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CERTIFIED
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HEARING IN THE MATTER OF

DOCKET NO. 20-32515-CON

NORWALK HOSPITAL

HELD ON

DECEMBER 14TH, 2022

THE HEARING OFFICER. All right, hello, as everybody was just informed, we are now going to begin this hearing. It is now 2:00 a.m.. My name is Hearing Officer Novi. Good morning, everybody.

The Norwalk Hospital Association d/b/a Norwalk Hospital, the Applicants in this matter, seek a certificate of need for the termination of inpatient psychiatric unit services to Connecticut General Statutes 19A-638(a)5. Specifically, Norwalk Hospital proposes to terminate inpatient psychiatric unit services.

Throughout this proceeding, I will be interchangeably referring to Norwalk Hospital Association as Norwalk Hospital for brevity purposes.

Today is December 14th, 2022. My name is Alicia Novi. Kimberly Martone, the executive director of OHS designated me to serve as as hearing officer for this matter, to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Section 149 of the Public Act No. 21-2, as amended by Public Act No. 22-3, authorizes an

agency to hold a public hearing by means of electronic equipment. In accordance with this legislation, any person who participates orally in an electronic meeting shall make a good-faith effort to state your name and title at the onset of each occasion, that such person participates orally during the uninterrupted dialogue or series of questions and answers.

We will ask all members of the public to mute the device that they are using to access the hearing and silence any additional devices that are around them.

This public hearing is held pursuant to Connecticut General Statutes Section 19A-639(a)2 of the General Statutes and provides that HSP may hold a public hearing with respect to CON application submitted under Chapter 368Z, although this will be a -- although this being a discretionary hearing that is not governed by contested case provisions found under Chapter 54 of the General Statutes, also known as the Connecticut Administrative Procedure Act or UAPA, and the regulations of the Connecticut agencies are Sections 19A9 through 24, and the matter in which OHS will conduct these hearings will be

guided by these statutes and regulations.

The Office of Health Strategy staff is here to assist me in gathering facts related to this application and will be asking the Applicant witnesses questions. I'm going to ask each staff person assisting with questions today to identify themselves with their name, spelling of their last name, and OHS title.

At this point, we'll start with Mr. Lazarus.

MR. LAZARUS: Good morning, Steven Lazarus. I'm the supervisor of the certificate of need program, and my last name is spelled L-a-z-a-r-u-s.

THE HEARING OFFICER: Okay.

MS. RIVAL: Jessica Rival, last name is spelled R-i-v, as in Victor, a-l, and I'm a healthcare analyst.

THE HEARING OFFICER: All right, also present is Maya Capozzi, staff member for our agency, who is assisting with the hearing logistics and will gather the names for public comment.

The certificate of need process is a regulatory process, and as such, the highest level of respect will be accorded to the

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

This hearing will be transcribed and recorded and the video will 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 the Office of Health Strategy are available for review through our certificate of need or CON portal, which is accessible on the Office of Health Strategy's CON web page.

In making my decision, I will consider and make written findings in accordance with Section 19A-639 of the Connecticut General Statutes.

Lastly, as Zoom informed us prior to the start of this meeting, sorry, I wish to point out that by appearing on camera in this virtual hearing, you are consenting to being filmed. If you wish to revoke your request, please, do so at this time.

Okay, so we'll move on from there.

The CON portal contains the prehearing table

of record of this case. At the time of its filing on Tuesday, exhibits were identified in the table from A to N.

The Applicant is here by notice and I'll take administrative notice of the following documents: The Statewide Healthcare Facilities and Services Plan, The Facility and Services Inventory, OHS Acute-care hospital discharge database, and the all-payer claims data -- all-player claims database claims data.

I may also take administrative notice of the hospital reporting system, HRS, financial and utilization data, and also prior OHS decisions, agreed settlements, and determinations that may be relevant to this matter.

Will the Counsel for the Applicants, please, identify yourself for the -- please, unmute yourself and then identify yourself for the record?

ATTORNEY JENSEN: Good morning, Hearing Officer Novi. My name is Ben Jensen, J-e-n-s-e-n, from Robinson & Cole representing the Applicant, Norwalk Hospital.

With me, also, is Attorney Lisa Boyle and Conor Duffy.

THE HEARING OFFICER: Okay, Attorney Jensen, will you taking -- will I be directing all questions to you?

ATTORNEY JENSEN: Yes, please.

THE HEARING OFFICER: All right, thank you.

All right, in addition to the exhibits listed in the table of record, a public comment found may be added and updated from time to time.

Attorney Jensen, do you have any additional exhibits you wish to enter at this time?

ATTORNEY JENSEN: Not at this time, thank you.

THE HEARING OFFICER: All right, we'll proceed in the order established in the agenda for today's hearing.

I would like to advise the Applicants that we may ask questions related to your application that you feel have already been addressed. We will do this for the purpose of ensuring that the public has knowledge of your proposal and for the purpose of clarification. I want to reassure you that we have reviewed your application, the completeness responses and the prefiled testimony, and I will do so again many times before issuing a decision.

As this hearing is being held virtually, we ask that all participants, to the extent possible, should enable the use of video cameras when testifying or commenting during proceedings. All participants should mute their devices and disable their cameras when we go off record or take a break.

Please, be advised that, although we try to shut off the recording -- the hearing recording during breaks, it may continue. If the recording is on, any audio or video not disabled will be accessible to all participants in the hearing.

Public comment taken during the hearing will likely go in order established by OHS during during the regulation registration process. However, I may allow public officials to testify out of order. I or OHS staff will call each individual by name when it is his or her time to speak. Registration for public comment will take place at 2:00 p.m. and is scheduled to start at 3:00 p.m.. If the technical portion of this hearing has not been completed by 3:00 p.m., public comment may be postponed until the technical portion is complete.

The Applicant's witnesses must be available

after public comment as OHS may have follow-up questions after public comment.

All right, so, with this portion, we will go to the Applicant.

Attorney Jensen, would you like to make an opening statement?

ATTORNEY JENSEN: I would, but briefly, before, Hearing Officer Novi, there are two quick issues I wanted to address, housekeeping items.

One, in the table of record, I believe Exhibit N, refers to Applicant's response to prefile and issues. That was actually submitted on December 8th, 2022, which was our deadline. It's listed as December 9th in the table of record. Just for the record, I want to make sure that was clear, that that was timely submitted on December 8th.

THE HEARING OFFICER: Okay, I do note that I did receive a copy on December 8th. I believe that was when the -- let me just ask Ms. Rival: Did you check to make sure it was uploaded on the 9th.

MS. RIVAL: No, I did not.

THE HEARING OFFICER: Okay, all right, we will adjust the date on Exhibit N so that it

reads the 8th.

ATTORNEY JENSEN: Thank you.

The only other item I wanted to address, it sounds like, from your introduction, that the public comment sign-up will begin at 2:00 and the public comment will begin at 3:00. I think one of the notices references a 1:00 sign-up and a 2:00 public comment, so I just wanted confirmation on that.

THE HEARING OFFICER: It will be 2:00 and 3:00. I believe -- I'm looking at the hearing agenda that I issued yesterday and it does have comment public sign-ups starting ago 2:00 p.m. and public comment at 3:00 p.m., so we will go by the agenda that came out yesterday.

ATTORNEY JENSEN: Thank you.

THE HEARING OFFICER: Okay, with that, would you like to go into your opening statement?

ATTORNEY JENSEN: Yes, please, and good morning, Hearing Officer Novi and members of the OHS staff. On behalf of Norwalk Hospital, thank you for the opportunity to present today in support of the hospital's CON application.

This application is about Norwalk Hospital's and its parent, Nuvance Health's, overall goal

for evolving its behavioral healthcare model to increase access to much-needed outpatient care for community members in the service area.

While technically designated as a termination of its inpatient psychiatric unit, this application is really about expanding, not limiting the available behavioral healthcare options to those patients.

Today, we intend to present testimony from four witnesses who will explain in greater detail the hospital's assessment of its historical and current model for delivery of behavioral healthcare and the hospital's plan to reallocate resources from underutilized inpatient services in order to increase access for community members in outpatient settings.

Dr. John Murphy president of Nuvance Health, will testify from a system-wide perspective about the opportunity that Nuvance sees to reinvest in the community and expand its outpatient behavioral care offerings.

Dr, Murphy will also share Nuvance's plan for developing a modern center of excellence for inpatient psychiatric care at Danbury Hospital that will ensure that patients in the need of

hospitalization will continue to have access to top-quality resources.

Peter Cordeau, president of Norwalk Hospital, will then testify about the hospital, itself, and its role in the community. In particular, Mr. Cordeau's testimony will address the growing demand for outpatient behavioral health treatment and how the current offerings in Fairfield County are often limited to only those able and willing to pay in cash, thus depriving a significant portion of the service area for much-needed treatment.

Mr. Cordeau will further testify concerning the existing status of Norwalk Hospital's inpatient psychiatric unit, which has been underutilized and understaffed for years. Those issues cannot be remedied without significant capital improvements that would affect Norwalk Hospital's ability to invest in other programs that would provide greater access to care and value to the community.

Next, Dr. Charles Herrick will tell you about Norwalk Hospital's assessment of its historical and current model for delivery of behavioral healthcare and its determination that

a new approach is needed to meet the public need for outpatient behavioral health services. He will also explain the various projects underway at the hospital to address those concerns, including the development of Intensive Outpatient Services, or IOPs, focused on specialized patient populations as well as plan enhancements to the Norwalk Hospital Emergency Department, including specialized bays for treatment of patients presenting in crisis.

Finally, you will hear from Stephen Merz, a healthcare adviser, that has worked with Norwalk Hospital and Nuvance Health to develop its long-term strategic plan around behavioral services. Mr. Merz will address from an industry perspective how the standard of care for health systems providing behavioral healthcare has evolved and how historical practices of relying on inpatient hospitalization and treatment in the emergency department, leading to suboptimal care and higher costs.

The testimony from these witnesses and the factual evidence presented with the application demonstrates that Norwalk Hospital's application is driven by an increasing patient access to

quality behavioral healthcare and is entirely consistent with OHS's mission. After this evidence is fully submitted and our witness -- and our witnesses address any questions OHS staff may have, we respectfully submit that OHS's statutory criteria have been met and the application should be granted.

Thank you.

THE HEARING OFFICER: All right, thank you, Attorney Jensen.

At this point, would you, please, identify all individuals by name and title who are going to -- I know you did that in your opening, but will you do that again? Will you identify all individuals by name and title who are going to testify on behalf of the application, and if they are not in the office or in the room with you, if you could have them turn on their cameras and unmute themselves.

ATTORNEY JENSEN: Sure. All four are here in the room with me. I'll have to allow them to take my seat. Do you want each one to come up as I introduce them or should I do introductions for all four?

THE HEARING OFFICER: You could do

introductions. You could just state their names and then they can come up and state their name and title, as well, while I swear them in.

ATTORNEY JENSEN: Okay, the first witness is Dr. John Murphy, president and chief executive officer of of Nuvance Health.

THE HEARING OFFICER: Oh, I -- I'm sorry, Attorney Jensen, do you want to just state their names first and then I'll have them each come up? We'll just make it easier for you. I do apologize.

ATTORNEY JENSEN: No problem.

After Dr. Murphy, the next witness is Peter Cordeau, president of Norwalk Hospital.

Next will be Dr. Charles Herrick, chair of the department of psychiatry at Nuvance Health.

Finally, Stephen Merz, chief operating officer of Shepherd Prep Solutions. He has also advised Nuvance Health on long-term strategy around delivery of behaviorial healthcare services.

THE HEARING OFFICER: All right, thank you. If you want to go ahead and exit the camera, we'll have Dr. John Murphy come and state his name. I will swear him in.

DR. MURPHY: Good morning.

THE HEARING OFFICER: Good morning, Dr. Murphy. If you could, please, raise your right hand so I could swear you in?

Actually, if you will just state your name for the record so that we know you are who you say you are.

DR. MURPHY: Yeah, my name is John Murphy.

THE HEARING OFFICER: All right, do you solemnly swear or solemnly and sincerely affirm, as the case may be, that the testimony you are about to provide will be the truth, the whole truth, and nothing but the truth, so help you god or upon penalty of perjury?

DR. MURPHY: I do.

THE HEARING OFFICER: Thank you.

Okay, go ahead, I will have the next person come in.

Hello, if you could, state name for the record, please.

MR. CORDEAU: Yes, my name is Peter Cordeau. I am president of Norwalk Hospital.

THE HEARING OFFICER: Thank you.

Do you solemnly swear or solemnly and sincerely affirm, as the case may be, that the

testimony you are about to provide will be the truth, the whole truth, and nothing but the truth, so help you god or upon penalty of perjury?

MR. CORDEAU: I do.

THE HEARING OFFICER: Thank you. All right.

DR. HERRICK: Good morning, Charles Herrick, chair of Nuvance Health Psychiatry.

THE HEARING OFFICER: All right, if you could, please, raise your right hand so I can administer the oath?

Do you solemnly swear or solemnly and sincerely affirm, as the case may be, that the testimony you are about to provide will be the truth, the whole truth, and nothing but the truth, so help you god or upon penalty of perjury?

DR. HERRICK: I do.

THE HEARING OFFICER: Thank you.

And we'll go to the last one.

MR. MERZ: Good morning, my name is Stephen Merz, chief operating officer of Shepherd Prep Solutions and advisor to Nuvance Health.

THE HEARING OFFICER: All right, if you could, please, raise your right hand so I can

administer the oath?

Do you solemnly swear or solemnly and sincerely affirm, as the case may be, that the testimony you are about to provide will be the truth, the whole truth, and nothing but the truth, so help you god or upon penalty of perjury?

MR. MERZ: I do.

THE HEARING OFFICER: Thank you.

All right, now that we have everybody sworn in, I would like to remind all witnesses that when you give your testimony, please, make sure to state your full name and adopt any written testimony that you have submitted on record prior to testifying.

The Applicants may now proceed with their testimony. I'll ask that all witnesses define any acronyms for the benefit of the public and clarity of the record that they use, okay?

ATTORNEY JENSEN: Thank you.

We first call Dr. John Murphy.

THE HEARING OFFICER: Good morning, Dr. Murphy.

DR. MURPHY: Good morning, Hearing Officer Novi and the staff of the Office of Health

Strategy. Thank you very much for the opportunity to testify today. My name is John Murphy, again, J-o-h-n, M-u-r-p-h-y. I'm the president and chief executive officer of Nuvance Health and of the Applicant in this matter, Norwalk Hospital. I'm also a licensed physician. I'm board-certified by the American Board of Psychiatry and Neurology.

I think my training is relevant in this matter given that, as part of my training, I did significant clinical rotation in psychiatry and had to pass an exam, a written examination of that for my boards.

THE HEARING OFFICER: Thank you, Dr. Murphy, can I interrupt for a quick second? Do you adopt your previously-submitted testimony?

DR. MURPHY: Yes, I do adopt my prefile testimony.

THE HEARING OFFICER: Thank you. Go ahead.

DR. MURPHY: Sure.

Essentially, what I would like to do is describe for you and your staff the vision that the organization has as it relates to behavioral health. I don't think it's a surprise to anyone that the need for behavioral health services has

groan exponentially over the past couple of years and I think the pandemic has certainly intensified that, and we feel it's incumbent upon us to offer an integrated system of care that provides a greater emphasis on outpatient access and outpatient strategies as opposed to the current focus, which I think is more tilted towards provision of inpatient care.

Ultimately, I think that the vision that we're proposing here and this particular application does promote improved access. I do firmly believe that it will improve the quality of care that we provide in that it will provide closer to the onset of the issues, and ultimately, it will provide that care in an environment of lower cost.

Here at Norwalk Hospital, and I think this is true about many inpatient units, the unit, itself, is tired, it's outdated, it's underutilized. In addition to that, if you were to walk through this emergency department, or most emergency departments, they're packed, and they are often packed with patients who do have behaviorial health issues. Some, actually, don't belong in the ED, but because outpatient access

is so limited, they don't know where else to go.

So, typically, the ED can be overloaded, the length of stay is much longer than it could be, and it is -- it can be a chaotic environment and I think the model that we are proposing is really trying to address that in that we get patients the care that they need before they get to the ED or before they have to be admitted to the inpatient unit.

Oftentimes, I think those admissions are regrettable in that if care had been provided earlier, perhaps, they might have been avoided. So I firmly believe that this model will provide patients with care much earlier in the onset of whatever it may be, even if it's simply anxiety or depression or an addiction or suicidal ideations. This model allows us to provide them care much sooner before they have to wait and get frustrated and ultimately go to the ED in crisis. We believe that if we can provide effective care in an outpatient environment by individuals who are particularly-specialized in the provision of outpatient care, again, the quality will be better, the cost will be less, and certainly, access will be greatly improved.

So, in some respects, I realize that the official language in the application is a termination of services and I understand why we had to use that, but perhaps a more apt description is, honestly, it's a relocation of services. We don't for a moment believe that inpatient care is unnecessary in this community, when, in fact, we believe that, you know, in -- we're all where resources are finite. We want to be as efficient as we can be in the application and utilization of those resources. We think the consolidation of the inpatient environment is actually a smart strategy, and the money that is saved -- for instance, we -- if we were the modernize the inpatient unit here at Norwalk, that would cost us in the neighborhood of $18 million.

We already have a plan to modernize and if this application is approved, expands the inpatient unit at Danbury. We believe that, one, essentially, co-located unit in Danbury will provide actually better inpatient care to the residents of the Norwalk Community, while at the same time, the money that would otherwise have been spent on modernizing the inpatient unit will

be better spent by redirecting those funds to the outpatient services that we have described, and essentially, I think those dollars would be repurposed in a number of ways, the first of which is we need more providers of behavioral health services, not only licensed psychiatrists, but also other -- other therapists, other psychologists, other licensed clinical social workers, et cetera, and in addition, we believe that if we can design programs like the Intensive Outpatient Programs, the IOPs, which we have every intention of doing, particularly for those who have dual diagnoses, a mental health diagnosis as well as substance abuse, and adolescents, which are -- the need there has exploded, that we can actually provide better care in those programs in the outpatient environment, and as I said, doing it in a much more cost-effective, convenient, and private environment than in the middle of a chaotic emergency department.

And as you know, we don't have an adolescent unit here on the inpatient side.

So we believe that taking advantage of those finite resources and redeploying them in terms of

getting more providers, creating the IOPs, but in addition, we want to improve the ED experience and environment here at Norwalk for those patients who do, in fact, have a crisis. Then, you know, you will spend a lot of time in crisis intervention situations and we believe that Norwalk ought to have secure, private treatment bays for patients with mental health needs who sometimes will be in the ED longer than somebody who's coming in with chest pain, of abdominal pain, and that we want them to be safe environments, and we will build units that are, in fact, safe and ligature-free, but also, that it offers a degree of privacy. These patients are in crisis and we don't want them traipsing around the ED if they have to use the bathroom, and we have built that into the design of the programs. We want to build, actually, six ED treatment bays for the adult and two for adolescents.

But then, importantly, in addition to the construction and provision of outpatient services, the modernization of the emergency department, we really do think that a larger, more contemporary, more aesthetically-pleasing

inpatient facility in Danbury is also -- will be a major asset for patients in the Norwalk Community who can be effectively and easily transferred, if necessary, up to the Danbury area that will be appropriately-staffed. I think it's easier to staff one more than two units, and I think we will also be able to attract more specialized providers who actually want to provide inpatient care.

Then, lastly, I would like you to look at the proposal in the context of Nuvance Health as a system of care as opposed to this merely being an outpost standalone system for behaviorial healthcare services in the Norwalk community.

Nuvance Health has started a psychiatry residency program. I think we take eight residents a year. It started a couple of years ago. The -- I think it's terrific. I firmly believe that having residency programs does, in fact, improve the clinical care that we provide. It also certainly improves access, and we will have the third-year residents do rotations, again, if this is all approved in the outpatient environment down here. I also think staff enjoys having residency programs and the turnover rates

will decrease.

The second component of the system of care that Nuvance Health provides here that I think is worth mentioning is the technology solutions that we can provide. The pandemic has taught us, as you know, how to use telehealth much more effectively and some of the barriers that existed prior to the pandemic have now disappeared.

So we would very much want to apply fellow psychiatry solutions to this plan of care where we would allow a rapid and effective communications, not only from the outpatient environment to the ED, from the ED to the inpatient unit, but also from Norwalk to Danbury. So, if we think that the use and the sophistication of some of the technologies that we can apply will greatly enhance the program.

And then the last comment I would make is that, and I'm sure you all realize this, but the country needs solutions like this. As I sit here on the tenth anniversary of the Sandy Hook tragedy, we know the cost that society bears by inadequate access to mental health services, particularly amongst young people.

The state and its policies certainly support

and underscore the need for these sorts of contemporary programs. The federal government has recognized this. As a matter of fact, Senator Blumenthal earmarked a couple of million dollars for the construction of these outpatient programs.

So I think this is the right program for today. I think It's well-thought out and it will ultimately serve the community of Norwalk very well, and I would ask that you approve this application.

So thank you very much for your time.

THE HEARING OFFICER: All right, thank you very much, Dr. Murphy.

ATTORNEY JENSEN: Thank you, and next, you'll hear from Peter Cordeau, president of Norwalk Hospital.

THE HEARING OFFICER: Thank you.

Hello, Mr. Cordeau. If you could, please, state your name and state whether you accept your -- whether you adopt any written testimony that was previously submitted, and I just want to remind you that if you have any acronyms, to, please, define them for the benefit of everyone anyone listening in.

MR. CORDEAU: Peter Cordeau, C-o-r-d-e-a-u, and I adopt my prefile testimony.

Good morning, Hearing Officer Novi and the staff of the Office of Health Strategy. Thank you for the opportunity to testify today.

As I stated, my name is Peter Cordeau and I am the president of Norwalk Hospital and the Applicant in this matter. I've also been a registered nurse since 1987 and have served in a variety of roles throughout my career, including as a bedside nurse, a supervisor, a manager, a director, a chief nursing officer, and a president, and I would like to talk about the needs to modernize the provision of care here in Norwalk.

Norwalk Hospital is and will continue to be an essential provider of health services for the greater Norwalk Community. However, we've historically focused behavioral healthcare efforts on delivering inpatient care and treating patients in crisis out of our emergency department.

As mentioned in our application, our unit census consistently is below the number of available beds. However, we still see patients

stuck in our ED without safe treatment options for discharge into the community, which leads to more patients institutionalized, more reliance on facility care versus ambulatory care.

We've reviewed the specific needs and requests of our patient populations and determined that our historical approach is no longer the best way for the hospital to serve its community. I am intimately involved in the community. I sit on the board of the Chamber of Commerce. I have quarterly meetings with the Norwalk Police Department who just actually hired a social worker to a bed within their PD. I have bi-weekly meetings with the health department. I have worked on creating a paid internship program with Norwalk Public Schools, the superintendent of schools, The Carver Center, Brien McMahon High School in order to give access to the underserved children in the Norwalk Community and provide a glimpse of what providing healthcare and what a hospital does.

I also work with the Norwalk Community Center, which is an FQHC, Federally-Qualified Health Clinic, that is right down the street in Norwalk, and our medical residents provide free

clinic care at the Norwalk Community Center, and we also have a pharmacy embedded in the Norwalk Community Center.

I work with Americares free clinics in Norwalk and also created a joint grant with the Norwalk Community College to provide continuing education for nurses who have received their associates degrees so they can receive a bachelors degree paid for by Norwalk Hospital and Norwalk Community College.

Our facility is aging. It requires significant capital investment, as Dr. Murphy mentioned, resources that we believe can more effectively be deployed towards an expansion of access to services that greater meet the need of our community.

So I sit here today to propose to expand access to essential behaviorial health services bu focusing on patient in the community where they live versus in crisis in our ED. This means expanding our programs and services, recruiting new outpatient providers, and establishing specialized outpatient programs while ensuring to continue access to inpatient care through our affiliate, Danbury Hospital, in a to-be-expanded

state-of-the-art unit, or at a facility of the patient's choice, because, certainly, there is patient choice in the determination of where they want to go for inpatient care.

You might ask about the ED, then. Then what happens to the ED? What happens when a patient shows up in crisis in our ED? Well, we have certainly thought of that in the planning. We're strengthening our crisis safeguards in our ED. ED Dr. Murphy mentioned about the behavioral health safe ligature-free beds that we will have in our ED. Those plans have been submitted to DPH and we are awaiting approval before we commence construction on that once those plans are approved. This will allow us to treat patients in the ED and then access to those outpatient facilities will allow us to safely discharge patients in our community.

So what are the benefits of this proposal? Delivery of patient care where those services are needed in the community, creating those safe beds for patients in crisis in the ED, opening a brand-new, beautiful $15,000 square-foot outpatient facility that is scheduled to open in January of '23 that will have IOPs, which stand

for Intensive Outpatient Services, to treat both adults and adolescent, and I think it's very important, as Dr. Murphy mentioned, we don't have an inpatient adolescent unit. So the benefit of this proposal, to be able to provide services to adolescents can't be expressed enough. As adolescents sit in our ED, the reason they are sitting in ore EDs is the lack of services to connect those patients safely and for us to safely discharge patients in our community.

Certainly, this is proposal is based on expanding access, specifically for our underserved populations, Medicaid, indigent, undocumented, by ensuring access regardless of their ability to pay. This will result in reduced wait times, greater provider availability, paired with reduced reliance on the ED for crisis management, which is a higher cost to the patient, the families, and the healthcare system.

We also have resources embedded in our primary care offices to provide behavioral health services at that point of service if we identify someone has a behavioral health need.

This proposal, as Dr. Murphy mentioned,

comes with a lot of community support, support from medical and state levels, Senator Murphy, Blumenthal, Representative Jim Himes, with the earmark that Dr. Murphy had mentioned as well as recent initiatives in Norwalk to reduce the stigma towards behavioral health treatment and to increase awareness.

As I previously mentioned, I am very active in the Norwalk community, including the school system, work force development, local Chamber of Commerce, and I received significant support from community and state coalitions for this proposal and our attempts to expand access and programs in the Norwalk area.

So I urge you to approve this and I believe this is the best -- we'll provide the best access and the best outcomes for the Community of Norwalk.

Thank you.

THE HEARING OFFICER: Thank you very much.

ATTORNEY JENSEN: Thank you, Hearing Officer Novi. The next presenter will be Dr. Charles Herrick.

THE HEARING OFFICER: Good morning, Dr. Herrick. If you could, please, state your name

and begin by stating whether you adopt your prefile testimony.

DR. HERRICK: Certainly, my name is Charles Herrick, H-e-r-r-i-c-k, and I do adopt my pretrial testimony.

THE HEARING OFFICER: Okay.

DR. HERRICK: Good morning, Hearing Officer Novi and the rest of your staff.

I -- instead of reiterating much of what Peter Cordeau and John Murphy have told you, I want to give you some background as a community hospital psychiatrist because I think that can shed some light and understanding of why this project I think is so critical.

So I've been a psychiatrist for 30 years. I've been a community hospital psychiatrist for Danbury for the last going on 25 years, and in -- historically, community hospitals have focused primarily on acute care. They've treated patients in the emergency room, they treated patients on the inpatient setting, and they've let the community essentially care for the patients in an outpatient setting, and it worked very well for many, many years, but with the rising demand for psychiatric services,

particularly in the last 10 years, and then the escalation with Covid, the demand has just dramatically increased, and as a result, many providers who historically have given back to the community, they were in the community and they provided care for patients in the community, have become so swamped, that they don't have to work with insurance companies. They don't have to work with hospitals anymore and they can basically decide on their own which patients they elect to treat and which patients they don't, and so, as a result of that, our hospitals have become inundated with patients for acute care when they could have been managed more effectively on an outpatient basis had they had the access to outpatient services.

So this really represents the radical change for community hospitals insofar as they are now recognizing the fact that, hey, we've got to get into the business of caring for patients in the outpatient setting, and we've also got to make sure that patients from all insurance backgrounds, regardless of what insurance they take, that we will accept them and we will care for them, and this is really critical for the

future of psychiatry because access to care is the single biggest predictor in terms of reducing suicide rates, particularly what we call Connect-to-Care, from inpatient settings to IOP, intensive outpatient settings to regular outpatient settings. So having a whole continuum of care that you have some degree of control over and you're able to manage effectively will improve outcomes, I think, quite dramatically.

Additionally, I think access improves through -- so, right now, what we struggle with primarily are the length of time patients are stuck in the emergency rooms because of lack of ability to access outpatient care or intensive outpatient care or even inpatient care, and then, when they get to the inpatient unit, we have discharge planning challenges that we struggle with and we're getting pressure from insurance companies, hey, this patient is stable. They need to be discharged, but we have a commitment to these patients for a safe discharge plan, but many times, we can't find that safe discharge plan for them because we don't have access to outpatient services. With this plan, hopefully, and I think -- I believe this will improve

dramatically in our community so that we can provide that kind of care that currently is lacking in our community. So that's really one of the major reasons why we're emphasizing this plan.

Now, the inpatient services, while, again, as they -- as they reported, it's a closure of the services in Norwalk. It's an expansion of services for the Norwalk Community because currently, the average volumes in Norwalk are around seven or eight patients, and historically, for the past 15 years, it's hovered around nine or ten because patients can access other hospitals in the service area and they often volunteer to do that, and we have to honor their choice. So they go to Silver Hill, they go to Hall-Brooke, which are freestanding psychiatric hospitals in the community. They can go to Stamford. They can go to Bridgeport. Many ask to go to Yale and a lot of it has to do with the environment of care, and by putting all of our resources into Danbury and expanding an inpatient setting, one of the challenges that all of our units face is providing a comfortable environment because we don't acknowledge -- we, ourselves,

know that the environment that we surround ourselves in has a huge impact on our emotional well-being. We somehow neglect that because we're focused primarily on safety on the inpatient setting, right?

Consolidating our resources in the inpatient setting, what we're table to do now is provide not only a safe environment, but a warm and comfortable setting that will go miles for improving the emotional well-being of the patients we care for.

In addition, it becomes attractive to staff, because as we know, there's been a dramatic decrease in hospital-based staff, and a lot of it can be attributed not just to the overwhelming volumes, but also the environment of care, and by improving the environment of care, people want to come and work here. So we have that available to us now by -- by following through with this plan.

And then, finally, in terms of staffing, what happened in Covid is a lot of people said, "I'm done with working in the hospital. I don't want to work in the hospital," and so many of them transitioned to outpatient care, and even with that, surprisingly, access to care has

continued to be a problem. We want to leverage technology to allow staff to be able to work in a hybrid model that would make it more attractive for people to come here, and more importantly, we want to leverage our educational program because we want to build the next generation of psychiatrists and social workers.

So we have a very extensive educational program that includes graduate medical education, undergraduate medical education, education for licensed social workers, education for nurse practitioners, and by, you know, allocating our resources appropriately, we're able to provide all of that to create the next generation of behavioral health staff who want to work for us, who want to be here because they see the commitment we have towards behavioral health.

So that's pretty much what I have to say at this point.

THE HEARING OFFICER: All right, thank you very much, Dr. Herrick.

ATTORNEY JENSEN: Thank you, Hearing Officer Novi. Next, Stephen Merz. Thank you.

MR. MERZ: Good morning, Hearing Officer Novi. Yes.

THE HEARING OFFICER: If you could, state your name for the record and state whether you adopt your prefile testimony before you begin.

MR. MERZ: Sure.

Good morning. My name is Stephen Merz, S-t-e-p-h-e-n, M-e-r-z. I'm chief operating officer of Shepherd Prep Solutions and I adopt my prefile testimony.

THE HEARING OFFICER:

MR. MERZ: I'm going to speak this morning in follow-up to the testimony provided regarding some of the state and regional factors that are substantially impacting the behaviorial healthcare industry and how this CON application materially addresses several of the undermet needs that have been identified in the application.

I have significant experience in the State of Connecticut, regionally, and nationally, having served in a variety of leadership roles both in Connecticut over the last three decades, as well as in other organizations. The organization I work with now is the largest not-for-profit behaviorial healthcare system, which is based in Baltimore, Maryland and I spent

a significant amount of time with organizations throughout the country that are understanding their needs and how they are responding to the significant lack of resources for behaviorial healthcare.

Significantly, Nuvance Health has spent significant energy and time in planning at the very deliberate strategy to improve access throughout the Nuvance Health network. As part of that planning, they're addressing some of the system changes that have happened in our industry as it has evolved.

One of the major changes is how the industry is tackling patients who are in behavioral crisis, The former system that Dr. Herrick mentioned of community hospitals relying on an outpatient network that was informally organized is no longer sufficient. Patients are increasingly needing to find care and in an absence of organized patient care network, they often in crisis and in the worst time of their care process, overly rely on emergency departments and for-care settings, and care teams at emergency departments are often left with very few choices for which to refer those patients,

and then, typically, admit them to inpatient levels of care, when, typically, the patient may not need that level of care, but that is the only level of care that's available in the community for which patients can be treated in a safe manner.

As a result, healthcare systems are breaking down throughout the country, being overwhelmed, as Dr. Murphy said, with tremendous volumes in their emergency departments. Nuvance Health, through this application with Norwalk Hospital, is taking a bold step and a very innovative step by expanding its access to outpatient services to address this undermet need. Systems are looking to find a more cost-effective way to provide care, including using their precious staff more effectively. Many systems are doing this by investing in ambulatory levels of care.

Why do you need to do that? As Dr. Herrick noted, outpatient care is essential to avoid people from having to go to a higher level of crisis care that can be provided by psychologists, social workers, psychiatrists in the community. Also, clinic services, which are currently provided by Norwalk Hospital, can be

expanded as they have continued to grow at Norwalk Hospital over these last several years. Specialized outpatient treatment, including Intensive Outpatient Services or IOP, are really important. Let me just pause on that a little bit and describe that.

For those who are not aware of what an IOP is, it is basically a structured day treatment program in an outpatient basis, which is more structured than a traditional outpatient practice where you will schedule an appointment with a social worker or a doctor. This is a defined program led by a psychiatrist, founded by a care team which distinct care points and management of care for a patient in an organized fashion in the outpatient community. When under the care of an outpatient team, you're less likely, the data tells us, to seek inpatient hospitalization. You are also able to have a network for which you can avoid access to emergency departments by having the care team in place. Hospitals and health care systems have also relied on Intensive Outpatient Programs as appropriate and safe discharge settings and step-down settings for patients who are discharged from a hospital,

often lessening the length of stay for patients on an patient unit. This care is also much more cost-effective, while an inpatient level of care can cost thousands of dollars a day. An IOP level of care can cost nearly hundreds of dollars a day, often $200 to $300 a day on average nationally, saving the healthcare system tremendous money.

Lastly, in terms of staffing, an Intensive Outpatient Program can take care of more people with less caregivers by employing group therapy approaches. Care teams in the outpatient basis can serve more people with less care team members, which makes it a very effective way to grow care. That's why the federal government continues to support this level of care in the current health systems to develop this resource.

Nuvance Health, in carefully studying the needs of the Norwalk market, quickly identified a lack of care currently in the community, largely driven by a lack of access to insurance and a lack of access to outpatient care.

Through the dual diagnosis population are those co-occurring with mental health and Substance Use Disorder. Adults with those

conditions without private -- the ability to pay for their care with a check, and having managed care coverage or the commercial insurance, often are lacking coverage. So Nuvance had identified that and is growing that with this program.

In addition, as noted before, adolescents are just a tremendously-growing population nationally with need for this care and this application makes tremendous enhancements in that care by offering IOP level of care and with the ability to accept insurance. So families with an adolescent that need care now will have a place to go in the Norwalk community.

Further, Norwalk is recognized in this community as a health professional shortage area designation. That means that it's a federal designation applied to a community in which there's not enough providers in that community to serve the needs by the ratios that the federal governments uses, HRSA. As a mental healthcare shortage region, this informs the community and the planning as part of the reason that state and federal lawmakers supported funding in this federal earmark to grow this program as they had identified this need and has Peter had noted in

his testimony.

The status quo at Norwalk Hospital is underperforming in addressing some of these needs. The inpatient census has been low and trending lower, which is very difficult to provide state-of-the-art care in that type of care model, where it's difficult to support all their resources required upon an inpatient unit, and through the reconfiguration with Danbury Hospital, a much more supportive, caring environment can be provided with more robust supports to provide a better patient care experience.

The investments in the emergency department can substantially improve the patients in crisis. By creating the specialized treatment pods in the emergency department, Norwalk Hospital gives a chance for a patient to stabilize in their crisis, to assess where they are, the care team can observe what's happening with the patient. That will provide increased likelihood that that patient will not just simply be admitted to a hospital, but instead, can stabilize and go to an outpatient level of care and avoid that hospitalization, which is very expensive and ties

up those beds for people who really need them.

So dedication of these outpatient services will add substantially the care needs and the community, bring care that doesn't exist to the community, and the treatment of adolescents and those with Substance Use Disorders and mental healthcare conditions, and provide a very supportive inpatient unit at Danbury Hospital that is more patients and family-centered focus.

In addition, I believe that this is consistent with the national trends. There simply is significant need in our ambulatory space since the 1970s, when the idea of deinstitutionalization came about, and the idea of decreasing beds and increasing community resources, the concept is great, but the application of it is often very difficult, and Nuvance Health at Norwalk Hospital's application is making a great move by expanding these levels of care and providing these necessary services.

Thank you.

THE HEARING OFFICER: Thank you very much.

ATTORNEY JENSEN: Thank you, Hearing Officer Novi.

ATTORNEY JENSEN: Thank you, Hearing Officer

Novi. That concludes the testimony of the witnesses for Norwalk Hospital.

THE HEARING OFFICER: Okay, at this point, do you have any questions for your own witnesses before we take a quick break and have OHS get their questions together?

ATTORNEY JENSEN: No questions.

THE HEARING OFFICER: Okay, so I would like to propose a quick break before we -- I think we're going to have a little bit of a -- some reconfiguration to do just to make sure we can see who we're asking questions to because we have one camera. So I'm going to take --

ATTORNEY JENSEN: I don't have any -- if the questions want to be directed to me, I'm happy to bring up the right person to answer the questions. However you want to proceed, that's fine.

THE HEARING OFFICER: Okay, let's take a quick break so that OHS can get their questions together and then we will come back.

Steve and Jessica, do you think we need 10 minutes or how long do you think we --

MR. LAZARUS: 15 to 20 minutes would be --

THE HEARING OFFICER: 15 to 20, okay.

Okay, so why don't we come back at -- let's come back at 10:15. It is now 9:59. We will take a 15-minute break. If we are a little later, I do apologize, but we will be back as promptly as possible, okay? So we will take a break until 10:15 at this time.

Thank you.

(Recess.)

THE HEARING OFFICER: All right, as you were all just -- you all should have just been informed, we are recording this hearing and by -- and by remaining in this hearing, you are consenting to being recorded. If you choose to not be recorded, you can leave the hearing at this time.

All right, now that we have -- nobody has left, we will go ahead and begin with the second portion of our evidence, which is questioning by OHS.

At this point, I will ask Attorney Jensen if all of his witnesses are still present?

ATTORNEY JENSEN: We are just waiting on one more. He should be back in just one moment,

please.

Thank you.

THE HEARING OFFICER: No problem.

ATTORNEY JENSEN: Thank you, Hearing Officer Novi. Everyone is present.

THE HEARING OFFICER: All right, great.

So, now that everybody is back, I will turn the questioning over to Mr. Lazarus and Ms. Rival.

MS. RIVAL: Thank you.

Good morning, everyone. I just have a series of questions to ask. You know, please, feel free to determine who the correct person is to address the question. I'll leave that up to your discretion.

And I would like to start with: If you could, discuss the community needs assessment that influenced the decision to close Norwalk's inpatient psychiatric unit and refer inpatient services to Danbury Hospital while increasing Intensive Outpatient Services and emergency room services.

ATTORNEY JENSEN: Dr. Murphy will take the first stab at your question. Thank you.

DR. MURPHY: Good morning. I'll take a stab

at your question, if I could, Jessica.

The top priority in the Community Health Needs Assessment is, in fact, the mental health needs of the community. I think, second, was, if memory serves me, was the burden of addiction and substance abuse, and those two have largely topped the -- the ballistics in every health community assessment, and really, that's what we're trying to respond to, is everybody feels this burden, you know, and as I mentioned earlier, I think, you know, our strategy is really designed to -- how do we get to it, to address those issues earlier because by the time they are distressed enough or the issue is severe enough that an inpatient stay is required, while we very much understand that, you know, that's our obligation to provide that inpatient environment, and we will.

You know, my sense is the community expects us to try to intervene earlier, and I think that if they could have, simply, in the Norwalk Community, let's say, local access that's relatively prompt as opposed to immediate access to an inpatient care, and you could choose one of those, they would much prefer, I think, greater

access. The way I look at it, just to put it in perspective, if you could, is I think that particularly younger people, you know, if you look at the data now, I think it's -- it's 30 percent of adolescents are experiencing significant mental health issues largely around anxiety and depression. 9 percent have committed or have considered suicide, and that, we have to figure out how, when stress arises in their lives -- you know, the inpatient units are expensive. They're dated and they are an intense environment where you basically -- I think you revive people. If you look at it as if this is a -- this is a river that people have fallen into, what we're doing is we've got lifeguards on duty, we're pulling them out of the water, that they are near drowning, and we are bringing them back with a great -- great expense, great teams, and we are basically saving their lives.

I think if you look at this -- this river, if you will, of -- of grief and stress and the various challenges we all face, I think that when you think about how this notion of people drowning, we've got to build some fences, and I think that the IOPs, for instance, and some of

these outpatient clinics are those fences to keep people from falling in that river, but more importantly, I think that, as we look further upstream and recognize that, sooner or later, we all fall in that river, that we need to teach people how to swim, and that's going to save more lives and that's where I'd rather spend the money, is teaching people to swim, which means that, whether it's in the school system or in the primary care offices where we imbed behavioral health consultants, at the first symptom, through training and education, how to properly question somebody to see, is there, perhaps, an early issue with substance abuse, is there anxiety and depression, and how you ask it in a way that doesn't stigmatize them. I think those are the swimming lessons. That's where we need to spend the money instead of waiting for them to drown or nearly drown and pull them out.

So I think if you ask the community of Norwalk what is it you want, they want -- they should learn how to swim so that they don't end up needing to be resuscitated six months down the line when they're in acute distress, but that's a long answer to your simple question, and I think

the simple question is: Mental health needs are at the top of the Community Health Needs Assessment and I think our interpretation of that is: The earlier the intervention, the better.

MS. RIVAL: Thank you.

On Page 636 of Dr. Murphy's testimony, Dr. Murphy mentions federal support for the proposal.

Could you, please, describe this federal support and how it was obtained?

ATTORNEY JENSEN: Yes, Dr. Murphy will address that.

DR. MURPHY: Yes, Dr. Murphy can.

That was an earmark. I forget the particular Senate bill that was passed. It was one of the ones that was passed within the last 12 months, and both Senator Blumenthal and Murphy awarded us, Norwalk Hospital, $2.15 million in federal funds and it was largely to support the provision of the outpatient behavioral health services.

MS. RIVAL: Thank you.

Could you describe what expanded emergency room and crisis services would look like and compare that with the current services offered at

Norwalk Hospital?

ATTORNEY JENSEN: Peter Cordeau will address that question. Thank you.

MR. CORDEAU: Hi, good morning.

MS. RIVAL: Good morning.

MR. CORDEAU: Currently, we have two rooms in our emergency department that are ligature risk-free and where we currently hold behavioral health patients. The new model to address, and as I mentioned, the actual plans are with the DPH now for approval, will be to create six rooms that are ligature risk-free, two of which would be for adolescents, so we can separate out any adolescent behavioral health from adults in that area.

Something else we have in the ED is we have the ability, through a combination of in-person and telehealth on the overnight hours, 24-hour/seven days a week access to a behavioral health provider, and that's really important. As Dr. Murphy and others have mentioned, if you get the dual-diagnoses patients, and many come in under the influence, it is nice to be able to get an eval done when the patient is ready and it's an appropriate time for them to get an eval and

if they can go home or get to another level of care.

The other piece of this -- this unit is to have dedicated behavioral health staffing the unit. Traditionally, in emergency departments, emergency department staff are caring for these patients in addition to the routine patient population, taking resources away from the other patients in the ED and often taking other ancillary staff away to sit one-on-one. So it becomes a much more therapeutic environment with case managers, behavioral health nurses to be able to actually provide treatment versus just monitoring somebody in the ED until we can find appropriate, safe discharge plans for those patients, whether that's transfer to a higher-level of care or to an Intensive Outpatient Program.

MS. RIVAL: Great, thank you.

What happens if an adolescent presents at the emergency department currently?

ATTORNEY JENSEN: Dr. Herrick will address that. Thank you.

MS. RIVAL: This is a three-part question, just to give you a heads-up.

THE HEARING OFFICER: Okay.

ATTORNEY JENSEN: Stay close.

DR. HERRICK: That question can be broken down into three parts, as well.

MS. RIVAL: Great.

DR. HERRICK: So patients come in to the emergency room and they are read and received by a triage nurse to determine, you know, what sorts of services they require, and if it's a psychiatric service that is required, then they are placed in one of the ligature-safe rooms and an ED doc then visits with the patient and medically clears the patient, speaks to the family briefly, and then drops a consult for a psychiatrist to see the patient. The patient is seen by, first, a crisis intervention social worker who collects the information and then discusses it with a psychiatrist who then evaluates the patient, talks to the family, obtains collateral information, speaks to outpatient providers, makes a determination what is the best (unintelligible).

MS. RIVAL: Great.

How would that change with the proposal?

DR. HERRICK: So what would change with the

proposal is we would have greater staff access. We, in addition, would have more specialized care. So, for example, they are seen primarily and managed primarily by the ED right now, and instead, what we would do is use behaviorial health-trained staff to care for and provide clearance of the patient in order to be evaluated for, you know, the next level of care. So the staff would be more dedicated towards the behavioral health bay and then the environment of care would be less ED like and more, not only psych-safe, but also just a warmer, friendlier environment.

MS. RIVAL: Thank you.

If there were patients that the emergency room space will allow for, where would they go?

DR. HERRICK: Well, there's always overflow, but the plan, I think you know, when we -- when we evaluated the needs for the hospital, we determined that, really, the sweet spot was six beds and so we're not anticipating a lot of overflow as a result of this plan.

In addition, we will able to move patients out of the ED faster than previously because having Intensive Outpatient Services dedicated to

adolescent care will help with (unintelligible). So, instead of patients waiting in the ED until we can find an appointment for them in the community, we have the appointment for them.

So we're hoping through -- through expanding the number of beds and also reducing the time in which they're in the ED, that should safely care for or manage any overflow issues that we might anticipate

MS. RIVAL: Okay, great, thank you.

On Page 656 of Mr. Cordeau's prefile testimony, it notes that there is a scarcity of psychiatric beds for adolescents and the proposal seeks to expands the availability of services to adolescents.

How does the proposal impact services for adolescents directly?

ATTORNEY JENSEN: Thank you, Mr. Cordeau will address that.

MS. RIVAL: Thank you.

MR. CORDEAU: Currently, Norwalk Hospital, and actually all the facilities within Nuvance, do not have inpatient adolescent beds. So the ability to have an adolescent IOP dramatically changes the care that we could provide for

adolescents.

As Dr. Herrick was mentioning, you know, previously, with an adolescent, or currently, with an adolescent, in the absence of those Intensive Outpatient Programs, the ability for a safe discharge is really delayed significantly until there are openings, and currently, in our -- in our service area, we don't have an adolescent IOP. So we see this as a great opportunity for adolescents, to be able to provide that service out of our ED, and then, you know, direct referral into our own program regardless of ability to pay, which is very important because that's another limiting factor currently in the market that we are in.

MS. RIVAL: Thank you.

Could you describe what expanded Intensive Outpatient Services would look like and compare that with the current services at Norwalk Hospital?

MR. CORDEAU: I'll take the first half and then I'll -- Dr. Herrick, do you want to take the whole thing? Okay.

ATTORNEY JENSEN: Just bear with us more one moment.

MS. RIVAL: Oh, take your time. Thank you.

ATTORNEY JENSEN: Thank you. Dr. Herrick will speak now.

DR. HERRICK: So, currently, we have an adult Intensive Outpatient Program. We do not have an adolescent Intensive Outpatient Program. We do not have a dual-diagnoses Intensive Outpatient Program. Our plan is to institute both of those Intensive Outpatient Programs.

MS. RIVAL: Okay, so would there be a total of two Intensive Outpatient Programs?

MR. CORDEAU: Three, there would continue to be the adult psychiatric IOP, and then, in addition to that, there would be the dual-diagnoses and the adolescent.

MS. RIVAL: Okay.

THE HEARING OFFICER: I'm going to jump in. I have a quick question.

Does the adult IOP program exist currently?

MR. CORDEAU: Yes.

THE HEARING OFFICER: Can you give us a little bit of information on that program?

MR. CORDEAU: So Intensive Outpatient Programs operate about three days a week, three to four hours a day, and it includes both group

and individual therapy and medication management, and it takes referrals from the community as a preventative measure towards hospitalization and also acts as a step-down from our inpatient unit when patients are ready to be discharged, and so it's providing that service currently.

THE HEARING OFFICER: Okay, and I have one follow-up question on that: Do you have a difficult time finding people to staff your current IOP?

MR. CORDEAU: So, yeah, I mean, we've been challenged across the system in finding staff for outpatient, inpatient, and you know, it's been driven primarily by the pandemic. There was a lot of burn-out, particularly in the hospital-based staff, and many of them left. I'm happy to say that we, with the expansion of both our training -- psychiatric training program and also training programs for licensed social workers, and in additional, the staff who left for telepsychiatry want to come back.

So we're in the process of recruiting and employing more staff.

THE HEARING OFFICER: Okay, thank you. Sorry, Ms. Rival. I just wanted to grab those

questions.

MS. RIVAL: No problem.

I did have one additional question: About how many slots are there for patients in each of the IOP programs?

MR. CORDEAU: So, again, that's a staffing-driven measure because the Joint Commission requires -- or Medicare requires a -- a maximum number for -- for staff. So, currently, we are -- I believe the plan is for 12 patients with the idea of expanding it to 16 per IOP.

MS. RIVAL: Okay, great, thank you.

Page 14 of the application notes that sustained low utilization of inpatient psychiatric services at Norwalk Hospital and ongoing staffing challenges for behavioral health clinicians and support staff.

Please, discuss where staff -- where the staff who did not want to relocate to Danbury were offered alternatives.

ATTORNEY JENSEN: Peter Cordeau will address that.

MS. RIVAL: Thank you.

MR. CORDEAU: So I've been I've been present

here since January of '19, and even at that time, you know, the census was capped at about 13 then. You know, you know over the years, it continues to dwindle. At the time -- at the time or in an attempt to keep staff, we've covered retention bonuses to maintain staff here at the hospital. We also have agency nurses, and all -- actually, at the time of the application, all employees were given the opportunity to, you know, apply for any and all positions. Geography plays a big role in that. We didn't lose any from a resignation perspective in that case, and actually have just re-upped a retention bonus for the current staff there on the unit today. We didn't re-up that today; meaning they already have a -- you know, the next series of retention commitments from the -- from the hospital

MS. RIVAL: And how do you plan to staff the new emergency department with the additional positions?

MR. CORDEAU: You know, great question.

Our plan would be, ideally, to, if approved, have the inpatient staff that is currently here relocate down to the ED to provide those services in the ED proper, and then recruit any additional

roles that we would deem necessary. In -- you know, in a holding, for extended holds, certainly, the nurse/patient ratio is going to be less need than in an acute setting. So it certainly is going to depend on the acuity of the patient, but our goal would be to retain the staff that is currently here and just redeploy them to a behavioral health suite in the ED.

MS. RIVAL: Thank you.

Page 14 of the application reads, "New outpatient and emergency programs will enable earlier intervention and increase the access to treatment in a lower-acuity and lower-cost outpatient setting for residents of the service area.

How will you be able to intervene earlier with the proposed new outpatient program?

MR. CORDEAU: I could start with that or Steve or Chuck?

Well, I think, as mentioned in my statements and others, we could intervene earlier because the program actually exists, right? So -- so, by having access to two additional programs, dual-diagnoses and adolescent, we'll have the ability to refer directly out of the ED.

Some of the congestion -- a lot of congestion is due to a lack of services available for us to refer our patients to, primarily due to insurance reasons, no ability to pay, et cetera. So I really do believe that that is -- I do believe that that is really the primary reason for our ability to have access.

The other piece of this is in conjunction with the school systems and others, we have the ability to -- so, for instance, yesterday -- we are looking to work with the local community and the systems to provide those services and the referrals, et cetera.

So it doesn't have to be directed out of the ED. It could be directed out of our primary care offices, referrals from the community, and having that access will certainly provide a much greater early upstream intervention.

ATTORNEY JENSEN: I think Steve Murphy is going to speak to that, as well, please.

MR. MERZ: I'm just going to add on to what Peter had shared.

In addition, Norwalk Hospital undertook a systematic way through a logging process of all the calls and inquiries that were coming in to

the local community and identified that community members seeking care were calling the Intensive Outpatient Services, seeking treatment for levels of care as an alternative to -- if their situation escalated, to emergency departments and higher levels of care.

So there were -- as identified in the certificate of need, the log indicated there were hundreds of calls coming in for levels of care that were not available. The conclusion that we reached and the planning process was that folks that were not able to get access to care when they needed it because the outpatient care wasn't available, were left with very little choice in the community and those would result in the hospitalizations and the use of emergency department that we were trying to avoid in this application.

MR. LAZARUS: This is Steve Lazarus. I just have a follow-up question to that.

You talked about a planning aspect for this proposal. How is the -- other than those phone calls and inquiries, how is the Norwalk community engaged as part of this process?

ATTORNEY JENSEN: I think Peter Cordeau

could speak to the community aspect of it.

MR. LAZARUS: Thank you.

MR. CORDEAU: Hello, again.

We did interview stakeholders, whether it was clergy, the folks from Americares, the federally-qualified health clinic, the schools. We also have a Community Care Team and a group of community participants that participate in the Community Care Team and the planning as it relates to the Community Health Needs Assessment. So we solicit the input from all of those sources as we proposed this plan, and if memory serves me correctly, some letters of support came directly from those groups regarding the plan, including conversations with the PD and the mayor's office, also.

MR. LAZARUS: Was this part of a study for looking at all behavioral health access or services in the Norwalk community, itself, or was this more of regional approach?

ATTORNEY JENSEN: Do you want that?

MR. CORDEAU: I'm going to pass it over to Steve Merz.

MR. MERZ: With respect to the Community Care Team process that Peter noted, that's been

an ongoing effort. Norwalk Hospital is among the first hospitals in the State of Connecticut to launch that process, which would involve these community stakeholders in an effort to provide a more meaningful and coordinated care approach to individuals who otherwise would more frequently than not utilize the emergency department as their primary access point.

So that effort was focused out of Norwalk Hospital and basically grew to include the broader Norwalk community. At a broader level, the planning for this certificate of need approach was based on a regional approach based on Nuvance Health's behavioral healthcare network and trying to leverage the resources of entire health system. As Dr. Murphy noted, having an integrated healthcare system afforded the system the opportunity to look at behavioral healthcare, potentially more strategically how to invest the resources in the most impactful ways.

MR. LAZARUS: Was there sort of a study or a report that was recommended by this community cares team's partnership?

MR. MERZ: I'm not aware of a specific study that was requested.

The information that was outlined in this certificate of need involves studies from various sources, including a national resource known as SG-2 that provides predictive studies of particular volumes. That study, for example, identified that the volume of need and outpatient services was four times greater than the growth rates anticipated in inpatient. So the team thought that's what -- a very needful area for investment.

The community also identifies key stakeholders. The City of Norwalk would place an initiative focused on mental healthcare. There was the previous involvement that Dr. Murphy noted of a federal and state legislative support. There's a clear need in the community for this and that drove a lot of the strategic priority decision-making.

MR. LAZARUS: Okay, how is this -- these -- all this information communicated by the team? You know, was it some sort of a written document? Was it, you know, just word-of-mouth? Was it -- I'm just trying to understand that. How was that information gathered and reviewed?

MR. MERZ: The Community Care Teams are an

ongoing process with regular meetings among the key stakeholders that Peter mentioned. I think, in addition, there were some stakeholder meetings with some of those leaders where this planning process was more deliberately communicated for the purposes of receiving feedback. The individuals involved in that involved the leaders in the emergency department, the Community Care Team, as well as some of the community government relations leaders for Nuvance Health.

MR. LAZARUS: Were there any minutes from these meetings or any kind of documentation?

MR. MERZ: I'm not aware of any specific sets of minutes; however, I know that reports on those meetings were shared orally in our strategic planning process meetings.

MR. CORDEAU: Steve, I think I can add one more thing.

Hi, Peter Cordeau again.

This proposal also was vetted and approved by the Norwalk Hospital board that's represented by every town in our service area. So, as the plan was shared, the information from SG-2 was shared as well as stakeholders in the community, whether it's the federally-qualified health

clinic, Americares, and those local needs were shared. That proposal was approved unanimously by the Norwalk Board to move forward, and there are minutes to that meeting.

MR. LAZARUS: Okay, yeah, and so the SG-2 probably provides some sort of a report that was used to -- that was shared with the board. I guess -- which is more reasonable, of course. I just wondered, with all these activity and -- related to local access, was there any sort of local report that was put together by this local cares team, which it doesn't appear to be?

MR. CORDEAU: I don't have the answer to that --

MR. LAZARUS: Okay.

MR. CORDEAU: -- currently. Dr. Herrick, you know, perhaps will want to talk about the patient migration to Danbury to you just as Steve --

DR. HERRICK: So, you know, I think there are were a variety of sources that came into making this decision and those sources included tapping into the community, just asking them questions as well as utilizing SG-2 -- SG-2 data. So it was -- it was really more of an outreach as

well as personal kind of experiences. You know, we have the deflection log. We have a variety of services in Danbury that patients were accessing from Norwalk and the surrounding community of Norwalk. I, personally -- just by way of example, I have an outpatient practice in Danbury and I routinely get patients coming up from the Norwalk area because they cannot find anyone in that community who will accept their insurance, but Danbury has a number of providers who do accept insurance.

So it's inclusive of a lot of pieces of information, both in terms of sophisticated studies as well as anecdotal information from psychiatrists, from the community, from primary care. I can't tell you how many calls I get regularly from primary care because they can't find -- they can't find access for their patients who have behavioral health problems. This is one of the reasons why we have a primary behavioral clinician in the primary care offices.

MR. LAZARUS: Was an alternative -- other alternatives considered to this, at least initially, such as increasing IOPs while maintaining the inpatient to see the effects of

that on the inpatient service, as we talked about, you know teaching the community to swim?

ATTORNEY JENSEN: Yeah, one second.

Would you repeat question for the witness, please?

MR. LAZARUS: I just wondered if there were any alternatives to this approach such as increasing local IOP services prior to terminating access for inpatient services to the local Norwalk community?

DR. MURPHY: Sure, and again, this is John Murphy. I think, actually, for the past couple of years, that that is the line of thinking that we pursued, particularly since it was -- you know, we merged with Norwalk Hospital, as you know, several years ago. We weren't anxious to do any closures or relocations too soon after that merger largely because I think that the community was sensitive about what's going to happen now?

So we have been trying to run both programs simultaneously. We have been paying, you know, for staffing at both programs, but then we confront the reality that the facility, itself, at least in Norwalk, is over 80 years old. I've

walked through it. I've talked to the docs. It's -- I've seen patients there. It's tired. It needs -- it needs to be modernized. It needs a contemporary and attractive aesthetic. I think patients deserve that and it would cost us 18 million bucks t do that, and you know, if this application is denied, we're going to have to do something along those lines, but we do believe, as I mentioned before, that there is -- we can put those dollars to better use and consolidate the inpatient care in Danbury, modernize it, attract psychiatrists who actually want to exclusively potentially practice in the inpatient environment and offer a variety of specialties.

When the Community Health Needs Assessment came back and said, "Hey, listen, mental health is at the top of the list; substance abuse is right behind it," you know, that gave rise to the dual-diagnoses IOP that, you know, this is a strategy we have to embark on right away because it would serve that population, but I think the more providers we can attract, the more slots we will have, the greater the access will be, and I think that's fine, but again, to that analogy I used before, that's putting a fence further and

further upstream, but I do believe if we are going to intervene earlier and when these stressors first appear, instead of letting patients adopt maladaptive behaviorals is in the primary care office, at the first sign of some sort of psychosocial distress, we provide them with instruction and counseling and coping mechanisms to say, "This is how you swim," because we all face these stressors.

Even in the school system, I think we can -- if those dollars are liberated to be spent differently, is -- we can figure out when kids are showing signs of distress and the school psychologist doesn't know what to do, we make ourselves somehow available, whether through telepsychiatry or some programmatic collaboration, but I think -- and by the way, the running two inpatient programs at the same time, there are ongoing operating losses that we incur every year. I would much prefer, if we can, to take those dollars, put them into one beautiful, contemporary, larger, properly-staffed unit, and put the remainder of those funds back into the community, where I think we will save people from the need to be admitted to an inpatient

psychiatry unit.

MR. LAZARUS: All right, when you reference the facility in Norwalk, you're talking about the hospital?

DR. MURPHY: The inpatient psych unit, the building that it sits in.

MR. LAZARUS: Okay, all right, thank you very much.

Thank you, Ms. Rival. I'm all set.

MS. RIVAL: I just had one other question along that vein: How would patients be notified of the new outpatient treatment programs? How would they become aware of them?

ATTORNEY JENSEN: Dr. Herrick will address that.

MS. RIVAL: Great.

DR. HERRICK: Well, I mean, part of it is what we've already been doing. We have the community stakeholders. They know exactly what our plans are. They're in full support of them. Those conversations happen on a regular basis, as Mr. Cordeau iterated about his relationships with the FQHCs, primary care offices.

So people are going to know and people are going to know pretty quickly when this program is

up and running. I think -- you know, one of the things that I get on a regular basis is from primary care physicians. They're going to want to know this and they're going to be given this information immediately when it becomes available.

So we are going to -- I predict we are going to be inundated with referrals.

MS. RIVAL: Thank you.

The next couple of questions I have relate to cost. Why is there approximately up to a 35 percent increase in the cost of services, inpatient services, between Norwalk and Danbury Hospital? Will patients that are transferred from Norwalk to Danbury be responsible for this increase in service cost? And for reference, I am looking at Page 29 and 30 of the Completeness Letter 1.

ATTORNEY JENSEN: That Page 29, 30, is that the Bates number at the bottom?

MS. RIVAL: This was not Bates-stamped. It just has on the top left -- it's a Word document that they submitted. It's the last two pages of the document.

ATTORNEY JENSEN: I'm just pulling that up.

One moment.

MS. RIVAL: Sure, take your time.

ATTORNEY JENSEN: We have the page up. Could you just repeat the question for us, please?

MS. RIVAL: Sure, absolutely.

Why is there an approximate up to a 35 percent increase in the cost of services between Norwalk and Danbury Hospital and will patients transferred from Norwalk to Danbury be responsible for this increase in cost?

ATTORNEY JENSEN: Thank you. Just one moment, please.

MS. RIVAL: Sure.

ATTORNEY JENSEN: Hearing Officer Novi, we have someone, Shannon Ritchie, from our finance group is probably best equipped to answer that question.

THE HEARING OFFICER: I will go ahead and swear her in, then, and she can answer that.

ATTORNEY JENSEN: All right, thank you.

THE HEARING OFFICER: Hello, Ms. Ritchie. If you could, please, just take your mask off to say your name.

MS. RITCHIE: I am Shannon Ritchie from the

Nuvance finance team.

THE HEARING OFFICER: All right, if you could, please, raise your right hand so I can administer the oath.

Do you solemnly swear or solemnly and sincerely affirm, as the case may be, that the testimony you're about to provide will be the truth, the whole truth, and nothing but the truth so help you god or upon penalty of perjury?

MS. RITCHIE: I do.

THE HEARING OFFICER: Thank you. Go ahead.

MS. RITCHIE: So I think it's important to note that the cost data that was provided in the completeness response is reflective of the patient mix and the acuity of the patient on the the unit.When we adjust that information to reflect, you know, an average cost per day, what we find is that the cost of the Danbury unit is actually less -- less costly than that of Norwalk.

MS. RIVAL: Would you have any evidence to support that since that was not provided to us?

MS. RITCHIE: I do have that evidence, yeah. We have not previously submitted it. I can tell you: We have run those numbers and what I found

is for fiscal year '21, as for an example, the cost of a self-paid patient on Norwalk Hospital on a per-day basis comes out to $1,945 per day and the equivalent cost of a self-pay patient at Danbury Hospital would be $1,696 per day.

MS. RIVAL: Okay.

MR. LAZARUS: Hearing Officer, can we get that as a late file?

THE HEARING OFFICER: Yes, I'm going to ask for that because I'm currently looking at Bates Page 583 through 584 and that does not square with the information provided there.

So I would also like you to explain any differences within Bates Pages 583 through 584 with the information you are now providing. We will mark that as a late file.

MS. RITCHIE: Absolutely.

So the difference is that data that's completed on those Bates pages was reflective of the cost per case, so over the entire length of the admission, and as we know, the acuity and intensity of patients at Danbury and Norwalk was different during those time periods. So what was submitted was that the cost of the self-pay patients at Norwalk Hospital was $9,205 in fiscal

'21 over the cost -- over the length of the admission; whereas that data point for Danbury Hospital specific to self-pay patients over the length of their stay was one thousand -- for -- sorry, I want to make sure I have the reference right. That piece of information, self-pay patient was $11,233.

So the information that I am sharing now is adjusted for a daily cost, cost per day.

THE HEARING OFFICER: Okay, so that will be -- we will be requesting that and any explanations of differences in numbers as a late file.

MS. RITCHIE: Absolutely.

THE HEARING OFFICER: Thank you.

MS. RIVAL: Thank you.

Next, could you describe the referral process between inpatient psychiatric services and outpatient psychiatric services?

THE HEARING OFFICER: I think we missed a question, actually.

MS. RIVAL: You're right, I'm sorry.

THE HEARING OFFICER: No. 10 was missed. If we could go back and cover that one?

MS. RIVAL: Absolutely.

Specific to behavioral healthcare, please, discuss the charity care program and the community benefit program, and this refers to Exhibit A, Page 36, No. 25.

ATTORNEY JENSEN: Just one moment, please. Thank you.

MS. RIVAL: Sure.

THE HEARING OFFICER: Just to clarify, it's Bates Page 45.

ATTORNEY JENSEN: Ms. Rival, Jen Zupcoe is going to speak to that.

Hearing Officer Novi, can we have her sworn in, as well?

THE HEARING OFFICER: Of course.

Hello, ma'am. If you could, state your name, spelling your last name, and your job title for the record.

MS. ZUPCOE: Sure. It's Jennifer Zupcoe, Z-u-p-c-o-e, vice-president of financial operations and analytics.

THE HEARING OFFICER: All right, if you could, please, raise your right hand?

Do you solemnly swear or solemnly and sincerely affirm, as the case may be, that the testimony you are about to provide will be the

truth, the whole truth, and nothing but the truth so help you god or upon penalty of perjury?

MS. ZUPCOE: Yes, I do.

THE HEARING OFFICER: Thank you. Go ahead and put your hand down.

Go ahead.

MS. ZUPCOE: So related to our charity care policy, that charity care policy is a Nuvance Health charity care policy. It applies to all patients, not just behavioral health.

THE HEARING OFFICER: Could you explain more about that? You did say that you had a policy. I'm looking to find out more about what that policy is. It is mentioned, but it says, "It has a general financial assistance policy, which will continually utilize the benefits of uninsured/underinsured individuals to enable access to medically-necessary care without regard for cost."

What does that mean?

MS. ZUPCOE: Yes, so, as you're aware, so hospitals all have charity care policies that we follow very specifically. That is applied consistently, you know, across our patient population to ensure that we are not obviously

charging or seeking reimbursement in excess from those patients that qualify.

We follow the 501R IRS guidelines, also, in terms of how we end up ultimately billing for services. So, overall, those policies would be applicable to patient population who are eligible. We share those charity care policies with the Office of Healthcare Strategy, as well, on an annual basis.

ATTORNEY JENSEN: Just for reference, that was included as Attachment E, I believe, to our application.

THE HEARING OFFICER: Okay.

ATTORNEY JENSEN: Which is Bates No. 57.

THE HEARING OFFICER: 527, Thank you.

MS, RIVAL: Okay, next, some questions that involve access.

Could you, please, describe the referral process between inpatient psychiatric services and outpatient psychiatric services?

ATTORNEY JENSEN: Thank you, Dr. Herrick will address that.

MS. RIVAL: Thank you.

DR. HERRICK: So each inpatient unit has a dedicated licensed clinical social worker who

accessing a variety of resources that are available from the inpatient unit to the outpatient services. Obviously, it depends on the patient. Patients that have a provider already in the community may be referred back if they needed more intensive level of care, they're referred to an Intensive Outpatient Program in the community.

Then, once that is secured, we try and get patients seen within five business days of their discharge, and from the standpoint of having access to outpatient care, that is our goal, and that's typically what happens.

Now, when Covid occured, every, every outpatient system was overwhelmed, and so, trying to access an outpatient appointment during Covid in the last year has been challenging, at best, including those patients with very rich insurance plans, and sometimes it's upwards of two weeks that we're not able to secure an appointment for a patient who is about to be discharged.

So that's really put a lot of pressure on the hospitals, and we've kept patients longer, or actually, our length of stay has increased in the past year, I think, primarily as a result of lack

of access.

MS. RIVAL: Thank you.

MR. LAZARUS: Ms. Rival, one second.

I just want to go back and follow-up on the question you had about the charity care and community benefits. I know we talked about the charity care.

Regarding the community benefits, can the Applicants talk a little bit about what the community benefits have been, say, for example, in the last year or so in the Norwalk Community related to behavioral health specifically?

DR. HERRICK: Well, before -- I mean, I think the question has multiple answers, but I think one of the biggest community benefits that Norwalk Hospital has provided is the Community Care Team, and this focuses on the highest-risk patients in our community who typically have three problems: They have a Substance Use Disorder, they have a psychiatric disorder, and they have a major medical condition, and as a result of that, they often seek their care in emergency rooms primarily, and those patients are provided the opportunity to sign on with a Community Care Team and it's a whole list of

resources in the community that comes together on a weekly basis and meets and discusses what the patients needs are.

Largely, there are social determinants of health, whether it be housing, access to healthcare, medical care, psychiatric care, substance abuse care, whatever resources are available that the community has access to are offered to the patient, including even case management services where they will physically help the patient get to their appointments on time.

So that's, I think, just one aspect of the question you asked in terms of how we address community benefit.

MR. LAZARUS: For the Community Care Team, is there some sort of documentation you might be able to provide us that talks about what its function is and what's the make-up of the Community Care Team?

DR. HERRICK: Sure. We can get that to you. I don't know if it was included in that -- in the documentation, but yeah, absolutely, we can get it to you.

MR. LAZARUS: Thank you.

DR. HERRICK: Norwalk want to expand into New York, as well.

MR. LAZARUS: Yes, anything you can provide to document that and provide some explanation with that, that would be helpful.

THE HEARING OFFICER: All right, I will order that as a second late file would be information on the Community Care Team.

MR. LAZARUS: Thank you, Ms. Rival. I'm all set. Back to you.

MS. RIVAL: Great.

The first completeness response shows a table on Page 7 with the average daily census for the inpatient psychiatric units at both Norwalk and Danbury for the past five fiscal years.

What are your expansion plans for the Danbury facility that will accommodate all of the Norwalk patients?

ATTORNEY JENSEN: Dr. Herrick will address that.

MS. RIVAL: Thank you.

DR. HERRICK: So I'm looking at Page 7 of 30 that include some demographics and numbers, but historically, between the two units, the average daily census has been running in the low to

mid-20s, and the plan is that we will have a 34-bed unit and that will include probably 12 doubles and -- and singles, and the planning, really, it involved both what we could do for the Norwalk Community based on the historical numbers as well as expanding bed capacity, as well, for the network in general, and in addition, it leveraged our experience for Covid so that we can operate in times of a pandemic. Single beds and -- meet the needs of the community with just converting everything to single, as well as the opportunity to expand and turn the single beds into double beds if we need to, if we exceed capacity. So it offers us a great deal of flexibility in our ability to manage patients.

Also, the way the unit will be configured is to potentially create areas of specialization so that patients with a particular condition can be separated somewhat from other patients in order to improve care. So it's a very thoughtful design that includes a lot of possible considerations for the future that we can adapt to.

MS. RIVAL: Thank you.

Page 672 of Dr. Charles Herrick's prefile

testimony notes that one of the strategies for staff improvement in Nuvance's -- is Nuvance's psychiatric residency program. Has this strategy been significantly tested or used at any of the other Nuvance facilities?

DR. HERRICK: Well, our Nuvance psychiatric residency program is rather unique to the network, whereas most of the residency programs are specific to a particular hospital. Our program crosses the network and our residents are placed in several hospitals, both on the New York and Connecticut side, including Sharon, Danbury and Norwalk.

Now, we haven't yet -- we haven't yet graduated a class. We don't graduate our first class until '24, but we anticipate that, in general, most residency training programs are able to retain about 40 percent of their graduates. If we even retain 25 percent of our graduates, we will have considered it an enormous success because we are a designated professional shortage area in mental health in both Danbury and Norwalk.

In addition, we are partnering with a federally-qualified health agency in Danbury that

is starting a residency training program. So we are collaborating with them and we're hopeful that they will have four residents per year, as well. So we're very positive about our ability to staff our plans, both in the Outpatient Intensive Outpatient and inpatient setting.

MS. RIVAL: Do you have any indicators that you can draw from the first graduating class of 2024?

DR. HERRICK: So "indicators" in terms of just conversations with them individually in terms of what they want to do in -- I'm not sure I understand the question about "indicators."

THE HEARING OFFICER: I can rephrase for you.

MS. RIVAL: Thank you.

THE HEARING OFFICER: Just as a generality, do you have any -- what -- even if it's anecdotal, any evidence that the first graduating class may meet that 25 percent maintain -- that stay with the system.

DR. HERRICK: Well, one of the things that we've emphasized in recruiting candidates is a real commitment to community psychiatry and to the geographical area. So we actually are quite

selective in the candidates that we want, and we look for whether they grew up in the area, whether they have family in the area, in some way, how are they committed to the -- of the western Connecticut area, when we choose these people.

So I'm very confident these are -- these are candidates who are committed to the western Connecticut area and want to stay.

THE HEARING OFFICER: Okay.

Ms. Rival, any follow-up questions?

MS. RIVAL: Nope, thank you.

Page 782 of Stephen Merz's prefile testimony speaks to the lack of accessible community providers of outpatient care and the effect on the emergency department and inpatient services. How will this proposal improve access to community providers?

ATTORNEY JENSEN: Stephen Merz will address that. Thank you.

MR. MERZ: Well, first off, the ambulatory program expansion that's proposed in the certificate of need application will be community programs and community providers, although hospital-based. So one way is to obviously add

to the portfolio of community-based services directly through the creation and expansion of those programs.

The second part is that in -- when -- by establishing an intensive outpatient level of care, there is an increased likelihood that community providers will be able to accept patients because they have been -- they have been stepped-down and they are stable in a community outpatient setting, so they're more likely to be accepted into the practice or the practices that exist.

I think the third thing is that Norwalk Hospital already has a -- a rich set of outpatient and ambulatory behavioral healthcare programs, some supported by DMHAS, the Department of Mental Health and Addiction Services of the state that are provided in the local community, and by having the Intensive Outpatient Programs and the other outpatient programs in Norwalk Hospital, that because it's basically going to enrich the fabric of community providers by serving Norwalk.

THE HEARING OFFICER: I have a follow-up question to that.

How will you find these community providers and what efforts will you have to get more community providers for the patients that come out of your -- your IOPs and through your ED?

ATTORNEY JENSEN: Dr. Herrick will speak to that.

DR. HERRICK: So, first of all, we have a dedicated recruitment team that is always out there attending conferences, soliciting interest, and always outreaching to find qualified staff for the public things that we have.

So, we have that, but more importantly, as I mentioned previously about our psychiatry residency program, I think this network has really learned that the best way to recruit/retain staff is internally. So we have really pushed hard to establish educational programs in a variety of areas including social work, PAs, APRNs, undergraduate medical education. The department of psychiatry alone has five medical schools that we are a clinical clerkship for.

So, historically, we have not been as big on education, but with the network and our understanding of staff shortages across all

areas, not just behaviorial health, we recognize that providing an educational foundation internally is the key to being able to recruit and retain qualified staff.

So we are very optimistic. We partnered with many of the schools in the surrounding area, including Sacred Heart University.

So we feel very strongly that we'll be able to staff to our needs

MS. RIVAL: The next question I have speaks to transportation.

There are 43 miles between Norwalk Hospital and Danbury Hospital. How will patients be transported between the two facilities?

ATTORNEY JENSEN: Thank you. Mr. Cordeau will speak to that.

MS. RIVAL: Thank you.

MR. CORDEAU: Hello.

Transportation between Norwalk and Danbury would occur if a patient required an inpatient level of care. Because it's a higher level of care, those patients would be transferred via ambulance.

MS. RIVAL: Okay, what happens when a Norwalk area patient is discharged from the

Danbury inpatient unit? How do they get home?

MR. CORDEAU: Yeah, so, from the time of admission, case managers work with both patients to families on an appropriate discharge plan that includes transportation.

So there are various ways that our case management team does that. One would be public transportation, which happens to be free, between Danbury and Norwalk currently. The other is family, and then, lastly, if that is not available and all those options are exhausted, we provide a transportation voucher and pay for the transport for that patient to be transferred back to their caregiver safely.

MS. RIVAL: Okay, and you mentioned the case manager, but how will the transfer centers coordinate these services?

MR. CORDEAU: Well, from an admission perspective, from Norwalk to Danbury, if that's the question, so we -- our psychiatrists at both Norwalk and Danbury have admitting privileges to both, so we're not transferring ED to ED. So, if Dr. Herrick, for instance, deems that I needed an inpatient bed, then he can call -- well, he can admit me directly to a Danbury bed. He -- you

know, he's the attending physician doing that admission. So that transportation is arranged per the ED. That patient goes directly to the inpatient unit at Danbury Hospital.

THE HEARING OFFICER: I have a follow-up question to this.

Norwalk -- Norwalk's Wheel Transit Hub to Danbury Hospital is currently two hours and 22 minutes. If a -- if a patient whose family is in Norwalk wanted to visit them in Danbury, it would take them almost five hours roundtrip to travel to and from Danbury.

Is there any sort of -- how would a family member actively participate in a -- in a patient's -- in patient rehab in -- or inpatient treatment if they could not get there within two hours?

MR. CORDEAU: Yeah, I'm not familiar with that reference.

ATTORNEY JENSEN: Hearing Officer Novi, are you referring to a particular reference in the application?

THE HEARING OFFICER: No, no, it's -- it's quite a drive. I mean, even Google -- if you were to drive, it would take you almost an hour

to get there. If you didn't have transportation, it could be quite likely, especially, you know, on a snow day or something, for somebody without transportation and somebody who may be could not afford to have their own transportation, how would you help family members actively participate in inpatient treatment at the Danbury Hospital from Norwalk?

MR. CORDEAU: Okay, so, based on the information provided here, it's approximately a 43-minute ride, 22.4r miles from Norwalk to Danbury on Google Maps.

So there's two public transportation options. Certainly, by train, probably less ideal, and by bus, publicly-available schedules indicate that the travel time is approximately an hour, and the bus schedules, I believe, are attached in our application, and if that's a misstatement, we can provide them.

Dr. Herrick is going to comment.

DR. HERRICK: You know, family meetings have -- have been a critical aspect of providing quality behavioral healthcare at the inpatient setting. So we are exquisitely sensitive to the fact that they have to travel and we will do

everything in our power to ensure they get out there in a timely manner, including vouchers, if we need to do that, but more importantly, one of the lessons that we learned that Dr. Murphy mentioned earlier is using technology, and so during Covid, we actually conducted family meetings via Zoom like we are doing right now, and we found it an incredibly effective, and we continue to provide that service to families and routinely run family meetings using Zoom services, and you know, the feedback from families has been largely positive.

So, you know between our efforts to support them in getting up there physically and leveraging technology, we do have an opportunity to really build out a very nice (unintelligible) telepsych program on the unit.

So we're -- we're very optimistic that this is not going to be any sort of barrier to having an effective family meeting for discharge planning and regular routine care.

THE HEARING OFFICER: Okay.

MS. RIVAL: Thank you.

And the last few questions that I have refer to quality.

If you could, please, describe any care coordination services to ensure patients remain connected to services from intake to discharge within and among the facilities?

DR. HERRICK: Again, you know, it's interesting that one of the things that we found when we had originally -- for example, with Danbury and IOPs, so what we found was that when patients had the opportunity to visit the IOP before discharge, our rates of Connect-to-Care increased dramatically.

We learned from that that by having a face to a name is a very powerful opportunity for patients to feel connected and to want to show up for those appointments. So, again, our opportunity this time is to leverage technology in order to put a face with the name so that we can ensure there's Connect-to-Care in a timely manner.

Secondly, by having access, obviously, if there's an appointment a week away, it's less likely that a patient is going to show up for their appointment then if their appointment is a day away or two days away. So I think by having greater access as well as leveraging technology,

we're very -- we're very positive that this Connect-to-Care is really going to improve. It's something that the entire state has been struggling with.

In fact, Beacon Options, which is a Medicaid healthcare provider, has found that that is a very important factor. In most hospitals, Connect-to-Care is about a month. So we're hoping to -- and we historically have been better than that. We want to -- that's really, I think, the single-most important quality metric for behavioral health we can monitor.

MS. RIVAL: Thank you.

Page 637 of the prefile responses by Dr. Murphy states that the intent of the proposal is to become a regional focal point for mental health treatment and that quality will be enhanced by Nuvance's network-wide performance standards and care coordination efforts.

Could you describe these standards and how quality is measured?

ATTORNEY JENSEN: Was that for Dr. Murphy or for --

DR. HERRICK: So, I mean, we have a number of metrics. First and foremost, as I had

mentioned as Connect-to-Care and I think that, as I said, is the single-most important quality of metric available, but also, we do look at variations in care across physicians as well as between hospitals. We look at length of stay. We look at discharge planning. We look at family meetings in order to ensure that the elements of care are maintained throughout this system, and that's -- you know, when Dr. Murphy writes about that by consolidating inpatient services under one roof, we have a much better ability to ensure that there's a standardizational quality across providers than between what is (unintelligible) hospitals.

So that's one of the major reasons for consolidating inpatient care, is to improve that quality.

MS. RIVAL: Excuse me.

DR. HERRICK: Gesundheit.

MS. RIVAL: Thank you.

DR. HERRICK: -- to improve that quality.

So those are some of the measures, and you know, in behavioral health, you know, ultimately, the single biggest quality measure, obviously, we've been seeing across the country are suicide

rates, and our hope is that, through these processes, because the studies have demonstrated access to care really is the biggest player in reducing suicide rates, that that is going to be the single most important factor in helping our community.

THE HEARING OFFICER: To follow up on your discharge clinic, would you tell us a little bit about what discharge from Danbury Hospital to an IOP in Norwalk might look like?

DR. HERRICK: Sure.

So all of our clinical social workers, whether they work in Norwalk or they work in Danbury, have access to the same resources, and our physicians, because we have a single electronic medical record across, the hospitals have access to both inpatient and outpatient records, we can -- we can task one another. We're able to immediately obtain an appointment for our patients and we know each other personally and professionally, and so it just moves the entire process of discharging a patient, whether they're in Danbury or Norwalk, to the outpatient services in Norwalk.

MS. RIVAL: And my final question: What if

a patient of the emergency department does not want to go to Danbury and wants to remain in the Norwalk Community? How would you address that situation?

DR. HERRICK: So we address it every day, in fact, and we always give the patients choice. Where would you like to go? And we give them options, and you know, as I mentioned earlier, there are a number of hospitals in the surrounding area that, sometimes, they prefer to go to, and sometimes we have no choice because either there are no beds available, or if they're an adolescent, we have to find an adolescent facility.

So we're not going to stop doing that just because we have this plan in place.

MS. RIVAL: That concludes my questions.

Hearing Officer Novi or Mr. Lazarus, I don't know if you have any additional?

THE HEARING OFFICER: Steve, do you have any? I have one, but --

MR. LAZARUS: I'm all set. Go ahead.

THE HEARING OFFICER: Okay, my -- my final question is: Why does moving from an inpatient to outpatient-focused care improve access to

low-income members or the indigent population of Norwalk?

DR. HERRICK: I think it's not just a matter of expanding the number of services that we offer in the outpatient side, including the Intensive Outpatient Programs, but one of the things that we haven't addressed up to this point is we're also planning on expanding outpatient services, general outpatient services, and because we're a clinic, we take all insurances, and one of the challenges that I think many of the DMHAS-sponsored outpatient clinics have struggled with recently have been staffing shortages as well as increased volumes. So we are going to accept those patients. We have every intention of accepting any patient regardless of the insurance plan and getting them in in a timely manner, evaluating them, determining what level of care they need, and providing treatment to them.

So, you know, we're -- we remain dedicated to treating the underserved, and I think that's something that is important to emphasize, that there's no one in the community, or very few people in the community, who accept Medicaid and

fewer and fewer people in the community are even accepting commercial insurance because they don't have to, and if they do accept a commercial payer, it's only because it's -- it pays well and it's administratively-easy, perhaps. That's created a tremendous burden on patients in terms of gaining access. So, as a result, they often come to the emergency room. They're stigmatized in the emergency room, and they end up on an inpatient unit, even if it wasn't necessarily an appropriate level of care, but it's the best level of care available to them at that point in time. Our hope is to avoid that so that these Medicaid patients can be treated with respect in in an outpatient setting in the community they desire.

THE HEARING OFFICER: All right, thank you very much.

All right, that is it for the questions from OHS. At this point, I will ask your attorney if he has any follow-up questions based on the questions that we posed to the Applicants?

ATTORNEY JENSEN: Thank you, Hearing Officer Novi. No further questions.

THE HEARING OFFICER: All right, so, at this

point, we are -- we are set for the morning section. We will hold closing argument and comments after the public comments -- sorry, we will do -- closing arguments will be heard after public comment. Sign-up starts at 2:00 p.m. Public comment will start at 3:00 p.m., if there is any, and then, after that, and if we don't have any, we will move to closing arguments at that time. If we do have them, we'll hear those first, then go to closing arguments.

It is now 11:39 a.m. and we will go to a break. I will check back at 2:00 to see if public comment has started. Otherwise, we will begin at 3:00 p.m..

Thank you, everybody, and have a nice break.

ATTORNEY JENSEN: Thank you.

(Recess.)

THE HEARING OFFICER: Hello, everybody, I just want to remind everybody -- welcome back. We will be having public sign-up from 2:00 to 3:00 p.m. and public comments from -- at -- begin at 3:00 p.m.. We will call the names of those who have signed up to speak in the order in which

they have registered.

We would like to remind everybody that if we have any large amount of people, I am allowed to limit your participation to three minutes; however, let's see how many people we have first.

Also, I do strongly encourage everybody listening to submit written comments to OHS by email or by mail no later than one week, that's seven calendar days, from today. Our contact information is on the Website and on the public information sheet, which was shown at the beginning of the hearing and again, my -- making public comments, and as stated previously in this recording, you are -- you're speaking today is either verbally without camera or with a camera is consent to being recorded. So your commons will be recorded and contained within our -- within our transcripts.

All right, and with that, I will go ahead and allow anybody who needs to register for public comment to register with Maya Capozzi. She will be keeping track. She will be keeping a list of individuals who have submitted their names and then she will give that to me when she is done.

So we will reconvene sat 3:00 p.m. for public comments. At that time -- if you would like to speak at that time, please, make sure you have registered prior to that.

Any other comments from the attorneys or the analysts?

ATTORNEY JENSEN: No, thank you.

THE HEARING OFFICER: All right, and I see nothing from Steve. All right everybody, well be -- reconvene at 3:00 p.m.. Thank you.

(Recess.)

THE HEARING OFFICER: As you were just informed by the Zoom -- by the Zoom voice, we are being -- we are recording these -- this hearing and your remaining in this hearing is your consent to being recorded. If you have any issues of being recorded, you may now leave the hearing at this time.

All right, welcome back. For those of you just joining us, this is the second portion of today's hearing concerning CON application filed by the Norwalk Hospital Association d/b/a Norwalk Hospital, Docket No. 22-32513CON -- CON. We

have -- we had the technical portion this morning. We will be calling the names of those who signed up to speak in the order in which they were registered. Afterwards, I will ask if there's anyone else present who wishes to be heard.

Speaking time is typically limited to three minutes. Since there are few registered, I will allow you to go beyond that. However, I do ask that you keep your comments fairly brief in nature.

Additionally, we strongly encourage you and anyone else listening to submit written comments to OHS by e-mail or mail no later than one week, that's seven days, from today, in which that would be December 21st. Our contact information is on our Website and on the public information sheet in which you were -- or sorry, on the hearing slide, which we provided at the beginning of the hearing. Thank you for taking the time to be here today and for your cooperation.

We are ready to hear statements from the public.

Ms. Capozzi from our office has been kind enough to keep a list of individuals who have

submitted their names, so I may need her assistance with this.

Anyone speaking, I'll remind you to turn on your video and to turn your video and microphone on.

MS. CAPOZZI: You have to go away now.

THE HEARING OFFICER: All right, the Applicants will have an opportunity to respond to your comments and your written submission in writing. Given the nature of your submission and -- sorry, and we'll have a chance to respond to your -- to your submissions in writing.

At the point, Ms. Capozzi, the first person, please?

MS. CAPOZZI: Diane Cece.

THE HEARING OFFICER: Hello, Ms. Cece. If you could, please, unmute yourself and turn on your camera, if possible.

MS. CECE: Good afternoon.

THE HEARING OFFICER: Hello, if you could, please, state your name for the record, please.

MS. CECE: Okay, my name is Diane Cece, C-e-c-e, and it's Olmstead Place in Norwalk, Connecticut.

Ms. Capozzi, it would be Cece or Cece in

Italy, so that was close, thank you.

I'm -- thank you, members of the board. I'm a little bit more used to speaking at public hearings within my own community, so I'm a bit nervous. I hope you bear with me. If I'm breaking any rules, just jump in and stop me here.

And I will say that I read through 99 percent of the documents associated with this application, and I am working today, but I followed as much as I could of the morning session to hear the Applicants, but subsequently had to take a whole bunch of kind of pick and scratch notes. So I did ask before and I am going to follow up, I believe, with a written comment.

I'm not sure how many people there are here to speak that are just regular residents. I'm not representing any organization or group. I'm just here as a resident of Norwalk and I wanted to open up by saying that I suspect if there's not a whole lot of folks, that it may be due to what I consider a severe lack of public notice about this application. In general, I think Nuvance or Norwalk Hospital had only posted the bare minimum, which was a small, you know,

two-font legal notice a year or so ago, and also, when OHS had published for the public hearing recently, the legal notice, I brought this to the attention, I think, to one of your attorneys, that that notice only describes the proposal as a termination of an inpatient service, and there's nothing in that document that would lead anyone in Norwalk to know that this is related to psychiatric and behavioral and mental health, and I think there's a disservice and I hope that can be addressed in the future.

I wanted to speak to you today because what I have read of this, and I know about it, and after listening to the testimony, I'm speaking to you today in opposition of granting this application for a whole host of reasons. I'll rattle these off as quickly as I can, and if you could, give me a warning here on the time.

No. 1, I believe that this application really serves only to benefit Nuvance and Norwalk Hospital. I don't see any benefit to our community, and contrary, I believe it provides an extraordinary burden on the patients who are served by -- in inpatient services, their families, their caregivers, and their current

professional and social workers who are within Norwalk.

I mean, it's easy for Nuvance to say, "It's just up the road a piece in Danbury," but to one of your Commissioner's points, that would be 45 to 60-minute commute via car and as much as two to two-and-a-half hours versus other types of transit, and I don't see -- I think that they should provide a great benefit to the residents and I'm not seeing that here.

You also heard them spoke(sic) about and in their document, they refer the IOP, Intensive Outpatient Services, that this would then actually increase while decreasing the inpatient beds, and I don't see that's being mutually-exclusive. I'm not seeing anything or reading anything where I understand where they couldn't make an effort along with the community to have a massive increase in IOP within the community and community-based services and still maintain the level of inpatient beds that they have, honestly, if not even increase them.

They talk about the ability to safeguard places here and the lack of services and I'm not really clear on the distinction of what Danbury

would offer, and if why there's going to be additional community services, that couldn't go hands-in-hand with the beds.

When they talk about moving these services, in the same breath, they also talk about low utilization and shortage of staff, and in my mind, if the utilization is that low, I think they said seven daily beds, daily census, if I'm reading that correctly and if it is that low, then why it is a burden on Nuvance to keep that service, increase the staff, which, in fact, they said they're spending an extraordinary amount of money on in terms of psychiatric interns and additional staff.

So I -- I'm just not, you know, getting that connect there. The -- I believe that one of your staff asked a question about the 35 percent increase in cost in Danbury versus Norwalk Hospital, and the lady who answered that, I'm not clear on that answer. I hope that you'll go back and look at the additional documents that you asked her to send because she was comparing something called the daily cost versus what the average day would be, and in that long-term average day number, it was significantly higher

than what Norwalk Hospital would bear -- Norwalk Hospital would charge and then a patient would be responsible for.

The -- in terms of being able to -- I think they talked to you about doing some investment pods that will be in the emergency room and having them be something that would be of more comfort and privacy in the future. Again, I don't think that's mutually-exclusive, the in-bed services, and they said, though, that the facility is over 80 years old and needs modernization and aesthetics and it would cost them $18 million in costs, and quite simply, I have no sympathy for that as a resident here when we have been deluged with publicity and marketing and public relations materials on Norwalk Hospital about to spend $250 to $300 million on a massive expansion of a new wing.

You also asked a question on how the community engagement information was gathered and considered and they spoke to you about key stakeholders, clergy, Norwalk Police Department, Mayor Rilling, the schools, et cetera, but I would say I'm a very engaged citizen in Norwalk and I would know nothing about this unless I'm

one of the three kind of losers in our town that read legal notices every single day. I would have no way of knowing that and I suspect that our community at large or residents know nothing about it, either.

The federal support that they mentioned that was supported by Senator Blumenthal and Murphy, the two point million, I think, was something that was already in the works regardless of this, so I'm not sure why they're linking that to a decision to move the services.

I do want to know, with the lack of communication so far, how the community would be made aware should you approve these changes.

And I know that I'm over my time and I -- so I just want to say, for those reasons, I'm -- after reading everything and listening today, I'm glad you're keeping this hearing open because what's happened now is I feel like I have even more questions than answers than I did before and so -- and all the questions that you asked were just so relevant and I just think asked in a manner that looks like you're trying to protect our community - both communities, actually - and I want to be -- because I was working, I wanted,

you know, to be able to have an opportunity to actually replay this entire session and then I hope to be able to submit some comments to you in writing because as soon as I hang up here, I'm going to think of the five other things I really wanted you all to know and consider, and I thank you for your time. I know I went over. I appreciate it.

THE HEARING OFFICER: All right, thank you. Thank you very much. I will go ahead and ask you to remute yourself, Ms. Cece.

Ms. Capozzi, the second person?

MS. CAPOZZI: I think it's Richard Maiberger.

THE HEARING OFFICER: All right, Mr. Maiberger, if you could, go ahead and unmute yourself and turn your camera on and then state your name and address for the record, please.

MR. MAIBERGER: Hi, my name is Richard Maiberger and I am a retired psychiatrist.

THE HEARING OFFICER: Okay, go ahead with your statement.

MR. MAIBERGER: I was a director of inpatient psychiatry at Norwalk Hospital from -- for most of my career. I was chairman of the

department from 2003 to 2007.

I would like to, first of all, support the expansion of outpatient services that is anticipated as a terrific idea for our patients.

I want to say that the closure of the psychiatric unit, currently called CP-3 is a great loss to our community. I agree with what Diane said, as there's been very little publicity about the closure of the unit. There's been publicity about the expansion of both outpatient services. I'm opposed for many reasons, but we -- the distance, I think, that it would require to get to Danbury Hospital for patients, for their loved ones, and for their loved one's participation in therapeutic activities is great and would, I think, inhibit care.

This says nothing about the fact that, very often, our patients are waiting in the emergency department for transfer to another facility, whether it be Danbury or otherwise, and even though they're improving the conditions there, there still is time alone, usually on constant observation with a sitter, and it's 24 hours a day and four walls, and even with the addition of behavioral therapists, I don't think that that is

anywhere near as ideal, to be honest with you, on the inpatient unit, and -- given the more intensive care.

The -- they talked about the addition of telepsychiatry and I think telepsychiatry has been terrific and is a convenience, but it does not measure up to one-to-one personal care.

As far as, you know, the idea of Connect-to-Care that was mentioned, I think that is extremely important as one of the most important things that happens on the inpatient unit, is that patients come in and become exposed to and become aware of the possibility of continuing their care as outpatients, which is so crucial because so many of them -- so many of the patients have denial and resistance to getting further care. At that time in CP-3, particularly in those early days, are so important to achieve that.

Also, in making those outpatient plans, they need to connect with people. We had people that would come that were case managers, there were people who would provide social support, people that could provide support of housing, case management. All of that was so crucial and

those people would come to the unit and meet with patients and that was very useful.

Let me just make a few comments of things that I heard this morning.

Inpatient treatment, as I just said, is far superior on one-to-one interaction in a bay in the emergency department.

The other thing that's so crucial is that the patients need to want to pursue care and they often don't come to the -- they don't come into the outpatient clinic looking for care. They are in crisis and they come to the emergency department because they're in crisis and that's when they -- you know, they have the opportunity to begin -- begin to get care, not everybody, but a lot of patients come that way.

They mentioned the patients that want to go to Silver Hill or St. Vincent's in Westport or Yale, and that's true, and people want to make that choice, but it's usually the more affluent among us that want to make that choice. You know, people would come to CP-3 sometimes that were affluent and they would leave. They would want to leave and go to Silver Hill, not because, I think, the unit was tired, and -- but because

they were exposed to patients that made them very uncomfortable, and I think that's why they would want to leave more than -- more than the physical surroundings.

Also, patients are admitted to the inpatient unit from outpatient services. Our outpatient services at Norwalk Hospital, they just do not -- the condition deteriorated and they needed to come in as inpatients. So, even though we are providing more outpatient services, it doesn't preclude them from being rehospitalized.

Adolescent care has always been limited and a lot of that has to do with the fact that it was very difficult to -- to find a child psychiatrist that would work at the community level. They generally wanted to work in the mental service or at a specific child psychiatry clinic or a hospital or adolescent clinic (unintelligible).

There was a comment about groups. I just want to say that groups are wonderful, but not because they're cheap. There's a tremendous amount of care provided in groups. It's terrific.

My experience was that discharge from the emergency department was based not so much on

whether there was an outpatient slot available, but based on safety, whether they consider it's safe to leave. It wasn't so much as we were waiting for an outpatient slot.

Most of our patients were referred that we had during the time that I was there working with people who had chronic illnesses or suffered dysphoric relationships, were feeling self-destructive, or had acute psychotic illnesses and needed to be hospitalized for those reasons. Then, when we wanted to discharge them, we always had the issue of where would they would go, and there are very few mental health workers, psychiatrists, psychologists, social workers in the community who would take insurance. They usually worked for the service. We depended on our outpatient clinic to pick up these patients, and we took care of patients of all degrees of severity.

I was -- I was encouraged to hear that -- about the residency program, which I heard about before, and I would think that, in the future, particularly if the -- if they continue the inpatient service, they would be able to staff a lot of that inpatient service with -- with those

psychiatric residents that are coming through this new program.

Unfortunately, when they announced that they were closing the inpatient unit about a year ago, I would say probably half the staff left, you know, because they were concerned about their jobs, so then that didn't help.

The census was lowered from -- it was running at about thirteen and it was lowered to seven because of the staffing issues after that occured.

There were a lots of references to finances and the cost of a new unit. I would hope that -- that if the unit closed, that that savings would be put towards the psychiatric care and well beyond probably what the cost of what the new outpatient services would be.

So I guess what I want to say is it's a loss. It would be a loss to our community of Norwalk. It would be a loss to our community of psychiatric patients, many of whom are poor and disabled by their psychiatric illness. I encourage you not to allow the termination of these services and not to take away their and our psychiatric unit, which has been serving the

Norwalk Community for so long.

Thank you.

THE HEARING OFFICER: All right, thank you, Dr. Maiberger. You can go ahead and remute yourself and turn off your camera, if you would like.

At this point, I'm going to go ahead and go over the late files and then we'll move on to closing arguments and statements from the Applicant's attorney.

Steve, would you like to read a list of the documents submitted for late file?

MR. LAZARUS: Yes, give me one second.

So I have -- my notes, two items for late file. The first one is the cost analysis and for -- that was strictly cited for Pages 583 and 584, so we're going to compare the costs related to the 35 percent of what we had discussed.

Along with that, the second late file I have is the information to the provided on the Community Care Teams. We're looking for what is it, what's its make-up, its mission, that type of information, every detail that you can provide on that would be appreciated, but those are the two late files I have listed.

THE HEARING OFFICER: Okay, thank you very much, Mr. Lazarus.

I'm going to issue an order that those items listed by OHS staff -- I'm ordering that those be produced as late files by the Applicant and that they -- Attorney Jensen, what would be an acceptable time to get those in? I know we're coming up to holidays, so I want to give you some time.

ATTORNEY JENSEN: Would the end of the first week of January be acceptable?

THE HEARING OFFICER: That's fine, as well. That should give you enough time to also get in by that date any replies to any -- any public comments that were filed in the seven days.

ATTORNEY JENSEN: Understood. That's January 6th, thank you.

THE HEARING OFFICER: Yeah, sorry, I was looking at the wrong calendar. The 7th was last -- was last year, but yes, January 6th is Friday, so we'll go with that date.

ATTORNEY JENSEN: Okay, thank you.

THE HEARING OFFICER: Okay, and I'm going to have Ms. Rival, if you could, memorialize that order in a letter, thank you very much.

At this point, we'll go ahead and move to closing arguments or a statement from the Applicant's attorney.

Attorney Jensen, if you would like to make a closing statement or respond to any of the remarks?

ATTORNEY JENSEN: Yes, thank you, Hearing Officer Novi and OHS staff. We appreciate the time today. We appreciate the public comments that you were submitted.

The testimony today and the evidence submitted establishes three facts: No. 1, the standard for providing quality behavioral healthcare has evolved and there is a compelling public need to provide specialized care to adolescents an adults in the community.

No. 2, the current behavioral healthcare offerings in the service area around Norwalk are not equipped to meet this public need. Currently, many of the local outpatient providers are largely unwilling to accept insurance and those that do have significant wait times to see patients, leaving most of the vulnerable -- the most vulnerable untreated. Instead, emergency departments have been forced to shoulder this

burden, which creates backlogs and inconsistent access to care for patients in true emergencies.

No. 3, Norwalk Hospital's inpatient psychiatric unit is understaffed and underutilized and is not positioned to address this compelling public need, particularly with respect to adolescents.

Mr. Lazarus earlier asked a key question: Has Norwalk Hospital considered expanding outpatient services in the way that we described and also just keeping the inpatient unit? The answer is that maintaining that unit in its current form is not sufficient and does not address this crisis involving adolescents. As we discussed, the inpatient unit currently does not -- is not licensed to treat adolescents. Further, it requires millions of dollars in renovations even just to maintain the status quo.

Now, in light of those facts, Norwalk Hospital faces a critical decision. Does it pour money into maintaining that said status quo or does it evolve its behaviorial healthcare model to meet this public need.

Through this application process, Norwalk Hospital has laid out a three-pronged approach

for evolving its behaviorial healthcare services consisting of outpatient programs, including ones focused on specialized patient populations like adolescents or individuals with dual diagnoses; Two, enhancing the capabilities of its emergency department the effectively manage patients presenting in crisis due to behavioral health conditions, and three, relocating patients that require hospitalization to the patients in the most severe need of treatment to Danbury Hospital, where a planned center of excellence is going to be constructed. This plan provides better care to patients at a lower cost. Further, when paired with Nuvance Health's residency program, it presents a tremendous opportunity to address the shortage of qualified mental health professionals in the area.

I want to briefly go through the different statutory criteria that OHS considers in reviewing any application under the certificate of need statute. First is the proposal consistent with the Statewide Healthcare Facilities and Services Plan? Here, the answer is yes, in that it seeks to expand access to lower-cost outpatient services for all community

members. It increases early intervention treatment to reduce the incidents of higher-acuity psychiatric incidents and decompensation. It lowers the cost of care by reducing higher-cost inpatient stays, via preventative and early intervention efforts in the outpatient setting and by better managing emergency and crisis situations in the emergency department, and finally, it avoids the duplication of services by relocating underutilized inpatient services to Danbury Hospital, all consider -- all consistent with the Statewide Healthcare Facilities and Services Plan.

Subsection 3 of the statute, whether there's a clear public need for the services proposed by the Applicant. Now, here, because this is actually a proposed expansion of services and not a mere termination, the factor is satisfied. There is a clear public need for the expanded services proposed due to the inadequate access to outpatient services present in the community. As witnesses today have testified, Norwalk is a federally-recognized HPSA mental health shortage region and this proposal addresses that need

through the creation of Intensive Outpatient Programs, IOPs, that will accept patients regardless of their ability to pay.

Next, the proposal has a positive impact on the financial strength of the healthcare system in this state in that the proposal is designed to lower the cost of healthcare by providing earlier interventions to limit crisis conditions.

The proposal is also financially-feasible for the hospital, itself, as Norwalk is stemming ongoing operating losses, and more importantly, avoiding significant capital expenditures necessary to renovate an underutilized facility with declining demand.

The proposal will improve quality accessibility and cost-effectiveness of healthcare delivery by shifting away from high-cost crisis interventions in the ED and inpatient settings and extend care in outpatient centers in the community at a lower cost.

Subsection 5 five of the statute, whether the proposal will provide quality accessibility and cost-effectiveness of healthcare delivery in the area, including for Medicaid recipients and indigent persons. That principle is at the core

of this proposal, an approach being advocated for by Norwalk Hospital, but I'll take those one at a time.

First, quality, the proposal improves quality of care throughout this spectrum of behaviorial healthcare through the development of Intensive Outpatient Programs focused on treating specialized patient populations like adolescents, as mentioned. It makes care more accessible and reduces stigmatization from inpatient admission in an institutional hospital setting.

Now, as Dr. Murphy testified, these programs can teach people to swim, not just to save them from drowning. That's better care and that's what we're they're trying to achieve here.

Next, enhancements to the emergency departments will provide immediate benefits to patients in crisis and the existence of these IOPs that I just discussed provide a much-needed mechanism to safely discharge patients from the emergency departments.

Inpatient quality will improve, as well, as the planned renovations at Danbury Hospital's inpatient psychiatric unit is going to be developed as a modern center of excellence.

Next, accessibility, this proposal improves accessibility by providing care in the communities where patients live. On patients requiring inpatient admission, they can be admitted directly to Danbury Hospital and transported without cost to the patient.

Cost-effectiveness, as discussed, providing outpatient care in the community as a lower acuity and a lower cost point benefits both patients and payers.

Subsection 6 of the statute gets to the Applicant's past and proposed provision of healthcare services to the relevant patient populations, and the pair are mixed, again, including access by Medicaid recipients and indigent persons.

As discussed, Norwalk Hospital has historically served a large population of medical and indigent persons and the proposal to expand outpatient services expressly commits the hospital to continuing to provide those services to all persons, regardless of their ability to pay.

Next, Norwalk Hospital has identified the population that will benefit from the proposed

expansion of services and demonstrated the need for those services among the Norwalk population.

Next, the inpatient -- getting to the utilization rate, which we discussed, the inpatient psychiatric unit has been underutilized for years in Norwalk Hospital and the available data indicates that this trend will only continue going forward.

By relocating inpatient services to Danbury Hospital, Norwalk is also avoiding duplication of services.

And finally, Section 10 of the statute looks for an explanation for reduced access to services for Medicaid persons, Medicaid recipients, or indigent persons. As discussed here, there is no reduction in services to Medicaid recipients or indigent persons. Those services are actually going to be expanded.

So, to conclude, the goal of this proposal is to provide the right care to patients in the right place. A system that relies on the emergency department and inpatient admissions to psychiatric units is not sustainable and is not consistent with evolved standards of behaviorial healthcare. Norwalk Hospital's plan is a result

of a careful analysis and is calibrated to maximize available resources to provide the highest quality of care to the people that need it the most.

The proposal has the support of the community for a reason because it best serves the community. For these reasons, Norwalk Hospital respectfully submits that a certificate of need application should be approved.

Thank you all for your time.

THE HEARING OFFICER: All right, thank you, Attorney Jensen.

I would like to thank everybody who attended this hearing today. This hearing -- it is now 3:35 p.m. and I will be adjourning this hearing, but the record will remain open until closed by OHS after receiving all of the late file exhibits from the Applicant, which, again, you have a -- those are due by January 6th, the close of business.

Again, I would like to thank everybody for helping today and for staying for the entire hearing. This hearing is now closed -- or sorry, the portion of this hearing is now closed and I will close the record once all of our -- once all

of our exhibits are returned.

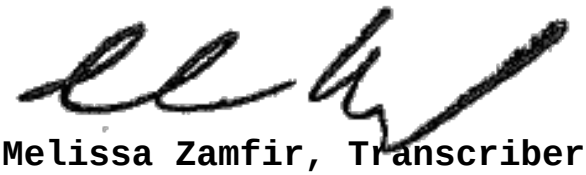
Thank you, everybody, for attending and have a nice day. Good night.

ATTORNEY JENSEN: Thank you.

(Concluded.)

CERTIFICATE

I hereby certify that the foregoing 138 pages are a complete and accurate transcription to the best of my ability of the Hearing in the matter of Docket No. 20-32515-CON held on December 14th, 2022.



Melissa Zamfir, Transcriber

Date: March 29th, 2023