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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH STRATEGY

PUBLIC HEARING

In Re:
Docket No. 22-32504-CON

Vassar Health Connecticut, Inc.,
d/b/a Sharon Hospital

Continuation of Public Hearing for the Proposed Termination of Inpatient or Outpatient Services (Intensive Care Unit) by Vassar Health Connecticut, Inc., d/b/a Sharon Hospital

HELD BEFORE: DANIEL CSUKA, ESQ.,
THE HEARING OFFICER

DATE: February 15, 2023

TIME: 9:30 A.M.

PLACE: (Held Via Teleconference)

Reporter: Robert G. Dixon, N.P., CVR-M #857

APPEARANCES (of record)

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(Begin: 9:30 a.m.)

THE HEARING OFFICER: Good morning. Do we have the Applicant? Looks like Sharon Hospital.

The Zoom room is the Intervener.

MR. KNAG: Good morning. It's Paul Knag here. We're at the Kent Town Hall, and the group who is associated with the Intervener here.

But the intervener himself has been delayed and he's not here yet -- but we can start.

THE HEARING OFFICER: Thank you.

Do you know when he is expected to arrive?

MR. KNAG: He was expected earlier, and we're not quite sure why he was delayed.

THE HEARING OFFICER: But no estimated time of arrival?

MR. KNAG: Sorry?

THE HEARING OFFICER: No estimated time of arrival at this point?

MR. KNAG: Well, he was supposed to be here already, and we weren't able to reach him. So I have to assume he must have had some type of patient issue, or other reasons for not being here.

But we can start, and hopefully he'll be here shortly.

THE HEARING OFFICER: Okay. It looks like Attorney

Tucci, I see you showing up under Sharon Hospital.

Attorney Knag, is that Julia Boisvert to your right?

MR. KNAG: Yes.

THE HEARING OFFICER: Okay. Attorney Tucci, do you have any other attorneys in the room with you?

MR. TUCCI: Yes. Also with me this morning is my colleague Attorney Lisa Boyle and also Attorney Connor Duffy.

THE HEARING OFFICER: Okay. Thank you.

MR. TUCCI: All on behalf of the Applicant.

THE HEARING OFFICER: Okay. I think we are ready to begin then. So Mayda, you can start the recording whenever you're ready.

THE REPORTER: And this is the Court Reporter. I would just ask until I get used to everyone, just identify themselves for my benefit. Thank you.

Sorry for the interruption.

THE HEARING OFFICER: No. Thank you. I appreciate that.

Good morning, everyone. Thank you for joining us. Vassar Health Connecticut, Inc, d/b/a, Sharon Hospital, the Applicant in this matter seeks a certificate of need for the termination of inpatient or outpatient services

offered by a hospital pursuant to Connecticut General Statutes Section 19a-638, Sub a, Sub 5.

Specifically, Sharon Hospital seeks certificate of need approval to consolidate its critical care services by terminating its intensive care unit and establishing a progressive care unit.

Today is February 15, 2023. My name is Daniel Csuka. Kimberly Martone, the former Executive Director of OHS designated me to serve as the Hearing Officer for this matter, to rule on all motions and to recommend findings of fact and conclusions of law upon closure of the hearing record.

Section 149 of Public Act Number 21-2, as amended by Public Act Number 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 their name and title at the outset of each occasion that such person participates orally during an uninterrupted dialogue or series of questions and answers.

We ask that all members of the public mute

the device that they are using to access the hearing and silence any additional devices that are around them. Before we get too far, I did want to talk a little bit about public comment and how that's going to run for this hearing since it's a little bit different than in recent past.

I am going to read mostly verbatim from portions of an order that I issued yesterday. It's Exhibit FF in the hearing record. I think that's the cleanest way of doing this.

So number one, every effort today will be made to conclude the technical portion of the hearing today.

Number two, if necessary, in the interest of concluding the technical portion, the public comment portion, other than public comments offered by public officials and clinicians signed up in advance will be postponed. This may mean that public comment other than from these select individuals may be held on the backup second day. That's February 22, 2023, at 9:30 a.m.

The time set for commencement of public comment is 3 p.m. today, but that's advisory only. The public comment portion of the hearing shall not commence until after the technical portion of

the hearing is concluded, provided however, that an allowance of up to one hour may be made for the receipt of comments from public officials, board members of the Applicant and any other entity with status in the hearing, and clinicians.

Individuals wishing to provide public comment must sign up in advance of this portion of the hearing. Individuals shall be given from 2 p.m. to 3 p.m. today only to sign up, unless signed up by the Applicant or the Intervener in advance of the hearing. At 3 p.m. sign-up to provide public comment will be closed, and the list of public commenters will be considered final.

The Zoom chat function will be disabled during the hearing except as necessary for OHS staff to administer public comment sign up. In other words, the chat function will only be available from 2 p.m. to 3 p.m. today. This is if it is necessary to hold a second date. No additional sign up will be permitted on or before that date.

Now I'm doing this for a few different reasons. First, at the last hearing involving Sharon Hospital there were many comments put into the chat section which were disruptive to the

hearing.

Second, those comments cannot be saved or are not part of the record. So it's my hope that by doing this we will encourage people to submit written comments outside of the hearing through the formal channels.

Third, at the last hearing I permitted public to sign up in perpetuity, and it was impossible to control the hearing when I didn't have an understanding as to what was still to come. It is my job as Hearing Officer to ensure that the proceedings run as smoothly as possible, and I hope that these changes achieve that today.

All that said, this public hearing is being held pursuant to Connecticut General Statutes Section 19a-639(a), Sub E. As such, this matter constitutes a contested case under the Uniform Administrative Procedure Act and will be conducted in accordance therewith.

OHS staff is here to assist me in gathering facts related to the application and will be asking Applicant's and Intervenor's witnesses questions.

I'm going to ask each staff person now to identify themselves with their name, spelling of

their last name and OHS title, starting first with Stephen Lazarus.

MR. LAZARUS: Good morning. My name is Steven Lazarus and I'm the CON Program Supervisor.

THE HEARING OFFICER: And that's L-a-z-a-r-u-s?

MR. LAZARUS: Yes, sorry. It's -- that is.

THE HEARING OFFICER: That's fine.

Next is Annalise Faiella.

MS. FAIELLA: Good morning. My name is Annalise Faiella. Last name spelled F-a-i-e-l-l-a, and I am a planning analyst at the Office of Health Strategy for the CON team.

THE HEARING OFFICER: And finally, we have Ormand Clarke.

MR. CLARKE: Good morning. My name is Ormand Clarke, and last name is spelled C-l-a-r-k-e. And I'm a healthcare analyst at the Office of Health Strategy.

THE HEARING OFFICER: Thank you.

Also present on behalf of OHS are Mayda Capozzi spelled C-a-p-o-z-z-i; and Faye Fentis, spelled F-e-n-t-i-s. They're assisting with the hearing logistics and will also assist with gathering names for public comment.

The CON process is a regulatory process and

as such, the highest level of respect will be accorded to the Applicant, to the Intervener, members of the public, and our staff. Our priority is the integrity and transparency of this process. Accordingly, decorum must be made by all present during these proceedings.

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

Next, as Zoom notified you, 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 consent, please do so at any time by exiting the hearing.

So in making my decision on this application, I will consider and make written findings in accordance with Section 19a-639 of the Connecticut General Statutes. There are twelve separate factors in that statute, but in very short, I'll be looking at need, cost effectiveness, quality and access.

I also want to point out that there are certain topics that are not the focal point for today's hearing, and the Applicant, Intervener and the public should make every effort to avoid those.

Those topics are number one, whether Nuvance Health or Sharon Hospital has violated the terms of the agreed settlement issued in CON Docket Number 18-32238-CON.

And number two is Docket Number 22-32511, which is the pending application by Nuvance Health and Sharon Hospital to terminate labor and delivery services, except as it may be necessary to refer to this docket in connection with Sharon Hospital's overall transformation plan.

As I indicated to counsel before we got here today, my plan is to end the hearing by 5 p.m. today wherever we are in the process, even if the technical portion is not done. We have another day reserved for next week if needs be, but under no circumstances will I allow another twelve-hour day.

The CON portal contains the pre-hearing table of record in this case. At the time of its filing yesterday exhibits were identified in the table

from letters A to HH.

Mr. Clarke, Ms. Faiella, does OHS have any additional documents to be added to the record at this time?

MS. FAIELLA: Eventually, we would like to upload some APCD data to the portal.

That should be coming at a later date.

THE HEARING OFFICER: Okay.

MR. CLARKE: None from me.

THE HEARING OFFICER: Okay. Thank you.

The Applicant and the Intervener are hereby advised, and I am also taking administrative notice of the following documents; the statewide healthcare facilities and services plan, the facilities and services inventory, the OHS acute care hospital discharge database, all payer claims database claims data, and the hospital reporting system that's HRS financial and utilization data.

I may also take administrative notice of prior OHS decisions, agreed settlements and determinations that may be relevant. I will call those to counsel's attention if I plan to do that.

Counsel for the Applicant, you identified yourself earlier, but can you please do it again for the record, please?

MR. TUCCI: Yes, good morning, Mr. Csuka and members of the Office of Health Strategy. This is Ted Tucci, T-u-c-c-i, on behalf of Sharon Hospital, the Applicant in this proceeding.

And with me this morning are my colleagues, Attorney Lisa Boyle, B-o-y-l-e; and Attorney Connor Duffy, D-u-f-f-y.

THE HEARING OFFICER: Thank you.

And counsel for the Intervener, Dr. David Kurish, can you please identify yourself for the record?

MR. KNAG: I'm Attorney Paul Knag, with Murtha Cullina. And with me is my partner, Judy Wasberg.

THE HEARING OFFICER: Thank you.

Attorney Tucci, are there any objections to any of the exhibits in the table of record or the noticed documents that I just discussed?

MR. TUCCI: Yes. Good, good morning, Mr. Csuka.

But before I address the table of record, which I will do briefly, I want to make two comments -- if I may?

First, I want to apologize to you for the state of my voice. It's unavoidable, but I'm a little bit impaired in my speaking voice today. I'll do my best to try to speak loudly and

clearly.

And the second thing is, I want to personally express my thanks on behalf of the Applicant, Sharon Hospital, for all of the work that the Hearing Officer did in advance of the hearing and the work done by OHS staff with regard to the rulings that were issued.

I want to assure you, the Hearing Officer and OHS staff, that the purpose behind those motions by the Applicant was to ensure that we had a hearing process that ran as smoothly as possible and that is fair and transparent to all.

And as I think you'll see here this morning, our objective is to use this process to provide OHS with all the facts that are relevant to this application so that your office can make an informed decision.

With that, I do want to note that with respect to the table of record, on behalf of Sharon Hospital we will, subsequent to the public hearing today, be filing a written objection to the exhibits on the table of record denoted as X and Y, which is petitioner's prefiled testimony of Dr. Kurish and petitioner's prefiled testimony of Victor Germack.

Very briefly, with respect to that written prefiled testimony, and especially in light of the two rulings that were issued by you, the Hearing Officer, yesterday, it's clear that there are significant portions of that written testimony that violate the orders that you issued with respect to improper argument, with respect to testimony that does not reflect appropriate qualification, education, background, and training of the witness, and also with respect to irrelevant and immaterial matters in terms of alleged violations of prior agreed settlements before this agency.

In addition, we will be objecting specifically and requesting that two documents, sets of documents be removed from the public record. The first is a hospital record that was put, attached as an exhibit to the prefiled testimony of Dr. Kurish without authorization of the hospital, and the second are photographs of the interior patient care areas of the hospital that were taken without authorization.

So again, I want to just note that for the record. We are here to try to make this proceed smoothly today, so we will not be asking for any

rulings with respect to those objections today. We will make them in writing in order for you to consider them fully and issue a written ruling at the appropriate time.

THE HEARING OFFICER: Thank you. I appreciate that.

So with the exception of those two exhibits, I'm going to enter the rest as full exhibits, and we will deal with your objection and any response if I permit it from the intervener.

I think I actually am going to allow a response from the Intervener considering it's their submission, but I'll certainly -- after you file it I'll set a date for when their response is due.

So Attorney Tucci, do you have any additional exhibits that you wish to enter at this time?

MR. TUCCI: Not on behalf of the Applicant. Thank you.

THE HEARING OFFICER: Okay. Attorney Knag, do you have any additional exhibits?

MR. KNAG: Yes. Based on your order yesterday that says that witnesses cannot go on for more than five minutes in their remarks this morning, I would like to submit the outline prepared by Dr. Kurish, which he's not going to be able to go through, but I'd like it on the record as to what

he was planning to say, or is adopting in connection with the remarks today that will be limited to five minutes.

THE REPORTER: Just as a note from the Reporter, it's extremely difficult to hear you. I can make you out, it's just very difficult.

MR. KNAG: I'll try to increase the volume.

THE REPORTER: It would be appreciated. Thank you.

THE HEARING OFFICER: Okay. Attorney Knag, that's fine with me. And I think that that might be helpful rather than -- yeah. I just think that might be helpful. So that's fine.

MR. TUCCI: Mr. Csuka, I'm sorry. If I may? This is Ted Tucci.

Again, with respect to the prior colloquy that we had with regard to objections, just please note for the record that Sharon Hospital will reserve the right to object to the content of this outline that, of course, we haven't seen on the same grounds that I articulated earlier.

It may very well contain information that is improperly before you in this matter.

THE HEARING OFFICER: Okay. We will get into late files, but I'll consider that a late file. So we'll get into when those will be due later in the

hearing.

But thank you, Attorney Tucci, and I'll allow you to file an objection as well.

MR. KNAG: So again, what you're saying, Mr. Hearing Officer, is that Dr. Kurish's testimony, or remarks from today in written form that I just offered will be submitted as a late file?

THE HEARING OFFICER: Correct.

I mean, since they already exist, though, it will probably be a much shorter timeframe, probably just like a day or two to submit those.

MR. KNAG: That's fine.

THE HEARING OFFICER: So with all that, we're going to proceed in the order established in the revised agenda, which was filed yesterday.

I would like to advise everyone that we may ask questions related to your application that you feel you have already addressed. The same goes for the Intervener and what they have submitted up until now.

We will do this for the purpose of ensuring that the public has knowledge about the proposal and for the purpose of clarification. I want to assure you that we have reviewed the entire record up to this point.

As the hearing is being held virtually, we ask that all participants to the extent possible enable the use of video cameras when testifying or commenting during the proceedings.

All participants should mute their devices and should disable their cameras when we go off the record or take a break. Please be advised that although we will try to shut off the hearing recording during breaks, the audio and visual may itself continue. If that's the case, any audio or video not disabled will be accessible to all participants in this hearing.

Again, if you're just tuning in, this is a reminder that sign-up for public comment today will only be from 2 to 3 p.m., after which point we will not allow for further sign-ups.

Are there any other housekeeping matters or procedural issues that we need to address before we start, Attorney Tucci?

MR. TUCCI: No. Thank you, Hearing Officer Csuka.

THE HEARING OFFICER: Attorney Knag, do you have any other housekeeping issues?

MR. KNAG: In your order you said we would have opening and closing statements? Are we going to do opening statements?

THE HEARING OFFICER: Yes, we are at the beginning of each case in chief.

And actually -- how do I normally do this?

We'll do opening statements at the beginning of each case in chief. So we're going to start first with the Applicant, since it's their burden to establish the need for the CON.

So Attorney Tucci, do you have an opening statement?

MR. TUCCI: I do. Thank you. May I proceed?

THE HEARING OFFICER: You may.

MR. TUCCI: Good morning, Mr. Csuka and OHS staff members. What brings us here this morning is a relatively straightforward application to relocate the critical care function of the Sharon Hospital ICU to the second floor.

The evidence will show that relocation of critical, critical care services will improve quality and enhance access to care because it will allow Sharon Hospital healthcare professionals to provide critical care and medical-surgical patient care in a single location with a unified staff.

It sounds relatively simple, but OHS's decision whether to allow this progressive care unit is one part of a larger healthcare policy

question that only OHS can answer about what is the appropriate path for the future of Sharon Hospital.

And that question is, what is a sustainable role and model for a 78-bed rural hospital with a service area population of about 50,000 people to deliver healthcare in our state? We're here this morning to help OHS answer that question, at least as it relates to delivery of critical care through the PCU model that we propose.

The one true fact that will come through loud and clear in the hearing this morning is that Sharon Hospital has been and continues to deliver high quality critical care services and has done so for years, but nobody with any expertise in this field would take the position or assert that Sharon Hospital operates an ICU unit at the same level as Danbury Hospital or Hartford Hospital, or any other large tertiary care facility.

Here's another fact that will be established. Moving the critical care function to the 2 North space will help address a serious nursing staff shortage problem by reducing temporary service interruptions and freeing up thousands of square feet of space in the hospital for other revenue

generating activities.

The witnesses that you will hear from this morning are three individuals with unique knowledge concerning the facts and circumstances of this application before you this morning. Our first witness is Dr. John Murphy. Dr. Murphy is a practicing physician, and he's the head of Nuvance Health, which is the parent of Sharon Hospital.

Dr. Murphy is going to talk at a high level from a system perspective about the critical care landscape today and how critical care is delivered in hospital settings. He'll talk with you also about the reality of Sharon Hospital's financial distress, and that the only way to begin to solve the problem is through constructive change. The PCU model that we're proposing here this morning is part of that constructive change.

He'll also talk generally with you about this PCU proposal from a healthcare policy perspective. That is, what is a vision for a sustainable future for a rural healthcare facility like Sharon Hospital? And why providing ready access to intermediate level critical care is the right role for a facility like Sharon Hospital to play in our healthcare system in Connecticut.

The next witness you'll hear from is Christina McCulloch. Ms. McCulloch is the president of Sharon Hospital and she's a nurse by training. She started her career in critical care, so she's intimately familiar with this field.

She will explain to you how the space that's currently called an ICU within the four walls of Sharon Hospital actually operates today and what its limitations are. She'll describe for you the extensive planning process that's gone into the development of the proposed progressive care unit model, and how a mixed acuity inpatient floor on 2 North will be staffed, will operate, and what the advantages are of this new model that's being proposed.

Another true fact that you will hear specifically and directly from Ms. McCulloch, and you will hear this unequivocally is that the same nurses, the same staff, the same doctors, all will be available to provide the same level of critical care that has always been available at Sharon Hospital.

Our final witness is Dr. Mark Marshall. Dr. Marshall practices internal medicine. He's a

palliative care doctor and he's also a hospitalist at Sharon Hospital. He's been a member of the Sharon community for more than 20 years.

In short, what you're going to hear from Dr. Marshall today is essentially a master class in what ICU care is, and what PCU care is.

From a quality of care standpoint, he'll explain to you the role that Sharon Hospital plays both in providing intermediate critical care to patients, and also to patients who present with critical care situations that Sharon Hospital currently does not have the capacity to serve, and the important role that Sharon Hospital plays in stabilizing those patients and safely transferring them to larger hospitals that have the necessary equipment and resources to treat them.

Let me conclude by saying that Sharon Hospital recognizes that there will always be opposition to proposed change. The last time we were here, the opponents of our prior proposal told OHS that it shouldn't matter that the labor and delivery service loses approximately $3 million a year.

Now those same opponents are here today saying, don't approve this progressive care unit

proposal because there's a theoretical possibility that Sharon Hospital might get $100,000 less in revenue if you approve the PCU model.

Let me just conclude by saying, Sharon Hospital intends to cut through the noise and present facts and reliable evidence that the proposed progressive care unit will provide continued access at the same level to quality critical care in a financially sustainable way that responsibly meets the needs of the patients that we serve.

Thank you.

THE HEARING OFFICER: Thank you, Attorney Tucci.

Would it be possible to get all of your witnesses in the camera frame at once? That way I can just swear them in all together.

MR. TUCCI: Of course.

THE HEARING OFFICER: Okay.

D R. J O H N M U R P H Y,

C H R I S T I N A M c C U L L O C H,

D R. M A R K M A R S H A L L,

called as witnesses, being first duly sworn by the HEARING OFFICER, were examined and testified under oath as follows:

THE HEARING OFFICER: Thank you.

So the Applicant can now proceed with testimony whenever it is ready. And it looks like we're going to start first with Dr. Murphy.

Your last name is spelled, M-u-r-p-h-y. Correct?

DR. JOHN MURPHY: That is correct.

THE HEARING OFFICER: Okay. And do you adopt your prefiled testimony today?

THE WITNESS (Murphy): Yes, I do.

THE HEARING OFFICER: Thank you.

Attorney Tucci, you can proceed whenever you're ready.

MR. TUCCI: Yes. My role in proceeding is to introduce to you Dr. Murphy who's going to speak about the subjects that I talked about in my introductory remarks.

THE HEARING OFFICER: That's what I thought, but I didn't want to presume anything.

THE WITNESS (Murphy): Thank you. And good morning, Officer Csuka and other members of the staff of the Office of Healthcare Strategy. Thank you for the opportunity to speak with you this morning.

I thought I would begin by providing you with some current financial circumstances, if you will,

just so that you can have a greater appreciation of the urgency of the application.

As you -- you may have already read, our current losses at Sharon Hospital are enormous. Although we had budgeted a loss in the first quarter of this fiscal year of 6 million, we have exceeded that loss. We're running it closer to 7 million.

Actually it's 6.8 million for the quarter, which would bring the annual losses in excess of 25 million dollars, which is clearly -- as I'm sure everyone who's listening to this discussion recognizes as unsustainable.

And I -- I share that with you simply to underline the fact that in our view, the status quo which has led to these losses is the single greatest threat to the future of Sharon Hospital. And the status quo, in our view, is doomed. We cannot continue to sustain these losses.

So as they have unfolded over the past year or two -- I think it's fair to say, so what have you done about it? What would a responsible leadership do? And we have done a great deal since the first day that we formed Nuvance Health to try primarily to understand what are the causes

of the losses.

Yet despite these losses for the past several years, coming up on four, we have managed to preserve terrific quality care. As you know, this is one of the -- the only five-star hospitals in the state of Connecticut. So we work very hard to do what we can with these ongoing losses.

We have engaged experts far and wide, among them the very best in rural health care in America. We've met with stakeholders broadly, regularly, and in a transparent and candid fashion. And we've examined the community needs to be sure that the plans conformed to what they in fact need, and we've come up with a plan.

I think it's a solid plan. It -- it is the benefit of lots of minds, and the people who have come up with the plan are committed to providing a sustainable future to Sharon Hospital.

I would contrast that with -- with our critics who have adopted a different and consistent singular strategy, which at least to me is simply just say no, but that won't get us anywhere. As it relates to this notion of progressive care units, which Attorney Tucci just touched on, and -- and the notion of Sharon

Hospital is presently providing ICU, you know, I've -- I've been in ICUs for a long time.

The first time I walked into an ICU was 40 years ago when I was a second-year medical student, and I've been in them regularly, including this morning when I made rounds in Danbury Hospital's ICU and met with the Chief of Cardiothoracic Surgery.

I -- I have a very clear understanding of why we need ICUs, who belongs there, how you run them, how you staff them, what services they can and should provide. And I also have an understanding of -- of what Sharon Hospital has done proudly, and -- and they have in fact provided life-saving care for many years and -- and will continue to do so.

But the care can extend only so far, and I think Sharon Hospital and -- and the physicians and nurses and staff who work there understand that. We regularly transfer patients to other ICUs within the system. We have the capacity to take care of critically ill patients with multi-organ failure. As many of the patients I saw this morning had, most are intubated. We -- we know how to do that.

We have a range of specialists and services available 24 hours a day, 365 days out of the year, and these are tertiary care ICUs. Sharon will continue -- Sharon Hospital will continue to provide care to the patients to whom it presently provides care, but it will also continue to transfer them when appropriate.

The care, however, that we will provide and do provide at Sharon Hospital needs to be provided in a cost-efficient manner. It is part of the financial remedies that we are applying to the hospital to create and preserve its future.

This application really is about those best practices. How do you create efficiency while continuing to provide high-quality care? I've devoted the last 15 years of my life to answering that question and threading that needle.

Our goal is to save Sharon Hospital. Our opponent's goal is to save the status quo. Our plan offers operational and clinical efficiencies. When you are co-locating, patients who can be adequately and professionally cared for by the same nurses, there are other efficiencies. Whether it's pharmacy, lab, environmental services, we can provide care in a much more

efficient manner.

In addition, this plan allows us to free up space, which we can repurpose for other services that the community needs and deserves and will, in fact, be part of the plan to save its future.

There are a few things this application will not do. It will not lead to increased costs, it will not decrease access, and it will not adversely affect the quality of care provided to the community of Sharon Hospital.

And in closing, I would like to remind everyone we have been patient. We have followed the letter of the law. We have followed every statute we've been asked to comply with. I received board approval 18 months ago from the Sharon Hospital Board and the Nuvance Health System Board. We are ready to go. The longer this takes, the more money we have lost.

And I would simply ask you to keep in mind that this plan should be reviewed -- or should be considered as a comprehensive strategy, because that's what it is. It is multifaceted. And I feel sometimes frustrated by this, this process which asks us to deconstruct the plan and have each element examined one at a time.

I think it's like looking at a three-legged stool, but only being permitted to see one leg of it and then being asked to opine, can you sit on it?

This is a comprehensive plan. It is the best plan. There is no alternative plan, and I would sincerely ask that you approve this application.

Thanks very much.

THE HEARING OFFICER: Thank you, Dr. Murphy.

MR. TUCCI: Good morning, Mr. Csuka. It's Ted Tucci.

The next witness who will speak in favor of the application is Christina McCulloch.

THE HEARING OFFICER: Thank you.

Ms. McCulloch, can you just spell your last name for the record, please?

CHRISTINA McCULLOCH: Yes. My last name is McCulloch. It is M-c-C-u-l-l-o-c-h.

THE HEARING OFFICER: Thank you. And do you adopt your prefiled testimony today?

THE WITNESS (McCulloch): I do.

THE HEARING OFFICER: Thank you. You can proceed.

THE WITNESS (McCulloch): Good morning, Hearing Officer Csuka and the Office of Health Strategy. Thank you for the opportunity to testify today.

My name is Christina McCulloch, and I am the

president of Sharon Hospital. I'm a former registered -- a former practicing registered nurse, and I've been a registered nurse for about 20 years where I started at the bedside in an ICU providing critical care services.

I came to Sharon Hospital in 2014, and have assumed positions such as Chief Quality Officer and Chief Nursing Officer before becoming the president of Sharon Hospital.

The purpose of my testimony today is to provide OHS with facts surrounding our proposal. I'm going to begin with the why we are proposing to relocate our critical care services to the second floor. I'll then share with you very specific details on how we are going to do that.

As a leadership team, we started many years ago looking at the services that we provide at Sharon Hospital and started to think about what services we needed to provide in the future in order for us to have a sustainable hospital for many years.

We specifically looked at the inpatient services that we're talking about today, and those are the medical-surgical services that are provided on the second floor of our hospital,

which is known as the unit called 2 North; and the inpatient services that are provided in the ICU, which is located on the first floor in our hospital, and the services provided in that unit are critical care services.

When we started looking at the size of the units and the capacity of the units, we looked at 2 North. It's a 28-bed unit with an average daily census of 10. So about 10 patients on any given day in a unit that has the capacity to hold 28 patients.

In our intensive care unit we have a nine-bed unit with an average daily census of about four patients. So you can see that when we're just looking at space alone, we have two underutilized units. So we started to think, why not take all of the services that we provide in these two distinct units and move them into one?

2 North is a larger unit. It's more modern. It has plenty of capacity to be able to handle all of the patients that we care for today and that we've cared for for many years.

Our initial thought was we would segregate part of the unit, call it an ICU, keep the remainder of the unit as a medical-surgical unit,

as it's been called for many years -- but when we started going through the planning process and looking at the patients that we've cared for, looking at data surrounding those patients, what we quickly learned was that the level of critical care services that we provide is not at the level of an ICU.

The level of critical care services that we provide is at an intermediate level. And you may hear different terms such as intermediate care, progressive care, step-down -- all really meaning they're critical care services, but they're certainly not at the level of an ICU that you would see at a larger tertiary care center.

And we provided some data in our application to support this. So you can look at the case mix index that we submitted, and we submitted an average case mix index in our ICU over a period of time and showed what that case mix index looks like compared to other hospitals.

The case mix index tells you how sick a patient is, what their severity of illness is. And you'll see when compared that our case mix index at Sharon Hospital on average over a period of years is comparable to progressive care units

or even medical-surgical units in some hospitals.

With all of that information, we came up with the plan that we're proposing today, and that is to take, again, all of the services that we provide, the medical-surgical services that are provided on the second floor, the critical care services that are provided on the first floor, combine them into one unified location, that location being 2 North -- but have what we call a mixed acuity unit, not an ICU because we're not providing ICU level of care. We're providing med-surg and progressive care unit level of care.

The benefits of a mixed acuity unit are, one, efficiency of staff. We're utilizing our space in an appropriate manager -- manner, and we're freeing up other space, the space that's currently used in the ICU to use for other services that are growing.

I want to talk about a couple of pieces of our plan, one being staffing, one being equipment, and others related to visible -- visibility of patients, and specifically talking about some of our alarms and how we monitor them. I'll start with talking about the critical care services that we do provide today.

As I mentioned, we do provide critical care services. We have the ability to treat patients that come in; we can triage and stabilize patients, and there are many patients that receive critical care services that are able to stay in our hospital today. I'll use the example of a patient that comes in with a heart attack.

If you come into Sharon Hospital with a heart attack, we are able to assess you and treat you and provide life-saving treatments today, just as we always have been, just as we intend to do.

But there are some things that we can't do. Some patients that have heart attacks need to go on and have procedures such as cardiac catheterizations or open-heart surgery. Those patients today are treated at Sharon Hospital, and then we arrange a transfer to a center that can provide those services.

We transfer out approximately 300 to 400 patients per year from Sharon Hospital. This is one of the things that we do very well. We provide high-quality, safe care, and it's because we know what our limitations are, we know what we can handle, and we know when we need to have a patient go to another facility because it's in the

best interest of the patient. We intend to continue to do all of that and not impact the quality of care that we provide.

Those opposed to our plan, specifically the Intervener that will present today, raised some concerns regarding equipment. I'd like to talk about the equipment that we have in our ICU today and the equipment that we have in our proposed PCU, because that equipment will not change.

In our ICU today we have the ability to provide cardiac monitoring. We have the ability to take patients' vital signs. We have oxygen therapy. We have suction. We have devices that provide breathing support for patients that need that, such as ventilators and BiPAPs and CPAPs. All of that will be able to be provided on a progressive care unit.

I'd like to talk specifically about cardiac monitors because this was raised as a concern. In our ICU today we have what's called bedside cardiac monitors. They're mounted on the wall, and you can see a patient's heart rhythm along with many other vital signs that are monitored.

What we have today in our new proposed PCU, which is currently our medical-surgical unit, are

cardiac monitors. We have portable cardiac monitors that are an upgraded new device that we recently purchased, much newer than the cardiac monitors in our ICU. They are portable monitors that can be used in any of the 28 rooms on the unit. So it gives us the flexibility to put patients in any of those 28 beds.

We also will be installing bedside cardiac monitors in a couple of select rooms for patients that may be a higher level of -- may need a higher level of critical care for our clinical staff, as this was something that was requested from our clinical staff.

Those cardiac monitors alarm to our nurses in a couple of ways. One, we have a central monitoring station. Two, the devices themselves will alert the patient or anyone in the room that the -- the alarm is going off, and an alarm indicate -- indicates that something is out of range. We also have installed two large cardiac monitoring screens on alternate sides of the unit so that essentially wherever staff is in the unit, they can see what alarm is going off in what room they need to attend to.

In addition to that, our nurses wear

devices -- and they're called Vocera, and they're mainly used as a communication tool for staff to talk to each other. But we have the new devices set up to alarm right through the Vocera so that a nurse is -- is receiving an alert immediately through the device that they wear, that there's an alarm going off on one of their patients.

So the concern that there are alarms that will go unattended to is not validated. We have a contingency plan and backup plans on the unit to ensure that all alarms are tended to in proper timing.

Next, I'd like to talk about the staffing model. In our ICU today we have nurses and technicians and unit coordinators and physical therapists and doctors, and a wide array of staff that care for the patients in the critical care unit. That, those same staff will care for the patients when they are moved to the unified unit on 2 North.

The concern related to ratios or staffing guidelines has come up. What we propose in our application is in a new mixed acuity unit for there to be a staffing guideline on average of one nurse to every four and a half patients. That is

not a decrease from what we do today.

What we do today is our current ICU is actually a mixed acuity unit. In our current ICU, on any given day you will find telemetry patients, PCU level of care patients, maybe even med-surge patients, and the occasional ICU patient.

Those nurses are able to flex their assignments to be able to accommodate any combination of those patients. It's exactly what we intend to do on 2 North, but when we're able to take all of our nursing staff and all of the other ancillary staff and combine them on one unified unit, you create efficiencies. And it will actually create more capacity in the unit because we'll have more flexibility with our staff.

Today we have challenges with nursing staffing specifically, and there are days when our ICU has to be capped and we can't take any additional patients. That's because of challenges with recruitment and retention, and that's not unique to Sharon Hospital or unique to our ICU. You likely have heard this across the state and across the nation, and it's challenges that most healthcare organizations are -- are dealing with.

In this new proposed model we anticipate not

having to cap because we're going to have more flexibility. The ICU nurses that are trained to provide critical care services today will be on the new unified unit. The medical-surgical nurses that are trained to care for medical-surgical patients today will be -- be provided training to be able to provide critical care services.

That will take some time and we'll be able to transition into that, but ultimately the end goal will be for all of the staff to be able to provide the same level of care to all of the patients on that unit.

I next want to address visibility. There was a concern raised that the new unit on 2 North doesn't have the same visibility from the central nurse's station that the current ICU does. The unit on 2 North has many rooms that are visible from the central nurse's station, and it also has rooms that are not -- and that's okay, because that's normal for a nursing unit, that standard of care for PCUs or medical-surgical units.

But we do have additional mechanisms in place so that all staff that need to be visible by our -- all patients that need to be visible by our staff can be visualized. One, we have, not only a

central nurse's station, but we have portable workstations that are called workstations on wheels. They're essentially computers on a wheeling station that can be wheeled into any room or any part of the hallway. We have about eight of those workstations.

So any clinician can take that workstation and go in any room, do their documentation if you need to watch a patient because you're concerned about something. You can sit right outside of that room and do so. So the idea that the central nurse's station is the only place that you can visualize a patient is not fact.

We also have windows in every single room on 2 North. These windows allow us to be able to visualize a patient even when the door is shut. Of course, we have privacy mechanisms in place such as curtains and whatnot, but the point is that all patients can be visualized from -- from any location in the hospital.

We also, in addition to that, have a program and it's called video monitoring. This is a program where we have technicians that are sitting in a central hub that happens to be at Sharon Hospital. And they are watching patients through

cameras, of course, with patient or family consent, but they're watching patients to be able to see if a patient is about to fall; if we have an IV fluid, that bag is about to run dry, or for any other safety reasons we can put a camera in a patient's room and have a technician watch that patient.

That technician can talk to the patient, can call the nurses via the Vocera device or a telephone. They can also sound off an alarm immediately to say someone needs to get into that room. So you can see that we have many ways to ensure that our patients are safe on 2 North.

In summary, we are locating the critical care services we provide in the current ICU, combining them with the services in our medical-surgical unit and creating a mixed acuity PCU. It's the same staff, same equipment, same patients, same services. It's a new location. We're calling it a new name, because we're renaming it for what it is.

Sharon Hospital can become a thriving rural community provider, but we must be permitted to transform our services in order to do so. A small community hospital cannot be everything to

everyone, but we can thrive as a small community hospital.

I respectfully request our application today to be approved to consolidate these services into a new mixed acuity progressive care unit. I thank you for the opportunity to speak today.

THE HEARING OFFICER: Thank you, Ms. McCulloch.

MR. TUCCI: And Mr. Csuka, our final witness of our direct presentation is Dr. Mark Marshall.

THE HEARING OFFICER: Thank you.

THE WITNESS (Marshall): Thank you.

MR. TUCCI: Thank you.

THE HEARING OFFICER: Dr. Marshall, can you just spell your name for the record, please?

THE WITNESS (Marshall): Yes. Mark Marshall; M-a-r-k, M-a-r-s-h-a-l-l.

THE HEARING OFFICER: Thank you. And do you adopt your prefile today?

THE WITNESS (Marshall): I do.

THE HEARING OFFICER: Thanks. You can proceed whenever you're ready.

THE WITNESS (Marshall): Thank you.

Thank you. Good morning, Hearing Officer Csuka and OHS team. I'm speaking to you today to support the relocation of the current ICU at

Sharon Hospital to the second floor, creating a single mixed acuity progressive care unit, which I believe will function better and more efficiently while continuing to provide the same level of critical care available at Sharon Hospital today.

I am a physician practicing at Sharon Hospital for more than 20 years. I'm board certified in internal medicine and palliative medicine, and I also function as the hospital's vice president of medical affairs.

After completing my residency at Albert Einstein Hospitals in the Bronx in 1999, I relocated to Salisbury, Connecticut, and started the hospitalist program at Sharon Hospital. Hospitalists are physicians that care for hospitalized patients, simply.

Over the years our program has grown, and we now admit the vast majority of patients to Sharon Hospital 24 hours a day, 7 days a week. I came to Sharon Hospital for two important reasons. First was the community. The Sharon community is a great place to live and work, and raise children. The second was, of course, the hospital.

I found Sharon Hospital to be of excellent quality, with board-certified physicians and

dedicated nurses and ancillary staff. At that time it wasn't essential that physicians on medical staffs in hospitals in the United States were all board certified, but even at that time Sharon Hospital required that as a condition of medical staff membership, and that continues to this day.

I was particularly drawn to Sharon Hospital to provide critical care services, including performing procedures in the ICU. In my training, I spent 14 months in critical care, and after my residency, spent three months as an ICU attending at Jacobi Medical Center in the Bronx.

Twenty-three years ago Sharon Hospital's ICU functioned as a mid-level ICU. Even then, patients with greater needs were transferred to a higher level of care. These were patients who required certain procedures or consultations that weren't available at Sharon Hospital, such as cardiac catheterization or hemodialysis.

Over the ensuing decades, hospital medicine and critical care evolved, as did medical technologies, to the point that the ICU at Sharon Hospital really became more of a progressive care unit. A higher level of care than a regular

floor, but less than a true intensive care unit.

Now patients who require advanced critical care services are expected to be cared for in an ICU with board-certified critical care physicians and all technologies available to them. This is what I want for my patients, my neighbors, and my family, and so should you.

In our current unit we care for patients with pneumonia, heart attacks, congestive heart failure, infections, and strokes, and this will not change with the unit's relocation. Patients with congestive heart failure who can safely be treated at Sharon Hospital will continue to be treated at Sharon Hospital. Patients with congestive heart failure who require treatments not available at Sharon Hospital will continue to be transferred to the most appropriate facility to care for their needs.

And that transfer is a collaborative process. The patient, their family, the accepting facilities all collaborate to determine what is the most appropriate place for them.

So I'll give you an example of how this works in practice. I'd like to describe two patients who were recently seen at Sharon Hospital, and

both came to Sharon Hospital with slow heart rates. This is a problem because if the heart rate is too slow, not enough blood can be pumped to the organs, including the brain, and this can result in organ damage and is a medical emergency.

So the first patient fainted and was taken to the emergency department. She was assessed and stabilized. She received medications and IV fluids, and some of her regular medications were held as they were felt to be contributing to the slow heart rate. She was hospitalized for two days at Sharon Hospital and was discharged with a stable heart rate on different medications and did very well.

The second patient arrived unresponsive. His heart rate and blood pressure were very low. He was on no medications, which may have contributed to the low heart rate. It was a case of heart block. This is when the electrical system of the heart is inadequate to keep the heart rate elevated. A permanent pacemaker, which is a device that's surgically implanted into the heart and prevents low heart rates, was needed.

To stabilize this patient, we placed a temporary pacing wire into the patient's heart

with good response. This is a catheter that is connected to a battery generator that actually increases the heart rate. The patient responded well with an elevation in heart rate and blood pressure and stabilized, and was then transferred to an appropriate facility where they may receive the necessary permanent pacemaker.

Now you may ask, why don't we put in permanent pacemakers? But I would say that you want to go to a physician and a facility where they do many, many permanent pacemakers in order to have your permanent pacemaker as opposed to any facility that just provides that service.

The treatment of these two patients will not change with the relocation of the first floor unit to the second floor. In my opinion, the efficiency and synergy of co-locating all patients on one unit with all nursing and ancillary staff will improve patient safety, employee satisfaction, and may actually result in fewer patients being transferred because of staffing issues.

There will be no change in the level of care provided for the types of patients admitted to Sharon Hospital today. This move will allow

better use of space and assure that Sharon Hospital will be strong well into the future.

Those who oppose the proposed relocation are misinformed. Critical care services will continue at Sharon Hospital as they are today. In fact, we are working with specialists throughout the Nuvance system to increase access to subspecialty telemedicine consultation, including infectious diseases, critical care, and neurology.

These changes will support the transition of Sharon Hospital and assure that Sharon Hospital is a vital resource for the health of the community for many years to come.

Thank you very much.

THE HEARING OFFICER: Thank you, Dr. Marshall.

Attorney Tucci, does that conclude the testimony from your witnesses at this point?

MR. TUCCI: Yes, our case in chief is concluded.

THE HEARING OFFICER: Okay. Attorney Knag, do we have an update on where the Intervener is at this point?

MR. KNAG: Dr. Kurish has arrived.

THE HEARING OFFICER: Okay, thank you.

I would like to take a five-minute break, and then we will come back and we'll move forward with

cross-examination of the Applicants' witnesses.

MR. KNAG: I'm sorry, I missed what you just said, Mr. Hearing Officer. We're taking a break?

THE HEARING OFFICER: Yes, we're going to take a five-minute break. We'll come back at 10:40, and then we will move forward with cross-examination of the Applicants' witnesses.

MR. KNAG: Very well.

THE HEARING OFFICER: All right. Thank you.

(Pause: 10:35 a.m. to 10:41 a.m.)

THE HEARING OFFICER: So if we could come back to our cameras now, I would appreciate it.

I believe we're just waiting for Sharon Hospital at this point.

MR. TUCCI: Yes, my apologies.

We are present and ready to go.

THE HEARING OFFICER: Okay. Thank you, Attorney Tucci.

Welcome back, everyone. This is a hearing regarding the application by Sharon Hospital. It bears Docket Number 22-32504-CON.

We just had the case in chief of the Applicant, and now we are going to move on to cross-examination by the Intervener Dr. Kurish.

So Attorney Knag, you can proceed with cross-examination whenever you're ready. I assume you're going to be starting with Dr. Murphy.

Is that correct?

MR. KNAG: Yes.

THE HEARING OFFICER: Okay. So Dr. Murphy, if you can come on to the camera, I would appreciate that?

THE WITNESS (Murphy): Ready to go.

MR. KNAG: Good morning, Dr. Murphy.

THE WITNESS (Murphy): Good morning, Attorney Knag.

CROSS-EXAMINATION (of Dr. Murphy)

BY MR. KNAG:

Q. So when Nuvance acquired this hospital, that was in 2019. Is that right?

A. Yes, that's correct.

Q. And then prior to that in 2018 the hospital was near break-even, reporting an operating loss of $142,483. Is that correct?

A. I -- I don't have those numbers in front of me, nor was I responsible for the accounting that reported those figures.

Q. So you don't know whether they were near break-even or not?

A. I do not as I sit here.
Q. And then in 2019 it went to a $6 million loss. Is that right for fiscal year 2019?
A. I don't have those numbers in front of me either. What we have provided I'm sure is accurate in that they were audited financials, if that's what you're making reference to.
Q. Right. And then you don't know whether it was 6 million or 20 million in 2019?
MR. TUCCI: I'm going to object at this point as to relevance. I've allowed some leeway here, but I don't -- this is not -- the history of Sharon Hospital's financial performance going back several years is not relevant to this application.
MR. KNAG: The applicant has spent time talking about their financial condition and I'm trying to wonder --
THE HEARING OFFICER: I'll allow it to move forward.
THE WITNESS (Murphy): Yeah, it wasn't 20 million. If -- if your question, Attorney Knag was, was it 20 million? It was not.
BY MR. KNAG:
Q. Then the loss ballooned to 20 million in fiscal year 2020?

A. Right.

Q. And since then it's ballooned further?

A. That is correct.

Q. Now -- but why did that happen?

A. There, there were a host of reasons. I think that as you heard during our presentation just a bit ago, I think primary among them is the -- the workforce shortage.

So that in order to keep the -- the facility open and properly staffed we are relying heavily on premium labor, contract labor, overtime.

In addition, the supply chain that was so disrupted during COVID, the -- the ability to get supplies was limited, and when we did we paid dearly for those supplies.

I would say the, you know, inflation hovering at 8 to 9 percent when our reimbursements were typically capped closer to 2 to 3 percent per year, it presents a very deep and substantial and pervasive challenge, is that your revenues are capped and your expenses grow well beyond that rate.

And I think those are the primary reasons for the increasing losses over time.

Q. But are you familiar with day Kimball Hospital?
A. I -- I know of it.
Q. And are they the other hospital that is of similar size in a rural part of the state?
A. Yes, I -- I'm familiar with -- with where it is located.
Q. And it's of similar size?
A. I -- I don't know the specific stats.
Q. Fifty-nine -- they have 59 staff beds.
How many of you have at Sharon?
A. We were licensed for 78. We run a census about half of that typically.
Q. But you report 50, 50-plus staffed.
Is that right?
A. Yes.
Q. And so they are comparable, but unlike Sharon Hospital although they are subject to these same -- the same general factors that you cited, they were able to go from a loss of a million five in 2020 to a gain of 10.2 million in 2021?
MR. TUCCI: Same objection as to relevance.
BY MR. KNAG:
Q. Do you have any explanation -- well, let me

ask a question. Do you have any explanation as to why the difference?

MR. TUCCI: Objection as to relevance. The question calls for the Witness to explain why another hospital in a different part of the state may have financial results that it does.

Objection, irrelevant.

THE HEARING OFFICER: Attorney Knag, do you have a response to that?

MR. KNAG: Yes, I think that, you know, it shows that these general conditions affecting all hospitals that were cited by the doctor didn't lead to losses in most of the hospitals in Connecticut.

Almost all of the hospitals made money in the last reported year, and in particular including Day Kimball. So I don't -- I think it shows that the general factors cited by the doctors are not a good explanation given the performance of other hospitals in the state.

MR. TUCCI: So I renew my objection and also note, again this will be the subject of our written motion.

This is all part of the Intervener's conspiracy theory that there has been a knowing effort to decrease the revenues of Sharon Hospital

for nefarious purposes.

That's completely out of bounds.

MR. KNAG: I object to the insult. And I'm just trying to elicit facts. And you know, the doctor is concerned about a 20-plus million-dollar loss, and I'm trying to elicit a few facts concerning that, and try to explain why the Sharon Hospital is such an outlier.

THE HEARING OFFICER: I'm going to allow it, but I am concerned as to where this is going, Attorney Knag.

MR. KNAG: I leave this, this topic once he answers that question.

THE HEARING OFFICER: Dr. Murphy, I mean, to the extent that you're able to opine on another hospital's financial condition, you're free to do that.

THE WITNESS (Murphy): Yeah, I don't know the specifics of Day Kimball or its accounting methodologies, or whether the physician practice is included in the financial report that Attorney Knag is -- is citing.

However, there were elements of his remarks that were incorrect. I about two weeks ago sat on the Greater New York Hospital Association board meeting. I'm a director there, and at that time

as of the first quarter, for instance of '23, 83 percent of the hospitals in the state of New York are reporting unsustainable losses.

Having chaired the board of the Connecticut Hospital Association for a number of years I'm quite familiar with the finances of many of the hospitals as an aggregated body. And the -- the notion that most of them made money is clearly a false assertion.

Yesterday I spent several hours with the CEOs of 20 of the largest health systems in the United States, and once again several of them are reporting losses in excess of a billion dollars. So I'm not quite certain of the relevance of the remark that is trying to characterize Sharon Hospital as unusual in that is -- it is sustaining these losses. And I would remind the attorney that 186 rural hospitals have been closed over the past 15 years because of the unique pressures on rural hospitals.

So I don't believe that there is anything atypical or nefarious about either the reporting or the losses. We are doing everything possible to stem them, but health care is under enormous pressure, and that includes all hospitals,

thousands of hospitals across the United States and within the state of Connecticut.

MR. KNAG: Just for the record, I was referring to the OHS report on financial status of the hospitals from September 2022, and I just was extracting information from that report.

BY MR. KNAG:

Q. And you don't dispute that you did move profitable services out of Sharon Hospital, or that Sharon Hospital moved those services as outlined in the Stroudwater report?

MR. TUCCI: Again this is -- this will be the subject of our of our written objection, but that this is clearly directed to the notion that somehow the rationale behind the transformation plan is as a result of some concerted effort to violate an agreed settlement.

That goes directly to your order Mr. Csuka, that this hearing not be turned into an attempt to vilify Sharon Hospital or its parent.

That's where we're going here.

MR. KNAG: What Stroudwater says is on the record.

So I'm withdrawing that question.

BY MR. KNAG:

Q. You say that the ICU is outdated.

Is that right?

A. I don't believe I said that.

Q. Okay. Is the ICU outdated?

A. I'm not sure that I understand the question. Could you explain it in a little more detail what, what about it might be outdated?

Q. Is it your testimony that the developments in the critical care indicate that a PCU rather than an ICU should be had by Sharon Hospital?

A. I -- I do believe that in the present circumstances a PCU is the most sensible solution for the problems we are trying to solve and the care we are trying to provide at Sharon Hospital today.

Q. And are you aware that 92, according to the article cited in Dr. Kurish's testimony, that 92 percent of rural hospitals similar to Sharon Hospital, that is with beds between 51 and 99 have ICUs?

A. And what is the question?

Q. Are you aware that according to the article that's cited by Dr. Kurish in his testimony that 92 percent of rural hospitals similar to Sharon Hospital, that is with 51 to 99 beds have ICUs?

A. I -- I did not read the article. So I do not know how the paper is characterizing or defining an ICU, because one could similarly characterize our progressive care unit.

If you were to call that, as these other hospitals have an ICU, then I suppose there would be no difference.

Q. So would you agree that most -- most hospitals have ICUs?

A. It depends I suspect on how one defines an ICU. If -- if the presence of telemetry qualifies as an ICU, then I suspect the answer to the question is yes, but I -- I don't want to play a word game here.

We -- we have been explicit in characterizing the nature of services that Sharon Hospital will continue to provide. There is no attempt to mislead anyone.

What Sharon Hospital does today is what Sharon Hospital will do tomorrow, but the environment in which that care is delivered will be more efficient both clinically and operationally. That's the distinction.

So the notion that some hospitals have ICUs and others don't, I -- I don't see how

that is -- is relevant to what we're trying to do at Sharon Hospital.

Q. Specifically with reference to intubation, you've mentioned the New Milford campus of Danbury Hospital having a PCU and closing its ICU. Do they in that, in that PCU do they have any patients who were transferred from the ER who are intubated?

MR. TUCCI: Objection, beyond the scope of the Witness's direct testimony and also irrelevant as to what may or may not be happening at some other hospital and what services they provide.

MR. KNAG: It relates to -- it does relate to the testimony as to the efficiency and the fact that he's claiming that the patient -- nothing will change.

And in particular, the intubation we claim is, for unstable patients particularly, is inappropriate for a PCU. And they had said the same thing in their admissions criteria that they attached to their application, and now they're saying something slightly different.

But so it's directly related to the question of whether the hospital really can properly treat the same patients if the ICU is closed.

THE HEARING OFFICER: Attorney Knag, you referenced referring to testimony somewhere. Were you referring to Dr. Murphy's prefile? Or --

MR. KNAG: Dr. Murphy just said just now -- just in the last few, few seconds or few minutes Dr. Murphy said, that there will be no change in the patients that we will be serving.

And our contention is that's wrong. There are certain patients that can't be served, and in particular those would be -- that would include the intubation, the intubated patients who are unstable.

And I'm trying to determine whether the claims that are being made that there won't be anything changed really is true. The fact is we believe that they cannot -- they can no longer accept unstable intubated patients if they switch to the PCU model.

And the fact that they don't do it in New Milford is directly relevant to whether it would be appropriate in Sharon.

MR. TUCCI: Well, that that actually proves the exact basis for my objection. Whatever may or may not be occurring at some other hospital is beyond the scope, and certainly irrelevant to what this

proposal is.

If counsel has a question relating to this proposal or the scope of patients who will be cared for, he can certainly ask that question, but you know that the Witness that he's asking this question of is the head of the entire system who did not testify at that level of detail.

So there are other witnesses who can certainly talk to the point that's being raised, but I'll certainly -- if Dr. Murphy has particular knowledge, a general level of knowledge about this I won't object to the question, as long as I understand what the question is that's being asked.

MR. KNAG: So let me just specifically cite to page 7.d of Dr. Murphy's prefiled testimony wherein he says, those who oppose change refuse to recognize that smaller hospitals moving to a PCU model such as New Milford Hospital have been successful.

So he has in fact brought up New Milford in his prefiled testimony in addition to claiming that everything will be the same. And so my asking him about New Milford Hospital PCU is directly relevant to -- directly related to what he's testified to in his --

THE HEARING OFFICER: Thank you, Mr. Knag. That that's what I was getting at. I did recall reading somewhere that there was reference to Danbury Hospital and New Milford as being sort of an example of this sort of transition.

I am going to overrule the objection based on that. So I don't recall what the question was -- but the question was?

BY MR. KNAG:

Q. The question is, does the PCU at Danbury Hospital's -- New Milford patients have any patients who were transferred from the ER who are intubated?

A. Yes.

Q. They do?

A. Yes.

Q. What about Vassar Hospital?

A. I'm not sure that I understand the question. Would you --

Q. Well, let me -- I'll move onto the next question.

Do they have any patients who are hemodynamically unstable, who have moved to -- who are intubated and in the PCU at New Milford campus?

A. I would suspect that the answer is yes.

Q. But you don't know?

A. I -- I'm -- I don't want to testify authoritatively, but it's hard for me to imagine that someone hasn't become hemodynamically unstable requiring transfer.

So it -- it would seem to me that the -- the implication is, yes, it has happened.

Q. So if it happened --

A. But if you said when --

Q. If it happened you would want to transfer that patient to the ICU?

A. We would want to transfer them to the appropriate level of care, wherever that might be in the interests of the patient and based upon the judgment of the treating physician.

Q. So if it was a hemodynamically unstable patient, that that patient belongs at the ICU at Danbury, rather --

A. Well -- well, no. I'm saying that the range of options could include transfer to an ICU. It could include two liters of saline.

It depends on what the doc finds and feels is necessary.

Q. You say that in your testimony that there's a patient preference for larger hospitals, but isn't it a fact that there has been a lot of -- a lot of public support for keeping Sharon Hospital as a full-service hospital?

MR. TUCCI: Objection, irrelevant to the CON factors in 19-639. This isn't a popularity contest.

THE HEARING OFFICER: Attorney Knag, do you have a response?

BY MR. KNAG:

Q. He says his patient -- he testified that he has a patient preference for larger hospitals.

A. Where is that?

Q. Hold on. Let me find it.

That's on page 3, item c.

A. Thank you.

Yeah. So I think that that statement needs to be taken in context. That if someone is going to have her ovaries removed because of a fear of cancer, I think that increasingly sophisticated patients are saying I'd like to have that procedure done in a facility that does it regularly, meaning larger facilities, as opposed to having it

done in a smaller facility.

I think patients are smart and they want to get care in larger volume facilities when it makes sense to do so, which is by no means a refutation of care being provided locally and patients wanting that.

I fully understand the distinction.

Q. And there are many patients who resist being told to go to other hospitals to get ICU treatment?

MR. TUCCI: Objection, no foundation, hearsay.

THE HEARING OFFICER: I'll sustain that.

If you want to ask -- if you want to provide a foundation, or ask a question differently, maybe I'll allow it -- but.

MR. KNAG: We have -- we're covering that in the testimony of Dr. Kurish. So I won't pursue that.

BY MR. KNAG:

Q. Now in questions 2 and 11 of the -- the answers to questions 2 and 11 of the first completeness response, and in the financial summary in the second completeness response you indicate that it will be 20 to 24 fewer patients per year. Is that correct?

A. Can you give me that reference again, sir.

Q. Questions two and eleven of the first completeness response?

A. The date.

MR. KNAG: That's August 17th?

THE HEARING OFFICER: This exhibit C in the docket. What were the questions, Attorney Knag, that you're referring to?

MR. KNAG: Two and eleven.

THE HEARING OFFICER: So to the extent possible I would just ask that you try to refer to Bates numbers. I think that might be --

MR. KNAG: All right.

THE HEARING OFFICER: I'm scrolling to it now.

MR. KNAG: I downloaded from the portal. You don't have Bates numbers on my sheets.

THE HEARING OFFICER: So I think we're referring to SH-00154. The question starts, table A on page 52. Is that correct?

MR. KNAG: Yes.

THE HEARING OFFICER: Okay.

MR. TUCCI: Table A on page 52 of what document?

THE HEARING OFFICER: It's Exhibit C. It's the first completeness response from the Applicant.

MR. TUCCI: Okay.

MR. KNAG: With reference to two --

MR. TUCCI: Just to note for the record, I put the exhibit in front of the Witness, so the Witness has it to refer to.

I'll note that this level of specificity is outside the scope of what Dr. Murphy testified about. So to the extent he's able to answer it generally I won't object, but he's not -- he doesn't have a specific level of knowledge.

BY MR. KNAG:

Q. So I'm referring specifically on page 3 of 18. As discussed further below, Sharon Hospital anticipates that the change that is from ICU to PCU could potentially impact approximately two patients per month being transferred to another medical ICU if the application is approved.

Do you see that?

A. I do so.

Q. So would you agree that you predicted there could be 24 fewer patients per year?

A. That that is a possibility.

MR. KNAG: And then also in the application on page 31 could you -- Mr. Tucci, could you provide that to the Witness?

MR. TUCCI: What page?

BY MR. KNAG:

Q. Page 31 of the application.

A. Okay. Got it.

Q. And do you see that at the bottom of the page 31, in the paragraph B it says -- I think the third sentence, the hospital anticipates a 10 percent decrease in volume as compared to the most recently completed FY-2021 volume?

A. I do. I do see that.

Q. It's predicting a decrease in volume of 10 percent compared with 2021 based on your proposal. Is that right?

A. Yes, the -- and again, if -- well, I'll let you continue with your questions.

That Dr. Marshall may be in a better position to answer some of these, the details than I am, but I'm -- I'm happy to take your question.

Q. And then in 2022 was there a further drop? Was there, in fiscal year 2022 for the first six months according to the information you provided, was there a 40 percent drop in patient days compared with the prior periods when you annualize the data that you've provided?

MR. TUCCI: Again, I'll object to this as being beyond the scope of the Witness's testimony, who testified at a very high level. To the extent counsel is asking him to read and say what documents say, I suppose I won't object on that ground just to move things along.

But this is clearly beyond the scope.

BY MR. KNAG:

Q. All right. Well --

A. I don't --

Q. Go ahead?

A. I don't have that document in front of me. So I -- I don't want to affirm it, nor do I want to oppose it.

But if -- if it's important, I'm -- I'm happy to look at the specific reference, but I -- I don't recall it off the top of my head the number of patient days in the first six months of 2022.

Q. Well, do you remember whether there was a big drop?

A. Oh, in patient days? I don't. We have the President of the hospital here and we have the Chief Medical Officer. So either of them could probably give you a better answer to

that.

Q. And now in the last several months, particularly from sometime in December to sometime in January was there a problem with availability of ICU beds?

MR. TUCCI: Objection, beyond the scope of this witnesses' testimony. He does not have knowledge at that granular level. I object. I think this is really beginning to get abusive.

There are witnesses here who are qualified to provide answers to those questions.

MR. KNAG: I'll withdraw the question.

That's all I have for Dr. Murphy.

THE HEARING OFFICER: Thank you.

Attorney Tucci, did you want to do any redirect with Dr. Murphy.

MR. TUCCI: Yes, I have limited redirect for Dr. Murphy.

THE HEARING OFFICER: Okay.

MR. TUCCI: Dr. Murphy, I want to go back to the beginning of some questions that you were asked about the overall financial picture and situation at Sharon Hospital.

And again I'm just going to speak in approximate numbers.

REDIRECT EXAMINATION (of Dr. Murphy)

BY MR. TUCCI:

Q. Is it my understanding that the operation of Sharon Hospital as a healthcare facility in the most recent fiscal year has generated a loss of over 20 million dollars?

A. Yes.

Q. And do I understand -- what does that loss reflect? Does it reflect the fact that the hospital is spending 20 million dollars more in funds than the revenue that's generated by the patient care activity that the hospital engages in?

A. Correct.

Q. Can you explain to Mr. Csuka and to the members of the OHS staff why over the long term it is not sustainable from a financial or healthcare policy perspective for a hospital to operate in a situation where it spends 20 million dollars more a year than it's able to generate by caring for patients?

A. Yes, and I have a sufficient degree of respect for Hearing Officer Csuka and his staff -- that it's probably self-evident, but

we -- we don't have the ability to sustain or absorb those losses.

The -- the system does not have a balance sheet, and nor do I know many systems that would allow it to essentially bleed $25 million a year ad infinitum, and create the expectation that those subsidies are going to come from other communities that are equally expecting that hospitals meet its needs.

I think the challenge is trying to provide care in a cost-efficient manner that is of high quality in an environment that satisfies patients, and somehow try to break even. That's what we're trying to do and it is virtually now impossible to do so.

And I would be the first to say, well, maybe I'm the problem. Maybe you need a better management team. We have had experts from around the country say, what else could we be doing?

We brought in Stroudwater who is specifically prepared to look over our shoulders, critique our work, second guess our decisions. And we met with them and many stakeholders and said, tell us what we should

be doing. We are trying to do that.

And the sum and substance of it is -- is you have to retool and reconfigure the range of services to meet the needs of the community, but that does not include doing all things for all people at any cost.

We -- we simply can't provide it, and our present financials are a reflection of that. There is a deterioration, that sooner or later is going to bleed the place dry.

Q. Dr. Murphy, if you as the head of the Nuvance system formulated a plan for the future of Sharon Hospital which was, let's keep subsidizing the hospital to a tune of $25 million a year and that's our plan for how we're going to manage Sharon Hospital, how would that affect your system's ability to invest in the latest medical technology to provide services to patients in the system, to attract the type of talent you need to provide care to people who live and work in this region?

A. I think you -- you can't do it. What happens is, you know, I've been in health care long enough and trained in enough hospitals and

visited enough hospitals that what happens when you start to have these kinds of losses, that you -- you don't have the capital that the community would expect that you are, in fact, investing.

Just as Christina said, you know, with -- with state-of-the-art cardiac monitors, Sharon Hospital and its residents deserve them. You need elevators that work. You need code systems that can be activated and responded to.

The staff need to be paid competitively. Pension plans need to be funded. Units need to be adequately staffed. You -- you need to try to attract very talented physicians to the community who expect to be paid competitively.

All of those things require some financial stability and capital to make those investments, and when you -- when you look away from losses like this and pretend they're not happening, none of what I just talked about happens.

You don't fix the elevators. The code systems are antiquated. Staff isn't paid

competitively, and they leave. You break your promise and you don't fund pension plans. You don't adequately staff EDs, and everybody is seen by a by a non-physician.

Those are shortcuts and compromises that we have consistently rejected, because as I said before we very much respect the -- the integrity and the authority of your office. And we're not doing anything that we shouldn't be doing, but we are asking for help.

And by help I mean, allow us to implement a transformation plan that has been guided by the best minds in the industry that's been informed by residents of the community, that is in fact I think the best plan that we have. And no one has offered a superior alternative.

MR. TUCCI: Thank you, Dr. Murphy.

Those are my questions.

THE WITNESS (Murphy): Thank you.

MR. KNAG: May I recross?

THE HEARING OFFICER: As long as it's limited to what Attorney Tucci just questioned him on.

RECROSS-EXAMINATION (of Dr. Murphy)

BY MR. KNAG:

Q. You said that no one has offered alternatives. Is that right?

A. I said a superior alternative.

THE HEARING OFFICER: Dr. Murphy also mentioned that earlier as well. So you had an opportunity to ask questions about that.

MR. KNAG: All right. We'll get to it. We'll get to that in due course.

THE HEARING OFFICER: Okay. Thank you, Attorney Knag. And thank you, Dr. Murphy.

THE WITNESS (Murphy): Thank you.

MR. KNAG: Next I would like to cross-examine Ms. McCulloch.

CROSS-EXAMINATION (of C. McCulloch)

BY MR. KNAG:

Q. So you testified about training for your med-surg nurses to function as critical care nurses?

A. Yes, we do intend to do that training.

Q. And what type of training do you intend to

do?

A. There when -- when nurses are being trained there's a certain list of competencies that a nurse must undergo and prove that they are competent in certain areas.

So there are specific competencies for different levels of nursing services. There are medical-surgical competencies, versus PCU competencies, versus competency for an emergency department nurse. So what we --

Q. How -- sorry.

A. Excuse me?

Q. I didn't mean to interrupt you. I'm sorry.

A. You can -- you can go ahead and ask your question.

Q. So what exact form will the training take?

Who will do the training, and where?

A. We have professional development specialists that will assist in the training of the nurses. There's a variety of different methods that we use to train nurses.

Some are in the classroom setting. Some are via electronic modules. A lot of it is via mentoring with live patients with nurses that are trained.

Q. So would you agree that med-surg nurses who were just about to -- who are just starting to learn about ICU competencies are not going to be anywhere near as effective as the nurses who have years of ICU experience?

A. So we are not intending to train any med-surg nurses for ICU competencies.

Q. I meant, PCU.

A. Yeah, so as with any nurse that's learning a new specialty it takes a period of time to do that.

Q. And you talk about monitors, and there were going to be some visual monitors that were mobile. And those monitors, some of those monitors are monitored by layman.

Is that right?

A. No, that is not correct.

None of what you said is correct.

Q. Okay. Tell me whether they're going to be non-nurses looking at monitors?

A. No, that is not correct.

Q. Didn't you say that -- didn't you testify that there were going to be monitor -- there were monitors that a technician would be looking at to see the patient?

A. So I --

MR. TUCCI: Objection to the form. If you understand the question, which is very vague, you can clarify as necessary in order to be able to answer.

THE WITNESS (McCulloch): I do think I know what he is referring to, and I was speaking in my testimony about two very different types of monitoring.

There are cardiac monitors, which you referenced in the question you just asked me, which is to monitor a patient's heart rhythm.

The monitors that I was speaking of earlier where a technician is -- is visualizing a patient, those are patient monitoring texts that are -- are visualizing a patient through a camera for things such as fall/safety reasons -- so that a patient doesn't fall. I also use the example of an IV bag that may be running low where a nurse can be alerted.

So those are non -- those are functions that do not require the level of a registered nurse. So they're very different types of monitoring.

BY MR. KNAG:

Q. So the usefulness of those monitors is less than in a situation where the nurses could directly visualize the patient?

A. No, it is -- it is another method that we use to be able to visualize patients.

Q. And not all your rooms have monitors, and some of them are going to rely on mobile monitors. Right?

MR. TUCCI: Objection to the form as to what kind of monitor is being referred to, since there have been multiple monitors discussed.

BY MR. KNAG:

Q. I'm talking about the monitors with cameras in them to visualize the patient?

A. Right. It is --

THE HEARING OFFICER: Overruled.

THE WITNESS (McCulloch): So it is not standard of care to have a camera in every single patient room visualizing patients. So that is not what we have on any of our units.

MR. KNAG: That's all I have for this Witness.

THE WITNESS (McCulloch): Thank you.

THE HEARING OFFICER: Attorney Tucci, did you have redirect for Ms. McCulloch.

MR. TUCCI: Yes.

Ms. McCulloch, you've got to come back.

THE WITNESS (McCulloch): Sorry about that.

REDIRECT EXAMINATION (of C. McCulloch)

BY MR. TUCCI:

Q. Ms. McCulloch, you were asked on cross-examination about various types of monitors.

Can you can you just succinctly explain the different type of both visual and clinical monitoring capability that is planned for the progressive care unit on 2 North?

A. Uh-huh. So I'll first talk about the clinical monitoring, which is really referred to as the cardiac monitors. So on 2 North we will, in the new progressive care mixed acuity unit, have two different types of cardiac monitors.

There is a portable cardiac monitor, sometimes referred to as telemetry monitor, which is about the size of a cell phone and it is connected to leads that are on the patient to be able to interpret a patient's heart rhythm.

The -- the monitor sits on the patient usually in the pocket of their Johnny coat,

or on their bed. On that monitor you can see a patient's heart rhythm and it also has additional capabilities such as telling you what the heart rate is, or telling you what the oxygen saturation of the patient is, how well are they oxygenating.

We have 10 of those monitors, and those monitors can be used in any of the 28 rooms. The information that that device is getting from the patient, the heart rhythm, the heart rate, et cetera, is transmitted to a central monitoring station.

So it's a larger screen. We have three screens, one in the central nurse's station and two larger screens that are on opposite sides of the unit where all of this information from every patient being monitored is transmitted so that you can see the information that is being interpreted from the patient.

We also will be installing what we call bedside cardiac monitors. They are cardiac monitors that are mounted in a patient's room, and we will choose -- we're in the selection process right now getting input

from our doctors and nurses and clinicians that will use them, but we will choose two rooms on the unit to install the bedside monitors.

These will be used for patients that require a higher level of care. The difference that -- the monitors interpret most of the same information. The bedside monitor is a larger screen. Again, that is mounted in the room.

And so some clinicians prefer that when a patient is, you know, more severe and sicker than others because it's able to be visualized on a large screen in the room.

Then there are the monitors that we use for, I'll call them. For safety reasons out there we have technicians, and they're called patient monitoring techs and it's a system where there are cameras that are on wheels that we can put in any of the 28 rooms if we determine that a patient needs closer monitoring.

But this monitoring is not like a heart monitoring, cardiac monitoring. It's for patient safety reasons. So if we determine

that a patient is -- has dementia and is a high fall risk, we can put that camera in the patient's room so that the technician on the other side can, if the patient tries to get out of bed, can verbally tell the patient through a microphone on the camera to please sit down; can alert a nurse, either through the Vocera communication tool or via telephone; or can sound off an alarm.

And there are varying types of alarm. There are emergent alarms; or there are, you should get here, but it's not emergent. That sounds in the entire unit so that staff know that a patient is a fall risk.

And those aren't just used for falls, those cameras, but they're used for other safety reasons as well.

Q. Thank you, Ms. McCulloch. Now I want to talk with you briefly about your testimony concerning nurse staffing and training on the proposed mixed acuity progressive care unit.

You remember you testified about that and were asked some questions on cross-examination about it?

A. Uh-huh.

Q. So as I understand it there are certain nurses currently assigned to provide care on the first floor in what's called the ICU. Correct?

A. Correct.

Q. And then there is another complement of nurses who provide care to patients who are in the medical-surgical unit on 2 North. Correct?

A. Correct.

Q. And is the plan that the those two separate complements of nurses will be combined to be put together on the mixed acuity PCU unit on the second floor?

A. That is correct.

Q. Can you explain from both a quality and access standpoint why that combined nursing model presents advantages to how patients will be cared for in the PCU unit?

A. Yes, I can. So the way that we will staff on the new progressive care mixed acuity unit is all of the nurses, as we described, will be able to care for, once that competency, those competencies and that training is completed, any of the types of patients that we have on

that unit. So there will be flexibility and caring for medical-surgical patients versus PCU patients.

Today some of our staffing challenges exist because -- let's use the example that there may be two nurses down in -- in our ICU and there are only four patients. So the nurses have one nurse for every two patients, but those patients are PCU level of care or med-surge level of care -- which is normal for what we have in our ICU.

Those nurses should be able to care for more patients. So they should be able to care for, let's say, up to eight patients if we had the patients to fill the unit.

So you can see that it's an inefficient model when we have an average daily census of two and we have units that have minimum staffing, our core staffing which is, you know, you -- you typically want to have two staff members in a unit just as a baseline minimum staffing.

By combining the staff on one unit we're going to have more flexibility and -- and there's no limitation to, you know, these

patients have to go in this unit versus these patients have to go in this unit.

By combining them we're -- we're creating more efficiency with all of the same staff together in one unified location.

Q. Now the training process that you talked about with respect to those new nurses who are currently assigned to care for medical-surgical patients on 2 North, is it part of the plan that those nurses who will be receiving the additional training with respect to core competency relating to critical care will not be assigned primary responsibility for critical care patients until they've completed that training?

A. Yes, that is correct.

MR. TUCCI: All right. Thank you.

Those are all the questions I have.

THE HEARING OFFICER: Thank you.

THE WITNESS (McCulloch): Thank you.

MR. KNAG: I have one more question.

THE HEARING OFFICER: Is it related to --

MR. KNAG: She just testified to? Yes.

THE HEARING OFFICER: Okay. I'll allow that one question.

RECROSS-EXAMINATION (of C. McCulloch)

BY MR. KNAG:

Q. You said that you're still in the process of picking out the monitor systems you're going to purchase. Is that right?

A. We -- we already have the portable monitors in place on the medical-surgical unit. The bedside cardiac monitors, we have them chosen and ready to go there.

There is a quite an expense. We're waiting for approval of this application to be able to move forward and install those, so.

Q. But Dr. Murphy testified that there was -- that they're all ready. You're all ready to go and that they were -- that you've been waiting for over a year to start the PCU.

So why haven't these things been finalized?

A. We are ready to move forward with the next step of the planning process, but there are things that we won't move forward with until we have approval to do so.

Q. And in your application on page 29 when you

were asked about equipment costs, proposed capital expenditures, you said the proposed capital expenditures are zero.

Is that right?

MR. TUCCI: Well, now i think we're up to four questions, and that's beyond the scope.

MR. KNAG: All right. I'll withdraw the question.

Let's move forward.

THE HEARING OFFICER: All right. Thank you.

THE WITNESS (McCulloch): Thank you.

MR. KNAG: All right. Now I'm ready for Dr. Marshall.

THE WITNESS (Marshall): Good morning.

MR. KNAG: Good morning, Dr. Marshall.

CROSS-EXAMINATION (of Dr. Marshall)

BY MR. KNAG:

Q. Now the Stroudwater report indicates that medical staff felt that the ICU should be retained even if a PCU is started, and that you needed a higher level of care to be available. Do you recall that?

A. Not specifically. I apologize.

Q. And let's talk about respirators. Do you know whether there are respirators used at

the PCU at New Milford for patients transferred from the ER?

MR. TUCCI: Objection, irrelevant. We've had testimony about the plan for this, this progressive care unit and what the current capacity is in the unit that's called the intensive care unit.

How could it possibly be relevant as to what may occur at some other hospital?

MR. KNAG: Well, Dr. Murphy answered the question and I'm not sure that his answer was correct based on my information. So that's why I'm asking this of Dr. Marshall.

MR. TUCCI: That has nothing to do with whether it's relevant or not.

THE HEARING OFFICER: I'm going to overrule the objection on the same basis. As I did it before, the fact that it was the PCU -- or the ICU to PCU at New Milford was referenced in a few different locations in the hearing record. So I'm going to allow that, that question.

MR. TUCCI: Thank you. And just for clarity, is the question that's being asked of the Witness what factual knowledge he has about the capacity at the New Milford hospital? Is that the question?

I'm asking counsel.

MR. KNAG: Yes, I asked him whether the PCU at New Milford was providing respirators to patients who were transferred there from the New Milford ER?

MR. TUCCI: If you know?

THE WITNESS (Marshall): I'm sorry.

Transferred to where?

BY MR. KNAG:

Q. From the New Milford ER to the New Milford PCU?

A. So patients who are admitted to the New Milford PCU? So just a point of clarification, when you're -- you're using the term respirator, I think you, here you're meaning ventilator. Correct?

Q. Yes.

A. I do not have first-hand knowledge on the practices of New Milford emergency department and -- and inpatient units.

Q. But you've testified that Sharon Hospital PCU will have the capacity to care for critically ill patients who require a ventilator to breathe, or who need hemodynamic monitoring or vasoactive medication? Is that right?

A. Yes, that is correct. Yes.

Q. And you didn't check to see whether -- in

making that decision you didn't check to see whether other -- whether the New Milford PCU attempted that?

A. So there's obviously varying levels of PCUs, just as there are varying levels of ICUs and medical-surgical units.

Our PCU, as it is proposed, will be a high level PCU that will be able to care for patients on ventilators with the expectation that those patients will require only short-term ventilatory support for stabilization, or short-term medications to support their blood pressure.

And in the event that those patients would require a higher level of intensive care they would be transferred to a true intensive care unit, but we would care for ventilator patients.

Q. Under those circumstances?

A. Correct.

Q. So suppose they were hemodynamically unstable, would that make any difference?

A. So patients who are hemodynamically stable should be stabilized and then moved to an intensive care unit.

Q. So hemodynamically -- you said if they're hemodynamically stable. You meant, if they're hemodynamically unstable they should be stabilized. Right?

A. Hemodynamically unstable patients require immediate stabilization, and once stable should be transferred to an intensive care unit.

Q. So you say physicians treating patients who are in a prolonged state of instability with respect to blood pressure, heart function, or compromised breathing may opt to transfer those patients to a bigger hospital with the resources to care for such high acuity patients. That would be your recommendation in all these cases. Is that right?

A. I think that the -- the term would be depending on the individual case and the ability to stabilize them quickly on the underlying condition.

But patients who require multiple modes of -- of physiologic support should be cared for in an intensive care unit with critical care board-certified physicians at the bedside.

Q. Is it true that respiration management is one of the most difficult duties of an ICU?

A. I'm not sure I really understand the question. What -- what do you mean by respiration management.

Q. Managing a patient on a ventilator.

A. Is that a complex process? Absolutely.

Q. Is that one of the most difficult duties for an ICU nurse?

A. I -- i really can't comment. I think that there are certainly lots of things that are difficult in the care of critic -- critically ill patients. The ventilator may or may not be the top of the list.

Q. And is it true that without skilled meticulous attention to detail the patient could rupture a lung, suffer brain damage and die?

A. With -- without meticulous attention to detail on -- in every aspect of what we do patients can suffer.

Q. So in 2021, in late 2021 you develop the admissions policy which is attached to the application and also to Dr. Kurish's testimony. Is that right?

A. So in 2021 we began the process of putting together a workgroup and establishing some criteria that we would consider as appropriate or inappropriate.

However, that policy as you described it is a draft and is evolving constantly. It's a living breathing product, and we actually meet periodically to discuss it.

And what you have referenced is not the latest version of that policy.

Q. And how has it changed?

A. Well you know, at the beginning of the process we wanted to be sure that it was very clear that there were points that could be followed by -- by a non-physician perhaps.

But over the evolution of the document we determined that certain -- certain perceptions were erroneous in that we would continue to care for critically ill patients who require ventilatory support.

And that each individual patient would be assessed on their own care, their own case, and the decision would be made at that point whether they could stay at Sharon Hospital or not.

It would include the -- the physician, the -- the nursing staff available, and the patient, their condition and their preference.

Q. So after the promulgation of this first draft of the admissions policy did you implement a policy concerning admitting patients to the ICU who required intubation?

A. I don't believe we implemented any new policies.

Q. Did you discourage physicians from admitting patients who required intubation?

A. Absolutely not.

MR. TUCCI: Obviously the Witness has answered the question, but just note my objection. This will be the subject of our written objection to the different variations on the conspiracy theory we've heard throughout these proceedings, which are completely unfounded.

THE WITNESS (Marshall): I would just add that those of us who care for patients who are critically ill are not opposed to caring for patients on ventilators.

I personally find ventilator management a satisfying part of my role.

BY MR. KNAG:

Q. All right. And was there an increase in the number of patients transferred from the ER at Sharon Hospital to other, other Nuvance hospitals?

A. So I know that we transfer a certain number of patients every month. We -- we follow those numbers. We -- we look at those cases.

I know that there have been times in the past year or two that staffing levels were not adequate to care for certain levels in our current unit and patients were transferred. For that reason there were patients that had been transferred for lack of availability of certain physicians and specialties.

So you know, I believe that that process of transfer and decision-making hasn't -- hasn't changed at that level. It's all based on a capacity and availability.

Q. During the period from December to January, December of 2022 to January of '23 were there problems with availability of beds, ICU and med surg?

A. I believe at that time we were experiencing

difficulties with -- with staffing by -- by nursing. We had some -- we had some nurses that went that were out for various reasons.

And so there were times during that period that that unit had to have a cap of four patients.

Q. But was there also a problem that the Vassar and Danbury hospital ICUs were full on various days during that period?

A. I'm sure that they were. There were -- there were periods of time over the past several years that, you know, critical care censuses have been high.

And absolutely, some of the other hospitals had -- had high levels of critical care census, sure.

Q. And there was a shortage of ICU beds all across the state and in other states as well.

Isn't that right.

MR. TUCCI: Objection as to relevance.

A VOICE: How is it not relevant?

THE HEARING OFFICER: Mayda, can you please mute Deborah? Thank you. I apologize for that.

That was a member of the public.

Attorney Knag, do you have a response to

Attorney Tucci's objection.

MR. KNAG: Well, he's claiming that this is in the interests of -- that they have these empty beds and it makes sense to -- that he's claiming that eliminating the ICU level of service is in the interests of the public.

And the fact is that we've had a shortage of ICU beds during that period that I just referred to, and during a previous period at the beginning of COVID where there were no ICU beds available and that was a big problem at Sharon Hospital and other hospitals all across the state.

And so it bears on the testimony of the doctor, that it makes sense to eliminate the ICU level of service.

MR. TUCCI: Well, again --

MR. KNAG: And to take eight beds out of -- take eight physical beds out of use.

MR. TUCCI: That completely misstates about the last three hours of testimony and information that has been heard.

This is not a proposal to terminate a number or reduce the number of beds. As witness after witness has testified, it is to relocate the same capacity to a different physical space on the

second floor.

MR. KNAG: So I would point out that they say they're going to take the eight beds and move them, and then those eight beds will be used for non-inpatient purposes, or for other purposes unspecified.

So on the net basis there they're eliminating beds, and yet we have had critical shortages of beds, both ICU and med surge. And I'm just trying to put that in the record through this, this Witness.

And it certainly is relevant to whether it makes sense to terminate these beds and move them away, and close that, that physical space down.

THE HEARING OFFICER: I think we've sort of lost track of what the original question was. You were asking Dr. Marshall about the rest of the state.

Wasn't that your last question?

MR. KNAG: Yes. My question was, wasn't there a general shortage of ICU beds available throughout the state?

THE HEARING OFFICER: I'm going to overrule the objection. I mean, Dr. Marshall, if you're aware of that you can certainly respond to it.

THE WITNESS (Marshall): Sure. Sure, absolutely. So

there are times in the past and in the present where there have been capacity issues in all the local hospitals, for sure.

The -- the issue with Sharon Hospital being, you know, a small rural hospital is that we've not been close to our maximum capacity. Any issues with availability have been mainly due to staffing mainly on the basis -- or let me not say, mainly on the basis, but often on the basis of having these two units geographically separated.

So for example, if you have one nurse in the first-floor unit with four patients and two nurses on the second-floor unit with twelve patients, if you move that nurse and those four patients upstairs you would actually increase the capacity of all of the -- the nurses and the unit.

Now there will be no elimination of beds because those beds are going to be filled as opposed to being remaining empty. And the empty space that lives on the first floor can be better utilized for another purpose.

Now when a patient has to be transferred to a higher level of care sometimes it's, you know, there are capacity issues and we have to find the most appropriate bed. We're not going to transfer

a patient who needs a certain level of care to -- to a hospital that cannot accommodate them.

And that decision is made by a conversation, a collaboration between the physician, the patient, their family, their loved ones, their caregivers; the proper disposition is made with the patient's consent and participation.

BY MR. KNAG:

Q. But if there were additional nurses that became available, you were able to find additional nurses you would be -- there would be eight fewer beds even if the staff was available to staff the available physical beds?

A. So I guess, literally speaking those physical beds would no longer be there, but it's only because that there is capacity on the second floor to take that number of beds and more.

So the overall functional number of beds shouldn't really change, but you are correct in a literal sense.

Q. So one of the things you raise is intensivists, which you don't have -- but isn't it true that only 52 percent of the hospitals in the country have intensivists

for their ICU?

A. So I think that first -- first, let me say I do not know that that is true.

Second, let me say that, you know, what is described as an ICU is going to vary.

And so you know, a unit like the proposed PCU some people might call that an ICU if they take care of ventilator patients, things like that, but in reality in -- in this century an intensive care unit at a tertiary care hospital is different.

Now our PCU will function at a high level, meaning that we will take care of patients who require physiologic support, ventilatory support, even procedures that we are able to perform at Sharon Hospital.

But -- but it will not be an intensive care unit based upon the current definition of that level of care.

Q. So one thing that you do have right now is tele-intensivists. Right?

A. We have a -- yes, a tele-ICU program that -- that can provide consultation via telemedicine, correct.

Q. And according to page 31 of the application,

they're going to be dropped?

A. So I -- I would say a couple of things. I would say that I don't believe that the tele-ICU program that we have has been well utilized, number one.

I don't think it's been terrifically helpful, and I know that there have also been some issues with classification of patients as ICU level versus step-down level.

But our plan is to expand telemedicine services from within Nuvance. And I've been in talks with some of our critical care specialists within the system to provide tele-critical care consultation to our physicians who are caring for those patients who are critically ill.

Q. And it's true that one of your nine rooms in the ICU is used for storage.

So it's not available?

MR. TUCCI: If you know?

THE HEARING OFFICER: Sorry. Attorney Knag, can you phrase that as a question.

BY MR. KNAG:

Q. Is it true that one of the rooms, one of the nine ICU beds is used for storage?

A. Yes. So -- so there is a room that was outfitted as a monitored room. I don't think anyone would have ever considered that an ICU room. At best it may have been a telemetry room.

And because of the lack of need it is -- it is used as a storage room, but it can certainly be converted back if -- if needed, but we have certainly not needed it.

Q. And you've mentioned, and it is the case that there have been times when the staffing of the ICU has been insufficient to support more than four people?

A. Yes.

Q. And then also there was a short time in 2022 when they closed for several days?

A. Yes, I believe that is correct.

MR. KNAG: That's all I have for this Witness.

THE HEARING OFFICER: Thank you. Attorney Tucci, did you have any redirect for Dr. Marshall?

MR. TUCCI: Yes, I do. Thank you, Mr. Csuka.

REDIRECT EXAMINATION (of Dr. Marshall)

BY MR. TUCCI:

Q. Dr. Marshall, you talked about the existing tele-intensivist ICU system that's in place now.

Can you explain what the advantages are of the plan to replace that system with a system that allows consults from specialized physicians within the Nuvance system?

How will that be better?

A. Sure. So that system will allow more integration between Sharon Hospital and other facilities within Nuvance. Those physicians will have access to imaging and records that -- that exist.

And often, or potentially frequently those physicians will be accepting physicians on the other end of a transfer.

So there are -- there are advantages.

Q. What kinds of specialists are you talking about that will be available throughout the system? Just give us a couple of examples.

A. Sure. So right now we have a tele-neurology program, and we're working on -- we're very

close to completing a tele-infectious diseases program.

The tele-critical care program will progress as our conversations increase, and we're also actually working on a tele-psychiatry system which is a little bit separate from this issue.

The -- I think that the, you know, the system-ness of this approach is going to be beneficial, because those patients that go to one of our other hospitals are going to return to the Sharon Hospital community, and all of that information will be easily available to their clinicians locally.

Q. So if you have a problem, if you have a patient who's on the progressive care unit who has some neurological issue that you think needs input or consultation from a neurological specialist within the Nuvance system, you're able to get that through this program. Correct?

A. That is correct.

Q. And is my understanding correct that that specialist neurologist, or neurology, whatever field they may be in, have the

ability to look at that patient's medical record as well?

A. That is correct.

Q. The same record you're looking at here at Sharon Hospital?

A. Yes.

Q. All right. Now let's talk about the physical space on 2 North. There's 28 beds on 2 North. Correct?

A. That's correct.

Q. And did I understand correctly that roughly speaking the average patient census for those 28 beds is what? Six? Eight?

A. Ten.

Q. Ten? Okay.

A. Yeah.

Q. So my math is not great, but if you have an average patient census where 10 of those rooms are filled on any given day, that leaves 18 additional rooms to care for critical care patients who might need critical care. Correct?

Those rooms can be amped up to provide that service. Is that true or not?

A. Yes, that is correct.

Q. As long as you have enough nurses you can care for them. Right?

A. Yeah.

Q. Okay. Doctor, is it correct that with respect to the level of critical care services that are currently provided at Sharon Hospital, you have the capacity to provide care to patients who need ventilator support?

A. That is correct.

Q. And will that be true tomorrow, or whenever when the progressive care unit is approved?

A. Yes, we're -- we're envisioning this unit as -- as having the capacity to care for the same patients that we care for today tomorrow.

Q. What does hemodynamically unstable mean?

A. So patients who are hemodynamically unstable means that usually their blood pressure or heart rate, or a combination are inadequate to provide enough blood flow to their organs and they risk tissue damage, organ damage and potentially severe complications.

Q. And do you, here at Sharon Hospital do you currently care for patients who exhibit signs

of hemodynamic instability?

A. We do.

Q. Okay. And when the PCU program is up and running, if and when it's approved, will you continue to care for patients who exhibit hemodynamic instability?

A. We will.

Q. All right.

What is vasoactive medication used for?

A. So most typically these are medications that allow a rise in blood pressure to better support the organ tissue perfusion.

Q. Wow. That was a mouthful. So if somebody has compromised blood pressure, meaning it's dangerously low --

A. Yes.

Q. There's medication you can give them to make sure their blood pressure gets to a more normalized level. Correct?

A. Correct.

Q. And do you currently provide that kind of therapy and service to patients who are in critical care here at Sharon Hospital?

A. Yes, we do.

Q. And will you continue to provide that kind of

medical support and therapy to patients who require it in the progressive care unit?

A. Yes, we will.

Q. All right. Now can you explain to me as a lay person with respect to these three types of patients, conditions and patients we just talked about from a quality of care standpoint and a patient safety standpoint, why is it not appropriate for Sharon Hospital to admit and care for those patients if they have those symptoms or those problems on a long-term basis?

A. So on a most fundamental level patients who require the input of multiple specialists to provide that level of care including critical care specialists, potentially kidney specialists, liver specialists, those patients and -- and patients who do not respond rapidly and stabilize rapidly or require multiple, multiple sources of support, those patients are best served by being under the care of that team of physicians with that technology.

And they have a much better chance of survival and better outcomes.

Q. That team of specialists isn't currently present at Sharon Hospital. Correct?

A. That's correct.

Q. And it won't be. That team of specialists isn't going to be at Sharon Hospital tomorrow if there's a progressive care unit. Right?

A. That's correct.

Q. And if that team of specialists didn't -- if that patient who required that team of specialists didn't have them readily available what could be the consequence?

A. They would -- they would probably die.

MR. TUCCI: I don't have any more questions for you, Doctor.

MR. KNAG: I have no questions.

THE HEARING OFFICER: All right. Thank you.

Let's just take a five-minute break.

MR. TUCCI: I need a break.

THE HEARING OFFICER: And then we'll come back.

Attorney Knag, I'll have you do your opening statement. And Dr. Kurish can make his opening statements as well, and then we'll go on our lunch break. So everybody, let's come back at 12:11 and then we'll go from there.

(Pause: 12:06 p.m. to 12:12 p.m.)

THE HEARING OFFICER: I know that was a pretty short break, but if we can get everybody back on camera again before we take lunch, I'd appreciate it.

MR. KNAG: Okay. I'm ready to go.

THE HEARING OFFICER: Okay. Attorney Tucci, are you ready?

MR. TUCCI: Yes, thank you.

THE HEARING OFFICER: Okay.

Welcome back, everyone. This is the hearing concerning Sharon Hospital in Docket Number 22-32504-CON.

We did the Applicant's case earlier, and now we're going to begin the Intervener's case prior to taking our lunch break. So I'm just going to start from where we left off.

I did want to remind everyone who is in attendance that public comment signup will take place from 2 p.m. to 3 p.m., after which point it will shut off. So if you plan to make public comment, please sign up during that time.

I'm going to turn the camera over to Attorney Knag to make an opening statement on his client's behalf.

MR. KNAG: First of all, I would start by pointing out that there is no financial rationale for this proposal, and that's because the Applicant itself states that its implementation will result in increased losses.

And while we feel that the amount of the incremental loss is understated, there's no dispute that it's going to result in incremental losses.

Furthermore, the Applicant in its application didn't list any capital costs, and now we're hearing there are going to be certain capital costs that were not scheduled, and that would increase the loss.

And we also know that the ICU volume decreased substantially by 40 percent in FY22. So we know that the criteria that the hospital has been applying already, even though the PCU hasn't been approved, has resulted in a substantial loss of income well beyond what they projected.

MR. TUCCI: Mr. Csuka, I must respectfully note an objection here. I believe that your order called for the delivery of opening statements. The purpose of an opening statement is to summarize the evidence that will be presented by a party or

an intervener in a proceeding, not to make a closing argument.

MR. KNAG: This is our evidence. Mr. Tucci set out his evidence, and I'm setting out my evidence.

THE HEARING OFFICER: Understood. How we got here isn't really as much of a question as, what do we do with this application?

So your comments that they implemented a policy at a prior date, even though there's no evidence of that up to this point, I understand your position -- but that's a little bit argumentative at this point.

MR. KNAG: Right, but what I'm saying is that Dr. Kurish is going to testify about that.

THE HEARING OFFICER: Okay.

MR. KNAG: And then we note that, as we pointed out, that there's been a shortage of ICU beds as well as med-surge beds, particularly in the December to January period, and also prior to that during the opening of the COVID circumstances.

And under these circumstances we believe that taking eight or nine beds out of service by closing the ICU beds makes no sense. And as it was, the hospital was in a situation during that period where people sat in stretchers in the ER

waiting for an available bed when no bed was available.

Now also the Applicant claims low, low utilization, but we will show that the utilization was understated because, number one, there was this room that was used as storage. And number two there, there were nursing shortages, understaffing shortages that has been a problem ever since the CEO came in and told the ICU nurses that the ICU would be closing. And the ICU --

MR. TUCCI: Move to strike it. I move to strike that.

Mr. Csuka, you've issued a very clear ruling here, that this goes to the heart of your ruling regarding any -- any allegations or assertions concerning the agreed settlement.

MR. KNAG: This has nothing to do with the agreed settlement. It has to do with the fact that the ICU nurses, they were short of ICU nurses and that that resulted in a limitation on the amount of patients that could be taken.

And it's already -- Dr. Marshall has already admitted that that was the case, and I'm just reviewing that as part of my whole big statement. And Dr. Kurish is going to further elaborate on that.

THE HEARING OFFICER: I'll allow it. Overruled.

MR. KNAG: Previously there were no problems at Sharon Hospital about staffing. Sharon is a wonderful place to work and it has had a strong record of recruiting and retaining staff. And we believe that over time this could be restored.

And there's also no doubt the termination of the ICU and the creation of the PCU will result in a loss of capability, accessibility, and quality. ICU nurses are trained to deal with ICU cases.

They must be able to identify arrhythmia, septic shock, and respiratory failure. They manage respirators with sedating medications, care for patients with detoxifying overdoses, support patients with massive GI bleeding, and manage post-op patients.

The med-surg nurses don't have this training and will not be able to adequately provide these services in the same way that they are being provided currently by the experienced ICU nurses.

Furthermore, the proposed ratio at the PCU is 4.5 to 1. And the ICU is supposed to be staffed at a ratio of two to one. And so the availability of nurses is going to be reduced, and they've mentioned that in addition to caring for the PCU

patients, some of these nurses are going to be asked to care for other -- other patients.

The proposed PCU rooms are patient rooms which are not designed for critical care. They're too small for the various equipment that's going to be placed in there. The HVAC units which provide negative air, negative pressure, are only in two of the five rooms that they have chosen to be the PCU rooms.

And most importantly, the patients are in rooms -- and not in the rooms and not in the line of site of the nurses as in the ICU. That's the biggest and most important point.

The consequences of all this is that it will not be possible for the nurses in the PCU to continuously monitor the patients as in the ICU. And that's why there are classes of patients that currently are being taken care of that will not be able to be taken care of once the PCU is in force and replacing the ICU.

The hospital claims that there will be no change, that they'll be able to take all the patients -- but at the same time both the application and the first and second completeness filings state that volume will decline by 24 cases

a year and 10 percent compared with 2021.

And as we've said, the actual -- as they've put pressure on doctors in terms of who could be admitted to the ICU, there's been a decline --

MR. TUCCI: Objection, false, baseless.

MR. KNAG: We're going to, you know, that's information that was not false or baseless, but rather that was supplied by the hospital.

THE HEARING OFFICER: Overruled. Attorney Tucci, if you want to include any of this in your written objection, you're free to do that.

MR. TUCCI: Thank you, sir.

I will refrain from further objection.

THE HEARING OFFICER: Thank you.

MR. KNAG: You know, the proposal that they could take intubation, intubated patients who are hemodynamically unstable is not consistent with the PCU level of care. And their claim that they could take these patients is not appropriate, and that these patients will be subjected to great risk if they are in fact taken.

So respirator management is one of the most difficult duties for an ICU nurse and without skilled, meticulous attention to detail, the patient could rupture a lung, suffer brain damage

and die.

We'll also show that another type of patient we're currently seeing are patients with GI bleeding who are not hemodynamically stable. These patients won't be accepted according to the policy, and the PCU doesn't have the capability to deal with the patients.

Another group that is being handled now and can't be handled in the PCU are patients who have sepsis due to UTI, urinary tract infection, or pneumonia and need vasodilators. And also arrhythmias; these patients need continual monitoring which is not available, and so they're not suitable for the PCU.

There are also patients who can't be transferred due to weather or unavailability of ICU beds. The hospital needs to be prepared for cases where they would like to transfer, but would be without remedy if the ICU is closed and no other hospital will take them.

So that's -- I think that's a key point, that we since we're isolated, we have to be able to take more serious patients and this change will undermine that.

The ultimate result of the approval list

proposal is that persons who are very sick will need to be transferred, which will imperil their health. They will not be treated at a five-star hospital, which is Sharon's status, and they will be subject to long transfer delays, hours and hours, and substantial incremental out-of-pocket costs which might not be covered by insurance, especially if the transfer is by helicopter.

They also will be far away from their loved ones at a critical time when they need support from their loved ones. Dr. Kurish gives us an example, one of his patients with a drug overdose who needed intubation.

The patient was treatable in the ICU, but the administration felt that he shouldn't be -- but then when they tried to find a bed, no bed was available. So he was kept in the hospital. And then when he was kept in the hospital, they treated him well, but in the PCU model this type of patient would be inappropriate.

And those people who are not transferred will be imperiled by the lower quality of the PCU compared with the ICU in view of all the factors that I've just mentioned.

Now it's said that --

MR. TUCCI: Mr. Csuka, may I respectfully inquire as to time?

MR. KNAG: I've got two more paragraphs and then I'm done.

The medical staff of Sharon Hospital voted 25 to 1 against the plan. The ED docs, surgeons, community internists were all against it. And the ER docs want to transfer patients out of the ICU quickly without spending time trying to find a place to transfer the person/patient.

Surgeons want the ICU for patients with complicated comorbidities and post-op problems, and internists need a place nearby to handle their most seriously ill patients. Closing services such as maternity and the ICU would gut the hospital.

Rather than doing that, the hospital should join us in working with state officials to obtain increased reimbursement from the State and raising money to support continued services and in taking other steps such as were taken at Nuvance's Putnam hospital, which has just reopened the maternity based on such efforts.

So now we're ready to have our two witnesses. The first one is the Intervener, Dr. Kurish, and

Mr. Victor Germack will be testifying after him on financial issues.

THE HEARING OFFICER: Thank you. And I did just want to remind Dr. Kurish and Mr. Germack that I'm going to be limiting them both on their opening statements to about five minutes.

Given the fact that I only issued that order yesterday, if you need to go over by a little bit I'll give some leeway, but really try to limit it to five minutes, if at all possible.

MR. KNAG: Are we ready to proceed, or do you want to take lunch?

MR. TUCCI: Let's proceed.

THE HEARING OFFICER: Yeah, let's just proceed and get these two opening statements on the record and then we can take lunch.

D R. D A V I D K U R I S H,

called as a witness, being first duly sworn by the THE HEARING OFFICER, was examined and testified under oath as follows:

THE HEARING OFFICER: Thank you. You can proceed.

THE WITNESS (Kurish): I'm Dr. David Kurish, a board-certified internist with cardiovascular training from the University of Rochester, who's

been here for 44 years, including in the ICU. My wife and I have both been patients in the ICU, so I'm aware of the situation.

As I've discussed in my prefile testimony, the intensity -- the intensity of care in a PCU is inferior to the care of an ICU. For example, the Nuvance PCU proposal does not allow for a nurse watching the EKG monitor at all times, as in the case in the ICU.

Without an RN watching a monitor at all times, serious arrhythmias and other potentially fatal events can then be overlooked. Additional differences are set out in my prefile testimony -- testimony.

Reflecting this, the Nuvance PCU policy specifically excludes patients that we care for here now. One, patients that are economically unstable with respiratory failure or are on BiPAP, patients with massive GI bleeding, unstable blood pressures; they need to be watched directly to see if they're vomiting, et cetera.

We care for serious ill arrhythmias that require continuous monitoring by an RN with prompt administration of medications when necessary, and monitoring with other vital signs.

We care for sepsis, as has been pointed out, with pneumonia or urinary tract infections that are hemodynamically unstable sometimes for days at a time. We take care of drug overdoses or alcoholism with DTs and seizures, and drops in blood pressures that need to be constantly watched.

Nuvance's policy regarding the PCU policy has evolved. Currently, the Sharon Hospital ICU has the ability to care for intubated patients on respirators in both the short term and the longer term, sometimes for a few days.

The initial transformation plan announced in 2021 said there will be no ventilator patients in the proposed ICU. In their August '22 letter to OHS to close the ICU, the Applicant says Sharon Hospital will not be able to provide long-term ventilator support.

Now, the latest PCU proposal provided by Dr. Marshall's testimony in the hearing says that we do not intend to reduce the level of care currently available to critical care patients -- talking about moving the goalposts. That contention is absurd.

By definition, PC -- PCU rarely have

respirators. And most institutions -- most institutions restrict respirators to ICUs where the skills and training are seen to manage patients. It's irresponsible, in my opinion, to claim that a med-surgical nurse in what Sharon Hospital called a PCU could safely handle an intubated respiratory patient.

Presently, none of Nuvance Hospital's PCU patients -- they have three PCUs, have intubated patients. And my sources at Danbury say those patients are not in the ICU down there either. Nuvance's testimony also alleges that patients on -- Nuvance testimony also alleges that patients on vasodilators treating septic shock would be cared for at the proposed PCU.

This claim has also evolved since the transformation plan was announced that vasopressors would not be allowed in our PCU here. The hospital policy changed to allow these short-term vasopressors. Now, a testimony by Dr. Marshall says that these will be allowed unless the doctor decides to transfer somebody elsewhere.

Nuvance is being reckless with patient safety. They are changing their narrative to

achieve the goal of shifting the ICU patients to an unsafe PCU. These unsafe patients shouldn't be in our -- should be in our ICU by any acceptable standards.

Our nurses and doctors in our PCU have the skills needed to treat these patients. In fact, there's -- in fact, Vassar's PCU did not care for patients requiring strong vasopressors. They do not take care of the patients that require strong vasopressors -- to emphasize that.

We do not need an intensivist, as I already pointed out, and 90 percent of hospitals our size in the Northeast have ICUs, not PCUs. Only eight hospitals in Connecticut have PCUs and all have ICUs. So for these reasons, I think it's totally unreasonable to consider a PCU in our community hospitals by sacrificing these services.

Patient safety and quality of care is of utmost concern. I think it's crucial for OHS to take these considerations for our patients and our community here.

Did I get five minutes?

THE HEARING OFFICER: You were well under five minutes. Thank you, Dr. Kurish.

So, Attorney Knag, does Mr. Germack have an

opening statement that he'd like to make as well?
MR. KNAG: Yes.
THE REPORTER: And could I have Dr. Kurish's spelling for his name?
THE WITNESS (Kurish): K-u-r-i-s-h.
THE HEARING OFFICER: And we can meet with you after the hearing as well if there are any other names that you need, or if there's anything else that you need from us.
THE REPORTER: Thank you.
V I C T O R G E R M A C K,
called as a witness, being first duly sworn by the HEARING OFFICER, was examined and testified under oath as follows:

THE HEARING OFFICER: Thank you. As with Dr. Kurish, I will give you a little leeway, but try to limit your commentary to about five minutes.
THE WITNESS (Germack): Thank you. Good morning, Hearing Officer Csuka and the staff of the Office of Health Strategy. My name is Victor Germack, and I'm a Vice President of Save Sharon Hospital, Inc.
As a financial expert, the arguments and data used by Nuvance to support discontinuing Sharon

Hospital's ICU and replacing it with a lower level of patient care offered by a PCU make no economic sense.

Dr. Murphy stressed cutting losses as the rationale for the PCU, but there is no financial rationale for closing the PCU, as Sharon Hospital suggests that this will cause them to incur additional financial operating losses annually.

Contrary to Sharon Hospital's statements, Sharon Hospital itself indicates replacing the ICU with the PCU will cause new patient transfers, at least 20 patients annually, but they say the same level of service will be maintained, which we have shown will not be the case.

Also, Sharon Hospital projects a 10 percent decrease in critical care volume compared with fiscal year 2021 -- but as we have seen from table two in my prefiled testimony, in fiscal year 2022 annualized, the actual drop in ICU occupancy was approximately 40 percent.

Nuvance's financial projections show a loss of $17,150 per patient in revenue loss. So in addition to losing access to care and a reduced quality of care, Sharon Hospital will incur a very substantial loss of income, which is contrary to

Dr. Murphy's stated objective.

Nuvance's current policies result in a lower ICU utilization, but they're roughly in line with Northern Dutchess Hospital. And Nuvance is not intent upon closing their ICU.

738 patients or 51 percent of the transfers from Sharon Hospital's emergency department have gone to Nuvance hospitals over the 2019 through 2022 period, primarily to Vassar and Danbury. This has significantly decreased the revenue available to Sharon Hospital to achieve financial break-even.

Sharon Hospital has not provided the reasons for these transfers, so we don't know how many patients could have been treated at Sharon Hospital if staff had been provided. However, the potential incremental revenue to Sharon Hospital with less transfers should generate several million additional dollars.

The fact that transfers to Charlotte-Hungerford, the closest hospital to Sharon Hospital, was only 2.8 percent of total transfers shows the favoritism towards Nuvance hospitals. This works to the detriment of Sharon Hospital patients, particularly those patients

with no insurance, Medicaid, indigent, and patients living below the poverty line.

The equity of transferring patients far away from home places a heavy burden and cost on them and their families. Not only are they being turned away at Sharon Hospital, but they are also being shipped further away from their homes than if the transfer had been to Charlotte-Hungerford.

Dr. Murphy's stated concerns about Sharon Hospital financial losses lacks relevance when a solution of a PCU will actually cost Sharon Hospital even more losses. And you know, their 2023 first quarter projected losses are just projections, and they're not our numbers. They're unaudited, and we don't know the expenses or the allocated charges for Nuvance.

So before Sharon Hospital was acquired in 2017, we know from state documents it showed a 1.1 positive gain. Now we have a $20 million loss? How did this happen? It happened because there's a patient volume problem, and the solution is to add back the patients and all the services that have been taken away.

If he's serious about losses, he should bring back the millions of dollars of services and

procedures that have been eliminated and/or moved to Danbury and Vassar Hospital, buy more primary care and specialty physicians that have not been replaced, expand the ICU staff and its ability to treat more patients -- and most importantly, not close labor and delivery.

Sharon has transferred many procedures and tests to Vassar and Danbury, as stated, which have had an economic value of approximately $6 million annually in lost revenues, according to Stroudwater. Stroudwater report tells us Sharon Hospital's IP, inpatient, outpatient, endoscopy surgeries declined 37 percent, 13 percent, and 31 percent over the 2018 through 2021 fiscal periods.

Other outpatient routine procedures such as OP imaging, cardiopulmonology, imaging, and physical therapy also decreased over the same period. However, Stroudwater tells us that Vassar Brothers Medical Center market share increased, indicating that Sharon Hospital's IP volume was retained within the system. Thank you.

Now, Dr. Murphy, please work with us and the community to bring back Sharon's revenue, and we can all make Sharon Hospital self-sustaining.

Thank you.

THE HEARING OFFICER: Thank you, Mr. Germack.

At this time, I would like to take lunch. I think if we do, let's say, an hour, we'll come back at 1:40. We'll pick up with cross-examination of the two intervener witnesses, and then we will proceed from there.

So with that, let's take a break until 1:40.

And I did just want to remind everybody from the public who's in attendance, sign-up for public comment will be from 2 to 3 only.

Thank you very much.

(Pause: 12:40 p.m. to 1:42 p.m.)

THE HEARING OFFICER: We can start the recording again.

Welcome back, everyone. This is Docket Number 22-32504-CON. It's an application by Sharon Hospital for the consolidation of critical care services into a PCU.

We have gotten through the Applicant's case-in-chief and all the cross-examination on that. And we've also done the opening statement and the preliminary statements from the two intervener witnesses.

Just to give everyone an idea of what the

rest of the day is going to look like, next on the list will be cross-examination and any redirect.

And then after that, I think we may take a short break, either that or we'll go directly into the public comment portion, to the extent that it will probably just be the comment from the individuals that the Applicant signed up in advance of the hearing.

There are 17 different individuals there, which I think will take up the bulk of an hour. And then we will go into the OHS questions at some point.

We will need to take a short break. I think the analysts will need to sort of regroup on their own questions to make sure they're not asking questions that have already been answered. So we will do that once or twice just to make sure that we're not wasting anybody's time.

I don't expect that we will be doing public comment from the remainder of the public today, as I indicated in one of my prior orders. I expect to do that on the follow-up date, which will be next week; it's Wednesday at 9.30am.

Public comment for this hearing, the sign-up is between two and three o'clock today. So the

public comment itself will occur next week on Wednesday.

If there is a need to ask further questions of the Applicant after that point, then we will need to decide on another date and time, and unless the Applicant's witnesses can be available on that particular day. So --

MR. KNAG: Hearing Officer, may I ask a question?

THE HEARING OFFICER: Certainly.

MR. KNAG: We are aware of certain public officials who have or will be signing up to participate, and we ask that consideration be given to taking them today.

They're planning to testify today and we don't think they'll take up too much time, but we hope that you'll find a way to accommodate them.

THE HEARING OFFICER: Yeah, that -- that should be okay. While we were on break, there was some e-mail correspondence about the 17 individuals that the Applicant had pre-signed up. It sounds like the only one who has the firm deadline is number one on the list, Mr. Dyson.

So I'll probably have him go first, and then the public officials, and then the remainder of the 17 other witnesses.

So with that, I would like to proceed to cross-examination of Dr. Kurish.

Attorney Tucci, do you have any questions for Dr. Kurish?

(Pause.)

THE REPORTER: This is the reporter.

I'm not hearing anyone.

MR. TUCCI: I apologize. We were off mic for a moment.

Mr. Csuka, yeah, we're prepared to proceed with cross-examination.

I'd actually like to call Mr. Germack first.

THE HEARING OFFICER: That's fine with me.

And once Mr. Germack comes up to the camera, I do just want to say one thing before we start.

Okay. Mr. Germack, I did just want to remind you that I placed you under oath earlier, so you are still under oath for the remainder of the hearing.

And now, Attorney Tucci has some questions for you.

MR. TUCCI: Thank you, Mr. Csuka.

Mr. Germack, good afternoon.

THE WITNESS (Germack): Good afternoon.

CROSS-EXAMINATION (of V. Germack)

BY MR. TUCCI:

Q. Can you hear me?

A. Yes, perfectly.

Q. Great. Mr. Germack, I'd like to just make sure as we begin our conversation today that I'm clear about your role in testifying here this afternoon.

You're here to testify in your capacity as a financial expert. Correct?

A. Yes, but in addition as a member of Save Sharon Hospital, and my general knowledge of the situation.

Q. I understand that, but to the extent you're offering opinions and substantive information, you're doing so based on your knowledge and training and experience as a financial -- as a person with financial expertise. Correct?

A. Correct.

Q. You'd agree with me, obviously you're not a doctor?

THE HEARING OFFICER: Let's just take that one at a time. You're not a doctor. Correct?

THE WITNESS (Germack): No. In fact, no.

BY MR. TUCCI:

Q. All right. You're going to have to get closer to the microphone, sir, so I can hear you.

All right. And I looked at your curriculum vitae, and it doesn't show that you have any education or training or experience in delivering health care to patients. You'd agree with me on that.

Correct?

A. In delivering health care to patients? No.

Q. And you'd agree that you don't have any training or work experience in the operations of a hospital unit that delivers critical care to patients. Correct?

A. Not in delivering care to patients.

Q. All right. At page 2 of your prefile testimony, if you could refer to it, please?

The bottom paragraph that begins, I reviewed in detail Nuvance's CON application?

A. Yes.

Q. The last sentence of your prefiled testimony indicates that one of the things you intend to show is that Nuvance's discontinuation of

Sharon Hospital's ICU and replacing it with a lower level of patient care offered by a PCU is not correct.

You don't have any medical education, training, or experience to support an opinion that patients will get a lower level of care at a progressive care unit at Sharon Hospital than what's currently available at Sharon Hospital. Isn't that so, sir?

A. I'm merely repeating the assertion that was made by Sharon Hospital and Nuvance in their filings.

Q. You would agree with me, sir, that you have no education, training, or experience to support a conclusion that if a progressive care unit is approved at Sharon Hospital, that the result will be that there is a lower level of care provided to patients who need critical care services. Isn't that so?

You're not qualified to say that?

MR. KNAG: Objection, asked and answered.

BY MR. TUCCI:

Q. Correct?

MR. KNAG: Objection. Asked --

THE HEARING OFFICER: Overruled. You may answer the

question, Mr. Germack.

THE WITNESS (Germack): I've already stated that I was merely repeating the assertion made by the Applicant in there, in their filings.

BY MR. TUCCI:

Q. I'm going to ask the question again, sir. In your testimony, it says that if there is a PCU at Sharon Hospital, it will end up replacing the current ICU with a lower level of patient care.

You have no knowledge, training, experience, or qualifications to render an opinion that a progressive care unit renders a lower level or intensity of care than the care that's currently offered at Sharon Hospital. Yes or no, sir?

A. I am not rendering an opinion. I am merely repeating what was stated by the Applicant in their filings. And I believe that's responsive to your question, sir.

Q. All right. One of the opinions that you do express at page 5 of your prefiled testimony is that closing the unit at Sharon Hospital that operates as an ICU doesn't make sense.

Correct?

A. What paragraph are we on?
Q. I'll refer you to page 5 of your prefiled testimony.
A. Okay. And where?
Q. Look at the middle of the page, sir. It says, in summary, quote, closing the ICU doesn't make financial sense. That's the opinion you expressed. Correct?
A. Yes.
Q. And in part you base your opinion on the projection in the CON materials that operating a progressive care unit will not generate as much revenue as currently generated by critical care services through the unit called ICU at Sharon Hospital.
Correct?
A. Yes.
Q. You say in your prefile that Sharon Hospital is, quote, projecting losses if the CON is approved. Correct?
A. Correct.
Q. And the projected losses that you're referring to come from the financial worksheet that was financial worksheet A to the November 14, 2022, completeness response.

Correct?

A. Yes.

Q. I'd ask you to go to that financial worksheet A, please, and focus your attention on the first page?

(Pause: 1:52 p.m. to 1:54 p.m.)

A. Yes, I have it in front of me.

Q. This is the data that you used to support your opinion that, in your view, moving the critical care function from the first floor to the second floor of Sharon Hospital doesn't make sense. In your words, closing the ICU doesn't make sense. Correct?

A. What I'm saying --

Q. Yes or no, sir? This is the chart that you referred to, to support your opinion?

A. Moving to the PCU will result in a loss of $115,000.

Q. All right. This chart shows that for Sharon Hospital on the left-hand column, the total operating revenue and the total operating expenses and then income or loss from the operations of the hospital. Correct?

A. Correct.
Q. And it shows the fiscal year 2021 actual results and then projections for fiscal year 2023, '24, '25 with and without the CON.
That's essentially what is depicted in this data. Correct?
A. Correct.
Q. So with respect to fiscal year 2021, the actual results reported with respect to the operation of Sharon Hospital, that is the total operating revenue as measured against the total operating expense to produce either an income or a loss from operations shows a loss of $20,207,000. Correct?
A. Yes.
Q. And that's not a projection. That's an actual report of the experience for fiscal year 2021. Correct?
A. Yes.
Q. All right. And then the projections there appear thereafter for fiscal years '23, '24 and '25. Right?
A. Yes.
Q. And let's just focus on fiscal year 2023. The projections for that fiscal year show

that if OHS grants approval for the progressive care unit model, Sharon Hospital projects that its total operating loss for fiscal year 2023 will be 19 -- approximately 19.5 million dollars. Correct?

A. Right.

Q. And further, the projection shows that for fiscal 2023, if the request to relocate critical care services to 2 North and establish a progressive care unit is not approved by OHS, then Sharon Hospital's projected operating loss would be approximately $19.4 million. Correct?

Or to be more precise, $19,422,000. Right? Correct?

A. Yes.

Q. So if the current model for delivering critical care remains in place for fiscal year 2023, that is the first floor ICU remains in operation and continues to have about 40 to 45 percent utilization, the result will be that Sharon Hospital at the end of fiscal year 2023 will show a net operating loss of $19.4 million. Correct?

A. All other things being equal, yes.

Q. All right. And for fiscal year 2023, if you look at the difference between the two projections with the CON and without the CON, the difference is that, as you've indicated, previously, is $115,000. Right? That's the total financial difference we're talking about here.

A. That's the financial loss, yes.

Q. Okay. And the total financial loss as measured by a percentage would be .59 percent, or about six tenths of 1 percent, correct?

A. Numerically, yes.

Q. Yeah. And you're here as a financial expert for the Interveners. That that's -- you described your various education, training, background, experience in about seven paragraphs in your prefiled testimony. Correct?

A. Yes.

Q. And you talk about your work experience in handling valuations. Correct?

A. Yes.

Q. Fairness opinions. Correct?

A. Yes, yeah.

Q. Being involved in the purchase and sale of companies. That's another area of experience you've had?

A. Yes.

Q. And also your familiarity with financial reporting requirements. That's another. That's another thing you talk about in terms of what your background is and what you're capable of giving opinions on. Correct?

A. Yes.

Q. So I take it you're familiar with the concept of materiality in accounting and financial reporting?

A. Yes.

Q. And that's a concept I'm not as familiar with. So I actually went to a website that is an authority on financial thresholds and discusses materiality. And what I learned from that website is as follows.

In financial and accounting and auditing, determining the threshold level of materiality requires that an appropriate base level and percentage be decided on. Traditionally, the financial community refers to accounting variables such as net income,

and the most commonly used base in auditing is -- excuse me, and the most commonly used base in auditing is net income, which is defined as earnings and profits.

Most commonly percentages are in the range of 5 to 10 percent. For example, an amount less than 5 percent is immaterial and an amount greater than 10 percent is material. So here we're talking about a difference of six tenths of 1 percent. And obviously, you'd agree that's well below the level of 5 percent?

A. If that's your standard, yes. But I --

Q. And --

A. I don't accept the definition that you're giving me.

Q. I understand that. You would agree with me that for purposes of financial reporting and accounting, a difference of six tenths of 1 percent ought to be viewed as immaterial for reporting purposes?

A. Depends. If -- if you have a situation where a company is losing money on the scale that they're representing they're losing now, why would they want to lose more?

Q. That isn't the question I asked you, sir.

The question I asked you was about --

A. But you want me to make a judgment about materiality --

Q. Excuse me, sir. Excuse me, sir. Your job is not to interrupt me when I'm asking questions. Your job is to answer the questions that I ask you.

Are you or are you not familiar with the concept of materiality in financial and accounting?

A. Yes.

Q. What do you understand that concept to mean?

A. Materiality is a relative concept. Depends upon --

Q. What --

A. -- based off what you're comparing it to. It depends. A definition, what's material in one case may not be material in another case.

It could be immaterial. It --

Q. So --

A. It really depends.

Q. I apologize for interrupting you. So your answer based on your 25 or 30 years, or 50 years of experience is, it depends.

Is that correct, sir?

A. That is correct.

Q. Okay. And here we're talking about six tenths of 1 percent in the financial operation of an entity. And is your testimony that you cannot say one way or another as to whether or not that's material?

Is that your testimony, sir?

A. Well, if this -- there's a number of factors which you have to consider. The first is, is this a correct number of 115,000? Is that the total extent of the loss?

In my estimation, it is not. It is understated. As my --

Q. The question that I asked you -- The question that I asked you, sir --

A. Well, I'm trying to answer your question, sir.

Q. No, I'm sorry, sir. You're going to have to answer the questions that I asked you. The question --

A. (Unintelligible) --

MR. KNAG: Mr. Hearing Officer, I object. He is interrupting the Witness. The Witness should be allowed to answer, and then --

MR. TUCCI: I move to strike the answer as non-responsive.

The question clearly to the Witness was, is six tenths of 1 percent material or not, in his opinion? And he refused to answer the question.

MR. KNAG: He was interrupted, Mr. Hearing Officer. I would let him -- I ask that he first be allowed to finish his answer.

And then if Mr. Tucci feels it was unresponsive, we can argue about it. But he wasn't allowed even to finish, so I believe that he should be allowed to finish.

THE HEARING OFFICER: I'm going to allow him to finish whatever he was saying.

I did just want to mention the chat appears to be disabled. So Mayda, Faye, whoever's in charge of that, please enable it, please?

All right. I'm sorry to interrupt you, Attorney Tucci. You can proceed.

MS. CAPOZZI: Will do. Thanks.

BY MR. TUCCI:

Q. Mr. Germack, my question to you is, is a difference of six tenths of 1 percent material or immaterial to the financial projection shown with respect to the

operation of Sharon Hospital?

Is that your testimony, sir?

A. I can't answer the que -- it depends. It's not a yes-or-no answer. It depends upon the other factors which you have to consider, Attorney Tucci, such as --

Q. All right. Thank you. You've answered the question.

Let's now look at page 4 of your prefiled testimony.

MR. KNAG: Mr. Hearing Officer, he interrupted the answer and he hadn't finished his answer. I ask that -- and you've already ruled that he was allowed to finish his answer. So I ask that the Witness be allowed to complete his answer.

THE HEARING OFFICER: Sure. Mr. Germack, you can finish what you were saying.

THE WITNESS (Germack): Thank you very much. The thing that has to be put in context is that Sharon Hospital also projects a 10 percent decrease in critical care volume, and I testified at that in my oral testimony this morning, compared to 2021.

But as we've seen from table two in my prefile, in fiscal year 2022 annualized, the annual drop in ICU occupancy was approximately 40

percent. So the loss, if indeed the loss that continues, if that occupancy continues for fiscal year 2022, the loss will be a lot greater than $115,000.

And so therefore, answering whether that number is material or immaterial is not really reflective of what the true situation could be.

So I'm arguing on a number of basis.

BY MR. TUCCI:

Q. I'm not asking you what you're arguing, sir. I'm asking you what you testified to. You testified to that there's going to be a difference of $115,000 if this CON is approved. Correct?

A. Yes. I also testified this morning that the number could be much greater than that. And if that's the case, then that number could be material. And --

Q. Show me where in your prefiled testimony there's any data or information that indicates that the number could be greater than the one you relied on.

Where does that appear, sir?

A. Take a look. Okay. We'll take a look at table two.

THE HEARING OFFICER: When you say table two, you're referring to page 7 of your prefile?

THE WITNESS (Germack): Yes, that's correct, table two. And looking here, we can see that the number is dramatically lower, 40 percent lower in the October to March fiscal year 2022 period.

So if that weren't allowed to continue for the rest of fiscal year 2022, their loss could be a lot greater.

BY MR. TUCCI:

Q. That shows an occupancy percentage. Correct, sir?

A. That is correct. It that occupancy --

Q. It doesn't show -- excuse me. Let me go into my next question.

It doesn't show any financial projections associated with that occupancy. Does it?

A. On this table, it does not.

Q. Thank you. Let's go back to page 4 of your prefiled testimony. Here in the paragraph toward the bottom of the page, three quarters, you say, beyond just the operating loss, other relevant cost considerations need to be considered. Correct?

A. Yes.
Q. So you're asking OHS to consider other, what you describe as other relevant cost considerations related to the operation of critical care services at Sharon Hospital.
Correct?
A. Yes.
Q. And you list four factors on page 4, the four other, what you describe as, relevant cost considerations. Right?
A. Yes.
Q. One of them that you list is the time and availability of ambulances to transfer patients. Correct?
A. Yes.
Q. You did not perform a study concerning in connection with your testimony here today regarding the potential impact on time and availability of getting ambulances. Did you?
A. It's based upon -- no --
Q. Sir, is there a study shown in your written prefile submission that assesses the impact of time and availability on getting ambulances?
A. No.

Q. In fact, your written prefile doesn't contain a study for any of the other three points you list, either. Does it?

A. It's based upon conversations I've had with a number of doctors and with people who have observed --

Q. I'm not interested in conversations that you had with anybody, sir. What I'm interested in, as a financial expert is whether or not you performed studies related to any of those three points that you say are relevant cost considerations. And the answer is you didn't. Correct?

A. Yes.

Q. You would agree with me, you did not perform such studies?

A. I did not personally perform such studies.

Q. Thank you. Now, in your written prefile submission at page 5 -- if you'd turn to page 5 now, please?

Do you have it?

A. Yes.

Q. One of the other points you make in your written submission that you think is relevant for OHS to consider is not taking into

account what you characterize as the negative impact on Sharon Hospital's profitability for lost emergency room visits and surgery volume if the ICU service moves to the second floor. Correct?

A. What statement are you referring to?

Q. Just a moment. I'll find the page reference.

A. Page 5, second paragraph.

Q. Yes. Yes, if you look on page 5 of your prefile testimony, the sentence beginning, finally?

A. Yes.

Q. Do you see that sentence?

A. Yes.

Q. Could you just read it to yourself, please?

A. I've read it.

Q. All right. And did I accurately understand and summarize your written prefiled testimony, that one of the things you think needs to be accounted for is the negative impact on profitability from what you characterize as lost ER visits and lost surgery volume if critical care moves to a progressive care unit on the second floor?

A. Yes.

Q. And you'd agree with me, sir, just as we talked about previously, there are no projections in your written prefiled testimony or analyses to quantify what you assert to be potential lost revenue from ER visits. Correct?

A. Yes.

Q. So there's no data that you've presented to substantiate the existence of any lost emergency room visits relative to this CON.

Do I have that correct?

A. Is it my job to do that?

Or is it Nuvance's job to do that?

Q. I didn't ask you, sir, to argue with me or to ask rhetorical questions.

A. All I'm making in the statement is Nuvance doesn't account for it. That's my statement.

Do they?

Q. I see. And you'd agree with me that neither do you account for it.

A. Well, that's not my job. Is it?

I'm not promoting this --

THE HEARING OFFICER: Mr. Germack, please answer the question.

THE WITNESS (Germack): No.

BY MR. TUCCI:

Q. As you sit here today, you don't know -- and you're under oath, sir. You don't know for a fact that there would be a single lost emergency department visit if the progressive care unit is established on the second floor. Correct?

A. No.

Q. And you don't know for a fact if there'd be a single diminished surgical case if critical care services are continued on the second floor. You don't have a fact one way or the other to substantiate that. Do you?

A. No. But the only --

Q. You'd agree with me -- you'd agree with me, sir, you don't have any information whatsoever to substantiate that that would occur. Correct?

A. My only statement in making it --

Q. Correct? Is that correct? Yes or no? Is that correct?

THE HEARING OFFICER: Mr. Germack, just answer yes or no, and then if you need to add clarification, you can.

THE WITNESS (Germack): Yes, I would like to clarify

this.

BY MR. TUCCI:

Q. Is that correct?

A. Yes.

Q. You're raising a question that you don't know the answer to. Correct?

A. I'm raising a question about something that's an issue. That should be accounted for by Nuvance.

Q. That you haven't accounted for?

A. That Nuvance hasn't accounted for.

Q. I didn't ask whether Nuvance accounted for anything. You're assuming something to exist that you have no knowledge about whether it will exist or not. Isn't that true, sir?

A. If Nuvance wants to make a change --

THE HEARING OFFICER: Mr. Germack --

BY MR. TUCCI:

Q. Yes or no? Yes or no?

THE HEARING OFFICER: Yes or no, and then you could clarify if you need to. But you can't just go off on your own narrative.

THE WITNESS (Germack): Yes, but I would like to clarify that.

THE HEARING OFFICER: You can do so.

THE WITNESS (Germack): The whole point of the exercise is that if Nuvance wants to make a change, and a major change, they should account for all the negative or positive impacts on Sharon Hospital's profitability for lost ER visits and surgery volumes as a result of the ICU closure.

The fact that they don't leaves one to believe that this is a missing piece of evidence that should be followed up. That's my point.

BY MR. TUCCI:

Q. All right, sir. One of the things you talked about in your discussion here and in your prefiled testimony is the utilization data related to the experience of the current ICU at Sharon Hospital. Correct?

A. What page are you referring to?

Q. Well, I'm just asking you, is one of the things you talked about to do some investigation or analysis of what the utilization or occupancy was of the current ICU at Sharon Hospital?

A. If it's in my testimony, then I did, sir.

Q. Did you -- as part of that analysis, did you do any -- do you know what the term "patient acuity" means?

A. Yes.

Q. Did you do any analysis of the patient acuity level of inpatients admitted to the Sharon Hospital ICU?

A. My testimony stands as it is.

Q. I didn't -- I asked you, sir, as you sit here today, did any of your analysis include looking at or evaluating the acuity level of patients who have been admitted to the ICU in the past. Did you do that or not?

A. No.

Q. You said in your prefiled testimony that you reviewed all the materials Sharon Hospital submitted.

Did you review the material that Sharon Hospital submitted that showed that the acuity level of the vast majority of its patients was more at the med-surge level than a true ICU level?

A. I looked at that information.

Q. Okay. Let's talk about this whole discussion of lost revenue.

Do you agree that your prefiled testimony makes various statements and conclusions that you're asking OHS to

consider about what you characterize as lost revenue to Sharon Hospital if this CON is approved?

A. What specific part of my testimony are you referring to?

MR. TUCCI: Why don't you go to page 9 of your prefiled testimony?

VOICES: (Unintelligible.)

THE HEARING OFFICER: Mayda, can you please mute Thelma and Andrea?

THE WITNESS (Germack): I'm looking at page 9.

And what are you referring to?

BY MR. TUCCI:

Q. One of the statements that you make in your written testimony -- is and I'll quote, the fact that transfers of Sharon Hospital patients to other hospitals has resulted in a loss of revenue to Sharon Hospital is clear.

That's the opinion you express in your written testimony. Correct?

A. Well, that's a fact.

Q. All right. And you arrived at that fact by doing a calculation. Correct?

A. Correct.

Q. Later on, on page 9, when you're explaining

that calculation part of what you say is the total potential lost revenue to Sharon Hospital is approximately $12.7 million.

Correct?

A. Yes.

Q. So previously above, you talked about a fact that there had been lost patient revenue. And then when you do your calculation, you use the word potential lost revenue, correct?

A. Yes.

Q. Would you agree with me that the only way that there could be a reliable conclusion that Sharon Hospital lost revenue due to patient transfers is if those patients were able to actually receive the medical care that they needed at Sharon Hospital.

Correct?

A. Could you repeat that?

Q. Yes. The only way to reach a reliable conclusion that Sharon Hospital lost revenue as a result of transferring a patient out of the hospital is if that patient could have actually received the care they needed at Sharon Hospital.

You can't lose revenue for services you

don't -- you're not capable of providing.
Correct?
A. Well, either capable or don't want to.
Q. I didn't ask about want, sir. I said if -- if that service was not available at Sharon Hospital, you'd agree with me that it can't be lost revenue because it's not a service they could have provided in the first place.
Correct?
A. I don't go with your premise. If your premise is, they can't provide it or wouldn't provide it, or chose not to provide it.
Which is it?
Q. You say in your own testimony, sir, we can't say for certain what patients could have been handled at Sharon Hospital --
A. Correct.
Q. -- if the ICU had been fully staffed or if Nuvance, quote, did not have a policy of transferring patients. Correct?
A. Yes.
Q. So you can't say for sure. Can you?
A. No.
Q. Because you have no idea why those patients were transferred out of the hospital.

Do you?

A. I do not.

Q. All right. Let's go to the calculation that you performed and see if we can understand it. You are telling the Office of Healthcare Services that in your belief there's -- as a result of patients being transferred from Sharon Hospital, there's a total potential lost revenue of $12.7 million.

Is that correct?

A. That's the total.

Q. And as I understand the calculation that you performed, you got that number by adding up the total number of patient transfers that were made from Sharon Hospital in three and a half fiscal years to other hospitals in the Nuvance system. Correct?

Danbury, Vassar, and Northern Dutchess?

A. Yes.

Q. And when you added up all those numbers over that three and a half year fiscal period, you came to a number of 738 patients. Correct?

A. Uh-huh, yes.

Q. Is that correct?

A. Yes.

Q. Those 738 patients, you have no knowledge or information or any other reason why those patients were transferred to other hospitals. Do you?

A. I personally don't, but Sharon Hospital does.

Q. I didn't ask that, sir.

I'm asking you what you know.

A. All I know is that --

Q. You don't know why they were transferred. Do you, sir?

A. All I know is the records exist --

Q. Do you know why they were transferred? Yes or no?

A. I personally don't.

Q. Do you know what their medical conditions were at the time? Yes or no?

A. No.

Q. Do you know what care they needed?

A. No.

Q. Do you know whether that care was available at Sharon Hospital?

A. No.

Q. Do you know whether any one of those patients needed a heart transplant that they had to get at Danbury Hospital, or some other place?

A. No.
Q. You don't know if any of those patients were critical care patients. Do you?
A. I'm sorry?
Q. You don't know whether any of those patients were critical care patients or not. Do you?
A. I don't know.
Q. You have no medical information whatsoever about any of those patients. Correct?
A. All I'm saying is the potential loss --
Q. Correct? You have no medical information about those patients one way or another. Do you?
A. I do not.
Q. Now so you take those 738 patients, and then you assign a lost revenue number of $17,150 per patient. Correct?
A. Yes.
Q. So again, my math skills are somewhat rudimentary, but 738 times 17,150 is 12.6 million dollars and change. Correct?
A. Right.
Q. So that, that's the lost revenue. That's the fact of lost revenue that you say Sharon Hospital lost because of transferring

patients, none of whom you know whether or not they were critical patients or not.

Correct?

A. Incorrect. I'm talking about potential lost revenue.

Q. Oh. So the fact of lost revenue is now potential lost revenue?

Is that your testimony?

A. That's your words. If you read my testimony, Attorney Tucci, you'll see --

Q. I've read your testimony repeatedly, sir.

A. Potential lost revenue. It does not say actual lost revenue. Does it?

Q. All right. And so the potential lost revenue that you're attributing to every one of those 730 patients over the last three and a half fiscal years is that every one of those patients would have been billed $17,150.

Correct?

A. I don't know whether they were --

Q. Is that correct, sir?

A. Incorrect.

Q. That's how you got your math done. Right?

A. You're using a wrong word. Billed? I don't know. All I'm taking was the number that you

used in your projection, sir.

If you take the 20 patients and you look at the revenue lost in your projection, it will come down to $17,150 per patient.

Q. I see. Uh-huh. And you applied that $17,150 number to 738 patients that you know nothing about, correct?

A. That's what the word "potential" means. It's potential, not actual.

Q. You're going to have to answer my questions one way or the other, sir. Is that correct? Yes or no?

A. No, it's not correct.

Q. All right. And with respect to those patients, you have no idea what actual care they received, do you?

A. I do not.

Q. You don't have any facts about how much revenue each one of those patients generated at whatever hospital they ended up. Do you?

A. I do not.

Q. You don't know if they were transferred to Danbury Hospital and the bill for their service was $1,000 or $100.

Do you?

A. Correct.
Q. So your calculation assumes that for every one of those 738 patients, Sharon Hospital could have collected $17,150.
Do I have that right?
A. That's the math.
MR. TUCCI: All right. Thank you. That's all I have for you.
THE HEARING OFFICER: Thank you. Attorney Knag, do you have redirect for Mr. Germack?
MR. KNAG: So just to make clear this, the table four relates to ICU and telemetry. Is that right?
THE HEARING OFFICER: I'm sorry. What table? Table four?
MR. KNAG: Table four on page 9 relates to ICU and telemetry.
THE HEARING OFFICER: Is that a question for Mr. Germack?

(REDIRECT) EXAMINATION (of V. Germack)

BY MR. KNAG:
Q. Yes.
A. My understanding is that it could include, it's not clear what patients it's really

referring to. It could be the whole mix of the payer mix of all the patients.

Q. Well, could you just elaborate as to what factors go to materiality?

A. In connection with?

Q. In connection with the projection that it would be $115,000 lost, additional loss if the CON is granted.

A. It depends upon -- it depends upon the payer mix. It depends upon -- it depends upon the type of treatment they were receiving.

All I was doing was trying to get a total cost. This is from the hospital's own projections that they would lose 20 patients. Dividing it right into the total revenue gives us a lost revenue of $17,150 per patient.

It's strictly a numerical calculation to try to show what the range of the loss would be per patient, assuming that patient could have been treated at Sharon Hospital.

Q. Do you know whether OHS asked Nuvance for information concerning transfers that was not provided by Nuvance?

MR. TUCCI: Objection. That's a completely improper

question. Whether he knows what -- OHS knows what it asked for and didn't ask for.

BY MR. KNAG:

Q. Well, they're saying that -- the claim here is that he doesn't know anything about the facts concerning the persons transfers.

And I'm trying to point out that Nuvance didn't supply the information even though it was asked.

A. So I'll answer the question. All that --

MR. TUCCI: There's an objection.

THE HEARING OFFICER: I'll overrule the objection.

If you're able to obtain that information through what has been provided, then you can answer it.

THE WITNESS (Germack): Hearing officer, my understanding is that the emergency department which transferred these patients in examining their individual medical records would ascertain the reason for the transfer.

I don't have that information. It is available, I'm sure, as I've been told by competent counsel.

MR. TUCCI: Object to the hearsay and speculation. Now he's repeating what his lawyer told him.

THE WITNESS (Germack): Actually, it was more than that. It was --

MR. TUCCI: Objection. The Witness should not be speaking when there's no question.

THE HEARING OFFICER: I'll sustain that.

MR. KNAG: That's all I have.

THE HEARING OFFICER: Okay. Thank you, Mr. Germack.

THE WITNESS (Germack): Thank you, Hearing Officer.

THE HEARING OFFICER: While we transition over to Dr. Kurish, Attorney Tucci, do you have questions for Dr. Kurish?

MR. TUCCI: Yes.

THE HEARING OFFICER: Okay. So while we transition over to Dr. Kurish, I did just want to point out to members of the public that the sign up in the chat feature is available now, and it will be available until 3 p.m.

If for whatever reason you're having difficulty signing up through the chat function in Zoom, you could e-mail concomment@ct.gov.

Dr. Kurish, just let me know when you're ready to proceed?

THE WITNESS (Kurish): Ready.

THE HEARING OFFICER: Thank you.

Attorney Tucci, you can proceed with

cross-examination of Dr. Kurish whenever you're ready.

MR. TUCCI: Thank you, Mr. Csuka.

CROSS-EXAMINATION (of Dr. Kurish)

BY MR. TUCCI:

Q. Dr. Kurish, you've been practicing at Sharon Hospital for many years. Right?

A. Correct.

Q. I gather you would agree with me that you have a reasonable level of familiarity with the equipment and resources that are currently available in the ICU location at Sharon Hospital?

A. I agree.

Q. So for example, you would agree with me that among the capabilities that currently exist in the first-floor critical care unit at Sharon Hospital would be the ability to do cardiac monitoring of a patient. Correct?

A. Correct.

Q. And the ability to do vital sign monitoring of a patient?

A. Correct.

Q. And if a patient needs support from a ventilator, a machine to help them breathe, that's available at the care unit on the first floor of Sharon Hospital. Correct?

A. Correct.

Q. And there's additional breathing equipment that can be used, CPAP and BiPAP equipment. Correct?

A. Yes.

Q. And that helps control airway pressure. Right?

A. Yes.

Q. And if a patient needs to have a chest tube, a tube that drains air or fluid in the space between a lung and a chest to guard against chest collapse, that capability exists today at Sharon Hospital in the critical care unit. Correct?

A. I can't answer that one.

I'm not sure about that one.

Q. All right. What about the ability to feed a critical care patient? The unit has enteral feeding pumps. Right? Which allow slow feeding of patients who can't eat for themselves?

A. Yes.
Q. And a defibrillator.
That's a device that sends a shock or a pulse to restore heart rhythm?
A. Yes.
Q. And an EKG machine, that that equipment is also available in the ICU today. Correct?
A. Yes.
Q. And an emergency code cart. That's a mobile cart that's used that has equipment on it in the event of a critical emergency with a patient?
A. It's there.
Q. Correct? And as you sit here today, you have no factual information -- do you? That all of the equipment that we just discussed, you have no factual information to dispute that all of that equipment is also going to be present in the progressive care unit on the second floor in 2 North. Correct?
A. What's your definition of factual?
Q. Well, a fact is you either know or you don't. Do you have any information to tell me that all of that equipment that we just discussed is also going to be available and capable for

use in the critical care unit on the second floor?

A. I do not know if it's going to be available or not.

Q. All right. You don't have any information one way or the other. Is that right?

A. You said all that equipment. I didn't say --

Q. Yeah, do you?

A. Some of it probably is there.

Q. Okay. Good. You're here opposing this proposal to move the critical care function to the second floor of the hospital.

Correct?

A. Yes.

Q. And you'd agree with me that as part of being informed on whether or not the level of care capability will be at the same level as currently exists at the hospital, it would be important to know what equipment and resources are going to be available in the proposed progressive care unit. Correct?

A. Correct.

Q. You agree?

A. Yes, correct.

Q. What did you do to inform yourself of what

the proposal is for the equipment and resources and capacities that are going to be made available for patients who need critical care once a progressive care unit is established?

A. Talking to the doctors and nurses at the hospital.

Q. All right. One of the concerns that you raised previously in your pre-filed testimony is the general observation that PCUs typically do not have respirator capability or handle patients on respirators.

You heard this morning that there is a definitive plan in place to have respirator or ventilator capability at the PCU at the hospital if this request is approved.

Correct?

A. I'm not sure about that.

Q. I'm asking you, sir, if you heard the testimony this morning to that effect?

A. I wish you would clarify it. You did not say if intubated patients would be staying there, or a tracheostomy patient would be staying there. For example --

Q. That's not what I asked you, sir. I asked

you whether or not -- whether or not you heard testimony that there would be the capacity for a patient who needed breathing assistance through a respirator on 2 North in a new PC unit.

Did you hear that testimony or not?

A. Yes, I did.

Q. All right. Are you aware that, in fact, the hospital has already installed the gases necessary to support ventilator equipment in at least six of the patient rooms on 2 North?

Did you know that?

A. Correct.

Q. All right. Now given your years of experience at Sharon Hospital, I gather you also know that in the current physical space where the ICU is located, one of the features that exist there is the existence of nine telemetry devices. Right?

A. I don't know if there's eight or nine.

Q. All right. Eight or nine, give or take.

What is a telemetry device? Can you tell us that?

A. Monitor the patient's heart rate, blood pressure, respiratory rate, and other things.

Q. Okay. So it's an important piece of equipment that's used to assist in monitoring patients who have critical care needs. Correct?

A. Indispensable.

Q. And you heard testimony today that an equal number of telemetry devices will be put in service in the progressive care unit on 2 North. Correct?

A. No.

Q. The telemetry equipment is movable. Isn't it? It can be moved from one room to another?

A. It's not the same telemetry equipment we have in the ICU.

Q. I didn't ask you that, sir. I asked you whether or not telemetry equipment is movable from room to room?

A. Yes, it is.

Q. Is there any fact or information in your written pre-filed testimony to dispute the fact that there will be telemetry devices available in the progressive care unit on 2 North if this CON is approved?

A. Say that again?

Q. Is there any information or facts in your more than six pages of pre-filed testimony to indicate that, in fact, telemetry devices will not be available in the progressive care unit at Sharon Hospital if this CON is approved?

A. Correct.

Q. You didn't present any information to contradict that at all. Did you, sir?

A. I was not --

Q. Correct?

A. At the time of the testimony I did not have that information available.

Q. Okay. And now you do?

A. Yes.

Q. You heard this morning that, in fact, there will be telemetry capability in the PCU. Correct?

A. I'm not sure what your definition of telemetry capability is.

Q. Well, the ability to monitor a patient, as you just indicated; an essential function of being able to take care of a critical care patient.

A. Which rooms?

Q. In the patient room?

A. In which rooms?

Q. I didn't ask you what room, sir.

I asked you whether that capability would be available. You heard that it will be available. Didn't you?

A. From basically what they told me I cannot verify that.

Q. Okay. One of the things that you appear to be concerned about is this issue of direct visibility from the nurses station. Now of course, you are aware that there is a physical nurses station on 2 North. Correct?

A. Correct.

Q. And you also know for a fact that there are several rooms located directly across from that nurses station. Correct?

A. Correct.

Q. Within a direct line of sight from the nurses or other care professionals who are doing work at that, at that nurses station. Right?

A. Some of the rooms, yes.

Q. So, for example, rooms 218, 220, 222, and 224, those are all directly across from the nurses station. Correct?

A. Correct.
Q. You've been up on that floor. Right?
A. Yeah.
Q. And you also heard Ms. McCulloch talk about heart monitors, and you know what those are. Right?
A. Sure, yes.
Q. Those are the monitors that exist on 2 North in the hallways outside of patient rooms. Right?
A. There are two monitors.
Q. Right. And those are located in the hallways outside of patient rooms. Right?
A. Not in front of the nursing station.
Q. I didn't ask you that, sir. They're located in the hallways outside of certain patient rooms. Are they not?
A. Correct.
Q. And they show the heart function of the patients who are in those rooms on that wing. Don't they?
A. They show the rhythm, heart rhythm.
Q. Heart rhythm, excuse me. And so any nurse or doctor, or orderly or LPN, or any other healthcare professional walking by can look

at that monitor and see the heart rhythm of all the patients in the rooms on that wing.

Correct?

A. Never seen that done.

Q. I didn't ask you that, sir. I asked you whether or not that information was shown on a screen in a hallway that any patient care professional walking by could see.

Yes or no?

A. If they took a look at it, yes.

Q. Okay. And you also know that nurses who provide care don't just sit at a nursing station. Do they?

A. Correct.

Q. They move around the floor in the unit to provide care. Correct?

A. Correct.

Q. And one of the ways they do that is through what you heard earlier is this workstation on wheels. And there are eight of those up on 2 North. Right?

A. Whatever they said, yes. They have some.

Q. All right. And you also know that all the patient rooms have clear glass windows to allow visibility into the room as a nurse

walks by. Correct?

A. They have a glass window in the doorway to the room.

Q. All right. And I'm not going to go through it all, but you heard the discussion from Ms. McCulloch this morning about the various types of monitors and alarms, and devices that are currently in use at the hospital and that will be in use on the progressive care unit. Correct?

A. Correct.

Q. Including the Vocera device that nurses carry around with them that transmit alarms directly to them if a patient is in distress.

Correct?

A. Correct.

Q. Now, one of the things you talked about was this issue of HVAC capability.

A. Right.

Q. And that's sometimes referred to as a negative pressure room.

Do I have that right?

A. Correct.

Q. I'm sorry, sir. I didn't hear you.

A. Yes.

Q. Okay. And the idea behind that, and it's especially important in these, in these days of COVID, is the negative pressure capability helps to prevent spread of airborne pathogens. Correct?

A. Correct.

Q. How many negative pressure rooms are there currently in the ICU space at Sharon Hospital?

A. I don't know the answer to that.

Q. Would it surprise you to know that the answer is one?

A. No.

Q. Okay. Now on 2 North, before a PCU is even approved, are you aware that there are actually two negative pressure rooms that exist on the second floor there in 2 North?

A. Correct.

Q. I take it you're also aware that, especially in these times of COVID, that that portable equipment exists.

So that even if a room isn't itself equipped as a negative air pressure room, it can be made to be a negative air pressure room through portable equipment?

A. Not aware of that.
Q. Were you aware that Sharon Hospital successfully used that equipment to help treat patients during the COVID pandemic?
A. We did.
Q. I want to talk to you about a statement that you make concerning utilization rates and patients being admitted to the critical care service at Sharon Hospital.

And I'd direct your attention to page 2 of your prefiled testimony.
A. Okay.
Q. If you look at the third full paragraph?
A. Okay.
Q. You write in your sworn prefiled testimony as follows.

Because of plans to close the ICU, and I'm quoting, and the adoption of a policy limiting admissions to the ICU as described below -- do you see that language?
A. Uh-huh. Yes, sir.
Q. And then you go on to cite attachment B, a document that you attach as attachment B in your prefiled testimony.

You go on to say, because of plans to

close the ICU and the adoption of this attachment B policy limiting admissions to the ICU, quote, patients who would otherwise be admitted to Sharon Hospital were transferred from the Sharon Hospital ED to other hospitals. Do you see that testimony?

A. I don't quite see that.

Which line was that on?

MR. KNAG: Page 2.

THE WITNESS (Kurish): I've got the page 2.

Okay. I see the first line, yeah.

BY MR. TUCCI:

Q. You're talking about a policy being adopted. Correct?

A. No, it's the other policy that we had in place at the time.

Q. I'm reading the language, sir. I want to make sure I understand what your testimony is.

You say, because of plans to close the ICU, and quote, the adoption of a policy limiting admissions.

Are you referring to attachment B?

A. Yes.

Q. Is that the policy that you refer to as being

adopted?

A. Yes.

Q. All right. Let's go to attachment B. Do you have attachment B in front of you, sir?

A. No. Oh, I do have it, I'm sorry. I've got it. Overlooked it, sorry. Yes.

Q. Is this the document that you referred to as a policy that was previously adopted?

A. It was adopted by the Department of Medicine at that time. It was voted on and passed. I abstained.

Q. Is this a policy that you're testifying under oath was adopted and in place and governed the operation of the ICU for the past year and a half? Is that your testimony?

A. It's not.

Q. Okay. So you would agree with me that the document that we're looking at is a document that is entitled, progressive care unit admission. Correct?

A. Correct.

Q. It doesn't say, intensive care unit admission at Sharon Hospital. It's not a policy that currently governs the intensive care unit at Sharon Hospital. Correct?

A. Well, I don't know if -- what -- what's happened since that time.

Q. I'm asking you, sir. You're a member of the medical staff. Correct?

A. Yes.

Q. Do you have any knowledge or information that this document has been adopted as a policy that currently governs the ICU? Yes or no?

A. Yes.

Q. In fact, if you look at this document, it has stamped on it as a watermark on all three pages, draft. Correct?

A. Correct.

Q. And in order for this to be a policy that is in effect at the hospital, it has to be approved by somebody. Correct?

A. Yes.

Q. Do you see the approved box on this attachment B that you have? It's blank.

Correct, sir?

And if you look over at the effective date, there's no effective date of this policy. Correct?

A. This paper, you're correct.

Q. And when it says original implementation

date, the reference is TBD, meaning to be determined. Correct?

A. Correct.

Q. And the last date that this was reviewed and revised was 15 months ago in November of 2021. Correct?

A. Okay. Yes.

Q. So there's nothing on this document that shows that this was a policy that is actually approved by or currently in effect at Sharon Hospital. True?

A. It's not listed on this document, but it was being followed.

Q. Okay.

A. I can elaborate on that if you wish.

Q. And let me ask you about your testimony where you say on page 6 of your prefile, Sharon Hospital will be terminating a level of care for many medical and surgical patients if a PCU model is adopted.

A. Page 6.

Q. Do see that testimony?

A. I'm looking for it now.

Okay. Which paragraph?

Q. Page 6 of your prefile testimony.

A. Yeah.
Q. At the top of the page, clearly you say -- and this is a statement you make under oath, Sharon Hospital would be terminating a level of care for many medical and surgical patients if the ICU is eliminated.
A. Correct.
Q. That's a statement you made sworn to under oath. Correct?
A. Yes.
Q. Okay. You've indicated you have a pretty high degree of understanding of the capacities that currently exist at Sharon Hospital to provide critical care services to patients. Correct?
A. I'm proud of them.
Q. All right. So for example, you know that if a heart attack patient needs cardiac catheterization, a procedure to move a catheter through a blood vessel to the heart, that's not a service that Sharon Hospital is capable of providing. Correct?
A. Correct.
Q. And you also know that if a patient comes to the hospital with a heart attack, and it's

determined that that patient needs to have their chest open to have open heart surgery, that's not a service that can be performed for a critical care patient at Sharon Hospital. Correct?

A. Correct.

Q. And Sharon Hospital doesn't have a burn center. So if a patient comes to the hospital with a critical emergency because of burns, that patient has to be transferred out of Sharon Hospital. Correct?

A. Correct.

Q. And a patient that comes to the hospital with a traumatic brain injury, Sharon Hospital doesn't have the capacity to perform a surgical procedure to deal with that patient. Correct?

A. Correct.

Q. And I could go on. Right?

A. Yes.

Q. If everything stayed the same at Sharon Hospital as it is today, all the types of patients we discussed would still not be able to be treated. Correct?

A. Rephrase the question again?

Q. Yeah. The existence of the critical care services at Sharon Hospital, if everything remained the same today, those patients that we just discussed still can't be treated at Sharon Hospital. Correct?

A. Correct.

Q. Your testimony that Sharon Hospital will be terminating a level of care for many medical and surgical patients, that testimony, as I understand it, was based on reference to the draft policy that we just discussed at Attachment B. Do I have that right?

A. Attachment B?

MR. KNAG: But it's on your phone.

THE WITNESS (Kurish): Oh, is this the same one? The same one, okay. Yeah. Yes, and subsequent ones as well.

MR. TUCCI: Okay. Thank you. Those are all the questions I have for you.

THE HEARING OFFICER: Attorney Knag, you can do a redirect if you have any.

REDIRECT EXAMINATION (of Dr. Kurish)

BY MR. KNAG:

Q. What patients can be treated today that can't be treated in the PCU? Or what patients could be treated over the past several years that can't be treated in the PCU?

A. Although they say they can; the standard care don't allow intubated patients on respirators or unstable blood pressures to be in a PCU, among other things.

We can't -- the same thing you can apply to people with complicated cardiac arrhythmias or hemodynamic instability that require two-an-hour vital signs. That's not possible in the PCU, regardless of where it is -- I mean, not categorically, but for the most part.

Q. And you mentioned earlier other categories of patients that are treated now?

A. Yes.

Q. That can be treated now and will not be treated later?

A. Septic shock, we can do very well now in our -- on our ICU if we're on prolonged

pressures for a few days. GI bleeders that are bleeding massively can still be supported.

People going through DTs, drug overdoses that might require intubation, they can be treated here. Patients with -- with TIAs or neurologic -- changing neurologic symptoms that need to be close -- closely monitored with two-an-hour neurochecks can be done there.

Two-an-hour neurochecks are not part of the purview of a PCU they have. Usually there are two four-hours, or maybe occasionally brief periods of time for Q2 hours, but not -- they don't do it at Q1 hours.

Insulin drips, you have to take a blood sugar every hour and go on sometimes for 12 to 24 hours to get your insulin controlled. Those -- those are -- those are, I think, beyond the capability of a PCU.

So a lot of conditions that we take care of now quite successfully that would not be -- I'm afraid it would not be adequately trade -- treating patients with some of the

consequences.

MR. KNAG: And why is it --

THE HEARING OFFICER: I'm sorry to interrupt you, Attorney Knag.

Dr. Kurish, you're speaking very quickly and you're using a lot of technical terms. So if you can just try to slow it down a little bit, I think we'd all appreciate that. Excuse me.

BY MR. KNAG:

Q. Why is it that these patients can't be treated in the PCU?

A. A PCU does not have an adequate level of nursing care. Instead of two-to-one nursing, it's -- usually the national standard is three to four patients per nurse, and Nuvance projects 4.5 --

Q. Hold on a second.

Okay. Go ahead.

A. The same thing with monitoring on EKGs, rhythm strips, oxygen levels; they need somebody more attentive than wandering around the floor with a monitor in their pocket, and then go into a room and try to figure out what's going on.

There's just too much delays. It's not

an adequate setup for a lot of these really sick people.

Q. And are you aware that Nuvance has proposed 4.5 to 1 as the ratio that it wants to put in the PCU?

A. Let's -- let's say you already have a couple of PCU patients in the stairs, and another one comes in the ER that has to go to a PCU, or an intensive care unit. You don't have staff to cover that patient.

What do you do for the third and the fourth, or fifth or the sixth patients? I mean, we could have -- during the COVID pandemic, we could have had six or eight people that required intensive nursing care.

A PCU is not going to be able to handle that, especially when they're scattered in these rooms around the whole entire floor. From what -- what you recently described, two rooms have negative pressure.

And so coms are going to put these patients in various locations that don't have negative pressure, don't have oxygen outlets, don't have monitors. They're going to have two rooms with -- with traditional cardiac

monitoring, patient monitoring.

The other rooms are going to have these portable units that are totally insufficient.

Q. In what sense were the standards in Exhibit B to your testimony applied to the ICU?

A. Well, they have at the bottom of the page -- at the bottom of the page it says, clinical conditions not -- that cannot be admitted to the PCU at Sharon Hospital. And they list a bunch of them there.

There's -- about 10 of them are in there, and that was pretty much the policy being followed until recently. They're trying to put --

MR. TUCCI: Objection, hearsay. No foundation.

BY MR. KNAG:

Q. Do you know what policy was being -- as a doctor in the ICU, do you know what --

A. I know --

Q. -- whether the policy was being followed?

A. -- that I had to deal with. If I wanted to admit somebody to the ICU, they say, admit to PCU, though it's still the ICU. They were calling it PCU.

I had a patient. There was a patient in

ER in January of 2022. Overdosed, as already previously referenced. Patient had to be intubated to protect his airways. He was intubated in the ER and they wanted to transfer that patient because they said you did not put intubated patients in the PCU at that time.

The patient was intubated, no place else for that patient to go. All -- all the places they wanted to transfer that patient were not available. He was kept here and he did fine. So although they don't have an official policy, it's been, in effect, the policy they've had there that I've had to experience.

I've had people that I'd like to admit there that sometimes they don't want me to admit to the ICU. They want me to transfer there, or transfer to another hospital, but I've oftentimes insisted on keeping that person there and the patient has done well.

So in effect, they're trying to deal with it as it's already a PCU and that they were doing intensive care services whenever possible.

I think a lot of that has to do with the credit of the nursing staff there. They're very attentive, very knowledgeable care. Most of them have many, many years of experience.

When I get called at ten o'clock at night and I talk to Ms. X, or Mr. So-and-so, I know from their judgment what I have to do; if I have to come in, or what I have to handle.

Nurses on the second floor do not have that expertise. It takes years to develop that expertise. You're not going to be able to develop that in a matter of a course for a few weeks or in audial-visuals, on a computer in their spare time.

You need to have those nurses with that expertise, and from the nurses I've talked to, a few of them have told me -- I know some have already left.

MR. TUCCI: Objection, hearsay. Move to strike it.

THE WITNESS (Kurish): Well, when somebody talks to me directly, is that hearsay?

MR. TUCCI: Objection, hearsay. Move to strike it. I'd like a ruling.

MR. KNAG: I would say that, first of all, if a patient --

THE HEARING OFFICER: Attorney Knag, I can't hear you. I'm sorry.

MR. KNAG: If a nurse tells the doctor that she's leaving for a certain reason or will leave, that's not hearsay. That's a statement of -- that's an action. She's indicating an intent to leave --

THE WITNESS (Kurish): Or he.

MR. KNAG: Or he. And that's not hearsay. That's something that is certainly entitled to come in, especially here in an administrative hearing where the standards are looser.

But even if it was in court, it would be entitled to come in.

MR. TUCCI: Well, there are basic due-process rights that apply to any contested case. And I can't cross-examine hearsay. I can't cross-examine people who aren't here.

MR. KNAG: A verbal act is admissible. If a nurse says, I'm leaving, that's something that can come in because it's a verbal act.

MR. TUCCI: That's not a verbal act. That's a statement.

THE HEARING OFFICER: I'm going to overrule the

objection.

BY MR. KNAG:

Q. Do you know whether the new policy effects has affected or will affect the level of ED admissions in surgery?

MR. TUCCI: Objection, beyond the scope.

THE WITNESS (Kurish): Well, not really.

MR. TUCCI: Objection, beyond the scope.

THE HEARING OFFICER: I'm honestly not sure what the question was. It had a couple of different parts.

BY MR. KNAG:

Q. I'm asking him whether there was a reduction in volume based on this policy, not only in the ICU, but also in surgery and ED?

A. I am aware of surgical patients.

MR. TUCCI: There's an objection. It's beyond the scope. I didn't ask this Witness any questions along those lines.

MR. KNAG: You asked him all sorts of questions about the volume, and this is relevant.

MR. TUCCI: No, I didn't.

THE HEARING OFFICER: I'm going to sustain the objection.

MR. KNAG: Okay. That's all I have.

THE HEARING OFFICER: Okay. Thank you.

MR. TUCCI: Mr. Csuka, one question, if I may, please?

THE HEARING OFFICER: Sure.

MR. TUCCI: Thank you.

RECROSS-EXAMINATION (of Dr. Kurish)

BY MR. TUCCI:

Q. Dr. Kurish?

A. Yes.

Q. Can you hear me okay?

A. Yes.

Q. Doctor, in your discussion with Mr. Knag, you gave a long list of different kinds of patients and conditions that you were concerned about that you believe are not capable or appropriate to be treated at a PCU level. Correct?

A. Yes, sir.

Q. So I'm not going to repeat all those cases, but with respect to that, that list or inventory of cases that you described, if you were given information that those conditions and patients representing those kinds of cases, that the PCU planned for Sharon Hospital at 2 North would have the capacity

in terms of the medical doctors and nurses, and the equipment to treat those patients, would that address your concern?

A. Probably not.

MR. TUCCI: Okay. Thank you. That's all I have.

THE HEARING OFFICER: Okay. At this time, the sign-up for public comment has closed. I want to take a five minute break. We've been going for about over just about an hour and a half at this point.

So let's come back at 3:11 -- actually, let's say 3:12. And then we will take the comment from the first of the individuals that the Applicants signed up in advance of the hearing.

Then public officials, and then the remainder of the Applicant's commenters.

So let's come back at 3:12. Thank you.

(Pause: 3:05 p.m. to 3:12 p.m.)

THE HEARING OFFICER: Welcome back. For those just joining us, this is a hearing concerning a CON application filed by Sharon Hospital in docket number 22-32504-CON.

We've had most of the technical component of the hearing earlier in the day. OHS still has

some questions that they're going to want to ask both the Applicant and the Intervener.

But for right now, we're going to jump into a portion of the public comment. That being officials, representatives, and 17 members that the Applicant has signed up prior to today's hearing.

Again, I don't expect that we're going to get to the remainder of the public given the number of questions that OHS has and my prior order that we're going to try to make our best efforts to complete the factual component today.

We, since January 11th, we have put it on record that there would likely be a second date for this. That second day is February 22nd at 9:30 a.m. I'm still of the opinion that we will be having the remainder of the public providing their comment at that point. And you know, it's possible that will change, but that's still where I am at this point.

And in the event that presents an issue for anyone, there's always the option of submitting written comment as well, which we've always strongly encouraged the public to submit.

So with that said, consistent with past

practice, we're going to go with -- well, mostly consistent with past practice. We're going to go with the elected and appointment officials and representatives, the Applicant's clinical professionals and executives, other clinical professionals and executives, et cetera, et cetera. But first, we're going to start with Mr. Dyson who has a sharp cutoff at 3:30.

Speaking time is limited to three minutes. Please do not be dismayed if I cut you off or interrupt you. I'm doing this in fairness to the others present and to ensure that everyone who wishes to speak has an opportunity.

And again, we'll receive written comment up to seven days after the second date of the hearing.

Participants are expected to maintain decorum at all times and to make best efforts to limit their remarks to hear information bearing on the agency's analysis of the merits of Docket Number 22-32504-CON.

If a participant violates this directive, I may limit their ability to speak. Participants should make every effort to limit the scope of their remarks accordingly.

So we are now ready to start with Mr. Dyson.

There you are. Okay. So whenever you're ready, you can begin with your comment.

ROBERT DYSON: Can you hear me?

THE HEARING OFFICER: I can.

ROBERT DYSON: Good. Thank you. My name is Robert Dyson. I live in the -- my family and I have lived in the Sharon Hospital service area for over six decades. I am also a volunteer board member for Nuvance Health.

I'm here to speak in favor of Sharon Hospital's CON requesting the approval of the move its existing critical care beds from a separate ICU into the progressive -- into a progressive care unit.

Everybody knows what the issue is. What is seemingly being missed is that no services are being taken away. All the same critical care services that have been provided at Sharon Hospital before, after this change will still exist in Sharon Hospital. Importantly, no nurses or other staff will be eliminated as a result of this change.

We need the existing nurses and staff for the PCU. Still this move is an essential piece of

Sharon Hospital. Sharon Hospital must evolve to meet today's healthcare challenges, and running a small rural hospital is getting increasingly difficult and financially unsustainable.

This effort here is to preserve what we can of the needed services related to the ICU and the PCU.

Thank you for allowing me to appear.

THE HEARING OFFICER: Thank you, Mr. Dyson.

So we're going to transition over to the elected officials and representatives starting first with Senator Steve Harding. Is he present?

SEN. STEPHEN HARDING: Yes, I'm present. Thank you. Thank you very much. I just wanted to testify today, and I appreciate the opportunity to testify.

I had the honor of representing Sharon Hospital or the district that contains Sharon Hospital, the entire town of Sharon and the entire area in Connecticut that is serviced by Sharon Hospital. I'm speaking against the application today.

As you're going to find and we've already found through testimony, that this is a critical aspect of our community and a critical aspect of

the care that individuals in our surrounding community receive. By removing this from Sharon Hospital, lives will be in danger. Health will be in danger for so many individuals.

This is a commitment that was made by Nuvance years ago that they're now moving away from. And OHS has a critical responsibility and job, and I hope that they see the significant need of this facility, of the ICU for the people of this district and have Nuvance continue to maintain this critical aspect of health infrastructure we have here in this community. It is desperately needed and lives could potentially be lost if it were to be removed.

So as the State Senator for this area of the state, I urge, strongly urge OHS to deny this application and to have this ICU continue to remain in this community for the benefit of everyone.

So thank you very much for allowing me to testify today.

THE HEARING OFFICER: Thank you, Senator Harding.

Just a reminder to everyone present, whether Nuvance Health or Sharon Hospital violated the terms of the agreed settlement issued in Docket

Number 18-32238-CON is not the subject of this proceeding, and I've done my best to try to keep that topic out of this proceeding and I'm going to try to do that going forward as well.

Next on the list is a New York Assembly member named Didi Barrett. Is Didi Barrett present?

MATT HARTZOG: Hi, yes, yes. My name is Matt Hartzog. I am a member of staff for Assembly Member Didi Barrett. She's prepared remarks that she's asked me to read.

It is my greatest honor to represent New York's 106th Assembly District, comprising parts of both Dutchess and Columbia County for the last 10 years. Many of my constituents, particularly those who live in Northeastern Dutchess County and Southeastern Columbia County, have relied on Sharon Hospital for medical services since its founding more than 100 years ago.

The proposed reclassification of Sharon Hospital from providing intensive care unit service to less acute progressive care unit service with a lower range of care means the closest five ICUs, three of them also owned by Nuvance, will be between 25 and 40 miles away.

For intensive life-saving situations every mile makes a difference. This proposed change will affect all of our neighbors, especially those without the means to travel to other hospitals in Rhinebeck, Danbury, Hartford, or Poughkeepsie.

This proposal is just another example of the diminishing services available at rural hospitals across our region, and comes on the heels of Sharon Hospital announcing the planned closure of its maternity ward.

Over the last decade, we have seen a slew of hospital mergers, affiliations, and networks, which were presented as offering our smaller community of hospitals the partnerships and flexibility to address the needs of the less dense communities. On the ground, however, this does not seem to be the case.

The Hudson Valley, Litchfield Hills, and Berkshires are full of vibrant communities that deserve access to basic medical services. Our goal should be to keep and attract young families to this beautiful area. To that end, we must do more, not less, to address their needs.

For many of my constituents and countless other residents of Massachusetts and Connecticut,

this proposal will have a devastating impact on their well-being and quality of life.

I thank all for the opportunity to comment and stand ready to work with Sharon Hospital and Nuvance to develop solutions that will support our rural hospitals and the essential work they do for all of us.

Thank you very much for allowing us to comment.

THE HEARING OFFICER: Thank you. And as a reminder, again the closure of the maternity ward is also not an issue that is the subject of this hearing.

Next on the list is First Selectman of Kent. That's Jean Speck.

MR. KNAG: Jean Speck, I think, mentioned that she was available at 4:30.

THE HEARING OFFICER: Okay. So wherever we are at 4:30 I'll -- do you know if it's only at 4:30, or how flexible is that time?

MR. KNAG: It could be after 4:30, yes.

THE HEARING OFFICER: All right. So we will come back to her. So we're going to go back to the list provided by Sharon Hospital. And we're going to go in the order -- Attorney Tucci, is it okay to go in the order in which they've been presented to

the agency?

MR. KNAG: Hearing Officer, I believe that there's a person named Chris Kennan who's the Selectman of the town of Northeastern New York, who's waiting to be heard.

THE HEARING OFFICER: Okay. I don't have him on our list. Okay. So Mr. Kennan, are you present?

CHRISTOPHER KENNAN: Yes, I am.

THE HEARING OFFICER: Okay. I apologize for that. I'm not sure what happened.

CHRISTOPHER KENNAN: I may not have been able to get onto the list in time. In any event, thank you for the opportunity to speak in opposition of the application. My name is Christopher Kennan. I'm honored to serve as Town Supervisor of the Town of Northeast, New York. Many people know the town better by the name of the village, which it encompasses Millerton.

Along with our sister town to the south of us, Amenia, we are geographically closer to Sharon Hospital than many Connecticut towns. Generations of Millerton and Northeast residents have relied on Sharon Hospital for a wide variety of health issues.

Sharon Hospital is an essential part of our

community. It is counted on for emergency visits, for same day procedures, maternity care, and a variety of other medical needs. Many of Sharon's staff live in New York State, and many of them in Millerton.

On behalf of the Town of Northeast, I want to express first and foremost my deep concern that the residents and constituents have for the health and well-being of Sharon Hospital. We are rooting for the long-term viability of this small rural hospital, serving a population that in some cases is hours away from a larger medical center.

Sharon Hospital plays an absolutely central role in the economic and social fabric of our community. We hope that Sharon can continue to offer the full range of critical care, including ICU-level services. Thank you for your time.

THE HEARING OFFICER: Thank you, Mr Kennan. And thank you all for attempting to keep your comments brief. I do appreciate that. We're trying to fit in as much as possible today.

Are there any other elected officials or appointed representatives that are present who wish to comment?

MR. KNAG: Not that we know of.

THE HEARING OFFICER: Okay. We're going to go back to the Applicant's list, then. And next on the list is Richard Cantele.

RICHARD CANTELE: Yes. Thank you. I'm the Chair of Sharon Hospital's Board of Directors, which is comprised of a group of residents from across the hospital service area who volunteer to serve as representatives of the communities that Sharon Hospital serves.

One of our responsibilities is to advise the hospital's leadership team as they make decisions about the hospital, including the application under consideration today. Sharon Hospital must evolve in order to meet the demands put on today's healthcare organizations and in order to remain a part of our community into the future.

Establishing a PCU is a responsible step to more efficiently use Sharon Hospital's resources. This plan will maintain the hospital's current level of critical care so we can rest assured knowing that we can turn to Sharon Hospital in our times of need, just as we always have.

As the Chair of the community board, I and my fellow board members consider decisions based on our individual backgrounds and understanding of

the community, as well as through discussions with Sharon Hospital's leadership team and independent verification from a variety of trusted sources.

In addition to the verification of a nationally respected consultant for rural and community health systems, our support for this plan was further driven by the clinical leaders who work most closely with Sharon Hospital's inpatients.

Sharon Hospital's chair of medicine and vice president of medical affairs are practicing physicians in hospital medicine and palliative care, and they have made it clear that this is the best possible plan to be able to provide the same level of care with the same staff while increasing efficiencies across the hospital. They feel strongly that this is the right decision for both the Sharon Hospital team and the entire community.

This plan was thoughtfully formed and thoroughly researched. It is clear that this transition will better position Sharon Hospital for the future as a more efficient, modern facility while maintaining the level of care offered today. I strongly believe that OHS should approve this application.

Thank you for your time.

THE HEARING OFFICER: Thank you, Mr. Cantele. Am I pronouncing your name correctly? Can-tell-ee [phonetic]?

RICHARD CANTELE: Yes. Yes, you're one of the few that can, that do.

THE HEARING OFFICER: Okay. Next on the list is Pari Farood.

PARI FAROOD: Almost. Pair-ee Fah-rood [phonetic]. Yes. Hello. Thank you so much.

THE HEARING OFFICER: Thank you.

PARI FAROOD: I'm here as the Vice Chairman of Sharon Hospital's Board of Directors, and I'm also the executive director of a breast cancer foundation. I'm here today in support of Sharon Hospital's application to establish a progressive care unit.

Our community board made up entirely of volunteers meets with Sharon Hospital's leadership frequently to best position our small rural hospital for the future.

As a community member, board member, and someone who spent my career in healthcare, I recognize the challenges that face this industry every day, and how they've only been intensified over the past few years with the pandemic.

The board understands the proposed plan. We've met with industry experts, members of the Sharon Hospital team, and our community. We live here and use this hospital. Of course we want what's best for patients.

Based on this comprehensive process, I understand and recognize that by centralizing Sharon Hospital's ICU and medical-surgical units into one PCU, the hospital skill teams will provide patients with the same level of critical care currently provided to our community, just in a new location with modernized technology.

This enhancement will enable the same care teams currently providing care at Sharon Hospital to evolve to do a better job and more efficiently.

You know, I chair the QPIC committee, Quality Performance Improvement Committee, at Sharon Hospital. I'm meet at the hospital at least once a month for pre-QPIC briefings, QPIC meetings, safety star presentations for exemplary employees, not to mention my mammograms, my blood work, et cetera.

The caregivers at Sharon -- and by that I mean the nurses and doctors and everyone who works there are wonderful, and they deserve the best

technology and the most efficient proven model for best practices to treat our patients. I encourage OHS to approve this application and provide Sharon Hospital the tools to continue offering five-star care right here in Sharon.

Thank you.

THE HEARING OFFICER: Thank you, Ms. Farood. Next on the list is Mimi Tannen.

MIMI TANNEN: Hello, and thank you for giving me the opportunity to speak today. My name is Mimi Tannen.

I'm a member of the Sharon Hospital community, a member of the Sharon Hospital Board of Directors, and a nurse practitioner. My experience in all these roles has inspired me to express my support for Sharon Hospital and their application for a progressive care unit.

I worked at Sharon Hospital as a nurse for 15 years, which gives me a lens into the level of care that Sharon Hospital's skilled caregivers provide to our community. As a community hospital in a rural area, Sharon Hospital cannot practically provide the same services offered in large academic hospital's ICUs.

Hospital care has changed over the years,

with more procedures being done the same day or outpatient procedures. The patients of a higher acuity, care which used to be formed in ICUs, is now standard in PCUs and med-surg floors.

Sharon Hospital offers a level of critical care that is critically important to the community, but by today's clinical standards, is more in line with the PCU. Sharon Hospital performs this level of care very well, and now as an older adult I'm comforted to know that I can go to my community hospital for the care and trust the decision-making; the medical professions are taking care of me.

I'm comforted to know that if I need a more intense level of care, transport will be fast and uncomplicated, and unhesitatingly provided so I can get care at the best possible location.

By allowing Sharon Hospital ICU and medical-surgical units to be centralized together, Sharon Hospital will be able to provide the same level of critical care as is provided to the community today, with the same teams in a new location with modernized technology.

As a nurse I feel strongly about the opportunities that this transition will provide to

the hospital's nursing staff. In this centralized unit, Sharon Hospital nurses will get more support from one another as well as from support staff, and they're going to have opportunities to grow their already impressive skills.

This is an application to make Sharon Hospital's team more efficient and flexible in providing the care that's available today as one part of a comprehensive transformation plan to prepare a community hospital for the future.

Extensive planning went into this proposal, and so I strongly urge the Office of Health Strategy to approve this application.

Thank you for your time.

THE HEARING OFFICER: Thank you, Ms. Tannen.

Next on the list is Dr. Robyn Scatena.

DR. ROBYN SCATENA: Hi, I'm Dr. Robin Scatina. I'm ICU Director here at Norwalk Hospital, a sister hospital to Sharon.

I'm board certified in pulmonary and critical care, and I can testify to the level of care provided typically in a PCU and an ICU, and the efficiency of maintaining critical care at Sharon Hospital while ensuring patients can be successfully transferred for higher level critical

care needs.

Here at Norwalk Hospital, our ICU is reserved for our most critical patients who require advanced treatment. This level of care is less common in smaller community and rural facilities like Sharon Hospital. Instead, the critical care provided at Sharon Hospital today is reflective of contemporary critical care standards of a PCU.

This proposal is primarily an acknowledgment of changing clinical standards in the services offered at Sharon Hospital today. In a PCU, the medical team will maintain their ability to provide critical care, and as stated in the application, which I reviewed, the level of care provided by Sharon Hospital won't change as a result of this transition. There are reasons to centralize critical care and med-surg services into a unified PCU. These mixed acuity units have extensive operational benefits.

Unifying the ICU and PCU into a single PCU unit will allow Sharon Hospital to bring two medical teams together to care for the same patients, creating more efficient and sustainable staffing models as facilities across the nation continue facing a healthcare workforce shortage.

At the same time, it will allow the medical team to remain flexible on the centralized unit based on patient volume and acuity.

As a critical care physician, I encourage you to approve this application to offer Sharon Hospital's current level of critical care while embracing operational efficiency. It's a smart solution to serve the community's needs while responsibly using our resources.

Thank you for your time.

THE HEARING OFFICER: Thank you, Dr. Scatina.

Next is Dr. Jean-Carlos Jimenez, or Jean-Carlos Jimenez?

DR. JEAN-CARLOS JIMENEZ: The first go was right.

THE HEARING OFFICER: Okay.

DR. JEAN-CARLOS JIMENEZ: Good afternoon. Everyone who doesn't know me, my name is Dr. Jean-Carlos Jimenez. I'm a hospitalist, Second Chief of Hospital Medicine, Chair of Medicine here at Sharon Hospital. And I'm here because I strongly support Sharon Hospital's application to establish a PCU or progressive care unit.

As someone who cares for Sharon Hospital's inpatients every day, I view this as a commonsense plan to shepherd our hospital into the future

without sacrificing the five-star care that we currently provide.

It's important to understand that our proposal does not represent a change to the level of care that our hospital provides. Again, patients will continue to have the same access to our resources, staff, and providers, including examples of ventilators and cardiac monitoring just one floor above where the current unit is.

If approved, the PCU will allow our caregivers to prepare the same patients we work with today just with improved efficiency and flexibility. For caregivers like my fellow hospitalists, this transition would also reduce the need to move quickly between departments and units and keep our care teams more consistent. I expect that our team's increased efficiency will also improve the already great care that we offer.

For members of our community wondering if the PCU is the best choice for Sharon Hospital, it may be helpful to know that, like Dr. Scatina mentioned, PCUs are increasingly being adopted and are effective. It's a contemporary model for providing critical care outside the large academic medical centers nationwide.

Before I joined Sharon Hospital and its team, I worked in the PCU down in St. Joseph's Medical Center in Yonkers, New York. St. Joseph's administration also made the same decision that Sharon Hospital is seeking to make today. I can speak to the high level of care that we provided there, and that we will continue providing here in Sharon if this application is approved.

I respectfully urge our office to approve the Sharon Hospital's application to establish a PCU. This transition will make our team more efficient in providing the same care that we offer today while strengthening the hospital to help us remain here whenever our community needs us.

Thank you for your consideration.

THE HEARING OFFICER: Thank you, Dr. Jimenez.

Next we have Dr. Ron Santos. Is he with us?

DR. RONIEL SANTOS: Hello, my name is Dr. Ron Santos and I am the Medical Director for Sharon Hospital's emergency department and the President of the medical staff.

I'm here to express my full support for the application to relocate critical care services from a standalone ICU in order to establish a progressive care unit at Sharon Hospital.

I'd like to start off by saying that none of the proposed changes here will affect our emergency department and the services we provide to this community.

Our emergency department team will continue to follow the same steps we do today to evaluate, treat, and stabilize patients when necessary, and decide whether or not they should be admitted to our hospital or transferred to another facility that may be better suited to meet their individual needs. I want to reassure our patients and our community that Sharon Hospital's emergency department will continue to be here for you.

Now that being said, I have seen firsthand the effects of how a staffing shortage impacts the hospital, and more importantly, the community that hospital serves. In an ideal world, our hospital would have everything and provide every service possible to our patients, but that's simply not reality.

I could attest to the hard work, often behind the scenes, that's been put in by our staff, including our supervisors, the nurses and physicians, as well as administration, as they constantly try to juggle staffing and bed

availability to make sure that we do not transfer patients needlessly who could otherwise be served here at Sharon.

Pooling our resources while not compromising the scope or the quality of care we give only makes sense. The proposed ICU, I'm sorry, PCU will have the same capabilities and take care of the same patient population that our current ICU admits.

I fully support this PCU transformation, and I ask that OHS approves this application, and I appreciate the opportunity to speak here today.

Thank you.

THE HEARING OFFICER: Thank you, Dr. Santos.

Next we have Dr. Thomas Koobatian.

DR. THOMAS KOOBATIAN: Hi, thank you for the opportunity to speak today. My name is Dr. Thomas Koobatian. I'm an emergency physician, and I also serve as the Executive Director and Chief of Staff at New Milford Hospital, and I'm here today to support Sharon Hospital's proposed progressive care unit.

Nine years ago, we made the same transition at New Milford Hospital, and it's proven to be a successful part of our transformation. The Sharon

community will be well served by this plan. In New Milford, we've been working for years to address many of the same issues and challenges faced by our colleagues at Sharon today.

New Milford and Sharon Hospitals are both vital parts of their communities, and we've been impacted by external forces that threaten community hospitals nationwide.

While small hospitals across the country are closing their doors, Sharon Hospital is making prudent decisions to ensure it's growing and investing in a promising future. Establishing a PCU is an important step in this transformation.

The proposed PCU will allow Sharon Hospital to continue delivering much of the same care they provide today, including cardiac monitoring and IV infusions. It will create a more modern and consistent experience for patients and a more efficient use of space and staff resources.

So today I'm asking OHS to please approve Sharon Hospital's application.

THE HEARING OFFICER: Thank you. Thank you, Dr. Coo-bay-shun [phonetic]. I apologize. I think I said your name wrong last time as well.

DR. THOMAS KOOBATIAN: No worries.

THE HEARING OFFICER: Next on the list is Dr. Tim Collins.

DR. TIMOTHY COLLINS: Can you hear me and see me okay?

THE HEARING OFFICER: Yes.

DR. TIMOTHY COLLINS: Hi, everybody. Thanks for the opportunity to speak. My name is Tim Collins, and I am the ICU Medical Director here at Vassar Brothers Medical Center, sister hospital of Sharon Hospital.

I'm also the Division Chief of Pulmonary Diseases, Critical Care Medicine, and Sleep Medicine here at Vassar. And I'm here to express my support for Sharon Hospital's application to establish a progressive care unit.

I was instrumental in leading the development of our PCU here at Vassar, also called a medical step-down in larger hospitals. So I have a direct knowledge of the critical care services offered in these settings. As critical care has evolved over the years, smaller hospitals have increasingly transitioned from ICUs to PCUs, or step-down units.

These units are solutions for patients who require critical care services like cardiac monitoring or even mechanical ventilation, but

don't necessarily require the most intense level of care that large medical centers provide.

PCUs offer care teams -- allow care teams to continue providing life-saving services in a critical care setting while ensuring ICU beds at larger medical centers like ours are available -- are available for patients who require the most advanced and intensive care services.

Many smaller hospitals, like Sharon Hospital, are reclassifying former ICUs into PCUs as a recognition of the level of care they already provide without necessarily changing the level of services that are available.

For years, Sharon Hospital has successfully triaged and stabilized critical care patients before determining whether their needs would be best met internally or at a larger hospital that could offer a more advanced level of care.

As a leader of one of the teams that regularly accepts patients from Sharon and other smaller hospitals within our system in area, I can speak to the success of Sharon Hospital's transfer process. If this application is approved, none of this would change. The main difference is that the level of care currently offered in Sharon

Hospital's ICU would instead be provided in the mixed acuity PCU.

Simply put, PCU is a different name for the level of care currently offered at Sharon Hospital that will continue to be offered at Sharon Hospital. Our team at Vassar Brothers and other neighboring medical centers will remain ready to accept these patients transferred from Sharon Hospital following the same processes that we have in place today.

With that, I recommend that OHS approve this application, and I appreciate you allowing me to speak today.

THE HEARING OFFICER: Thank you, Dr. Collins.

Next on the list is David Jensen.

Mr. Jensen, are you available by any chance?

DAVID JENSEN: There we go. Just making sure that the video is up for you. Thank you. Hello. My name is David Jensen, J-e-n-s-e-n, and I am the EMS coordinator here at Sharon Hospital and a practicing paramedic. I'm here today to ask for the support of Sharon Hospital's application to establish a progressive care unit.

As the EMS coordinator and as a practicing paramedic I regularly interact with EMS providers

in the Sharon Hospital service area. When a patient arrives in the emergency department, they are met by board-certified emergency medicine physicians and highly trained nurses, ancillary clinicians, as well as staff here at the hospital.

In working together with our EMS teams in the pre-hospital environment and Sharon Hospital staff providing life-saving care, the establishment of a PCU at Sharon Hospital will only enhance this already remarkable care.

If the PCU is approved, our EMS teams will continue to bring the same patients in need of care to Sharon Hospital, just as we currently do. The difference is that they will receive this care in a centralized unit located just up the stairs from where the ICU currently lives today. This will ultimately create a more seamless, consistent inpatient experience throughout their care here at the hospital.

As a rural hospital, Sharon Hospital is already highly practiced in triaging, stabilizing, and then, when needed, transferring patients who require specialty care not currently offered at our hospital, but has to be offered at a higher level of care in larger medical centers.

Our ability to provide comprehensive treatment and stabilization prior to transfer is key to contributing a factor in the ability to remain a five-star hospital, just as Sharon Hospital is. The establishment of a PCU is the right decision for Sharon Hospital, as it will create a more modern and consistent experience for the patient and more efficient use of space and resources of our staff.

As a first responder and a proud member of the Sharon Hospital team, I urge the Office of Healthcare Strategy to approve this application.

Thank you. I appreciate the opportunity to speak today.

THE HEARING OFFICER: Thank you, Mr. Jensen. Next is Dr. Leroy Nickles.

DR. LEROY NICKLES: Hi, thank you. Thank you for allowing me to speak today. My name is Leroy Nickles. I'm one of the emergency medicine physicians at Sharon Hospital, and I'm also the regional medical director for Team Health Northeast Group. I just have some prepared remarks I wanted to read.

So, as you're aware, Sharon Hospital continues to propose necessary changes that will

best position the rural facility in a place of strength for the future as healthcare organizations like Sharon Hospital meet new challenges and care delivery continues to evolve.

So our emergency department team, on a daily basis, you know, encountered these challenges, which is why I firmly support our Sharon Hospital leadership team and their commitment to meet the needs of our community as we head into the future, including the proposed establishment of a progressive care unit.

By combining critical care and medical-surgical services into a unified location, served by a combined team of clinicians already in place at the hospital, patients can be treated through a more efficient process.

All patients who currently come to Sharon Hospital for emergency and critical care services should continue to do so today and well into the future. The community should rest assured that the intention of the proposed PCU is to enable Sharon Hospital to deliver the same level of care as it does today.

The Sharon Hospital emergency department sees emergencies from throughout the region, and I know

that the new PCU will enable our teams to treat patients in emergent situations well into the future as the hospital continues executing its transformational plan.

With the new PCU, we will continue providing our current level of care, including oxygen, telemetry monitoring, ventilation services, which are needed to stabilize critical care patients.

When a patient arrives in the hospital, they will be evaluated, stabilized, and then sent to the next step of their care journey, whether that is remaining at Sharon Hospital in the PCU, or being transferred elsewhere.

This process is successfully implemented in the hospital currently every day and it allows patients to receive the care best suited to their needs. Patients can then return to Sharon Hospital for follow-up care closer to home if they were transferred.

As always, we continue to ensure our teams and partnership with the local EMS personnel are prepared for any emergency. We continue to meet on a regular basis with our local EMS squads to continue to ensure continuity of communication across all areas of Sharon Hospital as we adapt

these changes.

Sharon Hospital's emergency department is open for the community 24 hours a day, 7 days a week, and 365 days a year. And we will continue working closely with our colleagues in the inpatient units to treat outpatients and support the region for many more years to come.

I firmly believe that establishing a PCU is the right decision for Sharon Hospital, and I ask the OHS to approve this application. Thank you so much.

THE HEARING OFFICER: Thank you, Dr. Nickles.

Next is Dr. Cornelius Ferreira.

DR. CORNELIUS FERREIRA: Good afternoon. My name is Cornelius Ferreira and (unintelligible) --

THE HEARING OFFICER: I'm sorry, Doctor. You're very quiet.

DR. CORNELIUS FERREIRA: Hear me now?

THE HEARING OFFICER: It's not much better. Can the Court Reporter hear the Doctor?

THE REPORTER: I could barely hear anything he said. It was not clear at all.

THE HEARING OFFICER: Dr. Ferreira, it looks like -- okay. You were muted.

DR. CORNELIUS FERREIRA: How's that? Can you hear me?

THE HEARING OFFICER: That's much better.

DR. CORNELIUS FERREIRA: Perfect. I just had to switch speakers -- or microphones. So I'm Cornelius Ferreira, the System Chair for primary care at New Ben's Health. I'm here today in support of Sharon Hospital's proposal to establish a progressive care unit.

Based on my experience in healthcare, particularly my extensive work in rural communities across the country, I know that establishing a PCU will benefit both the Sharon Hospital team and most importantly, the patients we treat.

The proposed plan to centralize the essential care currently offered in our ICU into a new mixed acuity PCU will allow the hospital to more effectively assign staff and resources with minimal impact on the services offered to patients.

This centralized model has been adopted by facilities across the country to great success. And it is especially useful in helping rural community hospitals meet staffing demands amidst a national workforce shortage.

If the PCU is approved, Sharon Hospital's

care teams will remain equipped with their current tools to evaluate and stabilize patients who arrive at the hospital with critical care needs. As a primary care physician, I am confident that the emergency department clinicians will continue their excellent record of evaluation, stabilization, and treatment of all patients who arrive at the hospital.

If a patient's care team decides transfer is necessary, they will be transferred to the facility best suited to meet their needs, just as they are today. They can then return to receive follow-up care close to home, where they will be served by Nuvance Health's continued investments in primary and specialty care.

The intention of this application is to allow Sharon Hospital to provide the same level of care with the same staff using a more modern care model to reflect the services offered by the hospital today. This centralization will free up resources, helping Sharon Hospital remain sustainable and allowing the system to make further investments in the hospital and across the northwest corner.

I am confident with that, the approval of

this application, Sharon Hospital will be better positioned for the future and able to devote more time and resources to expanding the primary and specialty care services that are currently needed to serve our patients. This will ultimately lead to an overall healthier community with much happier patients.

Thank you for your time.

THE HEARING OFFICER: Thank you, Doctor.

Next is Dr. Paul Wright.

DR. PAUL WRIGHT: Yes, good afternoon, everybody. Thank you for allowing me the opportunity to speak. My name is Dr. Paul Wright. I'm the Senior Vice President and System Chair of Nuvance Health Neuroscience Institute, and I'm also the Stroke Director at Sharon Hospital. I've been a board-certified neurologist for over 20 years, and I'm here today to demonstrate my support for Sharon Hospital's proposed progressive care unit.

The centralization of the care currently offered in the intensive care unit with medical-surgical services into a PCA -- sorry, a PCU will allow our hospital to offer the same level of critical care while more efficiently utilizing our resources. The process for

stabilizing and determining whether to transfer patients will be the same as it is today.

Like many hospitals, Sharon Hospital's team is skilled at triaging and treating patients before deciding whether to admit or transfer them to receive a higher level of care. I see this process work regularly as it is currently implemented for all patients who come to Sharon Hospital for stroke care.

Many stroke patients stay at Sharon Hospital for the duration of their treatment. However, if the team determines that the patient may need neurosurgical or neurointerventional or other forms of care not offered on site, they will be transferred to a facility equipped with the resources to best support their care level.

They can then subsequently return to the community and have care delivered at home for many years, and it will not change if the PCU is approved. So I encourage OHS to approve the application to establish PCU at Sharon Hospital.

And I'm confident that the Sharon community will be served by this proposal to allow the hospital to more efficiently offer our current level of care.

Thank you for your time.

THE HEARING OFFICER: Thank you, Dr. Wright.

Next is Dawn Woodruff.

Is Ms. Woodruff available?

DAWN WOODRUFF: I apologize. I was on mute. Again, hello. My name is Dawn Woodruff, and I am the Chief Nursing Officer at Sharon Hospital. As a member of the hospital's senior leadership team, I am here today to share my support for Sharon Hospital's application to establish a progressive care unit. I have spent much of my career in critical care, starting as a frontline nurse in the ICU.

As a leader of Sharon Hospital's nurses, I am excited to see the opportunities this co-location will bring to our team. Our nurses are already incredibly skilled and centralizing our critical care and medical-surgical teams will only allow them to be more efficient in providing five-star care to our patients.

The plan allows Sharon Hospital to deliver the same level of care with the same staff in a modernized location within the hospital. While we offer the same level of services, the benefits for our internal team will be significant and will

ultimately create a more seamless, effective experience for our patients while helping position the hospital for long-term strength and success.

I ask OHS to approve Sharon Hospital's application to establish a progressive care unit. Thank you.

THE HEARING OFFICER: Thank you, Ms. Woodruff.

Next is Melissa Braislin.

MELISSA BRAISLIN: Hello. Can you see me?

THE HEARING OFFICER: Not yet. Your screen is black.

MELISSA BRAISLIN: Oh. I'm not sure why. Can you go to the next person? I could figure it out and come back? Or --

THE HEARING OFFICER: Sure. Yeah, we can do that.

Next is Amy Llerena.

AMY LLERENA: Hi, everyone. My name is Amy Llerena. That's spelled A-m-y, L-l-e-r-e-n-a, and I am here today in support of Sharon Hospital's proposed progressive care unit.

I'm the Director of Quality at Sharon Hospital, and I've played a close role in the clinical workgroups focused on planning for centralizing the essential care currently offered in our intensive care and our medical-surgical unit into a potential PCU.

I wish to share my insight into how this transition will enable more efficient delivery of high quality care for our patients. I want to be clear that Sharon Hospital already provides exceptionally high quality care, as demonstrated by our continued CMS five-star rating for three years running.

Our teams across the hospital are highly qualified and skilled at meeting our patients' needs, whether that means caring for them locally at Sharon or stabilizing and transferring them to another facility best suited for their needs.

Centralizing our critical care and medical-surgical services into one unified location will only enhance the care they provide. Our patients will be well served if Sharon Hospital is allowed to establish a PCU.

The care currently offered in our ICU is generally better aligned with a PCU level care by today's standards, and does not meet the standards of ICU level care provided at a larger tertiary center. As a result, the PCU will maintain our patients' access to the resources that are available today, which include oxygen, telemetry, ventilation, and other critical care services with

fewer transitions in location and care teams throughout the inpatient journey.

These fewer transitions will create more consistency, which we expect will create an even better experience for our patients and for their families. I commend Sharon Hospital and the Nuvance leadership team for seeking opportunities to evolve to more contemporary care models, while re-imaging our hospital space to best meet the needs of our patients now and into the future.

These changes, I believe, will ensure Sharon Hospital will remain a vibrant part of our community for years to come. I firmly believe that establishing a progressive care unit is the right direction for Sharon Hospital, and I ask that OHS approve this application to adopt a more contemporary care model. Thank you.

THE HEARING OFFICER: Thank you, Ms. Llerena.

Ms. Braislin, it looks like your camera is back up.

MELISSA BRAISLIN: Great, thank you. Thanks for having me today. My name is Melissa Braislin. I'm here today to support Sharon Hospital and the application for the progressive care unit. I live in the Sharon Hospital community, and I have

worked here for 20 years.

As an employee at Sharon Hospital, firsthand I've seen the demands of our staff and our resources and how they've changed over the past 20 years, but even more so during recent years. Centralizing critical care and medical-surgical services into one location will allow us to bring together two teams that are currently operating separately into one combined team.

As the Director of Rehab Services, my teams work with the hospital inpatients every day, including the current ICU space and in our medical-surgical unit where the PCU would live if approved. I know the proposed PCU will allow my team and our entire staff to be more efficient for caring for our patients in one location. A centralized model is going to maximize efficiency and flexibility for the staff. It will also enhance our patient experience because patients will be able to stay on one unit. They will have more consistent care throughout their inpatient stay.

I know that the PCU will allow Sharon Hospital to provide the same level of care with the same staff throughout a more modern care

model.

To mimic what Dr. Wright had said, I'm the Stroke Program Coordinator and work with him all the time, and I can speak to the level of stroke care that is currently provided at the hospital, and we will continue to be able to offer if this application is approved.

In most cases, we keep stroke patients here at Sharon Hospital, and they receive their stroke care here. If the individualized needs require them to be transferred, we transfer them to the correct facility, and our team successfully transfers patients. And when they are done with their inpatient stay there, we invite them back to Sharon Hospital for follow-up care. This process should not change.

Our community will have continued access to the same services we rely on today; as mentioned already, oxygen telemetry ventilators. The centralization of the second floor will free up resources and help Sharon Hospital meet the challenges that healthcare organizations across our country are facing.

I know that this change will help us meet current and future needs of our community and

create a more efficient care model for our staff. I kindly ask that the Office of Health Strategy approve this application, and thank you for your time.

THE HEARING OFFICER: Thank you, Ms. Braislin.

And last on the list of individuals who are signed up ahead of time are -- it's Jim Hutchison.

MR. TUCCI: Mr. Csuka, this is Ted Tucci. If I could just interrupt with a quick logistical request?

THE HEARING OFFICER: Sure.

MR. TUCCI: I know we're nearing the end of our list. I was just informed that Dr. Soucier, a cardiologist who was originally intended to be on our list, was left off by mistake. He's on a break from patient care and is available to speak at this moment, if you'll allow him to speak?

THE HEARING OFFICER: Certainly. Yeah, that's fine.

MR. TUCCI: Thank you.

THE HEARING OFFICER: We're going to need him to spell his name. Dr. Soucier, are you available?

DR. DONALD SOUCIER: Okay. Thanks. Can you see me?

THE HEARING OFFICER: Yes.

DR. DONALD SOUCIER: It's S-o-u-c-i-e-r, just like it sounds, Soucier first name's Donald. Okay? And, you know, I'm a cardiologist at Sharon. I've been

here for roughly 20 years, 18 to 20 years.

I've been a cardiologist for 40 years, and I've worked in Lancaster, Pennsylvania, before I moved here. I was with a group of 35 cardiologists, and we were at five different hospitals.

The five different hospitals; two were large hospitals like, you know, like our Poughkeepsie Hospitals and Danbury Hospitals, and the others were three small hospitals that were similar in size to Sharon Hospital.

What I learned when I was rotating through these different hospitals is how to triage, and I think that's very important. I think it has to do with, you know, taking care of patients, and I think it's very important for not only for patient care, but for quality of care.

Therefore, when I came to Sharon Hospital, you know, roughly 20 years ago, we've been doing triage medicine in Sharon, at least with cardiac patients, for that length of time. I think that most of the patients that we take care of in Sharon are PCU and med-surg patients.

And most of the cardiac patients are, when they become severe ICU patients or need ICU care,

we transfer them because I think we can provide better quality of care.

I think by this transformation that we are asking to get permission to do, I think that we can, you know, better utilize our staff. I think that we have excellent administration, and I think we can accomplish this in a well thought out unit.

I feel very convinced that after conversations with my colleagues, and by, you know, I'm one of the ones that is mostly involved in taking care of these sick patients, that a combined unit will benefit our staff, our patients -- is in the best interest of moving forward without affecting our quality of care.

Because if you look at the awards that this hospital has received, I'm very proud of this hospital. I'm part of those, part of this service that's provided, and I think it's important that we continue to grow and we continue to change in time. So, that's really what I wanted to say.

I just ask that OHS do approve the application. Thank you.

THE HEARING OFFICER: Thank you, Doctor.

And now we can do Mr. Hutchinson, if he is available.

JIM HUTCHINSON: Good afternoon.

Okay. Can you hear me okay?

THE HEARING OFFICER: Yes.

JIM HUTCHINSON: Very good. Thank you. So thank you for allowing me to speak today. My name is Jim Hutchinson, H-u-t-c-h-i-s-o-n. I'm a clinical navigator at Sharon Hospital and a proud member of the Sharon community.

I'm here today to show my support for Sharon Hospital and the proposed establishment of a progressive care unit. I've been coming to work at Sharon Hospital for 30 years, and during that time I've witnessed how the delivery of health care continues to evolve, and with that, how the demands of hospitals, their facilities, and their staff continually change.

The proposed plan to centralize critical care and medical-surgical services into a unified progressive unit will enable our leaders to assign our staff and resources more efficiently and provide continuity of care for our patients.

The progressive care unit will continue delivering critical care with our same talented team in a new location within the hospital, just upstairs from where these services are offered

today.

The transition of a progressive care unit is designed to have minimal impact on the patient care currently provided while creating a more sustainable model that will serve Sharon Hospital well into the future. I believe this transition is an integral component of our transformation plan to allow our hospital to remain a vibrant part of our community for years to come.

I stand with many members of the Sharon Hospital staff who support this plan and know it will serve our hospitals, patients, and community. I am here to kindly ask the Office of Health Strategy to approve this application to ensure Sharon Hospital can evolve for the future while maintaining our ability to provide advanced care to the community, and I thank you for your time.

THE HEARING OFFICER: Thank you, Mr. Hutchison.

We're going to take a five-minute break. I'm going to speak with OHS staff off the record. I'm inclined to change the trajectory of the hearing a little bit.

We have eight people who signed up from the public. So my thought is to take in their comments this afternoon, and then reconvene on

next Wednesday for all of OHS's questions, closing arguments, late files, et cetera.

So I'm going to speak with OHS staff and see what they think of that. I know last I heard there were about seven pages of questions. I don't think it would do any -- I mean, it would take probably about an hour form them to go through that to figure out which questions actually need to be asked versus which ones have already been answered.

So let's take a break from 4:17 until 4:22, and then we can come back on the record and figure out what we're going to do for the rest of the afternoon.

MR. TUCCI: Mr. Csuka, if I could just make a couple of comments for informational purposes so that you and the staff can take it into consideration as you think about a plan that makes sense for the remainder of the hearing?

I can tell you that all our witnesses are here, and if OHS staff can review its questions and is prepared to proceed, we're more than happy to stay for another hour, hour and a half to complete the hearing.

I think we've moved with good efficiency

here, where we're prepared and ready to respond to questions.

Obviously, I know we're going to need another session on Wednesday, but from our perspective, you know, we'd like very much to be able to get all the technical information that OHS needs today if it's possible to do that.

The one scheduling thing I know is going to be a problem is Dr. Murphy's not going to be available at the next date.

So I just ask you to keep that in mind as you're conferring with your colleagues.

THE HEARING OFFICER: Okay.

MR. TUCCI: Thank you.

THE HEARING OFFICER: To your knowledge, is he going to be away next week? Or are there other dates he might be available next week?

You can discuss that with him, and we'll talk about it when we come back.

MR. TUCCI: Thank you.

MR. KNAG: May I chime in? You know, I would like to see the questions to the witnesses who might not be available next week done now so that we don't end up having yet a third day, perhaps.

People have planned on -- I planned on next

Wednesday, but I might have -- we might have problems for other days. And so I'd like to try to get them in now.

THE HEARING OFFICER: The problem is, I mean, OHS's questions may be directed to any of the three witnesses, and I think they also have questions for Dr. Germack and Dr. Kurish as well.

So I don't know how they would separate out those questions, but that's just something I need to figure out with them. And when we come back on the record in five minutes I'll have an answer for you, or at least more, more of a direction as to where we can go with this.

But our previous experience is that around five o'clock we sort of reached a point of diminishing returns where everybody was just having trouble focusing and you know, the questions became harder to follow, and the responses became harder to follow. So I'm just trying to do what is most in everybody's interest at this point.

So let's come back at 4:26, and I will provide further guidance at that point.

Thank you.

(Pause: 4:20 p.m. to 4:28 p.m.)

THE HEARING OFFICER: Attorney Tucci, is Dr. Murphy available at any point next Wednesday?

Or is it completely off?

MR. TUCCI: So, the issue is he's available now. And if staff knows that it has questions for him now, we can deal with those now.

If that's not feasible, his schedule is he could be available at noon on the next scheduled date, but he's got firm commitments that would be very difficult to break before noon.

THE HEARING OFFICER: Okay. So would he be available only at noon? Or would it be like noon and later.

MR. TUCCI: Noon forward.

THE HEARING OFFICER: Okay. I think what we're going to do then is we are going to reconvene on that date probably at, I'd say one o'clock.

A VOICE: Recording in progress.

THE HEARING OFFICER: Okay. Thank you, Mayda. I didn't realize I hadn't restarted the recording.

So I think we are going to reconvene next Wednesday to go through all of OHS's questions. My understanding is that they, based on the public comment that was submitted by a lot of the

Applicant's witnesses, they do have some additional questions they want to add to their list as well.

And they also want to winnow down the seven pages that they prepared prior to the hearing. So as a matter of efficiency, I think it makes the most sense to just break for now.

However, I think it makes sense to try to take those, it's actually eight individuals who signed up from the public. That way they don't need to come back next week. And that way OHS, to the extent that it's necessary, can develop further questions from what they may have to say as well.

MR. KNAG: Mr. Hearing Officer?

THE HEARING OFFICER: Yes.

MR. KNAG: I have been informed that two of our witnesses -- or not our witnesses, but public witnesses heard you say that the, other than the public officials and the Applicant's witnesses, that the rest of the public would be heard next Wednesday. And we haven't been able to notify them that you wanted them now.

We haven't been able to reach them.

But we can do the rest and then maybe we'll

take the final ones on Wednesday.

THE HEARING OFFICER: I think that makes sense. And if they, for whatever reason, are not available next Wednesday, they can always submit written comment as well.

So with that -- and the same goes for the remainder of the eight individuals, since I did give contradictory statements earlier in the hearing. If any of these individuals are not available today, they can provide public comment next Wednesday.

So I'll just name them. That way everybody has an understanding as to who the people are. And that way, everybody gets the same understanding as to who has signed up within the designated period of time between 2 p.m. and 3 p.m. today.

So they are Lori Shepherd, Jill Drew, Nicholas Moore, Lydia Moore, Antoinette Lopane, Jim or James Flaherty, David Singer, and then Kathleen Friedman.

So is Lori Shepherd available?

LORI SHEPHERD: Yes. May I just say that I signed up to speak in the chat, but you didn't mention my name. I signed up at 2:20 -- and I'm happy to do

it next week, but I'm just saying as a matter of you can see my name in the chat to Maya -- Mayda Capozzi.

THE HEARING OFFICER: Okay.

LORI SHEPHERD: Thank you.

THE HEARING OFFICER: Did anyone else sign up who I didn't just name?

MR. KNAG: Jean Speck, the first election of Kent.

THE HEARING OFFICER: Was it Matushka?

EVELYN KRETA: Yeah. I'm sorry. I can't change that. But my name is Evelyn Kreta, K-r-e-t-a.

THE HEARING OFFICER: How do you spell the last name? I'm sorry. K-r-e-t-a.

EVELYN KRETA: Yes, thank you.

THE HEARING OFFICER: All right.

EVELYN KRETA: I'm happy to do it next week.

THE HEARING OFFICER: I appreciate that.

EVELYN KRETA: No problem.

THE HEARING OFFICER: I prefer to fit in as many as possible now. So if you're willing to stick around, I'd appreciate that.

EVELYN KRETA: Are you talking to me?

THE HEARING OFFICER: Yes.

EVELYN KRETA: Do you want me to try to do it tonight?

THE HEARING OFFICER: Yes.

EVELYN KRETA: Okay. I'll be more organized next week, but --

THE HEARING OFFICER: We're going to start with Lori Shepherd.

MR. KNAG: She's not here.

THE HEARING OFFICER: Okay.

MR. KNAG: She, she's one of the ones that we couldn't find to talk to.

THE HEARING OFFICER: I'll make note of that. Jill Drew. Is this Ms. Drew?

JILL DREW: Hi. Yeah.

THE HEARING OFFICER: Hi. Just a reminder you are limited to three minutes, and to the extent possible, please try to limit your comments to the CON criteria in our evaluation of this application.

JILL DREW: Okay. Good afternoon. I'm Jill Drew. I'm a resident of Sharon and I'm secretary of Save Sharon Hospital, Inc. I'm also a local volunteer emergency medical responder and I'm involved within several community-based groups.

I'm testifying today, or giving my statement today in response to some strong words that Dr. Murphy used in his prefiled testimony. The first is, quote, we cannot be held hostage by

uninformed opinions that seek to prevent Sharon Hospital from making even the smallest changes without regard for the costs and implications of the failure to evolve.

This statement is incorrect. I am among the many residents of the Northwest Corner who have tried to work with Nuvance. For example, I co-chair something called the Sharon Connect Task Force, which in April 2021 wrote a letter of strong support for Sharon Hospital to secure a $400,000 federal earmark to help fund a major technology upgrade at Sharon Hospital to boost its telehealth capabilities.

Sharon Hospital was successful in securing those funds, and our support was exact opposite of resisting change. The groundwork for that collaboration began in October of 2019 when I had a very productive meeting with interim Sharon Hospital President Denise George. We had a respectful and mutually beneficial discussion about working together on changes she saw that Sharon Hospital needed to make to better serve its patients.

Unfortunately, she was replaced as head of the hospital and that engaged relationship did not

continue with her successor. Instead, now anyone who disagreed with NUVANCE's corporate strategy at that point was muscled aside, which brings me to the other quote from Dr. Murphy.

We are being proactive while critics of the plan and its components cling to the status quo. Those who oppose creation of a PCU do not say what they are for or offer solutions to Sharon Hospital's financial challenges. This is also incorrect. Save Sharon Hospital's vision is clear, to lead a collaborative effort among community stakeholders, philanthropists, and hospital management to create sustainable and innovative model of high-quality, full-service, cost-effective medical care at Sharon Hospital.

We are being proactive in taking the only avenue open to us since Nuvance refuses to talk. We are in discussion with the chairs of four state legislative committees, appropriations, public health, human services, and finance, the last of which is co-chaired by our own State Representative Maria Horn, to build support for additional funding for Sharon Hospital during this legislative session, including increasing Medicaid reimbursements.

These elected officials, along with State Senator Stephen Harding, recognize that providing health care in rural communities is always going to be more expensive. There is talk of convening a statewide task force to discuss how Connecticut can be a national leader in protecting access to health care for all so that our rural communities don't become health care deserts. This is not resisting change. This is supporting our future. Thank you.

THE HEARING OFFICER: Thank you, Ms. Drew.

Next on the list is Nicholas Moore.

MR. KNAG: Could we ask that Jean Speck is now available?

THE HEARING OFFICER: Oh, sure. I'm sorry. I didn't realize Jean Speck had arrived.

MR. KNAG: She said let Nick go first.

THE HEARING OFFICER: Okay.

NICHOLAS MOORE: Thank you, Hearing Officer Csuka and the staff of the Office of Health Strategies. My name is Nick Moore, and I'm a member of Save Sharon Hospital.

I've been a full-time member of Sharon for most of my life. Nuvance has talked about the needs of our supposedly aging population as a

rationale for their transformation plan.

The proposed change of the Sharon Hospital ICU to a PCU would result in the transfer of elderly patients to distant hospitals. It's not just the patients who would be affected. Family members, caregivers, and friends would also have to travel long distances to an unfamiliar facility possibly needing accommodations to be near their incapacitated loved ones.

Rather than addressing safety concerns about transferring patients that could and should be treated at Sharon Hospital, Nuvance and their lawyers try to discredit dissenting expert witnesses who testify under oath and say that we engage in unfounded conspiracy allegations or wholesale speculation.

Our witnesses and our supporters are public officials, EMTs, and patients who have benefited from the services of Sharon Hospital. People are moving here because of the outstanding full services currently offered at the hospital.

Downgrading the ICU to a PCU would continue a trend by Nuvance and others to reduce existing services at Sharon Hospital. I'm concerned about testimony from David Jensen where he says the

mantra is triaging, stabilizing, and transferring. I think that we deserve a full-service hospital and I respectfully ask that you deny this application.

THE HEARING OFFICER: Thank you, Mr. Moore.

Looks like next is Lydia Moore.

LYDIA MOORE: Hi, thank you. Thank you, Hearing Officer Csuka, for the opportunity to speak. My name is Lydia Moore. I'm a full-time resident of Sharon. I've been an inpatient at Sharon Hospital and my PCP is part of Sharon Hospital. I'm also president of Save Sharon Hospital, Incorporated.

During the public comment period today in a well-coordinated and highly funded effort we've heard from several Nuvance employees and board members as they repeated the company line, that the same level of critical care will be provided at the proposed PCU, while consistently failing to mention that 10 percent of current patients would not be admitted as stated repeatedly in their documents to OHS.

On the other hand, you will not hear Nuvance employees disagreeing with Nuvance during public comment or as expert witnesses for the Intervener. Why is this? When my group has met with Nuvance

physicians and nurses who oppose the Nuvance transformation plan, they have told us they cannot testify in opposition to any aspect of Nuvance's proposal for fear of --

MR. TUCCI: That's inappropriate. I ask that that comment, the Hearing Officer direct this Witness not to engage in that kind of commentary.

LYDIA MOORE: This is what happened. We have spoken to many people who will not speak today at this public hearing.

THE HEARING OFFICER: I'll allow her to move forward.

LYDIA MOORE: Thank you. They are too scared to speak against their employer for fear of, not just being fired, but also being blacklisted from other hospitals in the future.

And I cannot blame them. When I had my second child at Sharon Hospital in 2019, I definitely felt prejudiced on the part of certain hospital employees because I had been a founding member of Save Sharon Hospital in 2018, opposing the closure of maternity at that time. And this is just how I felt as a community member, not as someone who relies on Nuvance for money to feed my family.

Now, who are you hearing from on the side of

the community? You are hearing from public officials who understand how important and necessary it is to maintain a local ICU. You are hearing from community members who are Sharon Hospital patients and from whom have either been in the Sharon Hospital ICU, or who have had family members in the ICU.

You are hearing from people with a vested interest in what is right for our community and, not just what may be right for a huge corporation whose majority of administrators do not live in the Sharon area and who do not rely on Sharon Hospital for their health care.

The changes those administrators propose will increase the hospital's losses while undermining its ability to serve patients it currently serves, some of whom will be referred elsewhere with a process that will potentially imperil their lives.

Save Sharon Hospital does not oppose change. Instead, we believe that just because we live in a rural area it does not mean that we should not have access to adequate health care. Instead of being opposed to change, we are working to change a state system that does not provide enough funding for rural hospitals that may need it. We

are doing this without Nuvance's help as they have been unwilling to look at solutions other than the ones they paid for.

We need this ICU to remain in our community. OHS, you are our community's only chance to make sure all of our vital services, our vital health services remain local. Please choose the side of what is right and deny Nuvance's application to close our community's ICU. Thank you.

THE HEARING OFFICER: Thank you, Ms. Moore.

MR. KNAG: This is Jean Speck.

JEAN SPECK: Good afternoon. Thanks for sort of shifting things around for me. I appreciate the time.

Good afternoon, Hearing Officer Csuka and OHS staff. Thank you for the opportunity to speak today. I'm writing to express my strong opposition to Nuvance's proposed closure of the ICU at Sharon Hospital.

As a chief elected official, longtime EMT, and public health advocate, I believe that this decision would have devastating consequences for the community and would put the lives of our community and the region at risk.

On the surface, this change seems relatively

small, from ICU to PCU, but the cumulative impact will send our communities down a slippery slope that are grave to the patients that most need this critical care and to the emergency medical services that provide the 911 transport services.

In Kent alone almost 27 percent of our population is over 65, and this directly correlates to increased need for more critical services. Our EMS providers will in turn be transporting more critically ill patients, taxing a system that is already taxing its volunteers to the brink.

We are a region of small community services, and we are eking every hour, every skill out of our volunteers, and we have a very limited pool in EMS. In order to better that system we need to keep those critical patients at Sharon Hospital in the ICU where the physicians and nurses and PAs can care for them.

I urge you to deny this application. Thank you very much.

THE HEARING OFFICER: Thank you, Ms. Speck.

Next is Antoinette Lopane. Is she still available?

ANTOINETTE LOPANE: Hello. Yes, I'm here.

THE HEARING OFFICER: Okay.

You can start whenever you're ready.

ANTOINETTE LOPANE: Thank you for allowing me to speak today. My name is Antoinette Lopane. It's spelled A-n-t-o-i-n-e-t-t-e, L-o-p-a-n-e. And I have been a member of Sharon Hospital's staff for over 33 years.

I am here today, and I'm speaking of my own accord to show my support for Sharon Hospital's application to centralize the essential care currently offered into a new progressive care unit.

Over the years, I've seen our hospital and team evolve with the healthcare landscape. The proposed PCU is a clear acknowledgement of these changes and a solution to embrace a more efficient model for providing the excellent care currently offered at our hospital. This transition will allow Sharon Hospital's team to offer the same level of care as today while helping our rural hospital to remain a vibrant part of our community into the future.

As a staff member, patient, and longtime member of this community, I'm excited about these opportunities available to both our staff and our

community if Sharon Hospital is able to move forward with the proposed PCU.

Sharon Hospital as a small community hospital cannot continue into the future unchanged. The recommended changes will contribute to the overall efforts and enable Sharon Hospital to remain a part of our community for years to come. I kindly ask you to approve this application, and I thank you for your time.

THE HEARING OFFICER: Thank you, Ms. Lopane.

James Flaherty?

JAMES FLAHERTY: Right, I'm here.

THE HEARING OFFICER: You can begin whenever you're ready.

JAMES FLAHERTY: Okay. Fine. Thank you. I'm Jim Flaherty, F-l-a-h-e-r-t-y. I moved to Sharon 48 years ago, and one of the reasons I moved -- picking a country town, living in New York, is a town that had hospital services. Then a few years later, I opened a large and meaningful business right next door to Sharon in Amenia, Troutbeck, a country inn a conference center.

Over the years, we had many guests, especially international corporations who came to have their high-level executive meetings there,

who would talk to me and say, Jim, are there hospital services nearby? And I said, absolutely. Within inside of ten minutes, we're right there.

So I also feel very strongly -- although my own children, by the time I came here, my children were past the middle school level, were I a parent of a child at Hotchkiss or Millbrook School or Kent School or Salisbury, I absolutely would want all hospital services right in Sharon.

The importance of Sharon Hospital is crucial for those of us who live in the five or six towns, or eight or ten towns that surround it. And I'm sure that most of the people speaking for Nuvance don't live here, because the difference of being shipped to Vassar, which is a fine hospital, or to Charlotte-Hungerford is an hour.

That's an hour, a very crucial hour. I have been in the ICU of Sharon, and I've had three surgeries over the past 48 years in Sharon, and I've had numerous friends who had to go there. So I speak emotionally about the importance of the hospital.

And I would hope that Nuvance and that the office that we are addressing, the health office, would recognize that Sharon is not just a small

community hospital. It is a crucial key to medical treatment for a number of towns.

And we all feel very fortunate to have it, and we want it to continue. Thank you very much.

THE HEARING OFFICER: Thank you, Mr. Flaherty.

We have three more. It will be Attorney Singer, Kathleen Friedman, and then Evelyn Kreta. So let's start with David Singer first.

Mr. Singer, are you still available?

DAVID SINGER: Yes, I'm here. Thank you for the opportunity to make a public comment today.

I'm a homeowner in Salisbury, Connecticut, and a member of the Board of Directors of Save Sharon Hospital. I offer this letter -- or I offer these comments as public comment regarding the CON at issue.

In my view, the closure of Sharon Hospital's intensive care unit will endanger the health and safety of local residents, and it is simply untenable.

Nuvance has presented its case in a very clever manner. It asserts that it will be providing the exact same level of care under its new proposal as it does currently. It has been, as we have heard this earlier today, a mantra of

sorts, repeated over and over again.

Nuvance describes the proposal as essentially moving the same services from one floor to another, a unification or consolidation of two floors onto one floor -- but how can that really be?

Nuvance makes this representation based on its admission that Sharon Hospital no longer provides ICU level care. This is an astonishing admission. It means that since it acquired Sharon Hospital in 2018, it already has degraded Sharon Hospital's ICU to a PCU, and has done so without prior authorization by OHS, and such violation is extreme and must not be countenanced by OHS.

Now, Nuvance counsel repeatedly references conspiracy theories and a kind of silly use of a politically charged phrase in a thinly veiled attempt to distract OHS from the serious substantive issues that are at stake in this matter. OHS should not allow itself to be so manipulated.

Now I am one of a substantial number of people who have either purchased country homes in, or have moved entirely from their city dwellings to the northwest corner of Connecticut. Many of

us are older, and for us the presence of Sharon Hospital, a five-star full-service hospital, has always been of critical importance. Indeed, we may not have bought homes in or moved here if Sharon Hospital did not exist.

Nuvance Health's proposals to eliminate the ICU will remove Sharon Hospital as a full-service hospital. Indeed, Nuvance admits that in the absence of an ICU, Sharon Hospital will not be able to admit seriously ill or injured patients. Indeed, they will either be transported by ambulance from their homes or place of injury to a facility that is an hour drive away, weather permitting, or treated at Sharon Hospital Emergency Department and then transported to another facility that has an ICU.

Nuvance offers no healthcare benefit that will result from eliminating Sharon Hospital's ICU. Regarding finances, Nuvance cannot transfer profitable services from Sharon Hospital to its other hospitals and then complain that Sharon Hospital is not making more money.

Moreover, Nuvance admits, as we have heard earlier, that its proposal to close the ICU will cause it to lose more money. Now, what could be

more irrational than that?

Inexcusably, Nuvance has failed to engage with the community, which has made clear that it is overwhelmingly in opposition to the closure of the ICU at Sharon Hospital in an effort to find solutions that will not demonstrably hurt or harm its welfare.

Nuvance must not be rewarded for its irresponsible behavior, and its application to close Sharon Hospital's ICU should accordingly be denied. Thank you.

THE HEARING OFFICER: Thank you, Attorney Singer.

Two more. Kathleen Friedman.

KATHLEEN FRIEDMAN: Yes, I'm here. Thank you. Good afternoon, Hearing Officer Csuka and members of the Office Health Strategy team. Thank you for this chance to speak.

My name is Kathleen Friedman. I'm a longtime resident of Sharon and a member of the Save Sharon Hospital group. I have been both a medical surgical and an ICU patient at Sharon Hospital.

Now, I realize that we are -- that hospitals are in a difficult place right now in the United States and in Connecticut as well, especially following the pandemic. And while I would like to

see Sharon Hospital retain ICU capacity, perhaps bookend it as long as we're speaking about innovations and moving on from the status quo, bookend it perhaps with medical surgical alongside a PCU, but retaining the capacity for higher acuity care.

I would like to go on and introduce another perspective on a perspective, and that is the one offered by Stroudwater. Dr. Murphy's prefiled testimony states, our transformation plan has been developed in consultation with some of the country's leading rural healthcare experts. Now, the study in question was led by Stroudwater Associates, as we know.

The consultancy that Nuvance engaged recommended replacing the current ICU with a PCU. Stroudwater's executive summary of late June 2021 makes for painful reading, frankly. It urges Nuvance to enhance, quote, system effectiveness and, quote, network optimization. It explicitly recommends stepping up patient transfer rates from Sharon Hospital to other Nuvance facilities.

And it notes approvingly that the latest data for patient transfers from Sharon Hospital to other Nuvance hospitals, that would be as of the

publication of their report, show that Nuvance is realizing, quote, the benefits of network optimization.

Now, if Nuvance has adopted Stroudwater's recommended total value system perspective, which is a core principle that they're advocating, in which the plan is to increase patient transfer, does that mean that services at Vassar Brothers Medical Center, for example, will expand at the expense of locally-based critical care needed here to treat patients who will inevitably present with varying levels of acuity?

Where does network optimization -- which lives on balance sheets, frankly, where does it leave us who live in the Sharon Hospital community?

Now, this is not a conspiracy perspective on my part, or any of our parts. It really -- it reflects a deep discomfort with a corporate model that threatens to be a disservice to community hospitals, and it leaves us feeling extremely, I would say, disoriented, and we need to find a way forward from this. So, thank you very much.

THE HEARING OFFICER: Thank you, Ms. Friedman.

And lastly, we have Evelyn Kreta.

EVELYN KRETA: Hi, thank you -- whoops. Can you hear me? Good. I just -- I'll make a few comments and put the rest in writing, because I know everyone is tired.

But I just want to say that, you know, Sharon Hospital was always there for us. Can you hear me? Okay. It was -- are you all there?

THE HEARING OFFICER: Yes.

EVELYN KRETA: Okay. I'm sorry, my screen was bouncing.

So we've lived here 33 years. The hospital -- we've been to the ER, we've been to the ICU, and many of us have been saved because of it, and I'm grateful for all of that.

When I listen, I hear that -- to these hearings, mostly the community and the people that we've elected to represent us, we're all in agreement, mostly, that we don't wish this application to be approved. So I just wanted to make that point, because I was trying to think -- and I want to thank you, the members of OHS, for listening to all of this.

And I say with all sincerity, and I was thinking about your name, the Office of Health Strategy. And I was trying to think, like, whose

strategy? Are you concerned with the hospital's strategy? Or like, each one of us, I personally have a strategy of why I moved here -- I live across the street from the hospital.

Or the nursing homes that had a strategy that they developed to be near hospitals for the people that they're helping. We have so many nursing homes. Or the 2,000 students that are in the prep schools, and their strategy in developing in our area.

We have all a health strategy, and when I listen to the hospital's strategy that they're presenting, I hear words like efficiency and staffing. Not that those are not important, and I think it's with the idea of providing a good service to the community.

However, they keep telling us that there's going to be no real change. However, I find that hard to believe because then we wouldn't need to be here, and the doctor, Dr. Tim, whose name I don't know, the last name -- he made it very clear to us what a PCU is. He called it a step-down unit.

There's intensive care, there's PCU, which is intermediate care, and then there's the care on

the floor. We should not lie to ourselves, and no one should be allowed, you know, allowed to pretend that an ICU and a PCU, you know, are the same. They're not.

So what does the hospital tell us? They tell us that, well, they've been transferring patients as needed, so why can't they keep doing that? If they need, you know, what happens, though, when -- you hear Dr. Kurish say, there was no bed available for that person?

So if you approve this application and they are a PCU, then legally they can't keep someone who needs an ICU, and I think that's part of the strategy, that they have that legal option or legal, you know -- I'm almost going to say shield, that we cannot keep you because we're not an ICU.

But let's face it, if you don't have insurance coverage, Dr. Tim said, we're ready to take you in Vassar, you know, but that's New York. But if you have Connecticut Medicaid, are you covered for a hospital in New York?

If you have an Advantage Medicare plan that's kind of a network plan and not like original Medicare, are you going to be covered if you go to New York? And you know who that leaves? That

leaves like two hospitals that are either 45 minutes or an hour away, maybe Hartford.

And you have to hope that they have a bed. If you happen to be somebody who is critically ill, and then you have to hope you make it there within that hour, and then you have to hope that it's not snowing, and you're not slipping and sliding into trees on huge hills.

And what I would ask is that if you were to just keep it as an ICU, Sharon Hospital can still transfer patients, they still have that option. They don't have to keep them if they feel they need more care. But if you take that away and you make them a PCU, then they are done. And we're done.

THE HEARING OFFICER: Ms. Kreta, please wrap up your comments. I'm sorry.

EVELYN KRETA: And all I have to say is that I will wrap -- I'm sorry. I got emotional. I had one other point, but you know, I'll put it in writing.

I just wanted to ask you as the members of OHS to take a ride up to the hospital here in Sharon. Imagine yourself being deathly ill, and then go ride, take a ride in your car to one of the other hospitals that you would be sent to

imagining what you're going through.

And imagining that you're an hour away, and now your family has to come to these places to visit you, hopefully, if they could, if they could afford it. You know, we have transportation in this area, these little buses, where we can get around. We can get to the hospital. We can get to our loved ones.

It's really unreasonable. If there's no change, then there's no change. We don't need to be here. If everything's going to be the same, why are we here? Thank you very much.

THE HEARING OFFICER: Thank you, Ms. Kreta.

MR. KNAG: Mr. Hearing Officer, you had earlier called Lori Shepherd. She wasn't there when you called. She's there. She's available now, if you were willing to take her.

THE HEARING OFFICER: Sure.

LORI SHEPHERD: Thank you, and good afternoon. My name is Lori Shepherd. I'm a resident of Salisbury. And I just want to say that I am against closing the ICU.

If everything is going to be the same, keep it. And I hardly believe that Nuvance honestly will not be letting staff go. They say everything

will remain the same with staff. I'm hoping that you will create some kind of condition in anything that you write that actually demands that they keep the staff, that they keep the services, and that they be a real ICU, not a PCU.

Our communities need the professional staff people in these communities. We need their children in the schools. We need them as part of our basic community, and I think it's very important to realize that they are a very lively and vital part of the Northwest Corner and nearby New York State.

I'm also disappointed that the advisory board for Sharon Hospital does not communicate with the community. And I think that a recent letter that they had in the Lakeville Journal was very nice, but there has been no ongoing sharing or community reporting from them as to what's going on. And I think that the community deserves better on that score as well.

Part of that is Nuvance's fault. In my opinion it is not the community board itself. Thank you. Good afternoon.

THE HEARING OFFICER: Thank you, Ms. Shepherd, and thank you for coming back.

MR. KNAG: Mr. Hearing Officer, I also want to make note that I've been informed that there were two people who are not available right now, but who have told us they signed up, but they weren't on your list.

And the names of those people are Dawn Wing and Lori Schneider. So they will, with your permission, we'll advise them to be available on next Wednesday.

THE HEARING OFFICER: We will check our records, and I'll advise further.

To my knowledge, we don't have a record of that coming in, but I'll have to confirm that with Ms. Capozzi and Ms. Fentis.

A VOICE: We were signed up under a different name, if that helps the situation.

MR. KNAG: What was the name?

A VOICE: (Unintelligible.)

MR. KNAG: All right. On Wednesday, we'll have them available. And they may have used another name when they were signing up, but they can make that known, and then you can rule as to whether they can speak.

THE HEARING OFFICER: That works. So with that, Attorney Tucci, do you have anything that needs to

be addressed before we adjourn the hearing for today?

MR. TUCCI: No. Thank you for asking. We stand ready to reconvene at our next session.

THE HEARING OFFICER: Thank you. Thank you for everyone's time and flexibility. Anyone who was not able to sign up for oral comment is still free to submit written public comment, and we encourage you to do so.

I do believe that we'll be reconvening at 1 p.m. at next Wednesday, subject to my confirming the hearing logistics with OHS staff. So everyone should plan to do that at 1 p.m. I will issue a written order tomorrow just to confirm that in writing.

Written public comment can be submitted up to seven days following the next session, whenever that is. To me, it's next Wednesday. That means it would be March 1st.

I do regret not being able to complete the hearing today -- but as I've mentioned, it is my job to make sure that the hearing progresses in as efficient a manner as possible, and this is what I've determined is the best path forward.

So assuming there are no further questions or

concerns, I'm going to adjourn the hearing for now. Thank you again, everyone, for your time, and I look forward to seeing everyone next week.

THE REPORTER: One quick question for the parties. Do any of the parties wish to request transcripts?

THE HEARING OFFICER: I believe OHS is typically the only one who requests a transcript and it's sent directly to us.

If there's an interest in having it expedited, the agency typically does not pay for that. We pay for the standard service, but if there's any interest from either Attorney Tucci or Attorney Knag, for an expedited transcript we can certainly address that offline, and we can figure out what the best approach is.

Maybe OHS will cover the main cost and then the parties would cover the difference.

THE REPORTER: Understood. Thank you.

MR. TUCCI: So Mr. Csuka, this is Ted Tucci. We will contact the Court Reporter directly, and we'll make a determination shortly about the possible need to expedite receipt of the transcript.

THE HEARING OFFICER: Okay.

MR. TUCCI: Thank you.

THE HEARING OFFICER: That works for me.

THE REPORTER: Have a good evening.

THE HEARING OFFICER: Thank you, everyone.

(End: 5:11 p.m.)

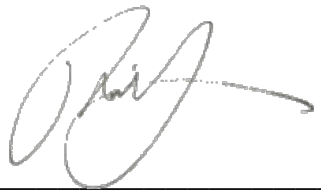
STATE OF CONNECTICUT

I, ROBERT G. DIXON, a Certified Verbatim Reporter within and for the State of Connecticut, do hereby certify that I took the above 292 pages of proceedings in the STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF HEALTH STRATEGY PUBLIC HEARING, In Re: 22-32504-CON, CONTINUATION OF PUBLIC HEARING FOR THE PROPOSED TERMINATION OF INPATIENT OR OUTPATIENT SERVICES (INTENSIVE CARE UNIT) BY VASSAR HEALTH CONNECTICUT, INC., D/B/A SHARON HOSPITAL; held before: DANIEL CSUKA, ESQ., THE HEARING OFFICER, on February 15, 2023, (via teleconference).

I further certify that the within testimony was taken by me stenographically and reduced to typewritten form under my direction by means of computer assisted transcription; and I further certify that said deposition is a true record of the testimony given in these proceedings.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

WITNESS my hand and seal the 9th day of March, 2023.



Robert G. Dixon, N.P., CVR-M No. 857

My Commission Expires 6/30/2025

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