSON: -- just let me know.

Regarding patient satisfaction and brand recognition, in prefile testimony, John Dempsey cited a study asking in 2019 and 2023, Which hospital do you

feel provides the overall quality of care? I believe this is an internal study that was done. There weren't citations or descriptions of the methodology.

Is this a report that exists that we could see so that we could see the methodology, understanding sample and all of that?

MR. HYERS: Yeah. Chris Hyers. Absolutely. Commissioned by us. I think Mr. Barwis said they also do them.

HEARING OFFICER JACKSON: Yeah.

MR. HYERS: Yeah. We've got a full report with all the who did it, what did it, where things came from. I'd be more than happy to submit that in a late file.

HEARING OFFICER JACKSON: And you teed it up. This is why I said when I started that I might bounce to the Intervenors.

I was going to ask Bristol Hospital if you also had -- I think you referenced that there was a report that shows that Bristol Hospital is also preferred by a number of patients -- or people in the area. If you could provide report.

MR. BARWIS: So, I would consider that proprietary because it does specifically analyze perception of our patients against the area hospitals.

And we just had to redact that as part of the lawsuit between St. Francis and Hartford HealthCare. So, I would say we'd be happy to provide specific stuff but not all of the report.

HEARING OFFICER JACKSON: Okay.

MR. BARWIS: And I believe the same company did it for them.

HEARING OFFICER JACKSON: Okay. We can be in touch about the confidential submission of information.

MR. HYERS: And I would -- I would just ask that apply both ways because we had similar issues that Mr. Barwis pointed out.

HEARING OFFICER JACKSON: Sure. So, Attorney Csuka can explain our confidentiality processes. But we'll put that down.

So, we talked about this a little bit earlier, and I'm going to invite another late file for further explanation regarding cost-effectiveness and the relative cost of care. John Dempsey says it's among the lowest cost in the state. Bristol Hospital presents its information regarding implied charge per discharge of 77% lower than John Dempsey --

MS. FELDMAN: Not charge. Expense.

HEARING OFFICER JACKSON: What they have is implied charge per discharge, is what the table says.

They --

MS. FELDMAN: Charge -- I would just clarify, who is it a charge to?

HEARING OFFICER JACKSON: So, in Table 8 of Bristol Hospital's prefile testimony, the final row in the table says "implied charge to discharge."

MR. BARWIS: We can correct that. It should say "cost to discharge."

HEARING OFFICER JACKSON: Okay. So, restating the question, John Dempsey says it's among the lowest cost in the state. John Dempsey says by our calculations we're cheaper.

Can you help to explain the discrepancy between the two testimonies? If anyone would like to speak to that now -- we can accept it as late file.

MS. FELDMAN: Sure.

HEARING OFFICER JACKSON: And if you would like to include your explanation of comparison with academic medical centers.

MS. FELDMAN: Correct.

HEARING OFFICER JACKSON: Provide space for that as well.

MS. FELDMAN: Okay. Thank you.

HEARING OFFICER JACKSON: So, a few questions about the expert report.

Throughout the testimony and prefile testimony, the changes described are between 2012 and 2024, and especially a citation to the Affordable Care Act and Medicaid enrollment.

If the -- if the bedding methodology is looking at utilization in the last three years, why is the difference in Medicaid enrollment from 2012 to 2024 -- why does that difference make this an invalid assessment?

MR. STRATMANN: This is Thomas Stratmann. The -- I mentioned that Dempsey was allocated about 224 beds, I believe, in that area, in 2012. That was based on the demand at that time. However, my point was that since then demand significantly increased. There are now over 400,000 raw Medicare-insured individuals in Connecticut than there were in 2012.

MS. FELDMAN: Medicaid.

MR. STRATMANN: Medicaid. Thank you. My point. My opinion. My point was that the methodology is not -- is static in a sense because it doesn't automatically account for the increase in demand that the -- which has shifted the underlying dynamics of the correlation.

HEARING OFFICER JACKSON: But the bed need assessment for an application, so difference in the

report, which estimates need, but for an application looks at the prior three years from today. So, the fact that there's more than 2012 doesn't affect that assessment.

We're looking at the last three years, looking at what the need has been over the last three years, and saying what is the need today based on the last three years. So, it doesn't take into account what the need was in 2012.

MR. STRATMANN: Okay. Let me try to answer this question differently, perhaps better. The -- the individuals that are enrolled in Medicaid tend to be, of course, by definition, poorer. People who are -- have lower income tend to have more healthcare needs. And I am not a medical doctor, but more healthcare needs also sounds to me that it is possible the cure rate is higher.

So, nowadays, when Dempsey admits a patient, they're going to admit a different mix of patients than before. Before, they did not admit that many poorer individuals because they didn't seek medical care because they did not have Medicaid. Now these new types of -- this -- these poorer health-type individuals are being pulled -- are being -- are being served, which then, therefore, results in an increase

in (indiscernible.)

HEARING OFFICER JACKSON: Are you arguing that the difference in need from three years ago, the Average Daily Census, the need that we calculate for an area, is based on the last three years of experience?

MR. STRATMANN: I'm saying that the patients that are admitted right now have more demand for intensive health services than in 2012.

HEARING OFFICER JACKSON: Okay. Okay. One of the things -- and this is going to require juggling a few minutes, so apologies.

You stated that it would -- it defies logic that a 2012 rate would -- or number of beds would still be acceptable in 2024. But in 2022, the occupancy rate for John Dempsey was, according to the HRS filing -- can one of my partners tell me -- 49.8% in 2022 and 57.4% in 2023. Did I get those right? Approximately 60%.

So, was -- was that an acceptable rate in 2022 still based on the same number that existed in 2012 but defies logic today?

MR. STRATMANN: So -- so, I said that it defies logic to not having changed the number of beds since 2012. And the reason I said that is because the healthcare industry is not static. It's dynamic.

Some -- as in all other businesses, some businesses are going to be on the upswing and other businesses are going to be on the downswing. So, my point is keeping the number fixed is an indication of not recognizing a dynamic market.

HEARING OFFICER JACKSON: Do you agree that it is -- it is updated based on three years in the past if there's an application? We would do a need assessment based on the most recent three years within the PSA and calculate that number. We're not saying the need that was calculated in 2012 still applies today. We're saying we look at today at the most recent three years and calculate an updated need, and that spits out a number for how many beds are needed in a PSA, primary service area.

MR. STRATMANN: Yes. I'm familiar that there is a Certificate of Need application process.

HEARING OFFICER JACKSON: Okay. So, it's not based on a number calculated in 2012?

MR. STRATMANN: I was saying that Dempsey right now has the same number of beds allocated now as it did in 2012.

HEARING OFFICER JACKSON: Okay. Your assessment focused only on the experience -- my understanding -- is focused only on the high occupancy

rates and diversion status for John Dempsey Hospital but does not consider other utilization within the primary service area at other hospitals.

MR. STRATMANN: I don't -- sorry. I don't understand the question. I mean, I talked about much more than diversion and the other thing you mentioned.

HEARING OFFICER JACKSON: Did you conduct your assessment for the need in the entirety of the primary service area within John Dempsey Hospital's primary service area?

MR. STRATMANN: I did not consider the primary service area. I considered the data that John Dempsey has.

HEARING OFFICER JACKSON: When you did the assessment, you said that you did the Connecticut bedding methodology with your three updates?

MR. STRATMANN: Yes.

HEARING OFFICER JACKSON: Was that for the entire primary service area of John Dempsey Hospital? So --

MR. STRATMANN: It was based on the Average Daily Census that -- that Dempsey had over the last 11 months.

HEARING OFFICER JACKSON: Of just John Dempsey Hospital, and not of the PSA.

MR. STRATMANN: Yes. I used the same method as I saw in your spreadsheet. So --

HEARING OFFICER JACKSON: Right. But the -- the Statewide Facilities Services Plan focuses on the bed need of the primary service area, not just of a specific hospital. Your analysis was of a specific hospital.

MR. STRATMANN: That's correct.

HEARING OFFICER JACKSON: Thank you. Okay.

For now, I'm going to turn to Bristol Hospital. So, now I'm going to turn to Bristol Hospital.

Are you aware of any instance where Bristol Hospital has refused to take patients -- we'll start with on diversion -- generally?

MR. BARWIS: From another hospital who goes on diversion, we generally try to accommodate a hospital that's on diversion.

But during the pandemic, I sat in the ER one night trying to transfer patients. I got called from CEOs all over the state. And I was being asked to take a patient from Johnson Memorial and other places, and it was impossible. I mean, we were being overrun. So, there are times when you can't do that.

If it's okay, I just want to point out a

comment to you or a fact to you. I worked in Maryland for almost eight years. And I think there's a complication in, look, comparing an approach to occupancy and bed capacity, because when I worked in Maryland, the law was you could not go on diversion, which plays into why the calculation is the way it is. And you also have significant -- in Western Maryland, rural hospitals, access hospitals, so their calculation can be very different from what you would apply in the state of Connecticut.

HEARING OFFICER JACKSON: Are you aware if Bristol Hospital has refused any diversion from John Dempsey Hospital, say, in the last 2 1/2 years?

MR. BARWIS: I am not -- I am not aware of that.

HEARING OFFICER JACKSON: In your prefile testimony, you spoke -- you argued that a bed increase would take patients away, but you also said it would make staffing more difficult. Could you explain that argument?

MR. BARWIS: Thank you. Yes. I sure can.

We had a fully staffed ICU. And we, because we're a Magnet hospital, we tend to get a lot of new graduates that come and want to be in that environment where you have shared governance.

So, we often have large classes of new graduates. And depending on the area that they go to -- so, if they go to family or they go to the labor and delivery area, it could take them upwards of 11 -- 10 to 11, 12 months to be able to be a productive nurse on the floor. ICU can be as much as seven months. ER environment, similarly. You know, so you're paying for them to actually become very competent and used to dealing with lots of patients.

So, literally, we lost -- the exact number is 11? Was it 11? Within -- within a couple months, we got devastated by the UConn Health center recruiting our staff. They literally came in and just took one after another, which caused us to have extreme costs, because we had to fill with agency people.

And, you know, we -- I can't compete with their benefits. You know, they -- some of them leave because the minute they work there they get free tuition to UConn schools, the colleges. And that's often the explanation you get.

I can't compete on the benefit level. But I feel like, you know, the damage -- you know, one of the reasons we lost significant money had to do with the fact that they're right down the street. We trained all our nurses, circulators, and all our nurses -- and

they have this significant ambulatory surgery enterprise where the nurses can go there and literally not have to take weekend or holiday call or work on the weekends because it's a, you know, during-the-week thing. So, we have a frequent loss of individuals there. I've lost two radiologists to there. And I just lost an ER doctor to the UConn Health center.

So, it's hard to compete when you're that close, whether it's 10 miles or 13 miles, and you have people that have family that live in the area, with the benefit level, which we've heard repeatedly is significantly more than what I can offer, especially in terms of time off, free tuition.

And I'd also point out, I would almost bet that the cost of the college tuition that gets done free for those individuals is not showing up as a -- as a benefit cost to the UConn Health Center.

So, I think, you know, all of those factors. So, that's really what I meant. And, you know, it's very difficult because we -- we tend to be a training ground. I know they have a nursing school. We actually have an agreement with them. We help train their nurses in our environment. They do rotations through us. But that was devastating. It was, like, one after another.

And that's what happens in that environment. We have a small ICU, 16 beds. And, you know, the first one talks and says, Hey, this is what I got, you need to talk to this person. The next one does the same thing. And it just went on and it -- it crippled us for a period of time.

HEARING OFFICER JACKSON: Do you have documentation of these people leaving for UConn specifically and/or how that compares to people who have gone elsewhere?

MR. BARWIS: Yes. Absolutely.

HEARING OFFICER JACKSON: Great. We're going to ask that you provide that, please.

When there's been diversion, has -- has Bristol Hospital acted to receive diversion patients from John Dempsey in the -- in the most recent three years?

MR. BARWIS: I can -- I can follow up with that and answer that question afterwards. I can't tell you for sure.

HEARING OFFICER JACKSON: Okay. I thought there was reference to patients being diverted without any issue. But, so, I would like to know if you've accepted patients and if there have been any adverse events for any patients diverted.

MR. BARWIS: Yeah.

MR. VOZZA: Can we have one second? One second.

MR. BARWIS: So, in their application, there are two occasions when they diverted to us without any issue whatsoever. It's in their -- it's in their application. But we will follow up with more detail. I will let you know.

HEARING OFFICER JACKSON: Going back to the cost issue, I think what we were getting at -- so, John Dempsey asserts their costs in the state. Bristol Hospital says they're cheaper than John Dempsey.

Is this just an issue of patient acuity? Is it that patients going to John Dempsey need more services, and so on a per-person-who's-treated basis their cost is higher because they needed more care?

MR. BARWIS: You know, as a finance person, absolutely not. I mean, their costs are higher. They have higher labor costs. There's a variety of reasons for that. And they are a teaching facility, so they have higher costs related to that.

So, you used "acuity" specifically or Case Mix Index. They do have higher level services. So, of course, they have a cath lab. We don't have a cath lab. So, there are going to be higher costs there.

But we are freestanding. We are a nonprofit facility. I would say the vast majority of our business is government-pay business. It's a miracle, literally a miracle that we are still standing and getting quality ratings on the safety ratings that we have.

And so, the little bit of subsidy that we got is -- as, you know, you were asking the question, the recent report that was issued by Cain Brothers says State subsidized our cash flow loss before earnings, interest -- and their EBITDA loss is $140 million annually that's being subsidized by --

MS. FELDMAN: I have to object. I don't think the Cain Brothers report is in the record, so why are we referencing it?

May I ask -- my objection -- we have submitted a financial Worksheet A, which reflects our costs. We also submitted all our data to OHS, which reflects our costs. There's really no reason to cite our costs with the source being the Cain report.

HEARING OFFICER JACKSON: So, this does go to the question that I asked about any supplemental financial assistance from the State. So, I'm -- I am not familiar with the Cain report itself.

MR. CSUKA: We haven't left your objection.

We understand that. We just need to understand more about what we're talking about before we're able to rule on it.

MS. FELDMAN: Right. It's not a primary source for information regarding financials.

If you have questions regarding -- and I thought our finance expert answered the questions about the support and the costs that are incurred. And they're all reflected in Worksheet A, so -- for John Dempsey Hospital. I think we're going down a rabbit hole.

MR. CSUKA: What is the source of the underlying data for the Cain report? Does that come directly from the hospital?

MS. FELDMAN: I don't know. It's not in the record, and I'm, you know, not familiar with their primary sources or what they looked at -- to. I could not tell you.

MR. CSUKA: What is Cain?

MS. FELDMAN: It's an investment banking firm.

MR. CSUKA: Okay.

MS. FELDMAN: Cain Brothers.

MR. CSUKA: Okay.

MS. FELDMAN: And I understand that the

Governor's office engaged them with respect to looking at options strategic for the health center, but it has no relevance to this hearing.

MR. VOZZA: I would just note that the reference to the Cain report is on page 6 of Mr. Barwis' prefile testimony.

MR. BARWIS: I'd also point out that it was -- the report was contracted for by the Office of Healthcare Strategy. So, they provided it.

MR. HYERS: No.

MS. FELDMAN: I don't think that's correct.

MR. HYERS: OPM.

MR. BARWIS: I'm sorry. Office of Policy --

MS. FELDMAN: That's a big difference.

MR. BARWIS: Yes. OPM.

HEARING OFFICER JACKSON: We're going to take one minute to discuss in our breakout room off the record.

(Recess from 3:58 p.m. to 4:05 p.m.)

HEARING OFFICER JACKSON: Okay. We are back on the record.

Attorney Feldman?

MS. FELDMAN: I think that one of our witnesses can provide some information that might seal the deal on whatever decision you're making here. So,

why don't you introduce yourself.

MR. BIANCHI: Sure. Chad Bianchi. Just in terms of the Cain report, or even the OHS report, it's important to remember those are based on different sets of costs, right. So, there's a lot of different ways you can report your costs.

Typically, those are pegged to your audited financials, because then you have an auditor come in, there's a verification, everyone has to agree, okay, this is a good number.

Our audited statements include costs that the GASB, the Governmental Accounting Standards Board, make us record related to state pensions that don't actually have anything to do with patient care and don't relate to actual cash flows out the door.

So, the State, as you know, has an unfunded pension situation. John Dempsey and UConn Health have to record their share of that unfunded liability. Now, as an unfunded liability, that's a long-term obligation of the State.

John Dempsey has paid in historically. They don't -- in theory, they shouldn't have to pay any more, but the State allocates the funds down. That goes on our books as a liability and an expense. Cash never leaves us for those. So, our numbers look worse

in our audited statements and our filings than -- with Cain than they do in reality.

HEARING OFFICER JACKSON: Thank you. We're going to overrule the objection as to relevance, allow Bristol to finish their testimony on the issue. We'll take administrative notice of the report itself, apply the appropriate weight, and we'll allow you to respond to the report in late files.

MS. FELDMAN: Thank you.

(Administrative Notice taken of Cain Brothers Report.)

MR. BARWIS: Could I -- you asked a specific question about confusion between cost. And I think the important thing is, whatever we're saying, you need to define what you mean by cost, because referring to this study here is -- this study that was added this morning, DD, the RAND study, is the cost that the health plan pays, an employer pays.

What I'm referring to is what's the real cost of a discharge, what's the real cost of care to someone, whether it's an employer or the State of Connecticut.

And if you process the difference, my payer mix adds 73% government pay, which pays less than cost, and I have over a 2% noninsured population. It's a

miracle that we're standing. So, $7 million is like an ice cube in Phoenix on a 110-degree day. It's nothing.

And at this point in the last year, we've dropped 21 million in run rate and reduced our cost per discharge by 9.5%. There is a huge difference.

And, you know, how is it right that I don't get subsidized for all of my Medicaid? How is it right that I'm taxed at an extremely high rate on net revenues in the state of Connecticut, over $12 million a year? They're exempt from that tax.

MS. FELDMAN: I'm going to have to object once again. According to the most recent case law in Connecticut on this issue, I don't think that Connecticut General Statute 19a-639a is intended to contemplate another party's business failures or failings in connection with this CON application for bed need.

I'm happy to provide the citation. And it's a decision that was issued May 30th, 2024. It involved High Watch Recovery Center versus the State of Connecticut. And you're probably familiar with it.

MR. CSUKA: Attorney Feldman, can you just explain a little bit more clearly how you think the High Watch decision applies to this and your objection?

MS. FELDMAN: All right. A great deal of

focus today and testimony has been about Bristol Hospital's economic woes and inability to fill its beds and its financial demise, including default on its bonds.

We're here today to talk about the need at John Dempsey Hospital for more beds. And a lot of the focus has been not on whether we need the beds but whether or not our beds somehow are going to negatively impact Bristol Hospital. And I believe that decision says that that is not within the jurisdiction of 19a-639a. That's what I'm saying.

MR. CSUKA: It sounds like you're making a relevancy objection?

MS. FELDMAN: Okay.

MR. CSUKA: And tying that into High Watch in some way. And I'm just -- I don't see the connection there.

MS. FELDMAN: Well, I -- in all due respect, I don't see the connection for much of the day with respect to hearing about Mr. Barwis sitting in the ED during Covid when we're trying to determine whether or not there was a need by JDH for beds and whether the methodology itself is a valid methodology in determining the needs of patients in the community served by specific hospitals.

So, I guess I would agree with you. And thank you for that. I object on the basis of relevancy.

MR. VOZZA: Can I just say something?

MR. CSUKA: Yeah. You can respond.

MR. VOZZA: It's relevant to two points which are part of the standard for a CON application, which is, first, the utilization of existing healthcare facilities and healthcare services in the service area of the Applicant; and second, whether the Applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved healthcare services or facilities.

MS. FELDMAN: And I would respond by saying that's the exact same argument made in the High Watch case by High Watch, and it was rejected.

HEARING OFFICER JACKSON: Okay. So, we'll sustain the objection as to the past financial difficulties of Bristol Hospital. We will ask that the discussion be limited -- to the extent there is discussion of the effect of the proposal on Bristol Hospital, keep it to strictly duplication of services in the PSA and utilization of services in the PSA.

MR. BARWIS: Yes. So, then I'll go back to the point that I made, which is that at all times we've

had 32 beds available within the primary service area of UConn Health center.

And now that I've checked the records, we have not turned down any diversions that I'm aware of in the last three years. And we've actually accepted two, and those patient outcomes were phenomenal. They were fine.

So, and from my perspective, you know, we have the beds, we're here, we're ready to take care of patients. And it will certainly serve our community well.

HEARING OFFICER JACKSON: All right. Any objection to that response? Would you like --

MS. FELDMAN: Well, on redirect I will refute that statement.

HEARING OFFICER JACKSON: Okay. But under the legal standard you were just citing.

MS. FELDMAN: Fine. I have no objection.

HEARING OFFICER JACKSON: Okay. Thank you.

Bristol Hospital proposed or requested the ability to discuss leasing already licensed beds within Bristol Hospital. Can you explain what you're requesting there?

MR. BARWIS: Sure. We have the capacity. And if you look at the situation that occurred between

Yale and Milford Hospital, very simply, Milford had a whole floor and Yale didn't have capacity, so they leased the floor from Milford, and then they operated that floor as Yale main campus hospital so they could utilize the capacity and the services at the hospital just like I've seen in other places.

I mean, in some -- in some states you can basically lease ORs and things like that. So, there's many constructive ways to do it. But I think it would serve the community well.

HEARING OFFICER JACKSON: I believe I heard a response earlier from John Dempsey. But does John Dempsey have a response to that idea or proposal that was articulated in the prefile testimony?

MS. FELDMAN: Absolutely. I can't -- unless, you know, you want to -- also just for the record -- you can make it part of the record or not -- to be factually accurate, Yale leased space in Milford Hospital, who's similarly -- who was having financial difficulties -- to open an inpatient rehab unit. It was a very distinct service.

And very shortly after that -- that didn't seem to make a big difference because they were not Milford Hospital's patients -- shortly after that, Milford became insolvent, and I've been before OHS

where Bridgeport Hospital acquired Milford Hospital.

Go ahead.

DR. AGWUNOBI: Well, this is the -- I would just say, first of all, this is the first time we've heard of the lease idea, so obviously it's something that we're -- we're responding to in the moment.

The way I think about it is, first of all, we have a lot of respect for Bristol Hospital, for their leadership. And we have demonstrated in the past that we want to collaborate. We have collaborated. We do collaborate right now. There will probably be opportunities for future collaboration as well.

But I think -- the way I think about it is that the ability to collaborate, whether that's -- whatever the form of that collaboration might take does not -- does not remove the need for beds, for capacity, that we have for -- that we need for our patients today on the JDH campus.

So, I guess what I'm trying to say is that both -- both can exist. You can have a collaboration and at the same time serve the needs of the patients who come to your emergency department who are high acuity patients, who need admission at John Dempsey Hospital or the services that we offer there.

So, I would just, in short, say we're not

ruling out any sort of collaboration that we can do with Bristol Hospital. But it doesn't take away from the need that we've come today for, and that is for our patients that we're serving today at John Dempsey Hospital.

HEARING OFFICER JACKSON: Thank you. I'm trying to clean up before we take a break and wrap this up.

Just for clarification, for -- when we were talking about Exhibit -- I think this is EE --

MR. CSUKA: Yes.

HEARING OFFICER JACKSON: -- the exhibit of charts, there was a back-and-forth about Case Mix Index versus acuity. If you could provide any sources and references about correlation of patient acuity, patient needs, Case Mix Index, the resources necessary as part of that late file, please.

MS. FELDMAN: Gladly.

HEARING OFFICER JACKSON: We've -- and this is for -- we've talked several times about changes over time from the 2012 plan to now we're in 2024. The preliminary plan, the Facilities and Services Plan, essentially reaffirms the Bed Need Methodology as determined by OHS.

Are there any material changes from the 2012

version of the bedding methodology to the 2024 that you would like to draw special attention to that you think are important to incorporate?

MS. FELDMAN: Our expert believes that -- okay. Brian?

MR. GIBBS: Brian Gibbs. Hi. There is one small change to the 2024 Bed Need Methodology, and it incorporates a new multiplier. I was looking at it, and it actually reduces the projected bed need, where the population increases it by, you know, a few percentage points based on the population expectation.

There is a new factor in there that is -- but it's new, its functions to reduce the new bed need. Do you know what I'm referring to? I have it here. I can tell you where it is.

HEARING OFFICER JACKSON: Do you have a page number of the --

MR. GIBBS: I'm looking now. I have so many things open.

HEARING OFFICER JACKSON: I understand. The bedding methodology is explained on page 81.

MR. GIBBS: Oh, okay. I'm on 51. Yeah. It is called Inpatient Discharge Trend Factor, and it's -- it looks like it's 96.8%, which effectively reduces the projected 86%. And I couldn't really find a rationale

or a footnote behind that. And it is described slightly on page 81. Item Number 4 is on page 81, the weighted ADC is multiplied by population. Do you see it?

HEARING OFFICER JACKSON: Yes. Okay. And so, do you disagree with that?

MR. GIBBS: Well, like I said, it does effectively reduce the projected ADC, sort of takes away the population growth projection in some cases. And of course the other thing that is different is the changing of the -- changing to regions from counties. And I'm not sure --

HEARING OFFICER JACKSON: From counties to regions.

MR. GIBBS: Yeah. You're right. Right. So, we are in the Capitol Region, and Bristol is in the Naugatuck Valley, so --

HEARING OFFICER JACKSON: Great. Okay. We are going to take a break until 4:35. When we come back, I'll ask any last follow-ups based on our conversations. We will do redirect and closing statements and go over late files.

(Recess from 4:27 p.m. to 4:36 p.m.)

HEARING OFFICER JACKSON: All right. We are back on the record.

I have no further questions at this point, so I will turn it over to Attorney Feldman for redirect.

MS. FELDMAN: Thank you. I have a redirect for Dr. Agwunobi.

You mentioned that today was the first time you've heard this concept of John Dempsey Hospital leasing space at Bristol Hospital. Is that a solution to your current bed need?

DR. AGWUNOBI: I don't believe it's a solution to our current bed need simply because when I think about John Dempsey Hospital and I think about the different mechanisms we're talking about of, you know, ED, for example, transferring out of the ED, that's extremely difficult for the reasons we talked about before, you know, when someone actually arrives at the ED saying we've medically stabilized you but now -- now you need to go to our -- our site over in Bristol or transferring from the -- from the units. I mean, it has to be a higher level of care, not to the same level of care or a lesser level of care. So, it's very difficult.

And then, if we look at things like diversion, we talked about one or two or three or four cases, I'm talking about scale here. So, when I sit back from it, we still need our 23 beds or the 23 beds

in John Dempsey Hospital.

That, however, does not preclude relationships and collaborations that we can do with Bristol Hospital, which is a very good community hospital, that we can do to work with them to help serve the patients in their community and potentially even help with their financial stability over time. So, it doesn't preclude that, but it doesn't replace the need at John Dempsey Hospital.

MS. FELDMAN: I have redirect for Caryl Ryan.

Ms. Ryan -- this is Joan Feldman -- there was some discussion regarding whether the current OHS Bed Need Methodology is -- is it 80% of just your med-surg beds, or is it 80% of your total licensed or -- new term for me -- available beds?

Can you tell me with respect to your maternal health beds what your occupancy threshold is?

MS. RYAN: Hi. It's Caryl Ryan.

So, right now we have -- we have maternal -- child -- maternal L&D, OB beds, but very difficult to put any patients down there that are med-surg due to competency levels of staff members, dedicated units, service lines, the fact that we could deliver three sets of twins in one night. Really, it's a very volatile area, and they're not equipped nor competent

for that.

MS. FELDMAN: Can you reallocate any of your other service lines, such as psychiatric beds, maternal health beds, or even, for that matter, your DOC beds to find additional med-surg beds?

MS. RYAN: So, our psychiatric ward is locked. And right now, even though I believe the ADC in that unit is 15 or 16, we go up to -- we will go up to 19. We really don't have many days when we have patients waiting in ED in our locked ward downstairs.

And really, as the -- as the patients for psychiatry come in now much more violent -- you know, we've had one instance where a patient with schizophrenia had an acute attack and tore down the entire new patient unit within about four minutes.

And, you know, they are coming in at a much more higher acuity. And that's not a place that we would ever look to -- especially within the State structure of behavioral health beds and the necessity, we would never move behavioral health, psych beds.

As far as the Department of Corrections, we're in a contract with the Department of Corrections for ten beds. That's another locked ward. We can't just put an inpatient person in there. And as was stated previously, they are contracted for ten beds, so

any DOC patient in an emergent situation could go to another hospital, but they then would be transferred to -- to John Dempsey.

MS. FELDMAN: Is there a different threshold for maternal health occupancy versus med-surg? For instance, we've been talking about an 80% threshold for med-surg. Is there a lower threshold for maternal health?

MS. RYAN: I believe it's 50%.

MS. FELDMAN: Thank you. One last question.

Caryl, there's been much discussion about efforts to, when you are on diversion, to find other hospitals, in particular, Bristol Hospital.

Can you tell me how many times you contacted Bristol Hospital in the last, let's say, 12 months or 18 months and they were unable to accept the patients?

MS. RYAN: So, I can't give you exact numbers at this moment, but I know that they did accept our diversion two to three times. But they are a -- a hospital that we call first or second dependent on New Britain. New Britain takes the majority, has taken the majority of our diversions. But Bristol has, you know -- and I respect fully disagree, but you have refused.

I don't have the data in front of me. It's

not ten times, but you have refused due to what you said was your activity in your emergency room. And I know, because those calls some straight to me. After the ED makes the call, they come to me to say this is where we're at.

HEARING OFFICER JACKSON: And I'll remind everyone that that's on our list of late files, any documentation of these calls.

MS. RYAN: Right.

MS. FELDMAN: I have no further redirect.

HEARING OFFICER JACKSON: Attorney Vozza?

MR. VOZZA: No redirect.

HEARING OFFICER JACKSON: All right. We will go over the late files that we have that we are requesting.

(Late File Requests.)

From John Dempsey Hospital, footnotes, citations for Ms. Ryan's testimony. Analysis and explanation of the private pay-per-discharge Table 8 including Yale from Exhibit EE, plus the maps, including routes, time of day, et cetera.

Information when John Dempsey has gone on diversion to whom outreach was made when and did they accept any patients.

How many days does it take, or how often does

it happen to discharge a patient who is ready to be discharged but John Dempsey's unable to discharge.

The number of Patient Days due to inability to discharge.

MR. CSUKA: We'll issue this as an order.

MS. FELDMAN: Yes.

HEARING OFFICER JACKSON: I will clarify in writing.

MS. FELDMAN: Yes.

HEARING OFFICER JACKSON: The John Dempsey occupancy rates for all beds.

The Exhibit V, available beds, and allotment to medical-surgical overtime. That's in the HRS Form 400.

How John Dempsey calculated its staffed available beds for Fiscal Year 2024, and expand that table to prior years, which is on page 22 of the prefile testimony.

The percentage of patients who present themselves in the ED and are then admitted to inpatient.

The total number of visits outpatient discharge, inpatient admissions.

The quality report mentioned in prefile testimony. And we can be in contact about how to do so

confidentially.

Clarification on the discrepancy in Bristol Hospital's Table 8. This is regarding the cost between -- the cost differentials between hospitals.

Any response to the Cain Brothers report that you wish to make.

And the Case Mix Index correlation to acuity and resources necessary to treat those patients.

MR. CSUKA: There was one other. Response to Public Act 10-104.

HEARING OFFICER JACKSON: Yep. For Bristol Hospital, I --

MS. FELDMAN: May I just request a clarification? When you issue your order, can you state the time periods you're looking for?

HEARING OFFICER JACKSON: Yes.

MS. FELDMAN: Okay. Thank you.

HEARING OFFICER JACKSON: And if there are any questions about the order that's issued, we'll clarify those.

MS. FELDMAN: Thank you.

HEARING OFFICER JACKSON: For Bristol Hospital, correction of Table 2 in the prefile testimony, ED discharges versus total discharges, or total ED visits, unclear, whatever -- whatever the

correct numbers are.

The quality report mentioned during testimony. Again, we can discuss confidential submissions.

Documentation of staff leaving Bristol Hospital for John Dempsey and for -- as compared to other places.

And if you -- in periods where you've accepted diverse -- diverted patients, any reports of adverse events for such patients.

And we will issue a hopefully clearly written order specifying exactly for each of those. But that's -- and we'll aim to do that by the beginning of next week.

MR. CSUKA: Attorney Feldman, I don't know if you're in a position to do this right now, but how long does your client expect they'd be able to pull that together?

MS. FELDMAN: We can pull it together rather quickly. I would ask for two weeks.

MR. CSUKA: Okay.

MS. FELDMAN: Is that fair?

MR. CSUKA: That's fine with me. And if you do need additional time --

MS. FELDMAN: Thank you.

MR. CSUKA: -- we're open to that.

The Intervenor, would two weeks work for you as well?

MR. BARWIS: So, I think the only issue -- and just a clarification, when you mentioned the patient quality report, it's a patient perception survey.

HEARING OFFICER JACKSON: Okay.

MR. BARWIS: So we know what you're asking for. I think that's, like, the only hanging item that we get resolved that would potentially impact the time frame. Otherwise, two weeks is fine.

HEARING OFFICER JACKSON: So, we will start with the Intervenors for closing argument and then turn to the Applicant to wrap up.

MR. VOZZA: So, Mr. Barwis will give our closing argument.

MS. FELDMAN: Just for clarification, we have to be done with closing -- how much -- I mean, I think I could do my closing in --

HEARING OFFICER JACKSON: If each party could limit it to no more than ten minutes --

MS. FELDMAN: I can.

HEARING OFFICER JACKSON: -- we can have a couple minutes to wrap up so our court reporter can

pack up and get out of the garage.

MR. BARWIS: I'll be quick. You know, I think the most important thing is -- and I heard Dr. Agwunobi say this -- is we're willing to collaborate.

Coming from Maryland, you know, my perception of how the community hospitals work with, you know, the state health center institution, academic teaching facility, is kind of informed by that. So, I'm willing for a lot more collaboration to really improve income -- you know, impact our community and provide services.

You know, I've said it, and I'll say it again. There's capacity within the service area, and I think that's important to note. I'm not sure that the data that we have seen supports the 23 beds. And I -- and I point to the confusion between the reports and the way it's calculated, which I think have become very clear from this hearing today.

I do think, you know, the question about 10-104 has to be looked at and resolved in some way, shape, or form, because it is a Connecticut Statute. It limits the number of those beds. And I appreciate that, that it's going to be looked at.

You know, I know probably not a good thing to

go to cost, but the truth is we're a very low-cost hospital, and we provide extraordinary outcomes with limited resources. And so, I think it's important that whatever happens does not in some way, shape, or form harm our facility and only helps it.

And then -- I think that would be my overall. We need better collaboration. We need to figure out how to make this all work within the construct of what we have and be focused on the broader concept of, you know, patient access within local communities and how we achieve that.

So, again, I don't see the support of the additional beds. But I absolutely want to try to collaborate and come up with a better approach that works for everybody to help the UConn Health center, to help us, to help our patients with support. Thank you.

HEARING OFFICER JACKSON: Thank you. Attorney Feldman?

MS. FELDMAN: Thank you. A little bit confused because of the statement that there's not a need for additional beds yet they would like us to place those beds in a lease arrangement at Bristol Hospital.

Anyway, I want to focus on what we tried to state in our prefile testimony and today, is that we

thought that the current methodology, which is 12, 13 years old, doesn't really accurately reflect the reality of operations at John Dempsey Hospital.

For one, the calculations include the Department of Correction beds, which is a locked unit, which we can't use; two, the observation beds are not included; and, three, there's a lot of confusion here in terms of what is a surplus of beds in the state.

I think the -- there's about 25% of the licensed beds in the state, according to the data, are unstaffed. So, when you look at the Bed Need Methodology, it's working with all licensed beds.

Unfortunately -- well, fortunately for some hospitals, they have a great vault of beds that they can pull from without having to come to OHS and ask permission and demonstrate need. Unfortunately for JDH, they do not have that reserve of beds, and that's why they're here today.

According to the Bed Need Methodology, in 2030, 5 1/2 years from now, based on the methodology, we're going to have 70 -- a surplus of 70 beds. That in itself demonstrates to me that the methodology is not accurate, not reflective of what the needs are.

We talked from our expert about the weighted factors and the decision to weight certain years and

not weight certain years or weight years three times or -- it all seems very arbitrary to me.

So, the other real disturbing point about some of the things that I heard today is the concept of patients who come -- who come to JDH being asked to transfer to a totally different hospital. We are separately licensed hospitals. We're not part of the same system. And even if we were part of the same healthcare system, we're separately licensed, operated hospitals. And I don't think OHS has the authority under the statutes to reallocate beds by -- from one hospital to another hospital. That's my personal opinion and perhaps my legal opinion.

It is worth noting that the 2024 plan does focus on the fact that the population of older adults is likely to present challenges to the current healthcare system and demand for services is likely to increase now and by 2030.

There's also recognition in the plan regarding the ongoing epidemic of behavioral problems and diagnoses both for substance use disorders and psychiatric problems and the need for inpatient psychiatric beds in the state of Connecticut.

There's also recognition of -- OHS has concluded that there's less use of surgical services by

Medicaid -- the Medicaid population. And I will point out that JDH's ambulatory surgery center has probably the highest Medicaid payer mix out of any ambulatory surgery center in the state.

So, it seems that the report concluded that there was absolutely no need for beds in this region or by this hospital, perhaps, and that the only place in the state where there is a need for beds is in the South Central planning region. That's very disheartening because that demonstrates to me that it's the same old, same old, same old. And I think that -- you know, we hope that that doesn't rule the day when you consider our application.

As you know, OHS in 2014 added a requirement that Applicants must demonstrate the proposals will not negatively impact the diversity of healthcare providers and patient choice in the region. I believe that we have demonstrated through our pervasive collaboration and willingness to be supportive to Bristol Hospital that we are not aiming or intending to do anything like that.

So, in closing, we would hope that OHS would look at the circumstances involving JDH if you continue to use the methodology that's in place. And we hope that you agree that we've demonstrated need and that

our need is not the cause of another hospital's decline or the solution for helping another hospital when it's our hospital that has the need for the beds.

This request is very modest, and I think it's very appropriate, and it's consistent with what -- I think there was original recognition that hospitals have to have some flexibility to self-correct when there are surges or evidence that there is a need. And if we stick to the methodology alone, that is not recognized, that concept.

So, that's basically it. And I thank you for your time and patience today. And I have nothing more to say.

MR. CSUKA: So, thank you to everyone for attending today, both here and online. Written public comment, again, will be accepted for the next seven calendar days.

The hearing for today is adjourned, but the record will remain open until closed by OHS following the submission of the late file documents.

(The proceedings adjourned at 5:00 p.m.)

STATE OF CONNECTICUT

I, ALEXA BUDIHAS, RPR, CRR, and a Licensed Professional Reporter/Commissioner within and for the State of Connecticut, do hereby certify that I took the preceding hearing of UConn John Dempsey Hospital Application for Increase in Licensed Bed Capacity on July 11, 2024, in person at 10 Franklin Square, New Britain, CT 06051.

I further certify that the witnesses were first duly sworn to testify to the truth, the whole truth, and nothing but the truth concerning their knowledge in the matter.

I further certify that the within testimony was taken by me stenographically and reduced to typewritten form under my direction by means of computer assisted transcription.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which this hearing was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

WITNESS my hand this 18th day July 2024.

ALEXA A. BUDIHAS, RPR/CRR
My commission expires 4/30/29