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STATE OF CONNECTICUT

OFFICE OF HEALTH STRATEGY

DOCKET NUMBER 23-32657-CON

A HEARING REGARDING MIDSTATE MEDICAL CENTER'S APPLICATION FOR AN INCREASE IN LICENSED BED CAPACITY

Hybrid Public Hearing held at 450 Columbus Boulevard, Conference Room B North, Hartford, Connecticut, and Zoom, on Thursday, January 25, 2024, beginning at 9:40 a.m.

H e l d B e f o r e:

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Also present:

BARBARA DURDY, Hartford HealthCare
MAYDA CAPOZZI, OHS
FAYE FENTIS, OHS

Public Speaker:

MAYOR KEVIN SCARPATI, Meriden

(The hearing commenced at 9:40 a.m.)

MR. CSUKA: Good morning, everyone. I'm sorry we're starting a little bit late. We were having some technical difficulties. We're obviously in a new hearing room, and things like this happen. So I apologize for that, and I apologize to anyone who is attending remotely who had probably no idea what was going on.

So we're here today because MidState Medical Center, the applicant in this matter, they submitted a CON application. They are a 156-bed acute care community hospital located in Meriden, Connecticut, and they are seeking to increase their licensed bed capacity by a total of 16 beds.

In MidState's application it represents that it is a member of Hartford HealthCare, an integrated health care delivery system, which has adopted an institute model to advance key services lines throughout the system. As a result, MidState asserts that substantial growth has occurred and is straining inpatient resources and capacity, necessitating the proposed increase of medical surgical beds. If approved, MidState has indicated that it anticipates that the new bed unit will open back over 2025, and the anticipated

capital cost for the project is estimated at $8.4 million.

I'm going to turn it over to Executive Director Dr. Gifford for a moment.

EXECUTIVE DIRECTOR GIFFORD: Good morning. Today is January 25, 2024. My name is Deidre Gifford, and I'm the executive director of the Connecticut Office of Health Strategy. I will be presiding over this matter today. I will rule on all motions, and I will issue a decision that includes findings of fact and conclusions of law on the petition.

MR. CSUKA: My name is Dan Csuka. I'm staff attorney with the Office of Health Strategy, and I will be assisting and providing legal counsel to Executive Director Gifford today.

This is a hybrid hearing, and 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 name and title at the outset of each occasion that such a person speaks orally during an uninterrupted

dialogue or series of questions and answers.

Sign-up for public comment has started and will continue until 1 p.m. If you would like to supply commentary, please sign up either in person or in the Zoom chat box.

For anyone attending remotely, unless you are actively participating in the hearing either as one of the applicant's witnesses or as a member of the public providing comment, at the designated time I ask that you mute the device you are using to access the hearing and silence any additional devices that are around you.

This public hearing is held pursuant to Connecticut General Statutes, Section 19a-639a(f)(2). Although this does not constitute a contested case under the UAPA, that's the Uniform Administrative Procedure Act, the manner in which OHS conducts these proceedings will be guided by the UAPA provisions and the regulations of Connecticut State Agencies beginning at Section 19a-9-24.

I generally will not be asking questions of the witnesses but Dr. Gifford will. In addition, the Office of Health Strategy staff is here to gather facts related to this

application and will be asking the applicant's witnesses questions.

At this time, I'm going to ask each staffperson assisting with questions today to identify themselves with their name, spelling their last name, and OHS title, and I will begin first with Andrea.

MS. HARRISON: Andrea Harrison. Last name spelled H-a-r-r-i-s-o-n. I'm planning analyst.

MR. LAZARUS: My name is Steven Lararus, L-a-z-a-r-u-s. And I'm CON supervisor.

MS. FAIELLA: My name is Annaliese Faiella, F, as in "Frank," A-I-E-L-L-A, and I am CON team lead.

MR. CSUKA: Also present remotely are Faye Fentis and a couple other OHS staff as well as Mayda Capozzi is in person with us. There are other OHS staff members that are assisting with the hearing logistics or gathering the names for public comment and provide 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 applicants,

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 the proceedings.

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

In making our decision, Executive Director Gifford will consider and make written findings in accordance with Section 19a-639a 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 the hearing room.

So we're going to start by going over the exhibits and the items that we plan to take administrative notice of. Then I will ask if there are any objections to those items.

The CON portal contains the amended prehearing table of record in this case which was filed yesterday. At the time of its filing, exhibits were identified in the table from A to Q.

Mr. Lazarus, Ms. Faiella and Ms. Harrison, do you have any additional exhibits that you wish to enter into the record at this time?

MS. FAIELLA: No.

MS. HARRISON: No.

MR. CSUKA: Thank you. So in addition to Exhibits A to Q, you are hereby noticed that we are taking administrative notice of the following: The Statewide Health Care Facilities and Services Plan and its supplements; the Facilities and Services Inventory; the OHS acute care hospital discharge database; the All-Payer Claims Database claims data; Hospital Reporting System, that's HRS, financial and utilization data; and the hospital's Community Health Needs Assessments.

We are also taking administrative notice of the following CON dockets which were referenced in one of the applicant's recent filings. They are 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.

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.

And Docket Number 22-32554-CON, in which Connecticut Children's sought to increase its licensed bed capacity for purposes of expanding its NICU services.

As the hearing progresses, we may also take administrative notice of other matters, including prior OHS decisions, agreed settlements and determinations that may be relevant to this matter but which have not been yet identified.

So counsel for the applicant, MidState Medical Center, can you please identify yourself for the record.

MS. FUSCO: Yes. I'm Jennifer Fusco, counsel for MidState Medical Center.

MR. CSUKA: Thank you. I know that we are awfully close, and I just want to make sure that you speak up for the benefit of the court reporter. And that goes for everyone else who is in attendance today.

Are there any -- sorry, Attorney Fusco, do you have any objections to the exhibits in the table of record?

MS. FUSCO: I do have some questions and one objection. There should have been a letter of support submitted yesterday from Kevin Scarpati, Mayor of Meriden. I believe he emailed it in. So I didn't know if other public comment had come in as well, but I don't see a section for public comment. We can upload that to the portal as well, if that makes it easier, but if that could be added to the record.

MR. CSUKA: To my knowledge, we haven't received that. Is that correct?

MS. FUSCO: We can verify who he emailed it to, but we can also upload it directly to the portal, if that's easiest. We have a copy.

MR. CSUKA: Okay. Yeah, if you can upload it, that would be great. We don't have -- we haven't received any other public comment, to my knowledge, which is why there's no other file on the docket at this point.

MS. FUSCO: Understood. I also did, I do have one objection but wanted to ask, to the extent we've take administrative notice of a

number of OHS databases, if there is particular information you intend to use from those databases, the applicant would ask for notice and an opportunity to respond before that information is used in a final decision.

In addition, we do have an objection to I believe it's Exhibit C which is the attachment to the completeness letter that had the analysis of bed need for four hospitals, MidState, Yale New Haven, Middlesex and HOCC. That came to us through the completeness letter with just an indication that we could comment on it. We've reviewed it. It doesn't have any sourcing. We're not sure who prepared it. It doesn't have any sourcing, so we can't validate the data. But it does include four tabs, and we had looked specifically at MidState information. We can't provide any comments on the calculations with respect to Yale New Haven or Middlesex because they're not HHC system hospitals.

And I think, as we've made clear in our submissions, we believe the calculation of bed need is more complicated than what that methodology suggests, and we wouldn't be privy to any information to be able to comment on their

actual utilization and capacity. And I guess we would raise the same issues with respect to HOCC that we've raised with respect to MidState and what we believe to be flaws in the model. So for that reason, I would object to its inclusion in the record and its use in any decision-making in this matter.

MR. CSUKA: We're going to reserve for now, but we will issue an order on that.

MS. FUSCO: And I will add. I will say that we object to it absent further clarify on its intended use and ability to respond, and it wasn't clear what you were looking for from us and whether we could even provide what you're looking for, but in a vacuum we would object to it being in the record.

MR. CSUKA: I'm going to ask OHS staff, do you anticipate asking questions about that in particular?

MS. FAIELLA: No.

MR. LAZARUS: No, not specific to that.

MS. HARRISON: No.

MR. CSUKA: So it shouldn't present an immediate issue.

MS. FUSCO: And to the extent that

there are questions, I'll just renew the objection for the record and we can deal with the questions as best we can.

MR. CSUKA: Okay. Perfect.

MS. FUSCO: Other than that, no objections. Sorry.

MR. CSUKA: Okay. So we'll render an order on that after we have an opportunity to speak. For the time being though, all other exhibits will be entered as full exhibits. Did you have any objections to the administratively noticed databases or dockets themselves?

MS. FUSCO: No, no objection to the databases or the dockets with the caveat that, if there's particular information you intend to use, we would like notice and an opportunity to respond.

MR. CSUKA: Okay. So with that, Attorney Fusco, did you have any additional exhibits that you wish to enter at this time?

MS. FUSCO: No.

MR. CSUKA: Other than the public comment.

MS. FUSCO: Yes, from Mr. Scarpati.

MR. CSUKA: So we will proceed in the

order established in the agenda for today's hearing. I would like to advise the applicant that we may ask questions related to your application that you feel you have already addressed. We will do this for the purpose of ensuring that the public has knowledge about your proposal and for the purpose of clarification. I want to reassure you that we have reviewed the docket, and I will do so again before issuing a decision. And Dr. Gifford, more importantly, Dr. Gifford will before she renders her decision. Excuse me. I'm using an old script. I apologize.

As this hearing is being held in hybrid fashion, we ask that all participants attending via remote Zoom enable the use of video cameras when testifying or commenting remotely during the proceedings. All participants of the public shall mute their devices and should disable their cameras when we go off and take a break. Please be advised that although we will try to shut off the hearing during the breaks, it may continue. If the recording is on, any audio or visual that has not been disabled will be accessible to all participants.

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. We will call each individual by name when it is his or her turn to speak. And as I mentioned, registration for public comment has already begun and is scheduled to start at 1 p.m. If the technical portion of this hearing has not been completed by 1 p.m., the public comment will be postponed until the technical portion is complete. In addition, if we end early, we still cannot start public comment until 1 p.m. We carve out the time. That way people who are on lunch break or who have set aside the time are able to participate.

The applicant's witnesses must be available after public comment as OHS may have additional follow-up questions based on the public comment.

Are there any other housekeeping matters or procedural issues that you would like to address before we start, Attorney Fusco?

MS. FUSCO: Just with respect to the availability of witnesses, do you need them to stay here through public comment or could they

rejoin remotely, if need be? I guess it depends on timing.

MR. CSUKA: We're okay with joining remotely.

MS. FUSCO: And we do have, I think I mentioned this to you in a phone call, we do, in addition to our sworn witnesses, I'll introduce Ms. Edwards who's here to answer questions to the extent that you have a question that would be better answered by her than one of the prefiled witnesses. She's available to answer questions.

MR. CSUKA: Thank you. So Attorney Fusco, would you like to make an opening statement?

MS. FUSCO: Sure. Good morning again, Dr. Gifford, Attorney Csuka, and members of the OHS staff. My name is Jennifer Fusco and I represent MidState Medical Center. Thank you for this opportunity to make what will be a very brief opening remark today.

MidState is before you requesting approval to add 16 inpatient beds to its DPH acute care general hospital license. The CON application is not just about demand, capacity and access. It's about quality and patient safety.

It's about a hospital and health system that is striving to provide the best in care while also delivering value for health care consumers. And it's about ensuring that all patients have access to the highest quality care in the most appropriate settings without undue delay that can have adverse consequences and drive up health care costs. MidState brought this proposal to the Office of Health Strategy with these exact considerations in mind.

So today we've brought, and this is unique to hearings I've done, three physicians with us. First, you're going to be hearing from Dr. Cardon, who is the chief clinical integration officer for HHC and the CEO of Integrated Care Partners. Dr. Cardon is going to share with you HHC's strategy to transform the delivery of health care. He'll discuss how the transformation of MidState from a community hospital to a destination for complex orthopedic and other specialized services embodies the system's core principles of excellence, access, affordability and equity. As a result of this transformation at MidState, the demand for inpatient services at the hospital continues to increase and additional beds

are needed to continue to provide timely quality care.

Next, you're going to hear from Dr. Jeff Finkelstein sitting at the end. He's the vice president of medical affairs for HHC's central region. And he is the former chair of the emergency departments at both Hartford Hospital and Hospital of Central Connecticut. Dr. Finkelstein is going to share with you MidState's quality and safety journey and how the hospital's commitment to excellence has made it a destination for patients, not just local patients, but patients from across the state.

He'll also tell you about how the enhancements in services at MidState and its reputation for quality have led to this growth in demand for inpatient services that's outpacing the hospital's available capacity.

MR. CSUKA: I'm sorry to interrupt, but people online are saying they're having trouble hearing you.

MS. FUSCO: Okay.

MR. CSUKA: I'm not sure why that is.

MS. FUSCO: Okay. I can try to speak louder, if that's okay.

Dr. Finkelstein will also testify about the efforts MidState has made to reduce readmissions and optimize its inpatient bed capacity and why the addition of licensed beds is the only viable solution to the capacity issues facing the hospital.

And then finally, you'll hear from Dr. Dan Engelberg, the director of emergency medicine at MidState. He'll testify about the practice of ED boarding which involves holding admitted patients in hallways and other areas of the ED while they're awaiting an inpatient bed. ED boarding can cause issues not just for admitted patients but also for those patients waiting in the ED for emergency care. Dr. Engelberg will also discuss the efforts MidState has made to reduce avoidable ED admissions and overcrowding. The addition of 16 inpatient beds will result in real progress for reducing ED boarding, improving patient flow, and enhancing the quality of care for all patients who present to the MidState ED.

As I mentioned before, we also have with us today Janette Edwards. She's the VP of operations for HHC's central region. Ms. Edwards was involved in preparing the bed need model for

MedState that was included with the CON application, and she's available to answer questions regarding that model and the hospital operations generally.

The evidence that's been presented in this matter up to this point and what you're going to hear today will show that there is a clear public need for additional inpatient capacity at MidState. The only way to address this need to ensure access, timely access to inpatient services at the hospital is to approve this request for licensed beds. Constrained capacity at MidState is a very real problem that can have real consequences for patients, and approving this application will provide much needed relief to the hospital so it can continue to provide high quality safe care to patients.

And with that, I'll turn it over to Dr. Cardon.

MR. CSUKA: So before you do that, I'm just going to swear all of your witnesses in.

MS. FUSCO: Sure.

MR. CSUKA: So Attorney Fusco, you've already identified them by name and title. I believe there's four of you, right? Can the four

of you please raise your right hand.

J A M E S P. C A R D O N,

D A N I E L E N G E L B E R G,

J E F F A. F I N K E L S T E I N,

J A N E T T E E D W A R D S,

called as witnesses, being first duly sworn by Attorney Csuka, testified on their oaths as follows:

MR. CSUKA: So to the witnesses, when giving your testimony, please make sure that you state your name and adopt your written testimony, and again please try to speak up to the best of your ability.

So Dr. Cardon?

THE WITNESS (Cardon): Cardon.

MR. CSUKA: You can continue.

THE WITNESS (Cardon): Thank you. Good morning, Dr. Gifford, members of the OHS staff. I'm Dr. James Cardon, chief clinical integration officer for Hartford HealthCare. I adopt my prefile testimony.

MR. CSUKA: Thank you.

THE WITNESS (Cardon): We really appreciate the opportunity to share Hartford HealthCare's strategy to transform the delivery of

health care specifically as it relates to the need for additional beds at MidState Medical Center. Our path to transformation is to ensure there's timely access to consistent excellent care that is both affordable and equitable. This enables MidState and Hartford HealthCare to participant meaningfully in risk based reimbursement models. I'll spend a little bit of time going through that.

MidState is really an excellent demonstration of the purposeful transformation we've undertaken. Historically what was a community hospital without the capability to provide more complex care that a hospital should be utilized for has been transformed into a center of excellence allowing us to provide care that traditionally was performed in tertiary quaternary care hospitals. This includes development of the Orthopaedic Institute, advanced oncology care, cardiovascular care, including performing complex arrythmia evaluations for people who have irregular and erratic heartbeats, and comprehensive vascular surgery, all done in the local community where people want to receive care and at a level of quality that is world class.

In order to ensure that we have continued our efforts around affordability, it was important that we keep a line of sight on the total cost of care and maximize MidState's capacity to provide higher level care. It's imperative that we also developed and deployed ambulatory sites of care that allow us to provide appropriate services in lower cost settings at a lower cost. The ambulatory sites not only afford us the capacity to do these procedures but also at a much better patient experience.

What I'd like to do is spend a little bit of time around each of the four components that were focused on to give some sense of the progress that we've made. First, excellence is really foundational to our transformation. We are committed to measuring and managing our quality and then seeking and looking for external validation of our performance in order to discern that we've made the progress we've made.

And that starts with our Leapfrog rating. We are very proud of the designation we've received. It's taken a great deal of hard work. The Hartford HealthCare system has now got "A" Leapfrog ratings across every inpatient

facility. Leapfrog is multi-dimensional measures of quality and safety that need to be performed. There are only three other systems of our size that have received A ratings across all our hospitals, and only 30 percent of hospitals in the nation received an A Leapfrog rating. And that is across all ranges of services that are performed in the hospital.

Secondly, CMS Star Rating. MidState has a Five Star rating, only one of two hospitals in the state that carry that rating, again, of broad measures of quality and safety that we need to perform at to receive that rating.

Thirdly, hospitals are held accountable for hospital acquired conditions. These are things that happen in the hospital, a reflection of your ability to care for people safely. We have for the last two years been able to avoid any penalties whatsoever from CMS that are imposed when you're above a threshold. We've been able to avoid all those penalties given the improvement in quality of care that we've done at the hospital.

Our patient experience is 4 stars out of 5. That's above the state average. It's above the national average. Orthopedics, one of our

focused areas of development, has had Five Star performance on hip, knees and spine surgery. The National Association of Nursing Excellence Award was attributed to MidState. And we have advanced certification on spine surgery, the first program in the nation to receive that, as well as hip, knee and hip fracture and shoulder surgery. All of that is the foundation which is why we are confident that the care we're delivering in that environment is not only more specialized, more advanced, but performed at a world class level of care.

Timely access to care becomes the critical nature. It's not good enough to just have a small place to do care. We want to make sure it's broadly applicable to everybody, and we have done a great deal to try and improve that access. We talked about the Orthopaedic Center, we talked about the complex neurospine and vascular, cardiovascular surgery. But importantly, as we've developed those kind of capabilities, we have increased the complexity of care we're taking care of in the hospital with a case mix index, a measure of that complexity, increasing 31 percent between 2016 and 2021.

In addition, the ambulatory environment has risen as we talked about building on access. It's not just the acute care hospital, but it's the ambulatory environment as well, and the ambulatory environment allows us an opportunity to deliver that care at a lower cost. This is the development of our ambulatory surgery centers. This is urgent care centers. This is effective coordination of primary care so that we can improve the access which has continued to be a challenge. All of that allows us to have affordable sites of care that can have a dramatic impact.

A few examples. Orthopedic cases, yes, increased significantly in the hospital setting from 1,600 cases in 2017 to 5,200 in 2023. But as importantly, those cases moved from typical inpatient, 20 percent were done in an HOPD setting, and for those that were being done in the acute care facility are now 80 percent of them are done in an HOPD, not as an inpatient. But importantly, we've moved cases out of the acute care facility and HOPD entirely. We've moved from 4,600 cases done in 2021 to 9,400 cases done in ambulatory surgery centers, not at hospital rates

in 2023.

We just recently had three general surgeons move their cases into the Hamden ASC which is further development of the capabilities we can do in ambulatory surgery centers. These are all done for appropriately risked patients, and we can ensure the exact identical kind of outcomes and quality that they receive in an acute care hospital but at a much lower cost and a better experience setting.

In addition, GI procedures typically done in an inpatient or outpatient, hospital outpatient department, we've increased that 66 percent from 15,700 to 26,000 of those procedures being done in ambulatory settings. Our urgent care strategy, a direct attempt to reduce low level ED visits for patients who can be cared for more conveniently and more effectively elsewhere, have increased from 25,000 visits to 79,000 visits, a 205 percent increase between 2018 and 2023.

In addition, we have seen the impact on ED level of care. Our Level 1 and 2 visits decreased by 18 percent over that time frame with 20 percent of total ED visits happened in Level 1

Level 2 historically, now down to 15.7 percent low level visits. So that impact is having the effect we want which is to decant the EDs of low level visits who can be cared for in other settings.

These are all in addition to the measures that we are singularly focused on in being at full risk in terms of our agreements. This is reducing inpatient admissions in general, SNF admissions, length of stay at skilled nursing facilities, reducing our complications is both cost effective and reduces utilization by decreasing hospital acquired type of conditions, readmissions, preventive care that we have in our community around hypertension and diabetes management where we look at those not only by the broad population that are attributed to our primary care physicians, but we subsegment that by at-risk communities to ensure that we're delivering the same care in more challenged communities as we do in the general population. And that has been a year-over-year measure of improvement. We're seeing control of blood pressure for our patients. 75 percent of them are at goal across the 110,000 folks that we're responsible for hypertension across the system,

and over 88 percent have their diabetes effectively managed with an A one C.

We still see some disparity between the at-risk communities and not, and it is a focused effort to figure out what are those barriers to make sure that that care is equivalent across all of our communities. These are all efforts to ultimately decrease the chronic conditions and the morbidity that is developing and causing people to be admitted in the first place.

Equity is a core value for us at Hartford HealthCare and we've developed a center of equity to look at both our delivery system as an employer to ensure that we are including the lens of diversity into that. It makes us better. It make us more relevant to the communities. It make us more successful at delivering care.

We have worked specifically through MidState with Racial Justice with the Equity Champions. This is a partnership we formed with the community and the facility to ensure that they have a voice at the table. We certainly recognize and have learned from COVID that we often had shown up in the past saying, well, we're here, we know what to do. We had to become sensitive to

listening to what the community needs and how do we adapt and meet them where they are because there are unique challenges that we need to get involved in, and this is the attempts to do that.

In addition, we have resource groups. We participate in the Fair Chance Program. We are singularly focused on ensuring that we are capturing race, ethnicity and language data, as well as social determinants and deploying our neighborhood health team. This is community based, partnering with communities to bring medical services and social services into the community to try and make access more affordable. And we've had several aligned perspectives across Meriden and Wallingford to bring that forward.

Lastly, the payment model, which is critical for us to continue to make this progress forward. We have to move away from the fee-for-service model into risk-based payments. We have embraced that wholeheartedly with a measure that is taken in Connecticut. We are taking full risk for over 55,000 folks who have Medicare Advantage and, in addition, with our joint venture Medicare Advantage Plan and the 8,000 members. And for that those 65,000 or so

patients we are looking to make sure we are performing well on quality, nationally benchmarked measures of quality that Medicare Advantage plans are held accountable to. Affordability becomes key in making sure that all of the efforts and what we built in this system of care allows us to have an opportunity to execute and perform well across many of the utilization statistics that we know are avoidable but need focused efforts to do so.

Lastly, I just want to highlight that we also participated in now year six of Joint Replacement, one of the supporting efforts that we did with alternative payment models, call it CJR, Comprehensive Joint Replacement from CMMI, CMS program, and the kind of intentionality and the dramatic results you can see when you're focused on this and have aligned partners and infrastructure. If we look at the quality of that program from year one to year six, our initial score when we joined that program we scored 4.4 out of 20, 4.4 out of 20. Our most recent results were 18.5 out of 20. Our complication rate was 1.4 percent; it's now zero. Our readmission decreased by 10 percent. SNF utilization went

from 87 percent to 5.3 percent. Homecare, 89 percent to 28 percent. Inpatient length of stay dropped from 3.2 days to 1.2 days. Inpatient to outpatient -- this is the not the ASC, it's not measured in the program, it's just moving to outpatient -- went from 5 percent to 77.6 percent. All of those things are demonstrating better quality, lower avoidable utilization and lower cost of care within the confines of the program.

So all these results have resulted in us being recognized as a destination for patients to receive care. My colleagues, Jeff Finkelstein and Engelberg, will go into this further with Janette Edwards. But it's important to understand we've exceeded our space capacity to provide the care that patients in our communities expect and deserve. I respectfully request you approve this application and happy to answer any questions.

MS. FUSCO: If I may, before we move on, I think people remotely still may be having trouble hearing us. So it wasn't me because he speaks louder. Is there a better way to capture our voices?

MR. CSUKA: My understanding is that there are microphones in that cabinet.

MS. CAPOZZI: On break I'm going to have somebody come in and try to fix it because we need it for public comment too. We need it for the public comment too. We need to figure out how to be able to do it online.

MR. LAZARUS: Do you want to take a break now?

MS. CAPOZZI: On break I have to get everything done.

MR. CSUKA: Attorney Fusco, are you okay with taking a break?

MS. FUSCO: Absolutely. I just want to make sure everyone can hear.

MR. CSUKA: So we're going to take what is hopefully a brief break to try to resolve the audio issues. And again, if you're your on camera, just be aware that people can probably see you, so just be careful. So we'll be back shortly.

(Whereupon, a recess was taken from 10:16 a.m. until 10:34 a.m.)

EXECUTIVE DIRECTOR GIFFORD: All right. We are back. Thank you, everyone, for your patience. We're still going to ask everyone to speak at the top of their range. You don't have

to shout. We've turned up the volume in the room, but it's still quiet up here, so we'll try to project from the dais up here.

I'm going to ask Dr. Cardon to please reenter his testimony into the record because members of the public were not able to hear. So we'll, with apologies, ask you to reread the testimony into the record.

Before we do that, I want to go back to your objection.

MS. FUSCO: Yes.

EXECUTIVE DIRECTOR GIFFORD: After discussing with our counsel, I'm going to overrule your objection. However, we will reissue the document that you referenced with all of the appropriate citations so that you have an opportunity to see the sources of that data. And of course you're free to send written commentary or responses after you receive the updated information.

MS. FUSCO: Okay. Thank you.

EXECUTIVE DIRECTOR GIFFORD: Dr. Cardon.

THE WITNESS (Cardon): First, can people hear adequately now when I speak at this

level? Good. Thank you. Good morning, Dr. Gifford, and members of the OHS staff. I am Dr. James Cardon, chief clinical integration officer at Hartford HealthCare. I adopt my prefile testimony.

We appreciate the opportunity to share Hartford HealthCare's strategies to transform the delivery of health care, specifically as it relates to our additional needs for beds at MidState Medical Center. Our path to transformation is to ensure there's timely access to consistent excellent care that is both affordable and equitable. This enables MidState and Hartford HealthCare to participate meaningfully in risk-based reimbursement models.

MidState is an excellent demonstration of our purposeful transformation strategy. Historically what was a community hospital without the capabilities to provide more complex care than a hospital should be utilized for, has been transformed into a center of excellence, allowing us to provide services usually performed in a tertiary or quaternary care hospital. This includes the development of the Orthopaedic Institute, advanced and enhanced oncology care,

cardiovascular care, including arrhythmia ablations for complex arrhythmia management and comprehensive vascular surgery, all performed in the local community where people want to receive care and at a level of expertise and quality that is world class.

It was important for us though to not just develop these services at the hospital but to keep a line of sight to lowering the total cost of care, and therefore it was important that as we maximize MidState capacity to provide higher level of care, we were simultaneously developing and deploying ambulatory care sites that provide lower cost sites of care for procedures that could and should be done in a less complex environment and in a setting that is both lower cost and lower price. So I'd like to spend a few minutes on each of those four key pillars and provide some examples of the progress we've made.

Excellence which is foundational to the transformation. We are committed to measure, manage our quality and look for external validation for the progress we've made. We are extremely proud of our Leapfrog rating. Leapfrog is an entity that looks at a multitude of measures

that evaluate both quality and safety within acute care hospitals. Hartford HealthCare has achieved Leapfrog "A" across all of our seven acute care hospitals. Only three other systems of our size have achieved that rating in the nation. And MidState has received Leapfrog A, which is only one of two hospitals within the state to do that. 30 percent of Leapfrog A -- I'm sorry, 30 percent of hospitals in this nation get an A rating. And I misstated that. That's not the Leapfrog that's one of two. That was our CMS Star Rating where we are one of two hospitals to receive a Five-Star CMS rating in the state. In addition, a focus on reducing harm and hospital acquired conditions, we've reduced those to where we have not received any penalties from CMS in the last two years.

Our patient experience score through HCAHPS, we received a Four-Star Rating since 2020, which is above both the national average and the state average.

Orthopedics has a Five-Star Rating from CMS for hip, knee and spine surgery. Our National Association of Orthopaedic Nursing has seen MidState receive an excellence award. And we've received advanced certification for spine surgery,

which is the first program in the country to achieve that, hip and knee and hip fracture surgery as well as shoulder surgery. All of this is really being developed so that we can provide that timely access in the community for world class care and no need for patients to travel to get those. Those include the capabilities we just went through, the orthopedics, complex neurospine, vascular surgery, cardiovascular, electrophysiology, and all of that is reflected in the complexity of care we're seeing within the acute care hospital where we have seen an increase in our case mix index, a measure of that complexity of 31 percent between 2016 and 2021.

But in addition, our commitment to the ambulatory environment includes ambulatory surgery centers, urgent care centers and continued alignment with our primary care initiative to provide access in the communities. All of that is a very concerted attempt to lower total cost of care and make care more affordable.

Orthopedic surgeries at MidState increased from 2017 to 2023 from 1,600 cases done in the acute care facility to 5,200. Those cases in 2017, 20 percent of them were in OPHDs, so an

outpatient hospital designation, which is lower cost. In 2023, 80 percent of the increased cases are being done in an outpatient location with an extended stay. Importantly though, the move to ambulatory surgery centers was critical. These are not at hospital rates. In 2021, we did 4,600 cases. In 2023, 9,400, a 103 percent increase of orthopedic surgeries move from inpatient to ambulatory setting at the same quality and performance that we would expect.

In addition, we just this week had three general surgeons move their cases from hospitals into the ASCs in Hamden as we continue to expand the kind of services that we can perform in ambulatory surgery centers.

From a gastrointestinal perspective, procedures done in an outpatient hospital setting, we've moved into the ambulatory, again, ambulatory surgery centers what was 15,721 is now at 26,000, a 66 percent increase. Urgent care visits are an opportunity to try and decant the emergency departments of low level ED visits has increased from 2018 to 2023 from 25,000 visits in the year to 79,000 visits in a year, a 205 percent increase. And that indeed has been reflected in

the reduction of ED visits of Level 1, 2 by 18 percent over that time frame. 20 percent of our total ED visits used to be Level 1 and Level 2. That's now been reduced to 15.7 percent. So as we've been able to give more opportunity and access for those people to seek care in a more convenient and expedited way, we have people not having to go to an expensive emergency department but receive that care in an urgent care center at a substantial lower cost.

This is in addition to all of the other measures we're looking at in terms of trying to control avoidable utilization from inpatient admissions to begin with, skilled nursing facility utilization, readmissions back to the hospital for those conditions that we can avoid that, reducing complications reduces hospital utilization. Our Leapfrog rating is a measure of many of these measures to demonstrate that we are making progress. But importantly, preventive care is a foundation for what we need to do. And as we look at managing risk conditions, hypertension, diabetes, that lead to end stage disease that often results in hospitalization or additional care, we've got a focused effort around our

ability to manage both hypertension and diabetes and segmenting that by at-risk communities versus the general population to ensure that we are addressing the inequities in health care that we know exist.

Currently we have managed the 110,000 folks that were responsible for hypertension. 75 percent of them are at goal at the end of the most recent year which is a year-over-year improvement we continue to see because it continues to be something we're focused on. And diabetes we're seeing 78 percent of patients with their diabetes adequately managed. And as we looked at disparities, where we see disparities in diabetes management in the at-risk zip codes, we are making good progress in decreasing that gap in targeted efforts to try and get outreach into those communities.

Lastly or next is really on equity. We've got a focused effort across Hartford HealthCare developing a center of equity. This allows us to look at and make sure we are attentive to the disparities that we see both in our workforce and in the communities that we serve in terms of providing care. We understand that

partnerships with community organizations and community leaders become an essential part for us to decrease those disparities and at MidState, particularly working with the Equity Champions as a focused effort to make sure we have their voice at the table. We have the colleague resource groups. We participate in the Fair Chance Program. We are focused on developing and making sure that we are adequately capturing adequate race, ethnicity and language data as well as social determinants. And we continue to deploy our Neighborhood Health Program, which we developed out of COVID-19, to address both testing and vaccine to bring community services from social services to medical care into communities to try and address access problems that many of those communities experience.

Lastly, and importantly, alignment and work with our payment model to ensure that we are able to take advantage of the system of care that we have built. We participate in full risk for Medicare Advantage in two models, one, our APN Connecticut where we have about 55,000 members in full-risk, as well as our joint venture partners, Medicare Advantage plan, which is another 8,000

members, and we are continually focused on quality ratings. This is a star rating for Medicare Advantage plans nationally these measures and patient experience measures to ensure we are attentive to delivering the same quality of care in the ambulatory environment. The affordability measures that we've already reviewed remains centers of focus with ED utilization, ED admissions, SNF transitions, length of stay within SNFs, or skilled nursing facilities, and a CHF program to manage that to ensure that we adequately care for those people to decrease utilization.

Lastly, but importantly, the focused effort to developing the center of excellence around orthopedics and our Orthopaedic Institute. We participated now for six years in the CJR Program through CMMI. This was a program that focuses on inpatient and hospital outpatient joint replacement. We've seen dramatic improvements across multiple measures demonstrating that when we can focus and we get full alignment through providers and the supporting staff that we can see significant improvement in overall measures.

As an example, our quality score when

we started the program was 4.4 out of 20. By the sixth year we are at 18.5 over 20. Our complication rate went from 1.4 to zero. Our readmission decreased by 10 percent. In addition, skilled nursing facility utilization went from 87 percent in the initial year down to 5.3 percent in our last performance year. Homecare dropped from 88.9 to 28.6. Inpatient length of stay went from 3.2 days to 1.2 days. And movement from inpatient to hospital outpatient 5 percent of our cases were done in hospital outpatient as we began the program. It is now at 76.6.

All of this work has resulted in being recognized as a destination for patients to receive excellent care. My colleagues, Jeff Finkelstein, Daniel Engelberg and Janette Edwards will go into these issues in greater detail. It is important to understand that we've exceeded our space capacity to provide the care that patients in the community expect and deserve. I respectfully request that you approve this application and are happy to answer any questions. And thank you for letting me repeat my testimony.

THE WITNESS (Finkelstein): Good morning, Executive Director Gifford and members of

the OHS staff. My name is Jeff Finkelstein, and I am vice president of medical affairs of the central region of Hartford HealthCare. I oversee clinical affairs at MidState Medical Center and the Hospital of Central Connecticut. And I adopt my prefile testimony. I'll pause. Can you hear me?

EXECUTIVE DIRECTOR GIFFORD: Excuse me, Dr. Finkelstein. How are we doing on the sound?

MS. CAPOZZI: I think we need to speak up a little louder.

(Pause.)

MR. CSUKA: I think the issue now is us that people are having difficulty so we're going to have to speak up.

MS. CAPOZZI: Yes.

THE WITNESS (Finkelstein): Thank you for this opportunity to speak in support of MidState's request for CON approval to add inpatient beds at the Meriden campus. Based on my experience in both clinical and administrative positions at MidState and within the Hartford HealthCare system, I am in a unique position to assist OHS in understanding the need for additional inpatient beds at MidState and the

benefits to patients of increasing licensed bed capacity at the hospital.

Over the course of the last 20 years, I have held various positions within the Hartford HealthCare system, including the first medical director of the Hartford HealthCare GoHealth Urgent Care, chief of the Department of Emergency Medicine at Hartford Hospital, as well as chief of the Department of Emergency Medicine at the Hospital of Central Connecticut.

My testimony today will focus on several issues. First, I will discuss inpatient capacity issues at MidState and the bed need methodology that was used to arrive at the need for additional licensed beds. My colleague, Janette Edwards, Vice President of Operations for the Central Region of Hartford HealthCare, is here with me today to answer any questions you have about our bed need calculations. I will also provide OHS with additional details regarding the high quality of medical care provided to patients at MidState.

My colleague, Dr. Cardon, mentioned several of the accolades received by the hospital in recent years, all of which show that MidState

is a high performing hospital where patients receive safe and effective care. This is the primary reason the hospital is as busy as it is, both in the emergency department and in the inpatient units and why additional bed capacity is needed.

Finally, I will testify about 30-day readmissions at MidState so that OHS has a better understanding of how the hospital's performance has improved on this measure, what we have done to realize improvement in readmission rates, and which readmissions are not necessarily within our control.

It is important to note that MidState performs well on readmission measures and the readmissions we do see, to the extent that they can be affected, would not avoid the need for additional inpatient bed capacity at the hospital.

So let's talk about capacity issues at MidState. Our deliberate focus on expanding service offerings and striving towards enhanced access, affordability, equity and excellence has enabled us to provide patients with better access to higher quality care in the most affordable and cost effective settings. As a result, demand at

the hospital continues to increase and additional inpatient beds are needed to meet that demand.

MidState's inpatient census has been increasing steadily for many years further straining capacity as patient demand continues to grow. MidState has seen a significant increase in inpatient discharges, observation cases, surgical volume, emergency department visits and extended stay patients over the last several years. In fact, like almost every hospital in the country, the hospital is currently experiencing census very near its licensed medical surgical bed capacity resulting in patients boarding in the emergency department while awaiting admission.

Currently there is more demand than there is available inpatient bed capacity. Between fiscal year 2020 and fiscal year 2023, patient discharges or transitions increased by 17 percent or 1,510 patients. The hospital currently has 131 licensed staff available adult medical surgical beds, and in FY 2022 we were operating at 84 percent of available capacity. This puts the hospital well above the industry target of 80 percent occupancy for community hospitals.

As the care delivery model for

orthopedic patients has evolved, MidState has also experienced an increase in extended stay patients, outpatients who are placed in an inpatient unit for post-procedure care, extended recovery time or recovery from a weekend or after-hours procedure. In just a one year period of time between fiscal year 2022 and fiscal year 2023, extended stay patients increased 13 percent from 3,036 to 3,431 patients, an increase of 395 patients.

Most extended stay patients at MidState are associated with the Connecticut Orthopaedic Institute and have an averages length of stay of approximately two days. These patients reside in an inpatient bed during their extended stay, therefore making it unavailable for other inpatient admissions. The Connecticut Orthopaedic Institute patients account for more than 6,000 additional patient days not included in the occupancy rate calculation that was used above. If they are considered, the inpatient occupancy rate at MidState increases to 90 percent.

At an occupancy rate of 80 percent per the Department of Health and Human Services standards for community hospitals, a community hospital has the need and essential flexibility to

respond to unforeseen fluctuations or surges in demand as experienced during the recent COVID-19 pandemic. We really want to admit our patients as quickly as possible to avoid delays in care and corresponding increasing costs.

In addition to the inability to respond to in surge situations strained inpatient bed capacity also results in an increase in admitted patients boarding in the emergency department as they wait for a bed to become available. As my colleague, Dr. Dan Engelberg will discuss, ED boarding is a significant issue at MidState. The practice can be detrimental from a quality and safety perspective to both those patients being boarded as well as other ED patients. ED staff burnout and attrition as a result of ED boarding is also a real concern.

MidState has submitted this request for approval to add licensed beds based on current capacity constraints and in anticipation of continued growth in volume. There is sufficient demand in the MidState service area to support these beds. Beds are needed to treat individuals who choose to obtain their care at MidState who need the specialized services offered at MidState

and whose treating physicians do not have privileges elsewhere. The demand for beds at MidState also exists independent of any other hospitals' available bed capacity. This includes available beds at The Hospital of Central Connecticut who serve a different community and for which future plans for use exist. Additional beds will allow the hospital to continue to provide timely access to high quality affordable care for patients, including those admitted through the emergency department.

Our bed need analysis. In analyzing bed need, MidState chose a model that is sensitive to the unique circumstances at the hospital and that most accurately estimates projected bed use. It is based on existing bed configurations at the hospital, actual patient days and average daily census, target occupancy rates by unit, and it includes a range of projected volume growth based on historic utilization and other factors. There is no one specific methodology to determine the optimal number of beds required at a hospital and differing models can be used to estimate this number in different contexts.

We understand that the Statewide

Healthcare Facilities and Services Plan includes a population based model for calculating hospital bed need. However, this model has many limitations and in this case is not an appropriate model to estimate MidState's bed need given the hospital's unique circumstances. The population that OHS proposes to use does not accurately reflect MidState's patient population. The weighted average daily census that OHS uses covers several years of the COVID-19 pandemic and does not factor in the tremendous growth in demand for inpatient services that MidState has experienced with establishment of the Connecticut Orthopaedic Institute and other quality and service enhancements. And the model does not account for present and projected future growth and demand independent of any growth or lack thereof in New Haven County population and a significant increase in extended stay patients the hospital is experiencing. It is simply and entirely the wrong model for the state.

The Statewide Health Care Facilities and Services Plan does however allow OHS to consider other factors when reviewing a request for additional inpatient bed capacity, and each of

these factors should be considered here because each factor supports the need for an increase in licensed beds at MidState. These factors include observation beds and days which MidState has experienced in addition to the significant volume of extended stay patients we've mentioned. An average weekday occupancy rate or census for two separate and distinct periods of 30 calendar days for the most recent 12-month period at or above 80 percent in total licensed beds which MidState experienced in fiscal year 2023. Particular innovations, changes in care delivery models or modalities, resources, including physical resources and building facilities needed to treat specific diseases or conditions, a criteria that appears custom built for the Connecticut Orthopaedic Institute and the changes it has brought to MidState. And quality or patient safety concerns which we would expect to experience more frequently as a result of inpatient capacity strains and higher levels of ED boarding.

Additional bed capacity will improve the quality of patient care by avoiding delays in treatment caused by ED boarding, improved patient

experience by reducing time spent in the emergency department, and reduced strain on emergency department and inpatient resources. These beds will also reduce ED length of stay and foster more cost effective care.

An added benefit of the additional bed capacity is the ability to cohort oncology patients in a single physical unit. The unit will have cancer trained clinical staff and be in close proximity to the hospital's brand new pharmacy. This will free up bed capacity currently used by oncology patients for other medical surgical admissions. Notably, the additional medical surgical beds will be available to all patients, including Medicaid patients, who comprise 17.6 percent of the hospital's payer mix.

Quality of care. As Dr. Cardon mentioned, MidState is an award winning institution for quality of care and patient safety. I would like to touch briefly on a few of MidState's recognitions that are particularly noteworthy from a quality, safety and patient experience standpoint. First, MidState, along with all the other Hartford HealthCare hospitals, was awarded a Leapfrog hospital safety grade of

"A." As you know, Leapfrog is a watchdog organization committed to transparency as the gold standard for evaluating the quality and safety of hospital care. MidState has received an A grade three of the last four years, and we are incredibly proud of this accomplishment.

MidState also received a Five Star overall hospital quality star rating from CMS. It is one of only three hospitals in the State of Connecticut and 483 hospitals nationwide to receive this top rating.

MidState has received many other accolades both national and regional which are detailed in my prefile testimony. The Connecticut Orthopaedic Institute, in particular, has achieved advanced certification from the joint commission and numerous other recognitions related to patient care, safety and patient experience.

There is no doubt that MidState provides exceptional quality of care to all patients for those needing community based hospital and emergency care to those seeking highly specialized orthopedic and other treatment in our hospital. The granting of the CON request to add additional licensed beds will ensure that

every patient who presents to MidState Medical Center in need of our inpatient services can receive those services in a timely manner ensuring the best possible outcomes -- best possible health outcomes.

30 day readmissions. Finally, I would like to touch briefly on the issue of 30 day readmissions at MidState given OHS's request that we provide information regarding efforts to optimize the use of our current inpatient capacity by reducing these admissions. First, it is important to note that MidState does very well with respect to readmissions, and there have been steady and substantial improvements in 30 day readmissions hospital wide between fiscal year '19 and fiscal year '22.

Looking at readmissions data just for the Medicare program for the time period spanning July of '19 through June of 2022, the hospital outperformed its peer group in three of the five 30-day All-Cause Unplanned Risk Standardized Readmission Measures. Specifically, MidState performed better than its peers on readmissions resulting from acute myocardial infarction, heart failure and pneumonia.

In the areas where MidState did not outperform its peers or where expected readmission rates were lower than predicted admission rates, the differences were not significant enough to suggest that MidState is an outlier when it comes to 30-day readmissions.

Reductions in readmissions at MidState are due to a number of factors including, but not limited to, improved efforts in our progression rounds for entire clinical care teams, medication reconciliation, care coordination utilizing transition care coordinators, daily family communication during hospitalization, and emphasis on establishing follow-up appointments within 72 hours of transition.

30-day all-cause readmissions have decreased by 35 percent or 276 readmissions. Readmissions over the expected rate have decreased from 85 to 24, or by 72 percent. Readmissions for individuals over 65 years of age have also declined by 38 percent. The financial penalty against MidState has decreased substantially from fiscal year '19 through fiscal year '23.

Despite MidState's efforts to educate and inform patients of the need for follow-up care

and the system's efforts to coordinate downstream care post-hospitalization, there are too few available post-acute resources in the community MidState serves such as skilled nursing facilities and homecare to address all of our patient care issues before they reach the point where readmission is necessary.

Also, every hospital contends with issues of patient noncompliance that increase the likelihood of readmission such as failing to attend follow-up appointments and to follow medical recommendations, as well as clinical complications that arise after discharge through no fault of the hospital.

MidState is committed to improving 30-day readmissions and continually improving the care we provide to patients. However, the hospital does not have the ability to eliminate readmissions altogether, and the readmissions we are seeing are consistent with national averages and do not impact MidState's need for additional bed capacity.

Thank you again for this opportunity to testify in support of MidState's CON request for additional inpatient beds. Our exemplary quality

of care and commitment to excellence make MidState the ideal hospital at which to approve additional licensed beds. These beds, which are needed to address critical capacity constraints, will be used to ensure that all patients admitted to the hospital, as well as patients in our emergency department, have access to high-quality, safe, timely care and the best health outcomes. For these reasons, I respectfully request that you approve our CON request. I'm available to answer any questions that you may have. Thank you.

THE WITNESS (Engelberg): Dr. Gifford, members of the OHS staff, good morning. My name is Daniel Engelberg. I'm going to adopt my prefile testimony. I'm the director of the emergency department of MidState Medical Center. I'm also the director of EMS. I'm also a working clinician in the emergency department so I get to deal with the real problems of boarding in the emergency department on a daily basis. I see what it does to our community and to my patients.

I want to thank you for this opportunity to speak in support of MidState's CON application for the addition of licensed beds at MidState Medical Center. Our hospital experiences

overcrowding and patient boarding due to lack of sufficient inpatient capacity. The proposed additional beds will help address this problem and will thereby improve patient care and flow in the emergency department.

My testimony today will focus on increasing the number of patient beds -- on the increased number of patients that are actively boarding in the emergency department at MidState Medical Center while awaiting inpatient beds. I'll also discuss in further detail, as evidenced in literature and practical experience, that ED boarding is detrimental to the quality of care and patient safety and it also increases health care costs across the board.

I'm going to discuss MidState's plan to reduce avoidable ED visits and lessen ED overcrowding. While these efforts enhance the quality and affordability of ED care, they do obviate the need for additional inpatient bed capacity at MidState Medical Center. Additional bed capacity will significantly reduce ED boarding and ensure that all patients that are admitted through the emergency department receive timely, focused and coordinated care on inpatient units.

As my colleagues have mentioned, enhancements in access to services and improvements in the quality have made MidState Medical Center a destination for many services, including emergency services. We focused on building relationships with first responders and the community at large. We've improved communication and we built trust. As a result, the number of patients that have been coming to MidState Medical Center has been increasing over the past few years.

ED visits have increased steadily since fiscal year 2020, growing 22 percent during this time which is about 8,400 visits. The MidState ED had approximately 46,000 patient visits in fiscal year 2023. More than 30,000 of these were coded as Level 4 or 5 visits which are the most complex visits to come to an emergency department. Our ED is a high volume ED. And despite our issues with boarding, we provide the highest quality and most efficient care possible. Our median time from ED arrival to ED departure for discharged patients is below the national average, as is the percentage of individuals who leave MidState without being seen. That means that people that are coming and

are being discharged from the emergency department receive timely quality care, and we're able to turn them around and see the vast majority of patients that show up. I see left without being seen as a real detriment to emergency care, and we focus specifically on lowering that.

As busy as MidState has been, the hospital has seen similar growth and volume across all service lines and inpatient units. Inpatient bed capacity has become strained with fiscal year occupancy rates reaching 84 to 90 percent with and without consideration of extended stay patients. This has resulted in an increased number of patients that board in the emergency department, particularly in hallway beds. JCO has identified boarding as a patient safety risk and practice that should not exceed four hours for any given patient. I'll tell you I believe any time is too long, to be honest.

ED boarding impairs access to timely emergency care. It results in care delays for patients waiting to be admitted and for those patients our clinicians are actively evaluating and treating. It also compromises care through necessary use of hallways and other sub-optimal

areas with limited resources. Finally, some patients give up and leave the ED without being seen at all. All of these downstream impacts from ED boarding drive up the cost of care for patients and for payers.

ED boarding also negatively impacts emergency physicians, physician assistants, nurse practitioners, nurses, ancillary clinical and non-clinical staff. Our teams are designed to deliver high-quality episodic care and are not equipped to manage inpatient patients in the emergency department for long periods of time.

Because boarding degrades the ED work environment, the ED regularly loses staff. The replacement of clinical staff in the emergency department consumes significant financial resources and disrupts the continuity of clinical practice.

Due to the increase in demand I and my colleagues have described, the number of patients who spend four hours or more in the emergency department prior to being assigned an inpatient bed has increased significantly from 1,610 patients in fiscal year 2020 to 3,704 patients in fiscal year 2022. From March 1, 2023 through May

31, 2023, 198 admitted general medicine patients were discharged directly from the emergency department. That's over a three-month span. These are patients who should have been admitted to the hospital who should have had an inpatient bed who were boarding in the emergency department for a long enough time that they were discharged directly from the ED and never made it upstairs. They were not transferred to an inpatient unit, and thus the strain on inpatient capacity is not sustainable and is sub-optimal from a quality and patient safety perspective.

In an effort to mitigate ED boarding, alleviate the strain on ED resources and accommodate increasing volume, we've opened temporary surge spaces. These surge spaces provide some relief to the ED, but are only a temporary solution and cannot be used as a long-term solution to address boarding and inpatient capacity issues.

Transferring patients to other hospitals does not solve the problem either. MidState does transfer patients to The Hospital of Central Connecticut, which is our nearest hospital, or to other hospitals in emergency

situations when deemed appropriate. Generally, however, when patients and their support persons are asked if they will agree to be transferred specifically to mitigate inpatient boarding, they often decline, citing reasons such as continuity of care, distance from their homes, or the fact that they've shown up at MidState and want to be admitted specifically to MidState because of the high quality of care that we are delivering. Patient preference is always respected.

The Southington campus of HOCC has very limited capacity. They don't provide the level of services that are required for critically ill patients, orthopedic patients or generally other patients that we've considered transferring, meaning it's not an option for most patient transfers.

With the addition of 16 inpatient beds at MidState, overall occupancy, including extended stay patients, will drop to 80 percent. This is the industry benchmark for community hospitals. The addition of 16 inpatient beds is a cost-effective solution to help mitigate ED boarding. It will improve patient flow through the ED and provide more rapid access to inpatient

treatment. Improved flow will also reduce ED overcrowding and facilitate quicker access for patients who need emergency evaluation, treatment and stabilization. It will also lead to less clinical burnout which is a major issue.

We've talked about reducing avoidable ED visits. I'd like to focus on this for a moment. OHS has raised the issue of reducing inappropriate utilization of the ED to lessen overcrowding. While MidState and HHC are continuously working to reduce avoidable ED visits and ensure that patients are receiving care in the most appropriate and cost-effective setting, reducing ED visits has no real impact on the issue of ED boarding and the need for additional inpatient beds. To be clear, patients who present to the ED and require inpatient admission are not avoidable. They have conditions that are so sufficiently severe that they require inpatient hospitalization and admission.

MidState and HHC have made efforts to ensure that patients receive clinically appropriate care in the right setting while still complying with laws such as EMTALA that preclude EDs from turning away patients who present for

care. Expanding access to preventive and primary care is essential for improving the health of communities and for reducing ED overutilization. ED access to both urgent care and primary care services significantly reduces the number of avoidable ED encounters. Urgent care centers play an important role in achieving the goal in reducing non-emergent emergency department utilization and have significantly reduced cost expenditures and out-of-pocket costs for patients.

As Dr. Cardon mentioned, urgent care volume in the MidState PSA has grown steadily since fiscal year 2018 and has increased by about 205 percent or more than 50,000 visits to urgent cares over a five-year period. Still our volumes are rising at the emergency department. Level 1, Level 2 visits at MidState, which are the lowest coded level visits, have declined by 18 percent since fiscal year 2018, and the percentage of total visits that were Level 1 and Level 2 have decreased from 20.2 percent in fiscal year 2018 to 15.7 in fiscal year 2023. We are getting sicker patients is the moral of that story. We're getting sicker patients who need to be admitted and need an inpatient bed.

Although our MidState ED volume has continued to grow due to the result of an aging population, prevalence of chronic conditions in the community, lower acuity volume has transitioned to these lower cost, more accessible urgent care centers. MidState ED staff as well as MediQuick staff work with patients to ensure that they have an appropriate primary care provider, that they have appropriate specialty care follow-up, and that we can provide any necessary services to avoid any avoidable ED admission that we can. These measures help to lessen the likelihood of avoidable ED visits in the future by connecting patients with PCPs and other specialty services in the community.

The hospital's efforts to reduce inappropriate use of the ED have been successful as it has been shown by significant increases in the urgent care volumes which I mentioned earlier. Use of urgent cares is just one of the strategies that we have utilized to manage that appropriate care is managed in the highest quality and most affordable settings.

Thank you again for this opportunity to speak in support of MidState's CON request for the

additional licensed beds. Approval of this proposal is critical to solving a significant issue of emergency department boarding at MidState Medical Center which is adversely impacting access, quality and affordability for patients in our community that are in need of emergency medical services. I urge you to approve the CON so that MidState can continue to provide the highest quality care for all patients who need our services. I'm available for any questions that you have. Thank you.

MR. CSUKA: At this time, I think it might make sense to take five minutes.

MR. LAZARUS: Ten.

MR. CSUKA: A ten minute break?

MS. FUSCO: Yes, absolutely.

MR. CSUKA: Does that work for you, Dr. Gifford?

EXECUTIVE DIRECTOR GIFFORD: That's fine.

MR. CSUKA: All right. We'll come back at 11:30, and we will proceed with some questions from OHS.

(Whereupon, a recess was taken from 11:19 a.m. until 11:31 a.m.)

MR. CSUKA: So this is the hearing regarding Docket Number 23-32657-CON. It's the application of MidState Medical Center to increase their licensed bed capacity. Earlier we had some testimony from the witnesses.

Attorney Fusco, did you have any questions for them before we begin with OHS's questions?

MS. FUSCO: No direct questions, but I'd like to reserve the right to redirect after your questions, if I may.

MR. CSUKA: Sure.

MS. FUSCO: Thank you.

MR. CSUKA: So we're going to start with OHS questions. I don't know who's up first.

MS. FAIELLA: Good morning. So in the prefile testimony the applicant discusses its intent to cohort oncology patients to free up inpatient beds across the hospital. Can the applicant cohort oncology patients without the additional beds?

THE WITNESS (Finkelstein): We already cohort oncology patients as much as we can, but we've run out of space. So they're going to be in a bed somewhere. We try to put them all together

currently on our Pavilion B, but it's not big enough, and it increases our boarding in our ED.

MS. FAIELLA: So you already cohort them currently?

THE WITNESS (Finkelstein): As best we can, yes.

MS. FAIELLA: So then how would these beds assist with cohorting further in Pavilion B to free up inpatient beds?

THE WITNESS (Finkelstein): Because we would move the oncology from currently where we can get some, but not all, to the new Pavilion F and cohort all of them, which is a much better space because it's close to the pharmacy where we mix up the chemotherapy. So we would have enough space to cohort all, not just some. And any beds that they vacate would be open to other med surg patients. Does that make sense?

MS. FAIELLA: Yes. Thank you. Why does the applicant use 131 as their available beds when they are licensed for 144?

THE WITNESS (Edwards): Sure. I'll take that, if that's all right.

MS. FUSCO: Just state you name.

THE WITNESS (Edwards): Sure. I'm

Janette Edwards. I'm the vice president of operations at MidState Medical Center. So 131 beds, that represents all of our med surg beds available on our Pavilions A, B, D, E, a progressive care unit on Pavilion C and our critical care beds on Pavilion C. So those are the beds that are in question today, those 131 beds that we are out of space on those units.

MS. FAIELLA: So the additional beds then that make up the 144, what are those used for?

THE WITNESS (Edwards): Those are used for our maternity care today. Those are not considered med surg beds. Those are reserved for our maternity care. We do utilize those for appropriate boarding issues, when necessary. So a female that may come in with a gynecological issue that needs admission, if we need a bed, sometimes, if a maternity unit is able to accommodate, we can put those types of individuals on a maternity unit, but they are not considered in our general medical surgical inventory beds from an operational perspective.

MS. FAIELLA: And then those maternity beds, are they full then usually?

THE WITNESS (Edwards): They are not full every day, but we are within our benchmark, our industry best practice benchmark. And again, maternity is a type of care -- and my colleagues here can speak more eloquently to it than I can -- we need to make sure that we have available capacity within that unit given the unpredictability of maternity care. Some days they are full. Some days they are not.

MS. FAIELLA: And so out of the 131 beds, or 144 even, how many of those are staffed?

THE WITNESS (Edwards): So they operationally are staffed virtually every day fully. So we use every available bed to our patient population every day.

MR. CSUKA: Annie, can you speak up a little?

MS. FAIELLA: Yes. Yes, I can. Is MidState aware that the Hospital of Central Connecticut is licensed for 414 beds?

THE WITNESS (Edwards): We are aware.

MS. FAIELLA: Is MidState aware that HOCC does not utilize all of their licensed beds?

THE WITNESS (Finkelstein): We are aware, but I don't think we really should be

considering HOCC. We have plans for those beds. And New Britain is very -- is a community we serve with The Hospital of Central Connecticut, and they have long-term plans for those beds to serve the community of New Britain.

MS. FAIELLA: So it was discussed that you are transferring some patients, not all, to HOCC. Can you further explain why you're not transferring additional? I understand that there's patient choice but --

THE WITNESS (Engelberg): It's patient choice. If we're transferring a patient to HOCC for neurosurgery, say, we don't have neurosurgery at MidState, so we transfer those without fail to a facility that can manage that. But we're talking specifically about patients that have the ability to stay at MidState that, you know, that would like to stay at MidState. We pretty much ask every patient that's being admitted when we are on high capacity alert would you be okay going to HOCC. We even try to utilize the terminology they have an Au Bon Pain. I've used every single term that I can to try to get patients over there, and patients don't want to go. These are Meriden patients, these are Wallingford patients. They're

in our community. They want to stay in our community. And then they're also, they get concerned that family members won't be able to visit them. They get concerned that they're going to get hooked into now a system at HOCC where all of their outpatient services are going to be dictated by that community. It's not a tenable answer to the problem that we have in our community.

As I said, HOCC is an excellent hospital, and I really do tell people that at all times. The problem is that people don't want to go. They want to stay in their community. And that's the essence of a community hospital.

THE WITNESS (Cardon): Dr. James Cardon. I just wanted to add something to that. It really -- the point is we are constantly transferring patients --

THE COURT REPORTER: Would you speak up a little bit for me?

THE WITNESS (Cardon): We try to get patients to the appropriate levels of care, and sometimes the severity of the illness will drive where we need to move them. If they need an ICU bed, we'll move them to another hospital. We do

firmly believe that the more we can keep care in the local community requires a lot less transfers of care. There's always a risk when you're handing patients off, putting them in an ambulance and moving them to another facility. So we only do it when we absolutely have to, and we don't have the ability to do it here.

A lot of our attention that I tried to go through was to really, we're trying to build out the appropriate capabilities in the community that we're working in to leverage what are very expensive facilities across the board to make sure we can keep people there and not have to continue to ship people around from facility to facility if we don't have to. We're trying to bring the care to them.

So although available to us and we do it every day, we're transferring patients every day across the system in a very coordinated way, the idea is that why would we move away from what is a high performing facility on the basis we just don't have the capacity for what we want to do.

MS. FAIELLA: My last question. Has MidState had any discussions with Hartford HealthCare regarding the reallocation of some of

Hartford HealthCare sister's hospitals beds?

THE WITNESS (Cardon): So we're oversubscribed across Hartford HealthCare. There is no reallocation that would make any sense for us as we look at what we have and what we're planning and where we're going and what we think we're going to do. So there's no shifting of that around that would make any sense. What we need is to fix the problem at MidState and in that community as we go forward.

MS. FAIELLA: Anybody else have follow-up?

EXECUTIVE DIRECTOR GIFFORD: I do but --

MR. CSUKA: Feel free to jump in whenever you want to.

MS. HARRISON: The applicant has testified that the orthopedic volumes have increased. However, on page 252 of their prefile testimony the volume of discharges has decreased from just under 2,000 in fiscal year 2019 to just under 600 in fiscal year 2023, however, the number of extended stay discharges has increased. Can you explain?

THE WITNESS (Cardon): Do you want to

go?

THE WITNESS (Finkelstein): Sure. If a patient is having a joint replacement, same hospital, same surgeon, same operating room, same bed, based on payer nuances, sometimes they're considered outpatient and then sometimes it's almost identical care but the higher risk patients are inpatients. So if they're an inpatient then they're considered a discharge or a transition. If they are an outpatient, even though same surgery, same bed, almost identical care, they don't count, so they're extended stay. They don't count in those statistics for discharges. But they still took up the same bed for almost the same amount of time. It's a payer nuance more than a care. They're still in a bed. They're still receiving care on an inpatient unit, but they're technically outpatients.

THE WITNESS (Cardon): Importantly, if I may just to continue that, it really is a shift from inpatient level of care into outpatient, which is at a lower cost, and again it was reflected in the performance that we saw when I described how length of stays have declined. So as we've expedited taking better care of patients,

we're trying to transition them out of the acute care hospital earlier. And because their length of stay is shorter, they are characterized as extended stay which means we get paid less for the care of those patients even though, as Dr. Finkelstein reiterated, these are the same hospital beds and otherwise, but because we can transition them out earlier, one, it opens up capacity; two, it does reside in a lower cost of care.

MS. HARRISON: My next question is what are the diagnoses in the emergency department that are waiting for an inpatient bed, like the type of diagnoses that you're having?

THE WITNESS (Engelberg): It can be all diagnoses. You know, first of all, we see everything. We don't generally admit trauma to our hospital. We'll see trauma. We'll see everything. The things that get admitted generally are people that have, you know, cellulitis, pneumonia, some kind of infectious etiology, they have, you know, a broken limb that needs to be reduced in the operating room, you know, someone having even heart attacks will stay at our hospital. So it's across the board. I

don't think that there's any specific diagnosis that sits in the emergency department, anything specifically, but it's really all patients.

MS. HARRISON: Please clarify. Is the ED becoming busier or is MidState boarding more people in the ED because of tight bed capacity?

THE WITNESS (Engelberg): It's both.

EXECUTIVE DIRECTOR GIFFORD: You can go ahead and finish. Are you done?

MS. HARRISON: Yes.

EXECUTIVE DIRECTOR GIFFORD: All right. I have a couple of questions, if you don't mind, some that follow up on Annie and Andrea's questions. Did you have any questions, Dan?

MR. CSUKA: No.

MS. HARRISON: I do have a couple more questions.

EXECUTIVE DIRECTOR GIFFORD: Why don't you finish.

MS. HARRISON: I'll do that. Thank you. The patients who are extended stay patients, are they coming in through the ED or are they directly admitted?

THE WITNESS (Finkelstein): The answer is both. The vast majority of extended stay

patients are orthopedic patients who are getting a joint replacement, either hip or knee. But if you came in with a kidney stone through the emergency department and were going to the operating room, you'd go from ED to the operating room. After the procedure if you needed 4, 6, 12 hours to recover, you'd be in extended stay. So that would be -- so they come in through the ED, but the vast majority come in through our Connecticut Orthopaedic Institute.

MR. LAZARUS: This is Steve Lazarus. Just to clarify, those orthopedic procedures, they're being done at the hospital, not off campus?

THE WITNESS (Finkelstein): Correct.

MR. LAZARUS: The procedure how it's labeled is outpatient or inpatient depending on the acuity, for example, of the procedure.

THE WITNESS (Finkelstein): Correct.

MR. LAZARUS: Thank you.

MS. HARRISON: And my last question is, what does the Community Health Needs Assessment say are the community health needs?

THE WITNESS (Cardon): Do you want me to take that?

MS. FUSCO: If you can.

THE WITNESS (Cardon): It's what I've addressed. Hypertension and diabetes is a perfect example of some of those acute needs. And we continue to see a predominance of cardiovascular disease as being the major driver of a lot of morbidity and organ disease that ends up really impacting the community. So it was widely focused on hypertension and diabetes, to very controllable risk factors, we can reduce that burden, and one where we know we have a good deal to improve. So that's really why we focused our strategies in that direction.

MS. HARRISON: Okay.

EXECUTIVE DIRECTOR GIFFORD: Thanks. So just to clarify, orthopedics was not on the list, did not appear in the hospital's Community Health Needs Assessment, the need for increased orthopedic services, is that part of the CHNA?

MS. FUSCO: We can answer that in a Late-File, if you want.

EXECUTIVE DIRECTOR GIFFORD: Okay. I'm trying to, like others, wrap my head around the patient flow with this extended stay. You provided us some helpful information in your

prefile testimony about the steep decline in inpatient admissions for orthopedics and the multi-fold increase in this extended stay. So am I correct that that increase is a lot of what's driving the need for additional beds? It's been about a 400 percent increase in the years that you --

THE WITNESS (Finkelstein): I think some of it, but a big number is increasing ED volume, right. I mean, our orthopedic volume takes up one pavilion and has spilled over to a few beds on the second pavilion. But for the most part, we've been able to manage the orthopedic volume because now 28 percent of outpatients, so you have your inpatients, outpatients, now 28 percent of the outpatients never even go up to a bed, they go home from the PACU. So even though our volume has gone up, it's some of it, but the largest is the ED volume, people coming in with strokes, heart attacks, pneumonia, chronic obstructive pulmonary disease, sepsis. Those are the people who are waiting for the beds upstairs that we need more beds for them.

THE WITNESS (Edwards): And as we look at our bed need analysis that we provided in our

application, we see that based on our fiscal '22 data when we look at inpatients only, so not considering the extended stay patients that we're discussing, we're at a current occupancy rate of 84 percent where the industry standard for a medical surgical unit is 80 percent. So even without the extended stay, our utilization and our capacity is at 84 percent.

EXECUTIVE DIRECTOR GIFFORD: Okay. I think it would be helpful for us, if it's not -- I don't recall seeing it, but if it's not in the information we have already, to see the non, the changes in the non-orthopedics related admission volume. You gave us the orthopedic, and I think oncology was in the prefile testimony, but it would be helpful to see just overall what you're referring to year over year.

THE WITNESS (Edwards): We'd be happy to provide that.

EXECUTIVE DIRECTOR GIFFORD: And along with that you mentioned the maternity unit.

THE WITNESS (Edwards): Yes.

EXECUTIVE DIRECTOR GIFFORD: It would be helpful to see average daily census on those beds.

THE WITNESS (Edwards): Sure.

EXECUTIVE DIRECTOR GIFFORD: As you know, DPH licenses beds, they don't license by unit. And you all have the ability to flex whether they are oncology beds or maternity beds, et cetera. And we tend to look at, at OHS we tend to look at overall beds taking away bassinets, which we typically look at separately, but look at overall licensed beds as well. So it would be helpful to know if there's any capacity in that.

THE WITNESS (Edwards): Sure, we're happy to find that.

EXECUTIVE DIRECTOR GIFFORD: Do you have a sense of on a given day -- you talk about the extended stay exacerbating your need for beds. Do you have a sense of the proportion of your inpatient beds that are occupied by extended stay patients? It's a very large number of discharges we saw in your -- so it would be helpful to understand how much of the hospital volume is being driven by that extended stay.

THE WITNESS (Edwards): I think we can provide that as a Late-File. The numbers that we have submitted are combined looking at our extended stay and our inpatient volume. But what

I can tell you is that, as we look at those 131 medical surgical beds, when we consider both extended stay and our inpatient volume, we are at a 90 percent capacity current state.

EXECUTIVE DIRECTOR GIFFORD: Right.

THE WITNESS (Edwards): And 84 percent capacity when we look -- or utilization, I'm sorry, when we look at just inpatient. So we're exacerbating our utilization by another 6 percent or so, but happy to provide, you know, the breakout between inpatient and extended stay.

EXECUTIVE DIRECTOR GIFFORD: Yes. So just so I'm clear on what I'm asking. Of the occupied beds on a given day, what percent of those occupied beds are occupied with extended stay patients.

THE WITNESS (Edwards): Sure.

EXECUTIVE DIRECTOR GIFFORD: That would be really helpful to understand.

THE WITNESS (Edwards): Happy to provide that.

EXECUTIVE DIRECTOR GIFFORD: Okay. I will speak up. Sorry.

MR. CSUKA: And we will go through the Late-Files towards the end just so that everybody

is clear, and then we'll issue that as a separate order probably tomorrow as well.

EXECUTIVE DIRECTOR GIFFORD: You mentioned that this HOPD plus extended stay is payer driven in some cases.

THE WITNESS (Finkelstein): Yes, in my opinion, yes.

EXECUTIVE DIRECTOR GIFFORD: Is there a difference in the charges for HOPD plus extended stay versus inpatient?

THE WITNESS (Cardon): Extended stay is HOPD. So by definition when it's extended stay that is in the HOPD bucket. They aren't two different buckets. It's one bucket, just extended stay sits in the hospital average.

EXECUTIVE DIRECTOR GIFFORD: And do you charge the same amount if somebody goes home directly from the PACU or if it's HOPD plus extended stay, if you follow me. I'm trying to understand. So when you book a patient to have a joint replacement under HOPD, you book a patient. Is it planned that they're going to have extended stay, or is it you plan just to do the procedure and then depending on the clinical circumstances in the recovery room you decide if they're going

to have extended stay or not?

THE WITNESS (Finkelstein): When you book the case, I think the first decision the surgeon makes is inpatient or outpatient, outpatient done at the hospital versus -- I guess the first decision, am I going to do it at the hospital or am I going to do it if I have an ambulatory surgery center. So let's just assume the surgeon decides he's going to do it, he or she is going to do it at the hospital. The first decision when booking is do I think this patient meets criteria, is complicated enough, in my medical opinion, are they going to stay two or more nights, I'm going to book that as inpatient.

EXECUTIVE DIRECTOR GIFFORD: I see.

THE WITNESS (Finkelstein): They're still going to come in the morning of surgery. If they're not inpatient, everyone else is outpatient. They go into surgery. Now, they may have had conversations with the patient and in their mind I think you are low risk, you have great support at home, you're healthy other than this joint, I think after four, six, eight hours I might be able to let you go home, or I'm a little more worried about you, why don't we keep you

overnight. Some of it's a discussion with the patient. So those ones who stay more than four hours are extended stay. Some actually just stay in the PACU and get discharged 7 p.m., 8 p.m. Most go up to a bed and then go home the next morning early, late morning. So it's really about inpatient versus outpatient and then the outpatient is divided into those that can go home same day versus those that stay overnight. We are industry leading, 28 percent of our outpatient joints done at MidState now go home same day.

EXECUTIVE DIRECTOR GIFFORD: Okay. So this is not an unanticipated extension of this extended stay, it's planned for in general for the most part, you know that 72 percent of the patients that you operate on are going to need an extended stay?

THE WITNESS (Finkelstein): And stay in a bed overnight, yes.

EXECUTIVE DIRECTOR GIFFORD: Okay. And just to go back, Jim, Dr. Cardon, is there a charge, a difference in charge between the patients who spend the night in a bed versus those that don't?

THE WITNESS (Finkelstein): Because

they're outpatient -- this is not my area of expertise.

EXECUTIVE DIRECTOR GIFFORD: If you want to get back to us.

THE WITNESS (Finkelstein): I may have to get back to you because I don't want to answer incorrectly.

EXECUTIVE DIRECTOR GIFFORD: Okay.

THE WITNESS (Cardon): There's a distinct difference between inpatient and outpatient.

EXECUTIVE DIRECTOR GIFFORD: Yes.

THE WITNESS (Cardon): Whether there's an additional add-on that they stayed longer than four hours, I'll get back to you exactly what that is. I'm not close enough to it.

EXECUTIVE DIRECTOR GIFFORD: Okay. What led to the establishment of the Orthopaedic Institute, what was the impetus behind establishing that?

THE WITNESS (Cardon): So obviously important and critical and, you know, and expensive series of procedures that often these things are being done in tertiary primary care, and we recognize that we have alignment to try and

build out exactly what we've said. We can do this more efficiently. We can move care from inpatient to outpatient and move appropriate cases to an ambulatory surgery center. We had alignment around physicians who wanted to continue to do this, and we knew that in what is often a very expensive proposition for everybody and not always getting the kind of experience people wanted, that we anticipated this change and opportunity and so did this in a very organized manner to try and create all that transition, allowing us to provide joint replacements, complex surgery and the appropriate people who need to be inpatient or outpatient, those that we can get in that in between place, get those there, but still not comfortable enough for all the cases that we can do in the ambulatory environment. So it was both a quality, a way to maximize your inpatient utilization appropriately, and at the same time lower total cost of care for the population of services that we know are fairly expensive in general. So that was the strategy.

EXECUTIVE DIRECTOR GIFFORD: So the institute was really a focus on -- let me ask you, was the focus on expanding the capacity to do

outpatient orthopedic surgery by establishing the institute, was that the goal, did I misunderstand you?

THE WITNESS (Cardon): All the above, access, affordability, equity. It's not just one thing. It wasn't that we want ambulatory so we've got to build this thing. It's we knew, and we had the line clinicians who believed in this vision, that we could do this better as we looked at a population of patients who are coming through. When we talk about population, you've got to define what population you're trying to, you know, build the program around. It's not all equal.

Orthopedics, you can focus on it in terms of ability to look at alternative payments, the recognition that we could do this better, tighter and more efficiently, and at the same time drive up the quality and performance by linking all these things together, not just focusing on the inpatient but how do we build this as an entirety of programs so if you're coming for orthopedic care, you'll get the right care in the right place at the most affordable option, and be able to do that, make it accessible so people aren't waiting for a long, long time to get their

hips and knees and other surgeries provided and use an inpatient facility for what it's best used for, for the most complex, sickest, more complicated patients.

So it's not just one thing. It was an entire program to look at it. But we had to do all of it. You can't just do a part of it because a part of it isn't going to get you what you want to do. Does that help?

EXECUTIVE DIRECTOR GIFFORD: Thank you. Last, I want to ask about The Hospital of Central Connecticut because there are a lot of excess licensed beds at that facility that are not staffed and are not utilized. I don't know if you have numbers available, but there are lots of excess beds. So help us understand why, given that many of these procedures that are requiring an overnight stay are planned, why isn't there an ability to somehow with two hospitals less than ten miles apart in the same system why isn't there an ability to either transfer some of those licensed beds, if that's something you've explored, or establish the capacity to do some of the work that you've been describing that you know in advance is going to be needed, why not combine

those with a facility that already has a lot of excess licensed capacity?

THE WITNESS (Finkelstein): I'm going to take the clinical part and I'll leave the license part to Ms. Edwards. The care that Dr. Cardon and I have described is highly complex, it's a partnership between the hospital and the physicians, and it's very deliberate. We want to be the place where physicians excel at their craft and that patients chose to come to because it's a "better mousetrap." And we have built that at the Connecticut Orthopaedic Institute. And we don't have that infrastructure at The Hospital of Central Connecticut. Physicians, even though I thought it was 10 miles or 18 minutes on the Chamberlain Highway, they are committed to MidState Medical Center and what we've built. And it starts with the outreach with navigators and education before they even have surgery. We have concierges and it's an experience to maximize the benefits to the patient and their health outcome that we have built at MidState Medical Center. And if I could franchise that, I might be, maybe retire, but it's special, and it's not as easy as just replicating it somewhere else. It really

takes the physician leadership and commitment and the administrative commitment, and it's not easily replicable. And it's really an exceptional product that we can deliver jointly with our physicians at MidState. So I can't just say, ma'am, you're having a joint, we're a little busy at MidState, go have it at HOCC. It would not be the same experience, nor would the physicians go.

EXECUTIVE DIRECTOR GIFFORD: Do most of your surgeons have privileges at both facilities?

THE WITNESS (Finkelstein): Actually, no. I would say 90 to 95 percent of our physicians at the Connecticut Ortho Institute do not have privileges at Hospital of Central Connecticut.

EXECUTIVE DIRECTOR GIFFORD: I see. So I think that's all my questions. Let me just --

MR. CSUKA: Dr. Finkelstein, you said you would speak to the clinical component but you would leave it to someone else to discuss the licensure aspect.

THE WITNESS (Finkelstein): Thank you for keeping me honest.

(Laughter.)

THE WITNESS (Edwards): The Hospital of

Central Connecticut, while it does appear unable to have a surplus of licenses available, as was previously mentioned, there are plans for future growth and development of HOCC. So I would not consider it in our planning process for those to be available beds. And HOCC has been growing itself over the course of the last number of years and has its own capacity constraints that we are continuing to work through. So in our planning process we are not considering those as options for this, to fill this need in MidState.

EXECUTIVE DIRECTOR GIFFORD: I want to just give you an opportunity to clarify something that was, I think it was in a response to one of our completeness questions. We asked about measures of avoidable ED utilization. You mentioned how you're coding the visits and that has changed over time, but we asked about specific measures and there are standardized measures that look at potentially preventable not only admissions but avoidable ED use, past exacerbations, UTIs, URIs, those kinds of things. And I think the response was we're not tracking that at MidState. So I just want to give you the opportunity either now or in a Late-File to share

any data that you have about avoidable ED visits.

THE WITNESS (Cardon): I can take it.

THE WITNESS (Engelberg): Yes.

THE WITNESS (Cardon): I just want to clarify, Dr. Gifford. You said coding issues. When we say Level 1 and Level 2, it's not that we're coding them differently.

EXECUTIVE DIRECTOR GIFFORD: All right.

THE WITNESS (Cardon): It's really that we have removed lower level visits of actual patients who are coming with those kind of conditions that we see as avoidable, they're being performed someplace else.

EXECUTIVE DIRECTOR GIFFORD: Right, but the data source was your coding, right?

THE WITNESS (Cardon): Yes. It's a way for us to track avoidable. So it's our measure to be able to track are we having an impact on avoidable ED utilization. So that was really the intent.

THE WITNESS (Engelberg): It's essentially saying that the patients present to the emergency department are sicker and more --

EXECUTIVE DIRECTOR GIFFORD: I understand.

THE WITNESS (Cardon): In terms of tracking, there are issues trying to track what you define as avoidable, and I realize there are some standards around that. We are trying to utilize are we seeing the patients who should be seen in urgent care centers and they're not being seen in the ED is our ability to track that. And that's the place level we use because we can manage to it pretty regularly is Level 1, Level 2, how many Level 1, Level 2s are still hitting our EDs that we could have taken care of somewhere else.

So we have some very direct strategies on that both in terms of giving people the capacity to go elsewhere, but also we follow up with a lot of those patients and say, hey, you could have gone to an urgent care center, you didn't need to go to an ED, and here's a location for you to go. So we do a lot of work to try to decant that as best we can. I understand that there's a host of diagnoses that say these could have been avoidable, some of them better management of chronic conditions leads to that bucket. We follow that in our CHF program and other things to try to manage them more

effectively.

There are other conditions that are in retrospect you say you can avoid but are very problematic at times with symptoms. A chest pain that's very atypical that ends up being you bruised your chest, patients don't recognize that all the time. So it gets a little bit hard to parse out sometimes was it really avoidable from the patient's perspective or is it just avoidable to a clinician. So all of that noise we try and really focus on the low level visits which are cleaner for us to be able manage. So it's not that we're not paying attention to it. It's just we don't necessarily parse it out as to the way others have defined those low level visits, if that give you some clarity.

EXECUTIVE DIRECTOR GIFFORD: Yes. You mentioned some of your value based purchasing arrangements that are tracking quality and utilization. So if you have any data from any of those programs --

THE WITNESS (Cardon): Sure.

EXECUTIVE DIRECTOR GIFFORD: -- that illustrate the standardized measures of avoidable ED utilization that you could share with us, that

would be helpful.

THE WITNESS (Cardon): Yeah, I'll look and see. We do have a comprehensive, pretty much what we're focusing on is two populations there. One, making sure that we have access to people before they get to the ED to check in with their primary care and make sure we can have a conversation to make sure that it's appropriate. The other program we had is people who are in the ED, if we can let them get home as opposed to admit them because we have access and outpatient availability to try and change that.

So those are the kind of things where we can have regular impact on patients to make sure they're getting the quality of care they need without requiring the inpatient piece. So it's across our -- in Connecticut. We're not specifically measuring and tracking the definition of avoidable. It's as I've described the way it works, but I'll see --

EXECUTIVE DIRECTOR GIFFORD: Okay. Thank you. That's all my questions.

MR. CSUKA: Okay. Attorney Fusco, do you need a moment or --

MS. FUSCO: No.

MR. CSUKA: Would you like to proceed with redirect, if you have any questions?

MS. FUSCO: If you can just give me a minute to see if anyone --

MR. CSUKA: Sure.

(Pause - off the record discussion.)

MS. FUSCO: I think we're good. Thank you.

MR. CSUKA: Okay. So at this time, I think we're ready to -- oh, I should ask, do any of you have any follow-up questions on Dr. Gifford's?

MS. FAIELLA: No.

MR. LAZARUS: No.

MR. CSUKA: Sorry, I should have asked that before turning it over to Attorney Fusco. So at this time, we're going to take a 50-minute break. We'll come back at 1 o'clock for public comment. Anyone who wishes to speak can sign up through Zoom or can attend the hearing in person and log their name. And I think that's it for now.

MS. FUSCO: So we're taking a break now until 1?

MR. CSUKA: Yes.

(Whereupon, a recess for lunch was taken at 12:10 p.m.)

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AFTERNOON SESSION

1:03 P.M.

MR. CSUKA: Welcome back. For those just joining us, this is the second portion of today's hearing concerning a CON application that MidState Medical Center filed. The Docket Number is 23-32657-CON. MidState seeks an increase in licensed bed capacity. We had the technical portion this morning, and we are now ready for public comment. Afterwards, we'll go through the Late-Files and do some closing remarks and then we will break.

So, sign-up for public comment has been all day in person and on Zoom in the comments section. If you have not yet signed up, please do. I believe we have one person who has signed up thus far. It's the Mayor of Meriden. So we will take him first. Speaking time is typically limited to three minutes, but for elected and appointed officials we generally allow for a greater flexibility around that time. And we strongly encourage you and anyone else listening

to submit any further written comments to OHS by email or mail no later than one week. That is seven calendar days from today. The email address is concomment@ct.gov. And our contact information is also on our website and on the public information sheet that you were provided at the beginning of the hearing.

So we are now ready to take public comment. Mayda, is it correct that we have one person?

MS. CAPOZZI: Yes, Kevin Scarpati.

MR. CSUKA: So if there is anyone else who would like to make a comment, they just have to raise their hand and then we will be able to process them to bring them into the meeting.

So, I believe we are now ready to allow the Mayor of Meriden in.

MAYOR SCARPATI: Can you guys hear me all right?

MR. CSUKA: We can. We can't see you though.

MAYOR SCARPATI: It is telling me the host has stopped or not allowed me to start a video. If you'd like to allow me to, I can pop that up for you. All right. How's that?

MR. CSUKA: There you are.

MAYOR SCARPATI: All right?

MR. CSUKA: All right. Thank you for joining us. So feel free to speak whenever you're ready.

MAYOR SCARPATI: Thank you. And thank you, Dr. Gifford, and the entire OHS team for holding this hearing and allowing me to speak. As mentioned, my name is Kevin Scarpati, mayor of the City of Meriden, home to MidState Medical Center in our city.

You know, we've had a great relationship with MidState officials. And really over the last several years I'm proud of the work that we've been able to accomplish with MidState and their entire team. We've really worked hard to build trust and a great strong relationship between our community members and our hospital. Unfortunately, when there are times that patients have to remain overnight in the ED after being admitted or are kept for hours on end, as you've heard in some of the testimony earlier today, on beds in hallways in our ED or in the waiting room for hours, or are constantly asked if they would consider transferring to a different hospital due

to capacity constraints, that hurts all the work we've done over the last few years to really build that relationship, especially coming off COVID when we did see a reduction in visits to our emergency department and overall hospital, as many did.

So I just want to also share with you a bit of a personal story. And the patients that unfortunately have to seek care all too frequently at MidState Medical Center is my mother. My mother is one that has a lengthy medical history and various health conditions and relies on us, her family, for not only primary care but also transportation. And so when she's in need of care, we have to, one, convince her to go to the hospital, which as you can imagine isn't anyone's favorite place to go to, but we know in going to MidState it's a place that she can be comfortable. And I don't just mean comfort as in the bed that she has to lay in, but comfort in knowing that she's in a familiar atmosphere and space. She's going to receive quality care. She's going to be in a quiet and safe setting, all of that with MidState. And then we know that, aside from just great care, we're going to receive a comprehensive

discharge plan when she leaves the hospital.

Unfortunately, at our last visit there she was one of the many, I'm sure, that had to stay in the ED overnight, her first night after being admitted, because there wasn't space. And then waking her up early in the morning to transfer her to a room that then allowed us to go and see her the next day, all of that only hurts, if that continues to occur, that frequency hurts not only the work we've done as a community but hurts the odds of me as her son to convince her to go to the hospital the next time because she doesn't feel as though she's going to get that same level of care. And all of that really comes down to what you've heard today, the strain on capacity within the hospital.

And so I speak to you today not only as mayor of our city and one that is proud of the work we've accomplished and want to see a growing facility delivering high quality care, but I come to you personally as someone that relies on the hospital for my needs as well as my family that we do need these additional beds. We need the additional beds, and I've seen it firsthand, unfortunately, impacting the care received by my

mother.

And so with that, I again thank you for allowing me to come on and testify but also allowing this hearing because it's truly a need at MidState. And to ask others to just treat them as numbers and plug them into a different facility that they're not close with or comfortable with just wouldn't be fair. So on behalf of the entire City of Meriden, I urge you to approve the Certificate of Need and the expansion of beds at our facility. Thank you.

MR. CSUKA: Thank you, Mayor. Has anyone else signed up, Mayda?

MS. CAPOZZI: No.

MR. CSUKA: So we're now going to proceed to discussing the Late-Files.

Actually OHS, did you have any questions based on the mayor's comments?

MR. LAZARUS: No, we do not.

MR. CSUKA: So now we can turn to the Late-Files. There is one document that OHS said it would be providing, and that's the Exhibit C spreadsheet with the sources of the data. We will be uploading that by Monday and then you'll be provided with ample time to respond.

MS. FUSCO: Okay.

MR. CSUKA: Which we can discuss after we've gone through everything else.

MS. FUSCO: Okay.

MR. CSUKA: So the first Late-File for the applicant is an explanation -- and OHS, feel free to jump in whenever you may want to offer any clarity -- explanation of how orthopedic need is tied into the CHNA. That's the Community Health Needs Assessment.

Number 2 is changes in non-orthopedic admissions volume year over year in addition to what has already been provided with respect to oncology.

MS. DURDY: I'm sorry. For what time period?

MR. CSUKA: We were thinking five years because that would help capture a little bit before COVID as well as current.

MS. FUSCO: Are you looking for us to break down the inpatient admissions and just pull out the ortho?

MR. CSUKA: Sorry?

MS. FUSCO: I apologize. Are you looking for us to break ortho out of inpatient

admissions and give you the balance, right, so as you had asked, Dr. Gifford, what's the percentage that is ortho admissions?

EXECUTIVE DIRECTOR GIFFORD: (Nodding head in the affirmative.)

MS. FUSCO: Thank you.

MR. CSUKA: Number 3 is average daily census of maternity beds, again, five years.

And we'll issue this as an order also. That way you have it in writing.

Number 4 is the percentage of occupied beds that are occupied by extended stay patients. And that, again, would be five years.

Number 5 is an explanation of whether there is a difference between inpatient and outpatient billing if staying overnight versus more than four hours. Maybe I stated that incorrectly.

MS. FUSCO: So it's HOPD patients, are they billed differently if they have an extended stay or don't.

EXECUTIVE DIRECTOR GIFFORD: Yes.

MR. CSUKA: Okay. And then number 6 is data from value based payment programs regarding tracking of avoidable ED visits.

EXECUTIVE DIRECTOR GIFFORD: Value based payment programs or other sources. I assumed that would be where you would be tracking them.

(Late-File Exhibits 1 through 6: Described in index.)

MR. CSUKA: Attorney Fusco, did you have any questions on those?

MS. FUSCO: I don't think so. And I think that covers everything I had on my list. All set. Just timing wise, what works, is two weeks acceptable?

MR. CSUKA: So that would be, let's say, February 9th?

MS. FUSCO: Sure.

MR. CSUKA: That's a Friday.

MS. FUSCO: Yes, that works for us.

MR. CSUKA: Attorney Fusco, would you like to make any closing remarks?

MS. FUSCO: Sure. And I'll keep them brief in the interest of time. I just want to thank you all again today for taking the time to hear our evidence on this very important CON, and we hope that our testimony has given OHS a better understanding of the situation that's facing

MidState Medical Center right now and why the addition of 16 licensed beds is critical to the hospital's continued ability to provide timely, safe, high quality care for all patients.

It's this agency's charge, as you know, to look at CON applications through the lens of the guidelines and principles set forth in 19a-639 of the general statutes, and so I just thought I'd briefly touch on a few of those criteria here.

First, MidState has shown unequivocally that there is a clear public need for 16 additional beds at the hospital and so these beds would not in any way constitute an unnecessary duplication of services. MidState has undertaken a well reasoned needs assessment that shows the need for substantially more beds than the 16 we're requesting. If you look, there's a range of beds needed for inpatient only and beds needed if you added extended stay patients, and those far exceed on the high and low range the 16 beds we're requesting.

I think we've shown that we have an occupancy rate, even without extended stay patients, of 84 percent which is over the 80 percent target optimal capacity for community

hospitals. And if you do consider extended patients, which you have to practically because they reside in inpatient beds and they utilize inpatient resources, then as Ms. Edwards said, your occupancy rate goes up to 90 percent which starts to become unworkable and is the reason why you have as much ED boarding as you do.

The practice of ED boarding, and remember, these are patients that are in the emergency department for upwards of two to four hours. They are in hallways. They are in chairs. It compromises care not just for them while they're waiting for sort of this more focused and coordinated inpatient care, but also for patients in the ED who are looking to come in and be seen in those very beds and treatment cubicles where these people are. So getting the inpatient beds is going to improve that throughput for sure.

The proposed additional beds are also going to enhance access to high quality and cost effective care for all patients, and that obviously includes Medicaid patients and the uninsured who comprise, I think, about 20 percent of the hospital's payer mix. Again, there are clearly issues accessing services if you have

patients who are boarding in an ED for upwards of four hours, you know, inpatient beds simply aren't available. These patients who need to be admitted need focused, coordinated longitudinal care which they just cannot receive in the emergency department from the emergency department staff that is not an inpatient staff and while those ED clinicians are trying to treat emergency patients.

You've heard everyone testify what we've done to try to improve throughput, to try to reduce length of stay, to try to reduce 30-day readmissions and ensure that patients are not utilizing inpatient beds or resources for any longer than they need to. Every effort is made by this hospital, and all system hospitals, to reduce length of stay and ensure that patients are getting the care they need but not staying in the hospital any longer than they need to. And all of those efforts have helped with this issue and made it so that things aren't completely untenable but still the boarding is happening and the capacity issues are persisting.

Adding licensed bed capacity with everything that's been done to try to correct this problem is really the only way to fix it, right.

Everything else we're doing is just putting a Band-Aid on a problem that's going to continue to get worse. Adding that bed capacity is going to bring immediate and meaningful relief not just to the ED patients but to the admitted patients as well.

We've talked a little bit today in our testimony about how the issues with ED boarding and delayed care for admitted patients raises quality and safety concerns. ED boarding obviously risks adverse outcomes for admitted patients. It's detrimental to the quality of care people are getting in the ED. And when you add these beds, you're going to substantially decrease the amount of time that these people are waiting, you're going to get them where they need to be, and you're going to free up so that they can get the care they need, and you're going to free up the capacity in the ED so that staff can focus on emergency patients.

And getting patients that timely care is also cost effective, right. Delays in care or elopement, one of the witnesses today talked about patients leaving without being seen, whether they were ED patients or admitted patients. These are

patients that need to be seen and there can be, you know, substantial adverse consequences if someone leaves the hospital without being seen, particularly someone who needs to be admitted. And as those consequences play out, those are things that can drive up the cost of care.

And also you heard from a cost perspective Dr. Engelberg testified about physician attrition. It's not easy to replace an ED doc who leaves because the boarding situation is not something that they can handle or an ED nurse, and so you avoid those costs too if you free up that capacity need and let them do their jobs.

If you look, you'll also see that the proposal is consistent with the guiding principles in the Statewide Health Care Facilities and Services Plan which, you know, is an advisory document that includes nonregulatory standards and guidelines. I mean, similar to what you're looking at in decision criteria, it ensures overall access to quality health care, it promotes equitable access to services, it facilitates access to the appropriate level of care in a timely manner is probably the most important, and

it just improves the overall quality of health care services available for state residents.

Staying with the State Health Plan. In evaluating bed need, we used our own bed need model, right, and it's a model that's sensitive to the unique circumstances at MidState. And it accurately reflects the patient population, which we've talked about today, being unique and different than some hospitals, services, staffing, and just the dynamics at MidState that impact their inpatient bed capacity and throughput.

The population based methodology, which I know we're going to get to comment on, is not an appropriate measure of bed need at MidState for reasons that we've discussed. It's a population based model that looks only at New Haven County, and we can tell you that patients come to MidState for the COI and other reasons from other areas of the state. And it doesn't -- you use a weighted ADC from three years prior that covers the COVID years, right, so it's not looking necessarily at the years where you're seen tremendous growth in inpatient utilization of beds.

And I think the biggest issue with that methodology is it doesn't acknowledge that there

are factors other than population growth that can move average daily census, right. It gives you an ADC, and it says if the population is growing the ADC is going to grow proportionate, and that oversimplifies things. There are a number of factors, including sort of the specialization of services we've talked about at MidState that can move and have moved ADC tremendously at MidState over the years.

But if you do look at the other factors listed in the State Health Plan that you can and should consider in bed need CONs, I think all of them are relevant. One of them refers to observation beds. We consider our extended stay similar, right. Extended stay patients are taking up inpatient resources, and they need to be accounted for. The hospital has had I think at least three months over the last 12 months where they've exceeded 80 percent of capacity for a period of more than 30 days, which is one of the factors. The plan also lets you look at particular innovations in health care and the change in care delivery to treat specific diseases and conditions which is exactly what the Connecticut Orthopaedic Institute is. And then

lastly and probably most important, it lets you looks at patient quality and safety concerns which we've talked about a lot.

So we would ask that you consider those other factors, that you consider the alternate bed need model. I know that we've administratively noticed some other CONs where this agency has looked at requests for beds or facilities that were modeled differently than the State Health Plan population based model. And there are different ways of doing this, and the agency has acknowledged that.

And finally, I think in terms of utilization of existing providers, there's sufficient demand in the MidState communities to support the requested beds. Beds are needed to treat patients who choose to obtain their care at MidState who need the specializes services that MidState offers whose treating physicians don't have privileges elsewhere. We talked about that with respect to the COI, like the demand exists at MidState independent of any other hospital's bed capacity. And I think we talked a little bit about HOCC, like another hospital's beds are not the solution to this problem, like those

hospital's licensed beds are intended to treat patients in that community, right, they are allocated for that community. They will be staffed for that community when they can. We need beds to treat the issue at MidState and to care for patients in the MidState community.

So with that, again, I thank you. I think that when you look at all the evidence we have established that we've met all the decision criteria. I think increasing capacity is going to improve throughput. It's going to stabilize the hospital's occupancy rate. It's going to reduce the number of patients boarding in the ED and ensure that all patients have timely access to save health care. And so for those reasons, we'd ask you to approve our CON request. And thank you again for the time today.

EXECUTIVE DIRECTOR GIFFORD: Thank you.

MR. CSUKA: Thank you, Attorney Fusco. I have nothing further.

Dr. Gifford, did you want to make any additional closing remarks?

EXECUTIVE DIRECTOR GIFFORD: No. Thank you for your testimony. We appreciate it. And thanks for your patience.

And thanks to the public for your patience with our technical issues today.

MR. CSUKA: Thank you to the witnesses as well, if they are still over there.

All right. So we'll issue an order with the Late-Files, and we will proceed in the normal course as we normally do.

MS. FUSCO: Thank you so much.

EXECUTIVE DIRECTOR GIFFORD: You're welcome.

MR. CSUKA: Thank you.

(Whereupon, the hearing concluded at 1:24 p.m.)

CERTIFICATE

I hereby certify that the foregoing 120 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken of the Hybrid Hearing held before the Office of Health Strategy in Re: DOCKET NUMBER 23-32657-CON, A HEARING REGARDING MIDSTATE MEDICAL CENTER'S APPLICATION FOR AN INCREASE IN LICENSED BED CAPACITY, which was held before DEIDRE S. GIFFORD, MD, MPH, Executive Director; and DANIEL J. CSUKA, ESQ., LEGAL ADVISOR, on January 25, 2024.

Lisa L. Warner, CSR 061
Court Reporter

I N D E X

WITNESSES: (Sworn on page 21)
JAMES P. CARDON
JEFF A. FINKELSTEIN
DANIEL ENGELBERG
JANETTE EDWARDS

LATE-FILE EXHIBITS