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1 STATE OF CONNECTICUT

2 DEPARTMENT OF PUBLIC HEALTH

3 OFFICE OF HEALTH STRATEGY

4 PUBLIC HEARING

5

6

7 In Re:
Docket Number: 22-32504-CON

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

9

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

13

14

15 HELD BEFORE: Daniel Csuka, Esquire
The Hearing Officer

16

17

18 DATE: February 22, 2023

19 TIME: 1:00 p.m.

20

21 PLACE: (Held via teleconference)

22

23 Reporter: Annette F. Brown, CSR 00009

24

25

1 **APPEARANCES:**

2

3 **FOR THE INTERVENER:**

4 **PAUL E. KNAG, ESQUIRE**
JULIA BOISVERT, ESQUIRE
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9 **FOR THE APPLICANT:**

10 **THEODORE J. TUCCI, ESQUIRE**
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Hartford, Connecticut 06103
12 **Telephone: 860.275.8210**

13

OHS STAFF:
14

Steven W. Lazarus
15 **Annalise Faiella**
Ormand Clarke
16 **Leslie Greer**

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1 (On the record at approximately
2 1:00 p.m.)
3
4 HEARING OFFICER CSUKA: Thank you.
5 Good afternoon. Today is February 22, 2023.
6 It is just about one p.m. This is the second
7 part of a hearing that commenced on February
8 15, 2023. It concerns the application by
9 Vassar Health Connecticut, Inc. d/b/a Sharon
10 Hospital, Docket Number 22-32504-CON.
11 Sharon Hospital is seeking a
12 Certificate of Need Approval for the
13 Termination of Inpatient Services Offered by
14 a Hospital, pursuant to Connecticut General
15 Statute 19a-638, sub A, sub 5.
16 Specifically, Sharon Hospital is
17 seeking approval to consolidate its critical
18 care services by terminating its intensive
19 care unit and establishing a progressive care
20 unit.
21 Thank you all for making the time to
22 come back for the second day. As I stated
23 previously, my name is Dan Csuka. I have
24 been designated to serve as the hearing
25 officer for this matter.

1 I ask that all members of the public
2 mute their devices and silence any additional
3 devices that are around them.
4 Again, the CON process is a regulatory
5 process, and as such the highest level of
6 respect will be afforded to the applicant,
7 members of the public, our staff, and to the
8 intervener.
9 Our priority is the integrity and
10 transparency of this process. Accordingly,
11 decorum must be maintained by all present.
12 Before we get into the substance of the
13 hearing, I did just want to call attention to
14 the fact the OHS member who was present last
15 time, Myda Capozzi, to assist with the
16 administration of the hearing, is out today
17 due to illness. She has been replaced today
18 by Leslie Greer, who has assisted with the --
19 these CON hearings in the past.
20 The agenda for this proceeding is
21 posted as Exhibit GG in the docket. Last
22 time we were together we handled all the
23 public comment and most of the technical
24 portion of the hearing.
25 What remains are the following:

1 Number 1, OHS staff's questioning of
2 applicant and intervener. Number 2,
3 discussion of late files, and Number 3,
4 closing arguments.
5 I plan to tackle them each in that
6 order, but before we get into that, I did
7 want to ask if there were any other
8 housekeeping matters or procedural issues
9 that we need to address before we do that?
10 So I'm going to the start first with
11 Attorney Tucci. Is there anything else you
12 would like to discuss before we get into
13 things?
14 Attorney? I think he -- Attorney
15 Tucci, are you speaking? He might be muted.
16 It looks like you're unmuted now.
17 MR. TUCCI: Hello.
18 HEARING OFFICER CSUKA: Yes.
19 MR. TUCCI: Can you hear me?
20 HEARING OFFICER CSUKA: Uh-huh. We
21 can.
22 MR. TUCCI: Apologies. I thought it
23 was unmuted and I am now. So no, we have no
24 -- no additional housekeeping or
25 administrative matters. Thank you for

1 asking.
2 HEARING OFFICER CSUKA: Thank you.
3 And, Attorney Knag, do you have
4 anything you would like to address?
5 MR. KNAG: No. We had two people we
6 thought had signed up, but they didn't
7 contact us again, so we -- we have nothing to
8 add at this time.
9 HEARING OFFICER CSUKA: Okay. Thank
10 you.
11 So, Attorney Tucci, are all of your
12 witnesses present from the last date?
13 MR. TUCCI: Yes, Mr. Csuka, and we're
14 ready to proceed.
15 HEARING OFFICER CSUKA: Great.
16 And counsel for the intervener,
17 Dr. Kurish, are your witnesses available?
18 MR. KNAG: Yes.
19 HEARING OFFICER CSUKA: Thank you.
20 MR. KNAG: Yes.
21 HEARING OFFICER CSUKA: So since this a
22 continuation of the prior date, I would just
23 like to remind all witnesses that they are
24 still under oath and they are obligated to
25 provide the truth, the whole truth, and

1 nothing but the truth in this proceeding.
2 And I also wanted to mention that if we
3 do need to take any breaks for any reason,
4 everybody should turn off their camera and
5 mute their devices because we might still be
6 able to hear you even though the recording
7 will be stopped.
8 With that, we're going to proceed with
9 the questions that the OHS analyst had
10 prepared for the applicant and the
11 intervener.
12 So I'm going to turn it over to Steve,
13 Ormand, and Annie.
14 MR. LAZARUS: Mr. Csuka, just give us a
15 moment. We'll have our witnesses come up so
16 that they're all available.
17 HEARING OFFICER CSUKA: Thank you.
18 MR. LAZARUS: Thank you, Attorney
19 Csuka, I think we're going to start with
20 Ormand starting -- asking the questions.
21 HEARING OFFICER CSUKA: Let's just give
22 them a moment to get settled.
23 All right. I think we're ready to
24 begin.
25 MR. CLARKE: Good afternoon, everyone.

1 My first -- the first question that we
2 have is -- this is on page 42 of the late
3 application. Are you able to give us an idea
4 of what utilizations look like since filing
5 the application in early 2022, and are you
6 able to provide updated utilization for April
7 2022 to the present?
8 MR. TUCCI: Mr. Clarke, this is Ted
9 Tucci. I apologize. We're having a little
10 bit of audio difficulty. I hate to ask you
11 to do this, but could you repeat your
12 question one more time?
13 MR. CLARKE: Certainly, sir.
14 Are you able to give us an idea of what
15 utilization has looked like since filing the
16 application in early 2022? Are you able to
17 provide an update of utilization volume for
18 April 2022 to present?
19 THE COURT REPORTER: I'm sorry. Who's
20 talking?
21 HEARING OFFICER CSUKA: Mr. Clarke
22 referenced page -- it was Bates Number SH-42.
23 MS. McCULLOCH: So we -- what we
24 understand you're asking is what has the
25 utilization of the current ICU been since our

1 application, which ended -- the data we
2 provided was through September; is that
3 correct? Is that what you're asking?
4 MR. CLARKE: Yes, since the submission
5 of the application.
6 MS. McCULLOCH: Okay.
7 So I don't know the exact number, the
8 volume. I can tell you that the utilization
9 is likely similar to what we presented just
10 anecdotally speaking based on what we see in
11 the unit each day, but I don't have volume
12 numbers today to share.
13 MR. CLARKE: And would you be able to
14 provide those for us after the hearing as a
15 late file?
16 MS. McCULLOCH: Yes, we can get that.
17 MR. CLARKE: We would request that.
18 MS. McCULLOCH: Yes. Okay.
19 MR. CLARKE: Thank you.
20 And what is the ICU's average daily
21 census and historical volumes from 2018 to
22 the present and per week -- in terms of per
23 week, per month, per year? And, again, that
24 may be submitted as a late file.
25 MS. McCULLOCH: Okay.

1 MR. CLARKE: And turning to page --
2 pages 42 -- 43 of the main application.
3 Therein you provided the current and the
4 projected payor mix for IC telemetry. It
5 does not include twenty -- the data for 2022.
6 Are you able to correct and update this
7 table? Also, we are interested in how I'm
8 going to --
9 HEARING OFFICER CSUKA: Let's just --
10 let's just take that one piece at a time.
11 Okay.
12 So...
13 MS. McCULLOCH: So yes, I believe we
14 can get the 2022 updated payor mix data.
15 MR. CLARKE: Thank you.
16 In addition, we are interested in
17 seeing how this compares to the hospital's
18 overall payor mix.
19 Are you able to provide a similar table
20 for overall hospital payor mix?
21 MR. TUCCI: I'm sorry. Again, I'm
22 having trouble hearing that question. I
23 don't know if it's our mic or your mic. But
24 if it's possible, if you could just get a
25 little closer or increase your volume, and

1 then if we can hear the question again.
2 MR. CLARKE: Sure.
3 We are interested in seeing how this
4 compares to the hospital's overall payor mix.
5 Are you able to provide a similar table
6 for overall hospital payor mix?
7 MS. McCULLOCH: Yes, we can provide
8 that.
9 MR. CLARKE: Thank you.
10 And on page 20, this page states in
11 part higher-acuity patients will be examined,
12 triaged, and maybe transferred to facilities
13 with more onsite -- more onsite capabilities
14 for treatment of high-acuity conditions.
15 MR. TUCCI: I'm sorry. Again -- I'm
16 sorry, Mr. Clarke. I apologize for
17 continuing to interrupt you. I'm just trying
18 to make sure that we get to the page
19 reference you gave.
20 MR. CLARKE: Page 43, sir.
21 MR. TUCCI: Thank you.
22 HEARING OFFICER CSUKA: I think what
23 might be helpful, Mr. Clarke, is going
24 forward if you are going to reference a Bates
25 page or a page number, you give them a moment

1 to open up --
2 MR. CLARKE: Absolutely.
3 HEARING OFFICER CSUKA: -- their
4 documents to where you're going to be asking
5 them questions.
6 MR. CLARKE: Yes. Certainly.
7 So for the previous question it was in
8 relation to page -- the information presented
9 on page 12.
10 MR. KNAG: Page 12. Excuse me.
11 MR. CLARKE: Page 12 of the main
12 application.
13 HEARING OFFICER CSUKA: That's Bates
14 Number 12.
15 MR. TUCCI: It's in reference to that
16 language generally there. Just the general
17 narrative language.
18 THE COURT REPORTER: Who was that
19 talking?
20 MR. TUCCI: I'm sorry. This is Ted
21 Tucci. I was just --
22 THE COURT REPORTER: Thank you.
23 MR. TUCCI: I was just pointing the --
24 my witnesses to the reference on the Bates
25 page of the executive summary.

1 I apologize, Mr. Clarke. You can
2 complete your question.
3 MR. CLARKE: If this proposal were to
4 be approved and ICU patients transfer to
5 other Nuvance Health facilities, what would
6 be the potential financial impact on
7 consumers?
8 MS. McCULLOCH: So I can answer that
9 question.
10 We don't anticipate any financial
11 impact to our consumers, our patients, and
12 our community members; and that is because we
13 intend to maintain the critical care services
14 that we provide today in the new progressive
15 care unit.
16 And as we explained in more detail last
17 week, we don't anticipate an increased number
18 of transfers out of our hospital because the
19 same services that we provide today will be
20 provided in the progressive care unit.
21 HEARING OFFICER CSUKA: So can I -- I
22 wanted clarification on that point because in
23 the application it says you're anticipating
24 retaining 90 percent of your critical care
25 patient admission volume and the remaining 10

1 percent would be transferred out.
2 So you're not saying there will be an
3 increase in transfers; you're saying
4 something different than that?
5 MS. McCULLOCH: Right. Yes. And
6 Dr. Marshall can explain how we got to that
7 number.
8 DR. MARSHALL: Sure.
9 So we when initially began the process
10 of considering how to relocate this unit, we
11 started off with a -- an idea that certain
12 cases that we were caring for at the time may
13 not be appropriate to keep in the hospital.
14 As we met with the most important
15 stakeholders including the nursing staff,
16 emergency medicine, hospital medicine, and --
17 and members of the community, community
18 medical staff and members of the Nuvance
19 medical staff, we determined that we would be
20 able to continue to provide the same level of
21 care that we were providing previously in our
22 unit on the first floor which has been called
23 the intensive care unit as we will on the
24 second floor in the new mixed-acuity
25 progressive care unit.

1 We hadn't been keeping patients for
2 many years that require high-level critical
3 care intensive care unit services. So after
4 several meetings and several permutations, we
5 decided that the most appropriate way to
6 proceed was to continue providing the same
7 level of care just in the different location.
8 MS. BOISVERT: So I have a question --
9 I have a quick follow-up question for that
10 then.
11 So you're saying that you haven't been
12 taking patients currently that are in need of
13 intensive care services and you've already --
14 MR. TUCCI: I think that's a
15 misunderstanding.
16 Dr. Marshall, could you explain --
17 DR. MARSHALL: Absolutely.
18 MR. TUCCI: -- the difference?
19 DR. MARSHALL: Absolutely.
20 So, you know, there's a difference
21 between critical care medicine and intensive
22 care unit medicine perhaps or an intensive
23 care unit as a facility or a unit.
24 So patients that require a higher level
25 of critical care that we're able to provide

1 at Sharon Hospital based upon technology,
2 subspeciality care, procedures available,
3 those patients who require that level of care
4 have been and will continue to be transferred
5 to the most appropriate facility, based upon
6 their needs and in collaboration with the
7 patient and their family, where best for them
8 to go.
9 Patients that require critical care
10 that are appropriate to stay at Sharon
11 Hospital in the new progressive care unit,
12 which is similar to the care that we've been
13 providing previously, will continue to stay
14 at Sharon Hospital.
15 MS. BOISVERT: Is it safe to say then
16 that Sharon Hospital never had an ICU -- a
17 legit ICU then?
18 DR. MARSHALL: Well, I think that
19 decades in the past when levels of care and
20 technologies were different Sharon Hospital
21 had a unit that was termed ICU. That was a
22 midlevel ICU at the time. We provided the
23 same sorts of care that we provide today only
24 that was considered an acceptable utilization
25 of an intensive care unit.

1 As medicine has evolved and as
2 technology has evolved, the patients that are
3 the sickest patients are most appropriate
4 under the care of specialists in intensive
5 care unit medicine at facilities that can
6 provide to them the subspeciality care that
7 they need.
8 So at one point we might have been
9 considered a midlevel intensive care unit,
10 but now the type of medicine that we practice
11 in the unit is really progressive care
12 medicine. You know, a high-level progressive
13 care medicine and excellent quality but not
14 intensive care unit medicine.
15 MR. TUCCI: Dr. Marshall -- this is Ted
16 Tucci -- can you just give OHS staff a quick
17 example or explanation of the difference
18 between what critical care -- how critical
19 care is delivered at a rural hospital, like
20 Sharon Hospital, versus what critical care or
21 ICU care is in a bigger hospital like
22 Danbury?
23 DR. MARSHALL: Sure. Sure.
24 Absolutely.
25 So let's use as an example patients who

1 have respiratory failure and require
2 mechanical ventilation, so they need to be on
3 a ventilator.
4 So a patient who requires respiratory
5 support on a ventilator, perhaps because they
6 have pneumonia and they're unable to maintain
7 their breathing and their oxygenation, may be
8 put on ventilator. That patient may require
9 IV antibiotics and fluids and other
10 treatments to keep them stable as they
11 improve and as they are then able to be
12 weaned off the ventilator. That's a patient
13 that we care for now.
14 If that same patient was in shock from
15 an infection, septic shock perhaps, and
16 developed multiorgan system failure requiring
17 dialysis for kidney failure or neurologic
18 interventions.
19 MR. TUCCI: Can you explain what you
20 mean by multiorgan system failure?
21 DR. MARSHALL: Absolutely.
22 So when a patient is in respiratory
23 failure, it means -- it means they need
24 support for their breathing. All of the
25 organs are potential targets of disease and

1 of failure: The liver, the kidneys, the
2 heart, the brain, et cetera.
3 When patients require what we would
4 describe as multilevel physiologic support,
5 multiorgan support, or even ventilator
6 management --
7 MR. TUCCI: Meaning they can't function
8 on their own, their organs can't function
9 without assistance?
10 DR. MARSHALL: Without assistance.
11 Exactly.
12 And even patients that are on a
13 ventilator but require a level of ventilator
14 management that is above the training of a
15 noncritical care intensive care unit
16 physician, those patients need to be
17 transferred to an intensive care unit.
18 There are modalities within ventilator
19 management, so you have a ventilator, but
20 there are different modalities that are
21 utilized in ventilator management, different
22 techniques, if you will, and some are within
23 the realm of an internist/hospitalist
24 practicing in a PCU and some are not.
25 MR. TUCCI: So why is the unit that we

1 currently call an ICU at Sharon Hospital not
2 capable or unable to provide care to the kind
3 of patient you just described?
4 DR. MARSHALL: Well, we don't have the
5 support services for organ failure,
6 particularly kidney failure. You know, we
7 don't have support for patients with advanced
8 congestive heart failure secondary to these
9 diseases, and we also don't have critical
10 care board certified physicians inhouse that
11 can manage these patients with complex
12 multiorgan system disease or even complex
13 respiratory failure requiring special
14 management of their ventilator that we cannot
15 do.
16 MR. TUCCI: So if their heart couldn't
17 function on its own or their kidneys were not
18 able to function in the way that they were
19 supposed to, there's a potential that patient
20 could die if they remained at Sharon Hospital
21 because you don't have the equipment you need
22 to provide them that assistance; is that a
23 true statement?
24 DR. MARSHALL: Absolutely.
25 And I'd add to that that a single

1 organs that's affected may be something that
2 we could handle if we have that capability.
3 We don't do dialysis, but we can manage
4 patients with congestive heart failure, but
5 when have multiple organ systems that are
6 involved, they require a higher level of
7 care.
8 MR. TUCCI: Meaning going to a bigger
9 hospital that has all that equipment, all
10 those services, and the specialist doctors in
11 those areas?
12 DR. MARSHALL: Absolutely.
13 MR. TUCCI: Okay.
14 DR. MARSHALL: And that's what we all
15 want for our patients.
16 HEARING OFFICER CSUKA: Thank you.
17 That was tremendously helpful.
18 So just going back to Mr. Clarke's
19 question though about the potential financial
20 impact on consumers, is it fair to say then
21 that since you're not anticipating an
22 increased number of transfers that there will
23 be no increase in negative financial impact
24 on consumers then?
25 DR. MARSHALL: I would agree with that

1 statement.

2 MS. McCULLOCH: Yes.

3 HEARING OFFICER CSUKA: So retaining or

4 admitting the same patients as you had been

5 before, that itself would also not increase

6 costs for consumers?

7 DR. MARSHALL: I don't anticipate any

8 change in the cost to consumers.

9 HEARING OFFICER CSUKA: Okay. Thank

10 you.

11 MR. CLARKE: Thank you.

12 How many transfers were made to area

13 service providers in the last five years?

14 And this you may provide as a late file as

15 well.

16 MR. KNAG: I'm sorry. Excuse me. I

17 didn't hear that. Could you repeat the

18 question?

19 MR. CLARKE: How many transfers were

20 made in the area service providers in the

21 last five years? And this may be submitted

22 as a late file.

23 MR. TUCCI: So, Mr. Clarke, we do have

24 some data on that in our materials if you

25 could just give us a moment, we can point to

1 where it is. It may need to be updated, but
2 we do have data.
3 MS. McCULLOCH: Yeah, we did submit
4 that in our application, but if you require
5 -- if it's not up to date, we can provide
6 more. It's on average 400 patients a year.
7 MR. CLARKE: I'm sorry. Please provide
8 it in terms of per week, per month, per year.
9 And that may be submitted as a late file.
10 MS. McCULLOCH: Okay.
11 HEARING OFFICER CSUKA: I don't know if
12 we need that level of specificity.
13 DR. MURPHY: Is the question do you
14 suspect there's some seasonality or a weekly
15 fluctuation? But annually that is about 400
16 as Christina said and monthly it varies from
17 35 to 40, and that's pretty constant over the
18 past five years.
19 MR. TUCCI: So I'm just going to direct
20 the witness to SH-00156.
21 Can you just briefly summarize what is
22 shown in that table?
23 MS. McCULLOCH: So we provided data on
24 our transfers broken down by service line
25 from the years 2019 through 2022. That was

1 current through July, and you can see an
2 average of about 400 transfers per year, but
3 it does fluctuate between 300 and here it
4 goes up to 448 in the year 2019.
5 HEARING OFFICER CSUKA: And where was
6 that in your submission? I'm sorry. I
7 missed that.
8 MS. McCULLOCH: This is on page 156,
9 and there's a table that says, "Transfer
10 volume from our emergency department."
11 HEARING OFFICER CSUKA: Okay.
12 MR. CLARKE: And reference --
13 MR. TUCCI: I'm sorry. Just for
14 completeness, I'll also hand the witness
15 SH-152.
16 Can you just describe the information
17 that's shown in that chart?
18 MS. McCULLOCH: Yeah.
19 So on page 152, we have the transfer
20 data. You'll see the same totals, number of
21 transfers per year, with the same time
22 period. Yet this table is displaying the
23 hospitals that are our patients were
24 transferred to.
25 MR. CLARKE: Thank you.

1 MS. McCULLOCH: You're welcome.
2 HEARING OFFICER CSUKA: Thank you.
3 If you could just update that, that
4 would be helpful.
5 MS. McCULLOCH: Just to clarify, update
6 it per year or would you still like that
7 broken down per week, per month, per year?
8 HEARING OFFICER CSUKA: Steve, what do
9 you think would be most beneficial to you
10 guys?
11 MR. LAZARUS: I think per month, per
12 year would be fine.
13 MS. McCULLOCH: Okay.
14 MR. LAZARUS: And this is Steve
15 Lazarus. I just have a quick follow-up
16 question.
17 So you were talking about the I -- the
18 difference between the ICU and the PCU as to
19 the services you were -- you've been
20 providing, and that was very helpful. I
21 agree with Attorney Csuka. That was good to
22 get on the record and have it on file.
23 When, in fact, was the last ICU service
24 that was provided by the hospital, and, you
25 know -- well, let's start with that: When

1 was last the ICU patient that was seen at
2 Sharon Hospital that received the ICU-level
3 of services?
4 MR. TUCCI: Mr. Lazarus, I just want to
5 to get clarification on the question because
6 there -- just so the record is absolutely
7 clear, the hospital maintains and continues
8 to operate on the first floor a unit that
9 provides critical care services to patients.
10 So there are patients in the hospital
11 today who are receiving critical care
12 services. So I'm not sure if you're asking a
13 different question, but certainly the
14 witnesses can testify to that.
15 MR. LAZARUS: I'm going back to the
16 level of service you were talking about under
17 critical care. You were saying you don't
18 provide the intensive care level. So that's
19 what I'm trying to understand is when was the
20 last time that service was provided at that
21 level, at the intensive care level?
22 DR. MURPHY: This is Dr. Murphy.
23 I would offer a perspective,
24 Mr. Lazarus, that it's a moving target
25 because if you recognize that, you know, a

1 number of years ago when a patient had a
2 heart attack and the treatment for that heart
3 attack would be rendered in an ICU, but the
4 treatment consisted of bedrest and an
5 aspirin.
6 I just finished a book on Eisenhower.
7 I was amazed that that's exactly what he got.
8 For a month he laid in bed. That could have
9 been rendered and probably was rendered in
10 the Sharon Hospital in the setting of what
11 was then known as an ICU.
12 But once the treatment of a heart
13 attack required a coronary stent or some sort
14 of percutaneous intervention, then all of a
15 sudden it really didn't meet the same
16 standard, and because Sharon Hospital doesn't
17 do cardiac catheterizations or stent
18 placement, all of a sudden now that patient
19 would have to be transferred to a facility
20 that could offer contemporary
21 state-of-the-art care.
22 So that varies depending upon the
23 clinical event that brings the patient to the
24 hospital and what is and isn't available at
25 Sharon.

1 So I would just offer the perspective
2 that it's difficult to be precise, but at
3 least that's my contribution. Mark, you may
4 want to add something else or, Christina.
5 DR. MARSHALL: Sure. Sure.
6 I would say that -- exactly as you
7 described, what defines that level of care
8 has evolved, and we have and continue to
9 provide critical care services to those
10 patients; and what defines, you know, the
11 level of intensive care is really based upon
12 resources that are available at a particular
13 facility.
14 And so we provide critical care at a
15 particular level, and when patients require a
16 higher level of care, based upon their needs,
17 their clinical needs, then they will be
18 transferred to a higher level intensive care
19 unit.
20 MR. LAZARUS: Thank you.
21 So, I mean -- I guess I mean you're
22 here for the termination of the intensive
23 care unit within this unit that provides us
24 -- provides all levels of care. So that's
25 what I was trying to understand, you know,

1 the differences that you were talking between
2 the two. For example, when was the last time
3 the ICU-level of service was needed or
4 provided by the hospital?
5 DR. MURPHY: Well, I can say the last
6 time that that level was needed was recently
7 when patients that we've had required
8 transfer to an intensive care unit. The
9 level of critical care that we provide in
10 that unit will continue when we locate that
11 unit on the second floor.
12 The historic naming of that unit as
13 intensive care unit, it was always a
14 mixed-acuity unit which means it always had
15 patients that were critical care patients and
16 patients who just required a heart monitor.
17 In the interval, we have begun to
18 monitor patients on our medical-surgical
19 unit. So a patient that just requires a
20 heart monitor are being monitored on now our
21 medical-surgical unit.
22 The critical care patients that have
23 remained in our first floor unit that has
24 been named intensive care unit, those
25 critical-care patients will be continued to

1 be cared for in the progressive care unit on
2 the second floor.
3 Now, I think I -- I'm understanding
4 your question because there's an issue of a
5 termination. So part of this maybe can be
6 explained by what was considered an ICU-level
7 of care in the past versus the present.
8 So in the past, years ago, simply being
9 on a ventilator was appropriate for an
10 intensive care unit. Things have evolved.
11 Things have changed, and with much more
12 rapidity since COVID because COVID showed us
13 that ICUs became full and overflowed, and we
14 had to start caring for patients with
15 respiratory failure outside of the intensive
16 care unit.
17 And so this is a continuation of that
18 evolution in that we will continue to care
19 for those critical care patients with the
20 caveat that those patients that require care
21 that we cannot provide, which has been
22 basically the case for years, will be
23 transferred to an intensive care unit.
24 MR. LAZARUS: All right. Thank you.
25 As far as the transfers, the numbers that

1 you're going to be submitting as a late file,
2 the majority of those patients would those be
3 considered critical care patients that we're
4 not being able -- you are not able to address
5 their needs at the hospital due to technology
6 or whatever services that are available?
7 MR. TUCCI: I'm sorry, Mr. Lazarus.
8 Can I just have that question again? I
9 didn't hear it.
10 MR. LAZARUS: Sure.
11 So a patient that -- we've talked about
12 providing the numbers, updating the numbers,
13 of the transfers to other facilities. I'm
14 assuming those patients that were transferred
15 were probably transferred because that level
16 of care could not be provided with the
17 technology, as Chris said, was not available
18 at Sharon Hospital?
19 DR. MARSHALL: So I think that the
20 answer to that is some of them, but these
21 transfer statistics include all transfers,
22 and that will include pediatric patients that
23 we do not admit to Sharon Hospital. We never
24 -- well, we had 20 or 30 years ago but not
25 recently -- or patients who require

1 psychiatric care that are not appropriate for
2 our geriatric psychiatry unit, or patients
3 who require surgical care or surgical
4 specialities that we do not have at Sharon
5 Hospital, so it's all of those patients, not
6 just critical care patients.
7 MR. TUCCI: So just for the sake of
8 clarity, Dr. Marshall, when the -- the data
9 that we looked at regarding Sharon Hospital's
10 transfer experience, just so that it's clear
11 on the record, that data reflects the
12 entirety of the experience of Sharon Hospital
13 and it should not be interpreted as being
14 data that reflects transfer of patients who
15 may require ICU or critical care services; is
16 that true?
17 DR. MARSHALL: That is correct.
18 MR. TUCCI: Okay.
19 MR. LAZARUS: All right. Thank you
20 very much.
21 HEARING OFFICER CSUKA: Are you -- I
22 don't know if these exist, but are there
23 scholarly articles or journals that you can
24 provide copies of that would help us to make
25 sense of that distinction that you're

1 discussing?
2 I do recall seeing articles about, you
3 know, what is a PCU, like what are the
4 services available in a PCU, but, you know,
5 something that can -- that can speak more to
6 the distinction between the two I think would
7 be helpful.
8 DR. MARSHALL: Yes.
9 MS. McCULLOCH: Okay.
10 MR. TUCCI: Absolutely.
11 MS. McCULLOCH: Okay. Yeah, I think we
12 did submit some, but we can take a look at
13 what we submitted and --
14 DR. MARSHALL: Absolutely.
15 MS. McCULLOCH: I also think it might
16 be helpful -- I just want to draw your
17 attention to our application where we
18 provided an average case mix index of our
19 patients, and it's important to look at that
20 data because the case mix index tells you how
21 sick our patients are, what their acuity
22 level is.
23 What we provided in our application was
24 an average case mix index of the patients
25 that are in our ICU, and we also compared it

1 to the case mix index of patients in other
2 ICUs. We also compared that to patients in
3 other PCUs so that you could see that the
4 acuity level of our patients is equivalent to
5 patients in other PCUs and even some med-surg
6 units, but it is not equivalent to patients
7 in other ICUs.
8 MR. TUCCI: Can you explain what
9 conclusion you draw from that data? Why is
10 that distinction that you're explaining
11 important in terms of helping OHS understand
12 what currently goes on at Sharon Hospital
13 with respect to the delivery of critical care
14 medicine?
15 MS. McCULLOCH: Right.
16 It goes back to your previous question
17 and further explains the difference between
18 our current ICU and ICU services provided at
19 other hospitals.
20 So while we do provide critical care
21 services, they are not the same level of
22 critical care services that are provided in
23 other ICUs that have those additional
24 resources.
25 MR. TUCCI: And how is that reflected

1 in the patients that show up in your case mix
2 index? What does that data tell you?
3 MS. McCULLOCH: The patients that we're
4 able to care for at Sharon Hospital are a PCU
5 progressive care level of care patients.
6 DR. MARSHALL: A lower level of acuity?
7 MR. TUCCI: Acuity meaning that their
8 conditions are not as serious; that's what
9 acuity means?
10 DR. MARSHALL: Yes.
11 MS. McCULLOCH: Yes.
12 MR. TUCCI: May be more stable; is that
13 another way to describe a potential for the
14 condition that you talk about?
15 MS. McCULLOCH: Uh-huh.
16 MR. TUCCI: They're still critically
17 ill but they're not in immediate jeopardy or
18 danger in terms of their stability; is that a
19 fair statement or just...
20 DR. MARSHALL: Sure.
21 So they're critically ill which by
22 definition means that they're certainly in
23 jeopardy of progressive illness or worsening
24 illness but not at the level of what would be
25 acceptable in an intensive care unit.

1 MR. TUCCI: But I'm just trying -- I
2 just want to the make sure this is clear on
3 the record.
4 In terms of what your case mix index
5 shows in terms of the patients that you
6 historically treat in what you call an ICU,
7 how does that compare with, say, for example,
8 what is called an ICU in a 700-bed hospital
9 like Danbury?
10 DR. MARSHALL: Right. Right.
11 Less sick.
12 MR. TUCCI: So in other words you have
13 a patient at Sharon Hospital who is located
14 physically in your ICU space. If that
15 patient went to Danbury, where do you think
16 they would likely end up being treated?
17 DR. MARSHALL: In a stepdown unit or
18 potentially a med-surg unit or a PCU type
19 unit.
20 MR. TUCCI: To say it colloquially,
21 their condition is not bad enough --
22 DR. MARSHALL: Not sick enough, right.
23 MR. TUCCI: -- of they're not sick
24 enough for them to actually be in the highest
25 intensity unit in the hospital?

1 DR. MARSHALL: Correct.
2 MR. TUCCI: That hospital?
3 DR. MARSHALL: Correct.
4 MS. McCULLOCH: Right.
5 HEARING OFFICER CSUKA: So I -- given
6 some of this testimony, I would like to give
7 the analysts a little time to go through
8 their questions and just see if these can be
9 whittled down even further. That way we're
10 not asking questions that don't need to be
11 asked anymore.
12 So I'm going to take a ten-minute
13 break. We'll come back at 1:51, and we will
14 proceed at that point.
15 Just a reminder to everyone, you should
16 probably your camera and your audio off.
17
18 (Off the record from approximately
19 1:41 p.m. to 1:51 p.m.)
20
21 HEARING OFFICER CSUKA: Just an update,
22 the analysts are still going through their
23 questions. We're going to take another 13
24 minutes. We'll come back and 2:05, and we
25 will proceed at that point.

1
2 (Off the record from approximately
3 1:52 a.m. to 2:05 p.m.)
4
5 HEARING OFFICER CSUKA: All right. I
6 think we have everybody back. Thank you for
7 giving as a moment there to -- for the
8 analysts to gather their thoughts.
9 So we're going to continue with
10 questions. This is Docket Number
11 22-32354-CON. It's the Consolidation of
12 Critical Care Services by Sharon Hospital.
13 So, Mr. Clarke, you can proceed with
14 your questioning whenever you're ready.
15 MR. CLARKE: Thank you --
16 MR. TUCCI: Mr. Csuka, this is Ted
17 Tucci. Would it be permissible, just based
18 on the last series of questions, if I ask one
19 question to help clarify?
20 HEARING OFFICER CSUKA: Sure.
21 MR. TUCCI: Thank you.
22 So I'll direct this first to
23 Dr. Marshall but if any of the other
24 witnesses care to comment.
25 So you heard in the prior discussions

1 some reference and use of the word
2 "termination." So just for the sake of
3 clarity, I want to ask you, Dr. Marshall, if
4 this CON application is approved, would there
5 be any critical care medicine service at
6 Sharon -- that Sharon Hospital does today
7 that will not be available in the PC Unit --
8 in the PCU unit on the second floor?
9 DR. MARSHALL: No. There will be no
10 change in the level of critical care that we
11 provide.
12 MR. TUCCI: Okay. What will be
13 different in terms of the physical space or
14 location?
15 DR. MARSHALL: Just the location.
16 MR. TUCCI: So when there's a reference
17 to a termination, can you explain how -- what
18 the physical difference will be between what
19 currently exists at Sharon Hospital and what
20 is proposed?
21 DR. MARSHALL: Yes. The space that is
22 designated as the unit currently, which is a
23 mixed acuity unit now will be relocated to a
24 combined unit on the second floor, and that
25 unit will cease to exist as it exists today.

1 MR. TUCCI: So in that sense, the use
2 of the space will be terminated, but the
3 function will continue in a different
4 location; is that a fair summary?
5 DR. MARSHALL: Yes, it is.
6 MR. TUCCI: Okay. Thank you.
7 HEARING OFFICER CSUKA: Thank you.
8 Mr. Clarke.
9 MR. CLARKE: How will the proposal not
10 adversely impact existing providers in terms
11 of referral patterns, volumes (inaudible) in
12 the proposed service area?
13 MS. McCULLOCH: So I can answer that
14 question. We don't anticipate any changes in
15 referral patterns or -- for any of the
16 providers that practice at the hospital. All
17 of that will continue as it is today.
18 MR. CLARKE: In reference to page --
19 Bates page 156, you provide a list of
20 patients by service line who currently
21 require transport to other hospitals.
22 Would this list be expanded if the --
23 if the proposal is approved and if so how, by
24 how?
25 MR. TUCCI: So is the question will

1 there be any different or additional at
2 service lines as a result of the operation of
3 the PCU; is that the question?
4 MR. CLARKE: I refer you -- I refer you
5 to page 156.
6 MS. McCULLOCH: Yes. Yes. We don't
7 anticipate any additional service lines being
8 transferred out of our facility, and we don't
9 anticipate much change in the numbers of
10 patients that are having to leave the
11 facility.
12 As you see, it does fluctuate on a
13 year-to-year basis, but, again, we're going
14 to continue providing the critical care
15 services that we provide today. All of the
16 doctors are going to stay the same, all of
17 the nursing staff and support staff are going
18 to stay the same. It's just a new location,
19 and so we don't anticipate an impact to any
20 of the transfers.
21 MR. CLARKE: And you also mentioned --
22 will the proposed improvement capabilities be
23 made anyway be made even if the application
24 is denied? What if the application is denied
25 would the proposed capabilities or

1 enhancements would will -- will they still be
2 established?
3 DR. MURPHY: Well, I guess -- this is
4 Dr. Murphy. I'll take a stab at it perhaps.
5 To the extent the application is
6 denied, in my view is that this would
7 prohibit us or complicate our ability to
8 provide care in a more efficient manner and
9 that is really the thrust of much of this
10 application and our overall plan is to
11 continue to deliver appropriate high-quality
12 care in the community, but to do so in a way
13 that is cost efficient. So in that respect,
14 denial of the application would be a
15 challenge.
16 HEARING OFFICER CSUKA: So just to
17 clarify it, I think in the first session of
18 the hearing it was discussed -- certain
19 things were discussed as being like new
20 technological capabilities that were going to
21 be brought into the PCU setting on the second
22 floor in terms of, you know, video monitoring
23 and additional heart monitors and things of
24 that nature.
25 I think the question was just, you

1 know, will that plan change even if the
2 proposal is denied, or do you anticipate
3 moving forward with the acquisition of that
4 new -- the new technology even if this is
5 denied, or is it contingent upon it being
6 approved?
7 MS. McCULLOCH: Right.
8 So much of the equipment that we
9 discussed last week is already in place on
10 the medical-surgical unit which is the --
11 will be the new location for the proposed
12 PCU. So the cardiac monitors, the remote
13 telemetry monitoring were installed on that
14 medical-surgical unit last year.
15 And that was installed on the
16 medical-surgical unit because that is really
17 the standard of care for medical-surgical
18 units. So we're able to monitor the
19 patients, their cardiac status, on the
20 medical-surgical unit. So those are already
21 in place. Those were purchased in 2022.
22 The video monitoring for the virtual
23 sitting that we talked about, that's already
24 in place. We use that across the hospital in
25 a couple different units, so that's not

1 **anything new.**

2 **What we did talk about that would**

3 **potentially be new in the new unit is**

4 **something that we currently have in the ICU,**

5 **and those are the wall-mounted cardiac**

6 **monitors. If we do move to have the PCU**

7 **upstairs, we would provide those in a couple**

8 **of the rooms. We do currently have those in**

9 **the ICU today, but I want to just talk about**

10 **the current ICU as it stands today.**

11 **Our ICU, the isolated unit that it's**

12 **in, is extremely outdated. We have a**

13 **nine-bed unit, and we have equipment that**

14 **needs updating. We have an entire unit that**

15 **really needs updating at a high cost, and so,**

16 **you know, we need to consider what we're**

17 **going to do should this application get**

18 **denied, we have an underutilized unit on the**

19 **second floor, and so that's why we're**

20 **proposing to take all of our patients and be**

21 **able to care for them in that underutilized**

22 **unit, so we can best utilize our space.**

23 **If we have to invest money into the**

24 **current ICU space, the storage stays the**

25 **same. We still have underutilized units and**

1 we're not creating more efficiencies or
2 really being able to move forward in the care
3 we provide, and we're not going to be able to
4 reutilize that space for something that, you
5 know, other parts of our plan. How we're
6 transforming the hospital, want to grow
7 different areas.
8 This is a -- really a critical piece of
9 us moving forward as a hospital.
10 DR. MARSHALL: And I just want to add
11 that up until recently the only place in the
12 hospital that patients could be on a cardiac
13 monitor was in that unit, but we've now
14 brought in telemetry monitoring, cardiac
15 monitoring to the med-surg unit on the second
16 floor thereby reducing the need for cardiac
17 monitoring in that unit, and where it's
18 appropriate for patients to be on a monitor
19 on the med-surg unit, that's where they're
20 going to be. They're not going to be
21 downstairs.
22 MR. CLARKE: So, Dr. Marshall --
23 HEARING OFFICER CSUKA: I'm sorry. I
24 just wanted to ask one additional follow-up.
25 Miss McCulloch, I think you referenced

1 the VaSera -- the VaSera units on the nurses'
2 wrists. Are those already implemented as
3 well?
4 MS. McCULLOCH: Yes.
5 HEARING OFFICER CSUKA: Okay. Thank
6 you.
7 Sorry, Mr. Clarke, you can keep going.
8 MR. CLARKE: Thank you.
9 So, Dr. Marshall, on pages 109 to 115
10 of the main application, the article you
11 provided talks about the difference in ICU to
12 PCU has been one relating to technological
13 capabilities. Would the proposed PCU have
14 the same tech capabilities as the ICU?
15 MR. TUCCI: So the -- just give us a
16 minute. I want to get to --
17 MR. CLARKE: Okay.
18 MR. TUCCI: Okay. Sure.
19 So I'm handing the witness the article
20 that begins at SH-00109. Just take a minute
21 to look at that.
22 DR. MARSHALL: Sure. (Witness reviews
23 document.)
24 MR. TUCCI: So if you just want to
25 comment briefly on that article, and then I

1 think Mr. Clarke's question was can you talk
2 about the technology capabilities in the
3 current space on the first floor and compare
4 it with what will be available in the
5 mixed-acuity PCU on of the second floor.
6 DR. MARSHALL: Sure. Sure.
7 So -- so the article references some of
8 the similarities between the care provided on
9 a critical care level in progressive care
10 units of various levels and intensive care
11 units.
12 So the technology that exists now in
13 our unit that we call the intensive care unit
14 is outdated, and so the technology that we'll
15 be bringing once this CON is approved will be
16 of better quality, and there will be an
17 enhancement of those monitoring capabilities.
18 So the short answer is that there will
19 be no decrease in the level of critical care
20 and technology only an improvement.
21 MR. CLARKE: Thank you.
22 And does Sharon have a long-range
23 service plan? If so, what does it involve?
24 MR. TUCCI: Dr. Murphy.
25 DR. MURPHY: Yeah. We do have a

1 transformation plan. This is a part of it, a
2 number of applications are actually part of
3 that transformation plan, and what we're
4 trying to do is offer the quality of care
5 that we can appropriately offer in the
6 community and supplement it with what we call
7 wraparound services, ambulatory services,
8 primary care, geriatric services, additional
9 geriatric psychiatric services; and there are
10 a number of other programs that we would like
11 to bring into the community including access
12 through telemedicine to additional
13 specialists, all of which really was
14 something that we worked on for the last
15 couple of years actually.
16 So that we stopped chasing these
17 losses, and we somehow turn the hospital
18 around so that it has a future. We do think
19 that our plan offers a viable successful
20 future for Sharon Hospital so that it's going
21 to be here 25 years from now.
22 And, you know, we've have tried very
23 hard to get smart people to help us with that
24 plan. We've had the hospital endorse it.
25 We've had medical staff leaders look at it.

1 We've shared it and had the community help us
2 create it, and we would be happy -- I'm sure
3 you have that plan, but we've given this a
4 great deal of thought, and actually the plan
5 was endorsed by the Sharon Hospital board as
6 well as the system board 18 months ago.
7 MR. TUCCI: Dr. Murphy, given the
8 geographic location of Sharon Hospital and
9 its size and capabilities, can you just
10 explain in a little bit more detail why the
11 services that you want to offer going forward
12 are the ones that make sense for the
13 community that Sharon Hospital serves?
14 DR. MURPHY: Yeah.
15 I think that this begins with an
16 understanding of what does the community
17 need, and, you know, we have done the
18 community health needs assessments, and we
19 are trying to responsibly position a range of
20 services that meet the primary and most
21 pressing needs of that community, and it has
22 to be a balance, we think, of inpatient and
23 outpatient services as well as emergency
24 services but increasingly ambulatory services
25 anchored by primary care, and that's really

1 what our plan has contemplated, and it has to
2 to be fashioned in a way that is financially
3 sustainable.
4 The present set of circumstances, as
5 you've heard many times, is unsustainable,
6 and I think if we don't quickly address those
7 issues and these enormous inefficiencies, the
8 viability of the hospital is at sake.
9 MR. TUCCI: Can you just explain how
10 reengineering the suite of services that
11 Sharon Hospital is able to offer to the
12 community will help bring financial stability
13 to the hospital?
14 DR. MURPHY: Well, we started really by
15 looking at what are the particularly
16 inefficient services that we're offering,
17 and, you know, we're not the first set of
18 individuals to look at this.
19 Perhaps I can share with you my
20 perspective on other rural hospitals in
21 America. Rural hospitals, as I'm sure you
22 know, Mr. Clarke, have been under enormous
23 pressure for a long period of time across
24 this great country.
25 And going back to actually 2012

1 Congress was sufficiently concerned by the
2 availability of care in rural communities
3 that the House Ways and Means Committee asked
4 MedPAC to prepare a study and analyze and
5 make a series of recommendations as to how
6 best to preserve access to healthcare in
7 rural communities. It brought forth that
8 report.
9 MedPAC, by the way, is a nonpartisan
10 independent agency of the legislative branch
11 of the federal government, and on MedPAC sits
12 17 of the nation's leading healthcare experts
13 and they are supported by 22 policy analysts,
14 bright individuals like yourself, and
15 supported by research assistants, so they
16 studied the issue.
17 The problem however didn't go away, and
18 in 2020 actually a rural hospital in the
19 United States closed every three weeks.
20 Congress, again, got concerned and
21 asked MedPAC to go back and refresh the
22 analysis, and the analysis, by the way, is
23 403 pages. It is available on MedPAC's
24 website, and it was published June 15th
25 actually in 2021, and it fundamentally

1 offered three core opinions as part of their
2 recommendations, and this gets back to
3 Attorney Tucci's question.
4 The first principle that it brought
5 forth, having studied the issue for more than
6 a decade, is equivalent access to care does
7 not mean equal travel time to those services,
8 particularly specialized services, that
9 require a higher volume of patients to
10 sustain, in a financially viable way, those
11 programs and services.
12 The second principle that the report
13 offered was that with respect to the quality
14 of care that rural hospitals offer, when
15 you're offering nonemergency services, there
16 should be equivalent quality in rural
17 settings and urban settings. Meaning if you
18 choose to offer a healthcare service in a
19 rural setting, it had better be as high
20 quality as it is in an urban setting for
21 nonemergency care.
22 For emergency healthcare services,
23 MedPAC acknowledged that there are difference
24 standards that should be applied because
25 there is lower volume, fewer staff, and less

1 technology.
2 Our proposal recognizes both of those
3 principles in that we're saying when care
4 requires a sufficiently high and
5 sophisticated level of intervention, those
6 people need to travel or would be transferred
7 to a tertiary care facility that is
8 appropriately staffed and designed to
9 accommodate them, but the more routine
10 critically-ill patients, if you will, who can
11 be cared for in Sharon, will be cared for in
12 Sharon.
13 But the third recommendation in
14 MedPAC's report I think is essential to the
15 integrity of our application here. What
16 MedPAC reviewed was four different methods of
17 payment to rural hospitals, and it said -- it
18 acknowledged rural hospitals need additional
19 incremental financial support.
20 So how best should we do that? And
21 what it concluded emphatically was you can't
22 just provide 100 percent or maybe 105 percent
23 of costs and say whatever it costs you to
24 deliver that care, we're going to give you 5
25 percent more because that didn't work. It

1 hasn't worked.

2 What they said was the payments should
3 be targeted, they should be empirically
4 justified, and they should be designed to
5 encourage efficient delivery of care which is
6 exactly what we are trying to do, to deliver
7 the same care in a cost efficient -- a more
8 cost-efficient manner.

9 The report went on to look at 40 rural
10 hospital closures in the United States
11 between 2015 and 2019. And there are several
12 conclusions that the committee drew attention
13 to that I think are relevant here.

14 The first is in all of these cases
15 prior to the closure of the hospital -- this
16 is all across the United States -- inpatient
17 admissions slowly but inexorably declined.

18 There wasn't a conspiracy to send
19 patients out of the community. It wasn't get
20 rid of nurses so you can't care for these
21 patients. This happened everywhere because
22 local residents decided to seek care at those
23 tertiary centers further from home. We
24 didn't invent this problem. We are trying to
25 confront it responsibly.

1 Another observation was newly-trained
2 physicians don't really often want to come to
3 rural communities to set up shop. It's too
4 difficult. This was seen all across America.
5 The third conclusion the report found
6 in looking at 40 hospital closures was that
7 even hospitals that belonged to big systems,
8 regional systems, it didn't matter. Once the
9 financial subsidies became too great to
10 justify, rural hospitals that belonged to
11 healthcare systems closed, and that, I'm
12 afraid, is what I'm worried about.
13 The CM -- the MedPAC then went on and
14 made another recommendation, and we're not
15 there yet and I hope we don't get there, but
16 it advised Congress and Congress
17 acknowledged, received, and acted upon this
18 recommendation in the Consolidated
19 Appropriations Act of 2021, it came up with a
20 new hospital designation for rural hospitals
21 called rural emergency hospitals.
22 That came into law, and you may have
23 seen this report in The New York Times, The
24 Washington Post in January of this year,
25 those payments are now available to rural

1 hospitals in America if you meet the
2 criteria, rural emergency hospitals. And
3 what they -- what the payment is is it's
4 predictable, it's monthly, it's enhanced for
5 both inpatient care as well as a 5 percent
6 bump in outpatient care, but it comes with a
7 catch, and the catch for this designation is
8 you are prohibited from providing inpatient
9 care, so you have to close the inpatient
10 units.
11 So I think that the federal government
12 is basically tipping its hand saying if you
13 want to stem these losses, close the
14 inpatient unit. What we are trying
15 feverishly to do is to avoid that fate. To
16 provide inpatient services, to continue to
17 keep those people employed to provide
18 outpatient services but to do it responsibly
19 and cost efficiently.
20 That is the very basis of this plan.
21 It has been shaped by experts, refined by
22 medical staff, endorsed by the board, and
23 broadly communicated to the community. We've
24 had 30 meetings over the last 16 months,
25 community meetings.

1 I think this is a highly responsible
2 plan. This application conforms to all of
3 MedPAC's recommendations.
4 You've heard from our critics who
5 represent, in my view, a small view of the
6 community. The majority of the community
7 thinks and thanks us for taking this on and
8 avoiding what I think could be around the
9 corner which is we can't keep loosing 20 or
10 25 million dollars a year. So we are trying
11 to reshape the services in a responsible way
12 to best meet the needs of the community.
13 That doesn't mean being all things to all
14 people.
15 Our critics I think have a distorted
16 view of the past, and they are reluctant to
17 look ahead at the future. This is the future
18 of Sharon Hospital. I think a failure to
19 endorse the plan represents an injustice to
20 the community and ultimately threatens the
21 viability of the hospital.
22 So that's perhaps a long answer to the
23 question, but I think that's at the heart of
24 what we're trying to do here.
25 MR. TUCCI: Well, I just want to ask a

1 couple of questions to address some of the
2 comments that you made just so it's clear on
3 the record.
4 Under the transformation plan as you've
5 described it --
6 MR. KNAG: I want to much -- I want to
7 object at this point. This is supposed to be
8 a period when the staff is asking questions.
9 I haven't objected to Mr. Tucci asking a few
10 questions, but I would think that we would
11 want to get the staff questions answered.
12 It's going to -- the weather here is
13 snow is coming in, and it seems like we're
14 moving back toward presenting further
15 testimony as opposed to answering the staff's
16 questions.
17 HEARING OFFICER CSUKA: All right. I
18 was planning to allow Attorney Tucci to do
19 some follow-up on the OHS questions anyway,
20 and I have determined that this is probably
21 the most efficient way of dealing with that.
22 A lot of the information -- or a lot of the
23 questions he's asking and the information
24 that's being elicited is responsive to the
25 questions that OHS has asked or follow-up

1 questions that OHS would be, I imagine,
2 interested in asking.
3 So I'm going to allow it, and also I'm
4 -- the intervener isn't allowed to make
5 evidentiary objections to best of my
6 recollection, so I'm going to overrule it for
7 that reason as well.
8 MR. TUCCI: Thank you, Mr. Csuka.
9 I just have two brief questions of you,
10 Dr. Murphy.
11 Can you -- can you tell Mr. Csuka and
12 OHS staff, is part of the transformation plan
13 in terms of its goals the ability to preserve
14 Sharon Hospital's capacity to continue to
15 have inpatient care at the hospital?
16 DR. MURPHY: Absolutely.
17 MR. TUCCI: It's not your goal to end
18 inpatient care?
19 DR. MURPHY: No, I want very much to
20 preserve it.
21 MR. TUCCI: All right. And what about
22 with respect to the emergency department,
23 under the transformation plan will Sharon
24 Hospital continue to operate and offer
25 services to community members of an emergency

1 department that operates on a 24/7 basis?
2 DR. MURPHY: Yes, I think that is
3 actually at the top of the priority list.
4 MR. TUCCI: If a patient who lives in
5 the service area has a life-threatening
6 emergency, will they be able to come to
7 Sharon Hospital under the 24 -- under the
8 transformation plan to get care at the
9 emergency department on a 24/7 basis?
10 DR. MURPHY: Absolutely.
11 MR. TUCCI: Do you want them to keep
12 coming to Sharon Hospital to get that care?
13 DR. MURPHY: Very much so.
14 MR. TUCCI: Thank you.
15 HEARING OFFICER CSUKA: Dr. Murphy, was
16 the MedPAC provided in connection with this
17 proceeding, if you're aware?
18 DR. MURPHY: I don't think so, but it's
19 on medpac.gov on June 2015, and I've made
20 reference to the contents largely contained
21 in Chapter 5.
22 HEARING OFFICER CSUKA: So I mean, we
23 aren't really allowed to look outside of the
24 record, so I'm just going to ask --
25 DR. MURPHY: Okay.

MR. TUCCI: We'll provide it --

(Voices overlapping.)

DR. MURPHY: It's 403 pages, so just get a printer handy.

MR. TUCCI: I apologize for talking over you. We will provide it.

HEARING OFFICER CSUKA: Okay. Thank you.

And I did have one other question based on something you said earlier, Dr. Murphy. You said there are, quote, "a number of applications that relate to the transformation plan." Are you referring to CON applications?

DR. MURPHY: Yes, Mr. Csuka.

HEARING OFFICER CSUKA: So I'm aware of only this one and the one concerning maternity, the termination of maternity services.

DR. MURPHY: Right.

HEARING OFFICER CSUKA: Is there something else?

DR. MURPHY: No, that's what we're

1 talking about.

2 HEARING OFFICER CSUKA: Okay. Thank

3 you.

4 MR. LAZARUS: This is Steve Lazarus.

5 Just one question as a follow-up, Dr. Murphy.

6 DR. MURPHY: Yes.

7 MR. LAZARUS: You have referred to

8 Sharon Hospital as a rural hospital which we

9 get geographically it is, would it also be

10 described as a rural hospital in CMS

11 definition, federal definition?

12 DR. MURPHY: Yes, I believe its current

13 designation is a sole community hospital

14 designation which is a type of rural

15 hospital.

16 MR. LAZARUS: And that's contained

17 within the definition of a rural hospital?

18 DR. MURPHY: Yes.

19 MR. LAZARUS: All right. Thank you.

20 That was my only question.

21 Ormand, you can go back.

22 MR. CLARKE: Thank you.

23 In reference to Bates Page Number 34,

24 there you claim that access won't be reduced.

25 If that is true, the statute requires a

1 showing of improvement in access.
2 How will this proposal improve access
3 to healthcare?
4 DR. MURPHY: I'll take a stab at it. I
5 think the question is how will this proposal
6 improve access to healthcare?
7 MR. CLARKE: Yes.
8 MR. TUCCI: Well, I think just
9 specifically we're focusing on access to
10 critical care services.
11 So can you talk specifically how you
12 believe the establishment of the mixed-acuity
13 PC Unit will improve availability and access
14 to critical care services?
15 MS. McCULLOCH: I can answer this
16 question.
17 Today we often have challenges in
18 staffing our current ICU. There is a nursing
19 shortage, and I don't think that's unique to
20 Sharon Hospital, but we certainly feel the
21 shortage in our intensive care unit.
22 There are periods of time where we have
23 to limit the number of patients that we can
24 care for, and that's related to having enough
25 nurses available to care for those patients.

1 We do anticipate that this change will
2 allow us to be able to staff more efficiently
3 by having all of these services located on a
4 centralized unit.
5 I'll just explain again kind of what
6 we're looking at. We have a unit on the
7 second floor of out hospital. It's called 2
8 North. It's a medical-surgical unit. It
9 has 28 beds with an average daily census of
10 ten patients. So it has the capacity to care
11 for, on average, 18 additional patients on
12 any given day.
13 Our ICU, which is on the first floor,
14 is a nine-bed unit with an average census of
15 four patients, and so you'll see that if we
16 take those four in addition to the ten that
17 we have the second floor today, that gives us
18 an average census of around 14, again, in a
19 28-bed unit.
20 So this will allow us to take all of
21 the staff that we have and be able to care
22 for all of our patients in one centralized
23 location, and there's a couple of benefits
24 from that. One is when you're dealing with
25 low volumes and a low number of patients, you

1 **don't have a lot of staff to care for those**
2 **patients.**
3 **So if we have two staff upstairs and**
4 **two staff downstairs, now in this new**
5 **consolidated unit you may have four staff**
6 **members to care for the patients.**
7 **So it's more resources. It's more**
8 **hands, and with our plan to educate our**
9 **nurses on the medical-surgical unit and have**
10 **them competent to care for our critical care**
11 **patients, we now have more nurses that are**
12 **going to be able to care for patients that**
13 **need critical care services.**
14 **So that will increase our capacity to**
15 **be able to care for those patients, limit**
16 **some of those caps that we have to put on**
17 **being able to care for those patients that we**
18 **experience today.**
19 **MR. CLARKE: Thank you.**
20 **How will the proposal impact staffing**
21 **of the hospital considering it states nothing**
22 **will change, the hospital in general?**
23 **MR. TUCCI: I didn't hear the question,**
24 **did you?**
25 **DR. MARSHALL: I didn't get -- how did**

1 the staffing change.
2 MR. CLARKE: How does the proposal
3 impact staffing at Sharon considering it's
4 saying nothing will change?
5 MS. McCULLOCH: Yeah.
6 So some of what I just described is how
7 that will be impacted. By having the same
8 staff in one consolidated unit, it will give
9 us more capacity.
10 Am I answering your question,
11 Mr. Clarke?
12 MR. CLARKE: Yes.
13 MS. McCULLOCH: Oh, okay.
14 MR. CLARKE: Thank you.
15 DR. MARSHALL: I think that the benefit
16 of having them in one unit is that, you know,
17 it's not only the nursing care but the
18 ancillary care. You know, the people who
19 clean, people who support the staff in other
20 ways, the unit coordinators they're all in
21 one unit so that the efficiencies can be
22 realized, and I think that that's really how
23 this improvement will play out.
24 MR. CLARKE: So this will not affect
25 ancillary staff -- staffing?

1 DR. MARSHALL: This will only improve
2 ancillary staffing.
3 MR. CLARKE: Thank you.
4 And can you provide a side-by-side
5 comparison of what acuity cases the ICU is
6 currently able to handle versus what it will
7 be able to handle as a PCU?
8 DR. MARSHALL: Sure. Sure. I can --
9 MS. McCULLOCH: We can put something
10 together.
11 DR. MARSHALL: Would you like a verbal
12 response or...
13 MR. CLARKE: Go ahead.
14 DR. MARSHALL: Okay. So currently our
15 unit can take care of patients who have any
16 number of illnesses such as pneumonia, heart
17 attacks, congestive heart failure,
18 infections, sepsis. The list goes on.
19 The new located unit will take care of
20 those same patients. So when we talk about
21 specific issues -- I'll give you some
22 examples. So one example is a patient with a
23 severe infection.
24 So a severe infection can cause a
25 syndrome that we call sepsis where the

1 **infection results in tissue damage or organ**
2 **damage, sometimes low blood pressure, and**
3 **sometimes those patients require medications**
4 **to support their blood pressure.**
5 **That type of patient is stabilized and**
6 **cared for in our ICU today and that same**
7 **patient would be stabilized and cared for in**
8 **our PCU tomorrow. Now that same patient, if**
9 **they do not respond to therapy and become**
10 **unstable or require additional therapeutics**
11 **that we don't typically provide, those**
12 **patients would be transferred just like they**
13 **have been in the past.**
14 **So all of those patients, the heart**
15 **attacks, the strokes, the congestive heart**
16 **failure, the pneumonia, all of those patients**
17 **that are currently cared for today will be**
18 **cared for tomorrow in the PCU.**
19 **MR. TUCCI: Can I ask one follow-up**
20 **question, Mr. Clarke?**
21 **HEARING OFFICER CSUKA: That's fine**
22 **with me so.**
23 **MR. TUCCI: Thank you.**
24 **Dr. Marshall, can you tell Mr. Clarke**
25 **in terms of the side-by-side comparison he's**

1 **looking for, has there been an effort that**
2 **you've been involved with to examine and**
3 **refine the initial draft of the policy that**
4 **was created around the operations of the PCU?**
5 **DR. MARSHALL: Yes. Absolutely.**
6 **MR. TUCCI: And have you been working**
7 **on that?**
8 **DR. MARSHALL: Yes.**
9 **MR. TUCCI: Is there a more recent**
10 **draft that has been prepared and/or is in the**
11 **process of being worked on?**
12 **DR. MARSHALL: Yes.**
13 **MR. TUCCI: We will offer that to OHS**
14 **as a late file.**
15 **HEARING OFFICER CSUKA: Thank you.**
16 **MR. CLARKE: Thank you.**
17 **Are you able to -- are you aware of any**
18 **studies that have been performed on what**
19 **happens to hospitals after they have**
20 **transitioned from ICU to PCU either at the**
21 **hospital level or at the service level, and**
22 **do some members leave? Do the hospitals**
23 **maintain surgical volume, ED volume, other**
24 **hospital volumes?**
25 **DR. MURPHY: Well, I don't know -- I**

1 can't cite for you a published study. I can
2 share with you personal experience in another
3 hospital in this state of which I'm the CEO
4 where we did the very same thing, and it --
5 at least very much satisfied the community
6 and preserved the opportunity to have
7 inpatient beds, and that was at Milford
8 Hospital.
9 So I think it's feasible. We've done
10 it successfully, but in terms of an academic
11 or peer-reviewed publication, I can't bring
12 one to mind.
13 DR. MARSHALL: I can tell you that
14 there was an article, and I can't cite it
15 exactly, but I could probably find it.
16 It talks about the changes in acuity
17 that have been seen in progressive care units
18 over the past several years, particularly
19 since COVID. And so I think, as I mentioned
20 earlier, when COVID was at its peak in the
21 early days of the pandemic, our ICUs
22 nationally became filled and overfilled, and
23 the care of those patients that were slightly
24 less acute fell to the progressive care
25 units, and as that -- those progressive care

1 units developed and were able to care for
2 those patients, it became more of the
3 standard that that level of care was
4 appropriate for a PCU.
5 And down the line you can see that the
6 care provided in some -- on some med-surg
7 units has risen in response to this change in
8 acuity over time.
9 DR. MURPHY: I think the other thing I
10 might offer, Mr. Clarke, is that one of the
11 reasons we reached out to a firm that
12 specializes in rural healthcare is to say,
13 hey, look, we don't -- we haven't seen
14 hundreds of hospitals, and as I may have
15 shared with you previously, I went to the
16 leadership at the American Hospital
17 Association and asked who they recommended as
18 the nation's leading expert on the provision
19 of services in rural hospitals in the United
20 States, and that's how I got Stroudwater's
21 name.
22 When they came and did their assessment
23 and met with a variety of individuals
24 including doctors, community leaders, and
25 boards members, I believe their first

1 recommendation was that we needed to do this.
2 What it is we are proposing today is that you
3 have to have this progressive care unit as
4 the first step in trying to preserve care but
5 delivering it in a more cost-efficient
6 manner.
7 So they were very quick to recommend
8 this, and I would say that the inference I
9 drew was that this is in fact done regularly
10 to preserve this level of care appropriately
11 in rural settings.
12 HEARING OFFICER CSUKA: Dr. Marshall,
13 the article that you referenced a little
14 while ago just in terms of, you know, the
15 change in PCU post-COVID from pre-COVID,
16 that's along the lines of the type of article
17 I asked if you were able to provide after the
18 fact. So thank you for referencing that. If
19 you're able to find that, I would appreciate
20 it.
21 DR. MARSHALL: Will do.
22 MR. CLARKE: Thank you.
23 If this proposal is approved or the
24 other proposal you have pending under Docket
25 Number 22-32511-CON, is not will you still

1 have move forward with this proposal?
2 And similarly, if the other proposal is
3 approved but this one is not, will you still
4 move forward with the other one? Why and why
5 not?
6 DR. MURPHY: Yeah, I would say,
7 Mr. Clarke, I'll try to take a stab at it
8 because perhaps I'm closest to the governing
9 body.
10 I firmly believe, deeply believe, that
11 we have done our very best thinking and
12 provided a comprehensive plan that represents
13 a whole lot of thinking, creativity, and
14 input, and really contemporary views on how
15 to preserve access to care in rural
16 communities.
17 We have been forced to compartmentalize
18 that plan and divvy it up by virtue of state
19 statutes and this process and we've respected
20 it.
21 As I mentioned last time, I think it
22 puts you in a little bit of an unfair
23 position perhaps in that we're giving you a
24 stool that has one leg and asking, you know,
25 can you sit on it. I think the right way is

1 to give you a stool that has all three legs
2 and ask can you sit on it. We need all three
3 legs.
4 I cannot imagine that the board is
5 going to allow me to continue to lose
6 enormous sums of money and not basically do
7 what other, as I mentioned a moment ago,
8 rural hospitals belonging to larger systems,
9 have done and say call it a day.
10 This model cannot continue. I can't
11 presuppose it. I have never discussed it
12 with the board specifically, so I don't have
13 a direct answer, but I've been in front of
14 them long enough, including yesterday for
15 two-and-a-half hours, to know that the rate
16 of loss is of enormous concern, and that a
17 fractured approach that represents part of
18 this plan is unlikely to be viewed in a
19 positive light.
20 MR. CLARKE: Thank you.
21 Let's refer to Bates Page 29 to 30 --
22 and 30.
23 MR. TUCCI: We're there.
24 MR. CLARKE: There you state here you
25 -- the proposal will have no impact on

1 quality. However, the statute requires a
2 showing of improvement in quality. So how
3 will this proposal improve the quality of
4 healthcare delivery?
5 MS. McCULLOCH: So I can take that.
6 We -- Sharon Hospital is a hospital
7 that delivers high-quality care. We are a
8 five-star hospital as recognized by CMS for
9 multiple years in a row, and we continue to
10 monitor all of the patient outcomes and
11 quality metrics to ensure that that
12 high-quality care continues.
13 We anticipate that that will stay the
14 same with this newly reproposed PCU. We will
15 continue to provide high-quality care. We'll
16 continue to monitor all of those patient
17 outcomes and quality metrics to ensure that
18 that occurs.
19 MR. CLARKE: Thank you.
20 Dr. Murphy --
21 DR. MURPHY: Yes, sir.
22 MR. CLARKE: -- can you explain how
23 this termination of services can be
24 implemented without negatively impacting
25 patient safety and the quality of care for

1 patients?

2 DR. MURPHY: Well, once again, I hope
3 you don't find this to be argumentative, but
4 I do feel that termination is a misnomer. I
5 really do. We're going to continue to
6 provide the same high-quality care that is
7 appropriate in the opinion of the clinical
8 staff that is taking care of these patients.
9 We're going to do it on a different floor in
10 a more efficient manner.

11 There's going to be more eyes on the
12 floor and I think actually that safety will
13 be enhanced because, as you know, the more
14 people around, sometimes you hear something
15 or see something as opposed to having two
16 nurses on the unit, one of whom needs to use
17 the restroom and all of a sudden 50 percent
18 of your staff is off the floor.

19 I do believe that co-locating these
20 patients in a mixed-acuity unit with
21 appropriate and updated technology is a step
22 towards improving the safety of the care that
23 we're delivering.

24 MR. CLARKE: Thank you.

25 HEARING OFFICER CSUKA: This may be

1 somewhere in the documents that you
2 submitted, but is there a minimum volume of
3 patients necessary to be able to provide
4 critical care services safely at the
5 hospital?
6 MS. McCULLOCH: No, that's nothing that
7 we've seen in any research that we've done.
8 HEARING OFFICER CSUKA: Okay.
9 DR. MARSHALL: But one of benefits of
10 this type of unit is that's flexible and it's
11 mixed acuity so that we can flex up or flex
12 down.
13 HEARING OFFICER CSUKA: Okay. Thank
14 you.
15 MR. CLARKE: Thank you.
16 I have a couple few questions referring
17 to the application itself.
18 A VOICE: Sure.
19 MR. CLARKE: Dr. Murphy stated that
20 there have been patients waiting in the ED
21 for an ICU; is this true? Are there wait
22 lists, and how long are the wait lists?
23 DR. MARSHALL: I can talk about that.
24 MS. McCULLOCH: Okay.
25 DR. MARSHALL: So there are times when

1 bed availability is reduced either due to
2 census or to staffing, and in the case of a
3 patient who is in our emergency department
4 that requires a monitored bed, they may if
5 there is -- if a bed is not available, they
6 may have to remain in the emergency
7 department until that bed becomes available.
8 Lately, the main reason for this has
9 been staffing, nurse staffing. With our
10 proposed progressive care unit, I believe
11 we'll see less of that because of the
12 efficiency of having all the nurses and all
13 the ancillary staff on one unit.
14 MR. TUCCI: Dr. Marshall, can you just
15 explain in a little bit more detail when you
16 talk about bed availability as it relates to
17 the capacity of nurses to provide care, it's
18 not that in the ICU you don't have enough
19 beds; is that correct?
20 DR. MARSHALL: Correct.
21 MR. TUCCI: You have the capacity to
22 physically house nine patients, correct?
23 DR. MARSHALL: Correct.
24 MR. TUCCI: What you may not have and
25 what you experienced in December and January

1 of this year is the inability to provide care
2 to patients who might be in those beds
3 because you didn't have the nurses?
4 DR. MARSHALL: Correct. Correct.
5 Without adequate nurse staffing, it
6 would not be safe to put additional patients
7 into the unit.
8 MR. TUCCI: So that -- how many nurses
9 are currently assigned to the physical space
10 called the ICU?
11 DR. MARSHALL: It's two most of the
12 time.
13 MS. McCULLOCH: Two per shift?
14 DR. MARSHALL: Yeah.
15 MS. McCULLOCH: Yes.
16 MR. TUCCI: So if somebody gets sick or
17 if there's an emergency and you only have one
18 nurse, you can't bring some other nurse in
19 from a different part of the hospital to do
20 that service; is that correct?
21 MS. McCULLOCH: That's correct. We
22 have limited trained critical care nurses.
23 DR. MARSHALL: Yes.
24 MR. TUCCI: And how would -- and how
25 would there be a benefit if you were able to

1 aggregate or create a single nursing team on
2 2 North in a PCU mixed-acuity unit? How
3 would that solve -- help alleviate the
4 problem?
5 MS. McCULLOCH: So in this proposed
6 model all of the nurses that we currently
7 have in our ICU and all of the nurses that we
8 currently have in our medical-surgical unit
9 will all be trained to care for critical care
10 patients.
11 So it will increase our ability to care
12 for critical care patients just by having
13 more nurses trained to provide that level of
14 care.
15 MR. TUCCI: So once all of that
16 training is completed you have more nurses
17 who are competent to provide critical care,
18 does that mean if there's increased patient
19 demand you have the ability to staff up the
20 number of nurses to safely care for those
21 patients?
22 MS. McCULLOCH: We should, yes.
23 MR. CLARKE: Thank you.
24 On page 2 of Dr. Kurish's prefile.
25 DR. MURPHY: Mr. Tucci, we're going to

1 need a minute.
2 MR. CLARKE: Sure. Sure.
3 DR. MURPHY: Just one second.
4 MS. McCULLOCH: Okay. We have it.
5 DR. MURPHY: We're good.
6 MR. CLARKE: Dr. Kurish stated that
7 there are nine ICU beds. I wonder is being
8 -- is being used for storage.
9 When calculating the transition, does
10 Sharon Hospital use eight or nine as their
11 denominator?
12 MS. McCULLOCH: So our current ICU has
13 nine physical beds all that can be used for
14 patient care if we needed them. Our average
15 daily census, the number of patients that we
16 have on any given day is an average of four,
17 and so it is rare that we need nine beds. We
18 do have nine beds all with the same
19 equipment, access to oxygen, and medical
20 gasses are in all nine beds.
21 There is one room that Dr. Kurish is
22 referring to that the nurses will place IV
23 poles or chairs or equipment that's not being
24 used in there, all of which can be removed in
25 the case that a patient is needing -- needed

1 to go in that room.
2 HEARING OFFICER CSUKA: So just to
3 clarify though, the data and the information
4 you have provided, does that assume nine beds
5 or does that assume eight beds?
6 MS. McCULLOCH: Nine beds.
7 HEARING OFFICER CSUKA: Okay.
8 MS. McCULLOCH: Nine beds.
9 MR. CLARKE: So, Miss McCulloch, still
10 on page 2, Dr. Kurish stated that the ICU has
11 closed from time to time. In particular he
12 stated it closed for six days from February 9
13 to February 15 in 2022.
14 When calculating volume does Sharon
15 Hospital use 365 days as its denominator or
16 days that the ICU is open?
17 DR. MURPHY: Do you mean in terms of
18 calculating the average daily census what's
19 the denominator?
20 MR. CLARKE: Yes.
21 MS. McCULLOCH: So I believe we do use
22 365 days, but I'd like to clarify the
23 statement that we are closed from time to
24 time. There was one period of time, and I
25 believe we submitted this with some of the

1 completeness questions -- I don't remember
2 the exact dates, but there were a couple days
3 that we weren't admitting patients.
4 This was solely due to not having any
5 ICU nurses to take care of patients for those
6 particular days, and so we weren't admitting
7 ICU patients during that brief period of
8 time, but that is the only time that the unit
9 was not admitting ICU level of care patients.
10 DR. MARSHALL: And that's not to say
11 that there haven't been times where we have
12 not had any ICU patients and had adequate
13 nursing but just not the patients.
14 MS. McCULLOCH: Right. And an example
15 is just this past week we just had a stretch
16 of three or --
17 DR. MARSHALL: Two-plus days.
18 MS. McCULLOCH: -- days where we had
19 zero patients admitted to the ICU. We had
20 nursing staff. That's just there weren't the
21 patients that needed to be admitted to that
22 unit for that level of care. So that also
23 contributes to the average daily census.
24 MR. TUCCI: Does that mean on those two
25 days you had nursing staff in that the

1 hospital, correct?
2 DR. MURPHY: Uh-huh.
3 MR. TUCCI: Prepared to deliver
4 care to patients who needed critical care
5 services --
6 MS. McCULLOCH: Yes.
7 MR. TUCCI: -- correct?
8 DR. MURPHY: Uh-huh.
9 MR. TUCCI: And there were no patients?
10 DR. MURPHY: Correct.
11 MS. McCULLOCH: Correct.
12 MR. TUCCI: And they were here?
13 MS. McCULLOCH: Correct.
14 MR. TUCCI: And you paid them?
15 DR. MURPHY: Yes.
16 MS. McCULLOCH: Yes.
17 MR. CLARKE: And on the final page of
18 Dr. Kurish's prefile, he stated that the
19 hospital adopted a policy of keeping -- let
20 me give you some time.
21 MS. McCULLOCH: Yeah, we're just
22 grabbing that. Okay. We have it.
23 MR. CLARKE: Dr. Kurish stated that the
24 hospital adopted a policy of giving
25 preferential admission to patients with

1 lower-acuity conditions or patients with
2 high-acuity, traditionally ICU-level patient;
3 is this true?
4 MR. TUCCI: So, Mr. Clarke, just for
5 the record, this is part of what we are going
6 to be moving to strike. I won't comment any
7 further on it because I don't think it
8 deserves to be dignified with comment, but
9 I'm going to allow witnesses to answer.
10 MS. McCULLOCH: So this is not true.
11 We never -- we never followed a new policy.
12 Our admission criteria has not changed for
13 the ICU.
14 There -- there is a work group, and we
15 talked about this earlier today, that has
16 been working on a new PCU admission policy
17 that would be used in this new proposed unit
18 should it get approved, and that's been a
19 work in progress. There's different drafts
20 as we get feedback from the clinicians that
21 care for our patients, but that policy was
22 never approved or put into use.
23 MR. CLARKE: Thank you. On page 6
24 Dr. Kurish stated that -- oh, let me give you
25 time.

1 MS. McCULLOCH: Okay. We have the
2 page.
3 MR. CLARKE: Dr. Kurish stated that
4 nurses have told him they will leave if the
5 proposal is granted.
6 Have any of you or any other executive
7 of your hospital received similar
8 information.
9 MR. TUCCI: Just note again this will
10 be part of the motion we submit to OHS. You
11 may answer the question.
12 MS. McCULLOCH: So our nurses have been
13 involved in this planning. Their feedback is
14 very important to us and we've made many
15 changes to the policy and to taking their
16 suggestions on equipment, an example of that
17 being the bedside monitors, and are adapting
18 what we're doing based on the feedback of our
19 clinicians because that's the most important
20 that they're going to be able to work in this
21 new environment.
22 I have not -- it has not been
23 communicated to me that nurses are intending
24 to leave due to this change. I have -- you
25 know, I've had conversations with many of the

1 nurses, and that has not been a part of that
2 conversation.
3 DR. MURPHY: And it has never been
4 communicated to me either.
5 DR. MARSHALL: Nor me.
6 MR. CLARKE: Page 6 to 7, 6 and 7.
7 DR. MURPHY: We're good.
8 MR. CLARKE: Dr. Kurish stated that if
9 granted, the proposed setup would be
10 insufficient for proper PCU monitoring.
11 Are the rules to be used fail to
12 provide critical care safely?
13 MS. McCULLOCH: Yes, they are, and I
14 know we talked a little bit about this last
15 week, but I can refresh your memory on that.
16 So we have a 28-bed unit on the second floor,
17 and the way that the mixed-acuity PCU will be
18 designed is that any of the 28 beds can be
19 utilized for any patient requiring either
20 medical-surgical or PCU level of care.
21 We are able to do that through all the
22 rooms have oxygen capability and suction
23 capability. We have portable telemetry
24 monitors that can be used in any of the 28
25 rooms so that we can monitor a patient's

1 cardiac status.
2 There are select rooms on that unit
3 that have additional capabilities. There are
4 six of them that have specific medical gasses
5 so that if a patient required respiratory
6 support through a ventilator, we would be
7 able to do that in these six specific rooms.
8 So that is really the only difference between
9 those rooms and the other rooms.
10 We also talked last week about the
11 visibility of the patients because that is
12 something that Dr. Kurish brought up as a
13 concern, but we have many rooms on the second
14 floor that are visible from the central
15 nurses' station. We also have additional
16 monitoring capabilities.
17 Those being we have one portable -- we
18 have many portable work stations that our
19 clinical staff can use to do their work,
20 their documentation or other duties, by using
21 a portable work station that can be moved to
22 anywhere on the unit including inside of
23 patient rooms.
24 We also have in all of the patient
25 rooms windows installed on the doors so that

1 if a door is shut a patient can be visualized
2 from the hallway, and we also have video
3 monitoring capabilities so that we can
4 utilize a camera on wheels that is used to
5 monitor a patient with a technician watching
6 the patient through the camera that's located
7 in a central room to watch that patient
8 either for fall precautions or other safety
9 reasons that we like to have a closer visual
10 on the patient.
11 So we have many mechanisms to be able
12 to ensure that we're providing critical care
13 services safely.
14 DR. MURPHY: The other piece that I
15 would offer a perspective on with respect to
16 your question, Mr. Clarke, is what
17 Dr. Kurish's letter doesn't contemplate is
18 the preservation of the status quo.
19 I continue to believe and worry that
20 all inpatient care might go away. This is a
21 highly desirable alternative to keeping
22 patients in an understaffed outdated unit,
23 this makes sense. This preserves care in the
24 community. This preserves jobs, and his
25 letter clings to an outdated model that we

1 cannot sustain.

2 MR. CLARKE: Is there -- is there

3 anything that needs to be done prior to the

4 establishment of the PCU on the second floor?

5 MS. BOISVERT: Meaning a --

6 MR. TUCCI: Any additional work?

7 MS. BOISVERT: Yeah.

8 MR. CLARKE: Logistically.

9 MS. McCULLOCH: No, the physical unit

10 will stay the same. The only additional

11 thing that we would like to do and this came

12 from our workers in feedback from our

13 clinical staff over the last few months is

14 there's request for bedside wall-mounted

15 cardiac monitors in addition to the portable

16 cardiac monitors that we have, and so we

17 would like to install those for certain PCU

18 patients that may require closer monitoring,

19 but other than that, there are no changes to

20 the physical layout of the unit.

21 MR. CLARKE: Does the hospital have any

22 plans to invest capital into the proposed

23 floor?

24 MS. McCULLOCH: So the only capital

25 investment, again, would be for those

1 wall-mounted cardiac monitors that came up
2 over the last couple of months, but the unit
3 on the second floor is a much more updated
4 unit than the current ICU. It is not in need
5 of any major remodeling.
6 There will be additional work stations
7 like a computer work station for a doctor or
8 a nurse because there will be more staff up
9 there. These are not high-dollar items.
10 These are things that we do every day in the
11 hospital and are just considered part of the
12 normal operating budget.
13 MR. CLARKE: Thank you.
14 So we have a few questions -- thank you
15 so much. We have a few questions for
16 Dr. Kurish.
17 HEARING OFFICER CSUKA: Before we get
18 into those, let's just take a five-minute
19 break.
20 MR. CLARKE: Okay.
21 MS. McCULLOCH: Okay.
22 HEARING OFFICER CSUKA: We'll come back
23 at 3:16 -- actually, let's say 3:17.
24
25 (Off the record at approximately

1 3:11 p.m. to 3:18 p.m.)
2
3 HEARING OFFICER CSUKA: We're not
4 recording yet we have to wait for the
5 applicant.
6
7 (Pause.)
8
9 HEARING OFFICER CSUKA: So we are
10 picking up from where we left off in Docket
11 Number 22-32504-CON regarding Sharon
12 Hospital's Proposed Consolidation of Critical
13 Care Services from the ICU into the PCU.
14 So, Mr. Clarke, do you have any
15 additional questions for the applicant?
16 MR. CLARKE: Yes. Yes, I do.
17 HEARING OFFICER CSUKA: For the
18 applicant?
19 MR. CLARKE: Actually, for Dr. -- no,
20 no. I've concluded my questions for the
21 applicant.
22 HEARING OFFICER CSUKA: Okay. Attorney
23 Tucci, do you have any additional follow-up
24 based on OHS's questions that you wanted to
25 address?

1 MR. TUCCI: No, thank you very much.
2 Appreciate that.
3 HEARING OFFICER CSUKA: So as
4 Mr. Clarke just mentioned, it sounds like he
5 does have some questions for Dr. Kurish.
6 So, Ormand, you can proceed with those
7 whenever you're ready.
8 MR. CLARKE: Thank you.
9 HEARING OFFICER CSUKA: Actually, let
10 me just verify, Dr. Kurish, are you available
11 to speak and ready to go?
12 DR. KURISH: Yes.
13 HEARING OFFICER CSUKA: Okay. Thank
14 you.
15 MR. CLARKE: Dr. Kurish, on page 2 of
16 your prefile --
17 HEARING OFFICER CSUKA: And, Attorney
18 Tucci, I know that this is also probably
19 going to be a subject of your motion, but I'm
20 just going to allow it for now, and then
21 we'll address it once we get to that.
22 MR. TUCCI: Thank you. I won't
23 interject in the questioning.
24 MR. CLARKE: Are you ready, Dr. Kurish?
25 DR. KURISH: Yes.

1 MR. CLARKE: Thank you.
2 You stated that you believe that
3 ambulance attendants know which patients are
4 apt to be transferred from Sharon Hospital
5 and will attempt to take many of these
6 patients to other hospitals to avoid future
7 transfer.
8 What is this based on? Can you provide
9 specifics?
10 DR. KURISH: From my patient
11 experience, that patients over the last
12 couple of years that summon an ambulance for
13 various reasons fainting, whatever, belly
14 pain and ambulance attendants want to take
15 them to Vassar. That's in New York state.
16 Patients want to come here, and if they
17 insist they're brought here. If not they go
18 to Vassar which is twice the distance. It
19 happened to me this last year where a person
20 who fell in a house because she was weak and
21 another patient with abdominal pain, and so
22 the ambulance attendants make a decision what
23 they think is going to -- the level of care a
24 patient is going to need and if they might
25 need a higher level of care they make that

1 decision.
2 MR. CLARKE: Thank you.
3 HEARING OFFICER CSUKA: Sorry.
4 Dr. Kurish, how many time would you say
5 that as happened over the past five years or
6 that you've been notified of that?
7 DR. KURISH: Three or four times in the
8 last year.
9 HEARING OFFICER CSUKA: Did it happen
10 prior to...
11 DR. KURISH: Years ago it never
12 happened. Never happened. Three years ago
13 it never happened.
14 HEARING OFFICER CSUKA: Okay.
15 MR. CLARKE: On page 4, Dr. Kurish...
16 MR. TUCCI: Go ahead.
17 MR. CLARKE: You stated you believed
18 that if the proposal is granted surgical
19 volume and emergency department volume will
20 decrease.
21 What basis do you have about what
22 you're saying please? Can you provide any
23 quality articles to support the conclusion?
24 DR. KURISH: I can't give you any
25 quality arguments but I just -- I just know,

1 for instance, now we have one surgeon instead
2 of two surgeons, and oftentimes there's not
3 surgical coverage for the emergency room, and
4 those patients when there's not surgical
5 coverage are taken elsewhere -- are sent
6 elsewhere when they're brought to our
7 hospital.
8 That's been a problem in the last --
9 since last May when we used to have two
10 surgeons. Now we only have one. So more
11 patients transfer for surgical reasons now
12 than used to be transferred.
13 HEARING OFFICER CSUKA: So how does
14 that relate specifically to this proposal?
15 DR. KURISH: Well, I think the same
16 thing would apply to medical patients, that
17 if we're not going to have an adequate number
18 of nurses and critical care beds, that those
19 patients will end up being transferred.
20 HEARING OFFICER CSUKA: Okay.
21 MR. CLARKE: Thank you, Dr. Kurish.
22 HEARING OFFICER CSUKA: Do you have any
23 questions for Dr. Germac (phonetic
24 throughout) -- Mr. Germac?
25 MR. CLARKE: No, I don't.

1 MR. KNAG: Mr. Hearing Officer, there
2 was certain questions that were asked of the
3 hospital as to which I'd like to ask
4 Dr. Kurish to be able to respond. They've
5 changed the -- they've changed their
6 goalposts from what they testified earlier,
7 in our opinion, and certainly from what
8 they've put in their application.
9 In their completeness questions, they
10 said there'd be -- in their application they
11 said 10 percent fewer patients, and then they
12 said 24 per year fewer patients, and they
13 didn't change that during the session last
14 week.
15 They said that they were going to be
16 changes in the -- in the admissions policy
17 but they only mentioned -- the only changes
18 they mentioned related to intubation and not
19 to other things. Now they're saying they're
20 going to be take everybody they take now.
21 So I think it's important to the
22 processes. This should -- all of this should
23 have been put out before the hearing last
24 week, and at the very least we need to give
25 Dr. Kurish a chance to respond to their --

1 **the points that they've made.**
2 **So I'd like to ask whether I may have**
3 **-- just bring that out in response to what**
4 **has been stated by the -- by the hospital.**
5 **MR. TUCCI: Mr. Csuka, if I may be**
6 **heard?**
7 **HEARING OFFICER CSUKA: Sure.**
8 **MR. TUCCI: So that -- I object to**
9 **that. That's highly out of order. It will**
10 **impair the orderly process of the hearing.**
11 **Quite frankly, this is not a debating**
12 **society. We're not going to continue this**
13 **endless batting back and forth over the net,**
14 **and frankly, it is actually I think**
15 **inaccurate to say that any of the information**
16 **that was discussed today is in any way**
17 **materially different than what the witnesses**
18 **said in their direct testimony, in response**
19 **to cross-examination, and in response to my**
20 **redirect.**
21 **All of this was discussed during the**
22 **main portion of the hearing and intervener's**
23 **counsel could have asked questions to his**
24 **heart's content about any of this. It was**
25 **all discussed, including the very point that**

1 Mr. Knag just addressed which is the history
2 of and genesis and changes in the draft PCU
3 policy which was discussed at length by all
4 the witnesses.
5 MR. KNAG: And, Mr. Hearing Officer, in
6 the last hearing they said that they were
7 making changes relating to intubation. Now
8 they're saying that they made other changes
9 so they're going to take everything that
10 they're taking now, and that's a big change,
11 and all I want to do is ask -- since you have
12 heard their answers to your questions, I'd
13 like to allow Dr. Kurish to respond to their
14 answers to your questions.
15 HEARING OFFICER CSUKA: (Inaudible.)
16 MR. KNAG: In respect to the cases that
17 are ICU level and the cases that can be
18 properly be taken now.
19 HEARING OFFICER CSUKA: I -- it would
20 be unusual for me to allow that. I will have
21 -- I will let you ask a few questions, but
22 I'm not going to let this turn into a long
23 back-and-forth series of questions. If you
24 have, you know, somewhere between three and
25 five questions that you just wanted to have

1 clarified by Dr. Kurish, that's fine with me.
2 MR. KNAG: Very good.
3 HEARING OFFICER CSUKA: I'm also going
4 to allow Attorney Tucci to do some cross
5 following whatever questions he may have as
6 well.
7 MR. KNAG: Who does the -- based on the
8 practice of the ICU at Sharon Hospital as it
9 has been for the last several years, who do
10 they take -- what type of patients do they
11 take that would also be suitable for the ICU
12 at a bigger hospital like Danbury Hospital?
13 MR. KURISH: Well, I think our hospital
14 takes a lot of critically ill patients and
15 gives them good care. I mean the hospital
16 says that they can take care of these same
17 people upstairs as they can take care of
18 downstairs now in ICU which is I don't think
19 would be the case at all.
20 For example, vi-sa-ra-tor (phonetic)
21 patients, as I pointed out in my testimony
22 the other day, that most standard-of-care
23 PCUs is not to take intubated people on
24 ventilators and not to take vaso --
25 (phonetic) -- shocky patients, septic

1 patients on vasopressors and which we do
2 right now in our ICU and take care of them
3 very well.
4 I think up -- in the ICU we have now we
5 have a nursing staff ratio of basically
6 around 2 to 1, sometimes a little bit more,
7 and that's what those kind of patients need.
8 You have a person on a respirator in a room
9 upstairs by themselves with a camera, it's
10 not going to be suitable for taking those --
11 taking care of those people properly.
12 They need to be monitored continuously
13 and their vital signs should be watched
14 carefully, the rhythm strips need to be
15 watched carefully by a nurse in a PCU, open
16 room watch the respirator, watch the patient.
17 They see exactly how they're doing. If
18 they're trying to pull out --
19 MR. KNAP: In an ICU?
20 MR. KURISH: ICU -- pull out their
21 tube, whatever, they're right there to see
22 the patient, not a room down the hall that
23 might be seen by a videocamera, might not be
24 ^ listen seen by a videocamera, and its setup
25 is totally unsafe where they propose it

1 upstairs. I could go into details about
2 other concerns I have about the unit
3 upstairs, but the main thing is being able to
4 have a nursing ratio for constant care for
5 those particular patients, continuous
6 constant care, that they would not have
7 upstairs with the ratios they're talking
8 about upstairs.
9 And that just applies, for instance, I
10 just mentioned the respirator patients, but
11 it would also apply to people coming in with
12 septic shock. Dr. Marshall thinks they can
13 have the same care upstairs and watch their
14 urine output every hour, their vital signs
15 continuously.
16 PCUs generally don't take care of
17 people that require vital signs or one or two
18 others, every four hours, sometimes every two
19 hours. Other examples of that would be
20 diabetics or someone who gets hyperglysemic
21 and they can't control their blood sugars
22 upstairs. They need to be in an ICU where
23 they get blood sugars every hour, have nurses
24 upstairs taking care of multiple patients one
25 nurse or total devotion of time. It won't

1 happen upstairs. They don't have enough
2 staffing.
3 What happens upstairs (unintelligible)
4 the PCU sign up there. Let's say they have
5 more than one sick patient up there, it's not
6 going to work. Same thing would apply
7 (unintelligible) into NG tubes, blood coming
8 out of the nose. Somebody has a monitor and
9 watch the monitor in the backroom is not the
10 same as having a nurse sitting at the bedside
11 or right across from the bed -- a whole wall
12 of windows watching those patients.
13 So the critical-ill patients that we
14 take care of now will not be getting adequate
15 safe care upstairs.
16 Somebody coming in with detoxification
17 for DTs is another example. Upstairs in
18 another room it's not the same as watching
19 someone having a grand mal seizure right
20 across from them. They're going to need IV
21 Valium to control that patient's seizure
22 activity. There's so many examples of the
23 same kind of thing --
24 MR. KNAG: How about a serious
25 arrhythmia?

1 DR. KURISH: Same thing.
2 THE COURT REPORTER: What?
3 DR. KURISH: They have the monitor and
4 they're sitting at the nursing station
5 watching their monitor. A serious
6 arrhythmia, tachycardia, the heart goes too
7 slow. It goes too fast a cardiac.
8 (Unintelligible) a nurse is there watching
9 that monitor.
10 MR. KNAG: But do you think that it
11 would be safer to have the model -- the PCU
12 model staffing with the nurses from the ICU
13 and the med-surg together?
14 DR. KURISH: No. Again, let's say you
15 have two or three sick patients, four sick
16 patients, that require Q-one hour monitoring,
17 upstairs you'd have three nurses, if you're
18 lucky maybe four, and how are they going to
19 take care of those critically ill patients if
20 there's more than one? It's not going to
21 happen, and the rooms that they propose are
22 down the hallway I put in my original
23 testimony.
24 They're not going to -- the person is
25 not going to see those patients. The alarm

1 goes off might be on the other side of floor
2 by the time they get there (unintelligible)
3 the alarm, their alarm system, it might be
4 too late for that particular patient. It's
5 just not the same. It's just not the same.
6 You can say (unintelligible) it's the same
7 people there, but they won't get the same
8 care. The ratios, you know, four, five to
9 one. It's not going to work. It's not going
10 to work at all.
11 MR. KNAG: That's all. I'll shut it
12 down there.
13 HEARING OFFICER CSUKA: Thank you,
14 Attorney Knag.
15 Attorney Tucci, did you want to do any
16 follow-up cross on Dr. Kurish related to any
17 of the statements he just made?
18 MR. TUCCI: Dr. Kurish.
19 DR. KURISH: Yes.
20 MR. TUCCI: Can you hear me?
21 DR. KURISH: Uh-huh.
22 MR. TUCCI: A couple of questions, a
23 couple of questions for you.
24 So you heard within the last hour
25 Miss McCulloch testify under oath that with

1 respect to six rooms on 2 North they have
2 already had the appropriate medical gasses
3 installed. Did you hear that testimony?
4 DR. KURISH: Yes.
5 MR. TUCCI: Do you have any reason to
6 doubt the veracity of what Miss McCulloch
7 said?
8 DR. KURISH: Gases, no.
9 MR. TUCCI: And the purpose of those
10 gasses is to allow appropriate equipment to
11 be hooked up including respirator equipment
12 that will assist patients in breathing,
13 correct?
14 DR. KURISH: Does not have a cardiac
15 monitor, does not have --
16 MR. TUCCI: I didn't ask you that, sir.
17 Sir, you have to answer the question that I
18 ask you.
19 The reason those gasses were installed
20 in those rooms is to allow those gasses to be
21 available for use with ventilator equipment,
22 correct?
23 DR. KURISH: Yes.
24 MR. TUCCI: And ventilators are used to
25 help patients who can't breathe on their own,

1 correct?

2 DR. KURISH: They need more than a

3 ventilator.

4 MR. TUCCI: All right. And you talked

5 about the issue of patients being down the

6 hall. You are aware of the physical

7 configuration of the hallways --

8 DR. KURISH: Yes.

9 MR. TUCCI: -- and rooms on 2 North,

10 correct?

11 DR. KURISH: Correct.

12 MR. TUCCI: And there is a physical

13 location where the nurses' station is, right?

14 DR. KURISH: Remotely, yes, from the

15 rooms. Yes.

16 MR. TUCCI: I'm asking you, sir, are

17 you aware that there's a physical location

18 where nurses are stationed, correct?

19 DR. KURISH: Yes.

20 MR. TUCCI: And at the nurse's station

21 there are computers and monitors that are

22 there for the nurses to be able to view,

23 correct?

24 DR. KURISH: No video monitors, just

25 EKG strips, no oxygen levels --

1 MR. TUCCI: And --
2 DR. KURISH: No respiratory rates.
3 MR. KNAG: I just ask that the witness
4 be allowed to finish his question -- his
5 answer.
6 MR. TUCCI: I apologize for
7 interrupting. You go ahead right ahead,
8 Dr. Kurish. Say whatever you'd like.
9 DR. KURISH: They don't have a complete
10 monitoring system there. They just have an
11 EKG rhythm strip with the heart rates.
12 MR. TUCCI: I understand that. What I
13 want to focus on is your understanding of the
14 physical layout and configuration of 2 North.
15 And it is -- it is correct, is it not,
16 that within the direct sight line of the
17 nurses' station across from the hallway are
18 patient rooms, correct?
19 DR. KURISH: Not PCU rooms.
20 MR. TUCCI: I asked you, sir, whether
21 physically there were rooms directly across
22 from the nurses' station --
23 DR. KURISH: Yes, there are.
24 MR. TUCCI: -- isn't that a fact?
25 DR. KURISH: That's a fact.

1 MR. TUCCI: There's approximately five
2 rooms within direct sight line of the nurses'
3 station, correct?
4 DR. KURISH: Parts of the rooms are,
5 yes.
6 MR. TUCCI: Right. And --
7 MR. KNAG: Excuse me. Mr. --
8 Dr. Kurish was not allowed to finish his
9 answer. Please allow him to finish his
10 answer.
11 DR. KURISH: Yes, you can see into the
12 rooms. You're not necessarily going to see
13 the patient. You're not going to see their
14 face. You're not going to see their legs.
15 It depends upon the view of the station down
16 the hall into that room. Depends on whether
17 the door is opened or closed.
18 MR. TUCCI: I'm talking about --
19 A VOICE: (Inaudible.)
20 DR. KURISH: Okay. I'm talking about
21 the rooms directly across from the nurses'
22 station.
23 DR. KURISH: Uh-huh.
24 MR. TUCCI: A nurse can be seated at
25 the nurses' station and, without the need to

1 look at a monitor or any other device or
2 binoculars or whatever, see directly across
3 the hallway into those rooms, correctly --
4 correct?
5 DR. KURISH: You can see into the room
6 but not the patient.
7 MR. TUCCI: Thank you very much.
8 HEARING OFFICER CSUKA: Is that all you
9 have, Attorney Tucci?
10 MR. TUCCI: Yes. Thank you.
11 HEARING OFFICER CSUKA: Okay. Thank
12 you. I just wanted to make sure.
13 So I think that concludes all the
14 questioning at this time. I think we are
15 prepared to do a run through of late files
16 that have come up today and last time as
17 well, and so going we're to do those and then
18 we're going to take maybe a five- or
19 ten-minute break. We'll do closing
20 arguments, and then we'll wrap up for the
21 day.
22 So, Attorney Tucci, Attorney Knag, are
23 you prepared to discuss the late files right
24 now?
25 MR. TUCCI: Yes.

1 MR. KNAG: Yes.
2 HEARING OFFICER CSUKA: So the first
3 one I have is actually for the intervener.
4 Dr. Kurish -- Attorney Knag, you said
5 you'd be submitting the written version of
6 Dr. Kurish's opening statement from --
7 MR. KNAG: Yes.
8 HEARING OFFICER CSUKA: -- the first
9 session?
10 MR. KNAG: Yes.
11 HEARING OFFICER CSUKA: I would like to
12 have that one filed by close of business on
13 Friday.
14 MR. KNAG: Yes.
15 That's 4:30?
16 HEARING OFFICER CSUKA: Yes.
17 And I think the rest of these will
18 pertain to the applicant. So OHS has sought
19 an updated utilization volume, and
20 Mr. Clarke, Miss Faiella, and Mr. Lazarus,
21 feel free to jump in with any clarification.
22 So I have these listed in, you know,
23 the way I would write them, but if these are
24 listed incorrectly, just let me know. So I
25 wrote down updated utilization volume from

1 September through the present as Number 1.
2 Number 2 is average daily census by
3 month and year for 2018 through the present.
4 Number 3 is transfers made to other
5 area service providers by month and by year
6 for 2018 through to present.
7 Number 4 is articles regarding the
8 distinction between ICU and PCU, specifically
9 high-level versus low-level units. And
10 that's in reference to some comments that
11 Dr. Marshall made about this being a
12 high-level PCU versus a low-level PCU, the
13 proposed unit.
14 Number 5 is the MedPAC report from
15 2021.
16 Number 6 is the most recent draft of
17 the hospital's PCU admission policy. An
18 earlier version of that was provided in the
19 application, so we're just looking for the
20 most recent version of that.
21 And Number 7 --
22 MR. KNAG: Mr. Hearing Officer?
23 HEARING OFFICER CSUKA: Yes.
24 MR. KNAG: Much our testimony was
25 directed to the initial draft that was

1 supplied and now we're going to supply a
2 revised draft. I would request that we be
3 given a chance to comment on it once it's
4 produced.
5 HEARING OFFICER CSUKA: Attorney Tucci,
6 do you have a response to that?
7 MR. TUCCI: Yes. Again, I think that's
8 highly irregular, outside of the scope of the
9 normal CON process. We are through with the
10 evidentiary portion of this process, and, in
11 essence, what intervener is apparently asking
12 to do, asking for is the ability to further
13 to comment on and/or object to evidence,
14 which I think is directly contrary to your
15 rules.
16 MR. KNAG: They should have -- they
17 should have provided us with the most recent
18 admissions policy so we could have commented
19 on it in the direct testimony.
20 We should be able to comment on
21 whatever the current version is. Otherwise,
22 our input has been unreasonably limited.
23 MR. TUCCI: Well, I respectfully
24 disagree. This is not a trial. The
25 intervener is not a party, and what we are

1 doing is satisfying our obligation to provide
2 information in response to technical
3 questions asked by OHS. That's hat this
4 hearing is. It's not a popularity contest,
5 and it's not a trial.
6 HEARING OFFICER CSUKA: I think enough
7 information has been gathered today to
8 satisfy the agency in terms of how to make
9 sense of this updated admissions policy and
10 also the additional articles, and the last
11 late file that I'm about to get to I think
12 will provide enough information such that we
13 don't need any response from the intervener.
14 So I'm going to deny that request,
15 Attorney Knag, and move on to the last late
16 file request which is Number 7, a
17 side-by-side comparison of the types of
18 acuity cases that can be handled by an ICU
19 and PCU as it specifically relates to Sharon
20 Hospital and what their capabilities would be
21 if this proposal was approved versus not
22 approved.
23 Steve, Ormand, Annie, did I miss
24 anything?
25 MR. LAZARUS: No, everything's on the

1 **list. Thank you.**

2 **HEARING OFFICER CSUKA: And, Steve,**

3 **Ormand, Annie, does anything need to be**

4 **clarified? Did I ask those -- or did I say**

5 **those in the correct way?**

6 **MR. CLARKE: No, I do not think so.**

7 **HEARING OFFICER CSUKA: Okay.**

8 **Attorney Tucci, do you understand -- do**

9 **you have any questions about any of those**

10 **requests or need any clarification?**

11 **MR. TUCCI: No, thank you. That was --**

12 **that was -- the list was clear. We don't**

13 **have any questions about the requests.**

14 **HEARING OFFICER CSUKA: Okay. So I**

15 **will -- we're going to take a ten-minute**

16 **break. You can discuss with your clients how**

17 **long you think putting those together might**

18 **take, and when we come back from that**

19 **ten-minute break, we'll have closing**

20 **arguments and also discuss the late file**

21 **deadline as well.**

22 **MR. TUCCI: Thank you.**

23 **HEARING OFFICER CSUKA: So let's come**

24 **back at 3:56.**

25

1 (Off the record from approximately
2 3:46 p.m. to 3:57 p.m.)
3
4 HEARING OFFICER CSUKA: Thank you.
5 Once again, this is Docket Number
6 22-32504-CON, and it's Sharon Hospital's
7 Proposed Consolidation or Critical Services
8 from an ICU into the PCU.
9 We have completed almost everything for
10 the hearing. I'm going to ask, Attorney
11 Tucci, did you have an opportunity to speak
12 with your clients about a deadline for when
13 you think you might be able to get us the
14 late files?
15 MR. TUCCI: Yes. Thank you, Mr. Csuka.
16 We would suggest March 17.
17 HEARING OFFICER CSUKA: I see no issue
18 with that, so we could say by 4:30 on March
19 17?
20 MR. TUCCI: Yes, thank you.
21 MR. KNAG: Okay.
22 HEARING OFFICER CSUKA: So with the one
23 caveat being that we're going to have the
24 intervener submit Dr. Kurish's written
25 statement by 4:30 this coming Friday. That

1 is February 24th at 4:30.
2 So we're going to go into -- I'm sorry.
3 MR. TUCCI: Excuse me, Mr. Csuka, I'm
4 sorry to interrupt but if I could just speak
5 to that point briefly and, again, just to
6 complete the record on timing?
7 HEARING OFFICER CSUKA: Sure.
8 MR. TUCCI: So as we've indicated sort
9 of at the beginning of the hearing and
10 throughout the course of the hearing, we, the
11 applicant, will be filing a motion addressed
12 to the written prefile of the intervener, and
13 we would request until March 6th to file that
14 motion with you.
15 We will include in that any response
16 necessary to Intervener Late File Number 1.
17 HEARING OFFICER CSUKA: That works for
18 me.
19 MR. TUCCI: Thank you.
20 HEARING OFFICER CSUKA: I think we'll
21 have to evaluate, once you file your motion,
22 the amount of time that may be needed for the
23 intervener to respond to that. So I'm not
24 going to set a deadline on that right now. I
25 do want to see the motion before I decide on

1 a deadline for the intervener. So I'm going
2 to -- I'm just going to hold off on doing
3 that for right now, but March 6th for the
4 submission of your motion is fine.
5 MR. TUCCI: Thank you.
6 HEARING OFFICER CSUKA: So with that I
7 would like to first start with the closing
8 argument from Attorney Knag.
9 MR. KNAG: Very well. Thank you.
10
11 (Closing argument of
12 Attorney Knag.)
13
14 MR. KNAG: OHS has already made a
15 finding in its determination letter that a
16 CON is needed here because the applicant
17 wishes to terminate the ICU level of care.
18 It is -- and it made a determination
19 it's not simply a consolidation of care but a
20 change in the level of care bing offered.
21 You should deny the CON application for
22 three main reasons under the CON factors.
23 The lack of identified financial benefit, the
24 loss of access in needed ICU services in this
25 rural hospital far away from other hospitals,

1 and the negative impact on quality of care.
2 First of all, the financial benefit:
3 The applicant has spoken about its plan to
4 stem its losses, but nevertheless in
5 assessing the impact of this particular CON,
6 the applicant assumed a further small
7 financial loss in its projections as set
8 forth in its completeness responses.
9 It has not claimed that there would be
10 any savings whatsoever from the -- resulting
11 from the proposal based on the financial
12 worksheets that it submitted. We believe
13 that this, however, is likely very much
14 understated.
15 In its application and first and second
16 completeness filings, the applicant projected
17 the volume will decline by 24 cases a year
18 and 10 percent compared with 2021, but we --
19 the thing that we'd like you to take a close
20 look at is that after they issued this
21 policy, which they'd said wasn't implemented,
22 but which Dr. Kurish says was, after they
23 implemented this policy it was a decrease in
24 ICU volume of by approximately 40 percent on
25 an annualized basis. That's what they say in

1 their submission and they say -- they said
2 today that they didn't know exactly what the
3 figures were thereafter, but they were more
4 or less the same.
5 So what we've seen is a 40 percent
6 decrease in ICU volume, and this does not
7 include -- this information about finances
8 does not include the setting up of a PCU such
9 as the cost of monitors.
10 The hospital's financial losses are
11 also out of line to similarly-situated
12 hospitals in the state and must be evaluated
13 as such.
14 A look at another rural community
15 Connecticut hospital with a similar number of
16 beds, Day Kimball, shows it's now making
17 money again without proposing any elimination
18 of critical services such as maternity or the
19 ICU.
20 And per OHS data in the last published
21 report in 2022 only five hospitals in
22 Connecticut had operating losses for FY 2021.
23 While the hospital's counsel has chosen to
24 call the -- some of the claims that we make a
25 conspiracy theory, we know that the hospital

1 itself was told by Stroudwater Associates to
2 move volume to applicant's other hospitals
3 with a view toward the overall system's
4 bottom line and that it should evaluate
5 Sharon Hospital's bottom line to include the
6 benefits to the system from items taken from
7 the Sharon Hospital income statement.
8 Nuvance's actions are align with this
9 advice. It is interesting to further note
10 that a decision has been made to discontinue
11 to use of the tele-intensivists at the ICU
12 and replace them with guidance from doctors
13 at other Nuvance hospitals who they -- the
14 hospital states would likely be involved in
15 arranging for transfers.
16 Again, the facts show that Nuvance's
17 actions have resulted in moving patients out
18 of Sharon to other Nuvance's hospital. This
19 is data. It's not a conspiracy theory.
20 Now, let's talk about the loss of
21 access, so there's no financial savings as a
22 result of this. Let's talk about the loss of
23 access. The decrease in volume is tied to a
24 loss of access to ICU service. Although the
25 applicant claims the revised admission policy

1 was never formally adopted, Dr. Kurish says
2 it was adopted, and he gave -- he gave an
3 example of a patient with a drug overdose who
4 needed emergent intubation in the emergency
5 room. The hospital insisted the patient be
6 transferred but an ICU bed couldn't be
7 located in another hospital, and the patient
8 was admitted to Sharon's ICU and did well.
9 The applicant seeks to justify closure
10 by the claim of low utilization of the
11 nine-bed ICU, and one key reason for the --
12 the one key reason for the low utilization is
13 that the unit has been limited to four
14 patients on many days due to nurse
15 unavailability, and that was a problem that
16 was exacerbated by the applicant when this
17 hospital's CEO told the ICU nurses that the
18 ICU was closing promising a -- prompting a
19 group ICU nurses to quit and ever since then,
20 there's been chronic understaffing problems
21 in the ICU. This has never been a problem
22 previously because Sharon is a wonderful
23 place to work, and it has a strong record of
24 recruiting and retaining staff.
25 Additionally, we mentioned that one ICU

1 room was used for storage, not patient care.
2 We know that 92 percent of the hospitals in
3 the northeast the size of Sharon have ICUs.
4 In recent -- it's not true that in
5 general these -- that the hospitals in the
6 northeast have been closing the ICUs. In
7 recent months and also at the start of COVID,
8 there's been a shortage of ICU an med-surg
9 beds.
10 On certain days Sharon, Danbury, and
11 Vassar all were full to capacity. Under
12 these circumstances, it makes no sense to
13 take eight or nine beds out of service in the
14 state by closing the ICU, and we would point
15 out that Dr. Marshall admitted that by
16 approving this application nine physical beds
17 will be taken out of service.
18 The applicant hasn't revealed what it
19 plans to do with this vacant space that would
20 be available at critical periods such as
21 we've just experienced.
22 In addition, Sharon Hospital is in a
23 rural and remote part of the state, 37
24 minutes from the closest ICU in optimal
25 travel conditions. And today it's going to

1 snow, and I'm very apprehensive about how
2 long it will take me to get home from this
3 area.
4 As Nuvance predicts, its proposal would
5 decrease the ICU patients by 20 to 24 cases
6 annually and we -- or now they say there'd be
7 none, but we say it would be many more, and
8 that would mean that more families would have
9 to travel unnecessarily to visit with their
10 critically-ill family.
11 And also we know that the patients
12 would be -- would be subjected to additional
13 costs, for example, if the patient needed to
14 be moved, the insurance might not cover it
15 especially if it was an air transport and
16 also the transferring hospital might not
17 participate in the same payor contracts as
18 the -- as Sharon Hospital.
19 Furthermore, in representing hospitals,
20 one of the first things you do is you go to
21 the community leaders and show that the
22 community leaders feel there's a need, and
23 you append to the CON statements of support
24 from the community leaders. Here nothing
25 could be further from that circumstance, and

1 in particular we've submitted many letters
2 from state legislatures, from the town
3 leaders, but I would point you to the letter
4 just received on February -- dated February
5 17th from Senators Blumenthal and Murphy and
6 Representative Hayes.
7 In particular, this letter urges
8 rejection of this application and states that
9 the northwest Connecticut community strongly
10 supports a viable Sharon Hospital that
11 provides a comprehensive range of services.
12 And this assessment by the community
13 leaders from Senator Blumenthal and Senator
14 Murphy on down show that there's a strong
15 need to continue access to the hospital's
16 core services including the ICU.
17 It's not a pressure tactic as Mr. Tucci
18 said. It's an assessment by the community
19 leaders as to what the community need is, and
20 just as it would be taken into account if the
21 hospital was putting it in in support of its
22 application, it certainly should be strongly
23 taken into account when the leaders are all
24 clamoring for this application to be denied.
25 Let's talk about the key issue and

1 **another key issue and that is a loss of**
2 **quality. There's no doubt that the**
3 **termination of an ICU and creation of a PCU**
4 **will result in a loss of capability and**
5 **quality.**
6 **The ICU nurses are trained to deal with**
7 **ICU cases. They must be able to identify**
8 **life-threatening arrythmias, septic shock,**
9 **and respiratory failure. They manage**
10 **respiratory patients with sedating**
11 **medications, detoxify patients with overdoses**
12 **that can seize or become psychotic, support**
13 **massive GI bleeders with low blood pressures,**
14 **and manage complicated postop patients.**
15 **The med-surg nurses don't have this**
16 **training now. The applicant states that the**
17 **ICU nurses will mentor the med-surg nurses**
18 **who will receive additional training online,**
19 **but it is clear that having nurses who have**
20 **spent decades doing this in a**
21 **highly-specialized ICU care is superior to**
22 **trying to train the med-surg nurses to take**
23 **on these duties on a part-time basis.**
24 **Furthermore, we know that the mere**
25 **announcement of the proposed conversion from**

1 ICU to PCU has led some ICU nurses to quit.
2 Some med-surg nurses have stated that they
3 will leave the ICU if in fact it is closed,
4 and they would do so for fear of loosing
5 their licenses due to what they perceive as
6 unsafe practices.
7 So the shortage of critical care nurses
8 that we now have would get even worse if this
9 application is approved, and there will be a
10 loss of the trained ICU-level nurses. If the
11 CON is denied there will be the opportunity
12 to get these nurses back who left in
13 anticipation of an ICU closure.
14 Because the ICU is a higher level of
15 care, the ratio of patients to nurses is
16 higher in the PCU than the ICU. According to
17 the application, the proposed ratio in the
18 PCU is 4.5 to 1. Whereas, in the ICU the
19 ration is supposed to be two to one.
20 The national standard for PCUs is three
21 or four patients to one nurse, but they're
22 proposing a worse ratio. In addition, the
23 proposed PCU are patient rooms which are not
24 designed for critical care and are too small.
25 There are only a small number of patient

1 rooms that are partially in the line of sight
2 of nurses at the med-surg nurses' station,
3 but the med-surg nurses may or may not be
4 sitting at the station and the patient -- the
5 fact that part of the patient room may be
6 visible is a lot different from the line of
7 sight that exists in the ICU where the rooms
8 -- where there's glass on one side of the
9 room so that the entire patient, all the
10 patients, are in the direct line of sight of
11 the nurses.
12 Much information was presented as to
13 the cardiac monitoring with alarms, but
14 alarms are different from direct observation.
15 Furthermore, the eight proposed -- the eight
16 actual cardiac monitors, the portable cardiac
17 monitors, only monitor heart rate. They do
18 not include respirator rate or oxygen
19 saturation.
20 Again, today they said only two rooms
21 provide -- are proposed to have hardwired ICU
22 quality monitors. Whereas, all the ICU rooms
23 have hardwired monitors now, and while laymen
24 watching monitors designed to see whether the
25 patient is suffering, a fall may be

1 sufficient for a medical-surgical patient,
2 the level of -- this level of monitoring is
3 not equivalent to continuous visual
4 monitoring by a specialized nurse which takes
5 place in the ICU.
6 We all know that we've -- I'm sure
7 everyone has been in a hospital where alarms
8 have gone off and no nurse has done anything.
9 It's a lot different than having a nurse in
10 direct line of sight.
11 So if this application is approved,
12 there's also going to be a loss of average
13 competence in the nurses. The average
14 training and experience will decline. The
15 staffing ratio, as I said, will decline and
16 patients will be in rooms where there's not
17 the open architecture of the ICU.
18 Therefore, with all these factors, the
19 hospital will not be able to provide the
20 continuous visual monitoring that they're
21 able to provide in the ICU. Now, they say
22 that everything will be the same and they'll
23 take the same patients, but they can't do
24 that safely.
25 According to the 2021 policy, the PCU

1 would not accept patients with respiratory
2 problems needing intubation or ventilators or
3 bypass support who are not hemodynamically
4 stable. These patients are currently being
5 handled in the ICU, and Dr. Marshall says now
6 they can be -- they will be handled in the
7 PCU, but Dr. Kurish states such care is not
8 provided in New Milford or Vassar and would
9 imperil the patients if provided.
10 And Dr. Marshall has admitted that the
11 proposed standards for the new PCU would take
12 higher-acuity patients that are not admitted
13 in New Milford Hospital, and he also admits
14 that ventilator -- respirator management is
15 one of the most difficult duties of an ICU,
16 and ICU requires, without skilled meticulous
17 attention to detail, the patient could
18 rupture a lung, suffer brain damage, and die.
19 Other groups being handled now in the
20 ICU but not so suitable for the PCU include
21 hemodynamically unstable patients requiring
22 prolonged close monitoring, clinical
23 conditions requiring ICU nursing care and
24 prolonged hourly monitoring. Examples would
25 be GI bleeding, not hemodynamically stable,

1 patients with sepsis, with UTIs, upper
2 urinary tract infections, or pneumonia who
3 need prolonged vasopressors.
4 Vasopressors are medicines designed to
5 keep the blood pressure up in the normal
6 range until the infection is brought under
7 control, and also arrythmias that need
8 continuous monitoring by a nurse.
9 The big difference is the nurses and
10 the monitoring. You have fewer nurses. You
11 don't have line of sight. You can't monitor
12 them in the way that they are monitored in
13 the PCU, and therefore these higher-acuity
14 cases that are currently taken cannot safely
15 -- they can change the policy and say they'll
16 take everyone, but they cannot safely be
17 taken.
18 Furthermore, in Sharon we have the
19 problem that it's remote and there are times
20 when patients can't be transferred due to
21 weather or unavailability of ICU beds. They
22 may need to take cases that normally they
23 wouldn't want to take, and they need to be
24 prepared for these cases in the best way
25 possible, and closing down the ICU level of

1 care, which is what they're asking to do and
2 instead substituting the PCU level of care
3 would mean that dealing with these patients
4 that can't be transferred immediately would
5 be more difficult or impossible imperiling
6 the lives of these people.
7 The ultimate result of approval of this
8 the proposal is persons who are very sick or
9 have serious injuries but could be treated in
10 the ICU will need to be transferred even
11 though they say that they won't, which could
12 imperil their health.
13 They will not be treated in a five-star
14 hospital which Sharon is, and they will be
15 subject to substantial incremental costs, and
16 they also will be far away from their loved
17 ones, and those patients who are not
18 transferred will be imperilled by the low --
19 lower quality of the PCU compared with the
20 ICU in view of the factors I've just
21 reviewed.
22 Someone intubated or on vasopressors
23 and hemodynamically unstable would, as the
24 hospital has indicated -- had indicated in
25 its drafted admissions policy would be in

1 appropriate for the PCU and would be
2 imperiled if they were admitted as now is
3 being suggested.
4 Now, what else do we know besides the
5 fact that the community opposes this and the
6 community leaders opposes this, we know that
7 the medical staff of Sharon Hospital voted
8 against the plan 25 to 1. This shows that
9 the doctors who deal with this -- these
10 patients who were treated in the ICU, the
11 doctors who everyday have to handle their
12 patients, agree that this is the wrong thing
13 to do.
14 ED doctors, surgeons, and community
15 interests were all against it. The ED
16 doctors want to admit their patients from ED
17 quality quickly without spending time trying
18 to find a place to transfer the patient. It
19 could take three or four hours from the time
20 a decision is made to transfer patient until
21 the ambulance leaves with the patient.
22 Surgeons want the ICU for patients with
23 complicated comorbidities and postop problems
24 and interestingly neither place nearby to
25 handle the most seriously-ill patients.

1 **Closing services such as the ICU would**
2 **gut the hospital, and rather than doing that**
3 **the hospital should join with the community**
4 **and working with Maria Horn and the various**
5 **committee chairmen of different state**
6 **legislative entities who are interested in**
7 **finding a way to obtain increased**
8 **reimbursement from the state for the services**
9 **being rendered by rural hospitals and in**
10 **particular Sharon.**
11 **And also, they should work with the**
12 **community to find contributions that would**
13 **help to subsidize the services that are**
14 **rendered and also taking steps to restore**
15 **volumes which they haven't taken, that is to**
16 **replace -- in particular to replace the**
17 **various doctors that have left.**
18 **And I would point out and as Maria Horn**
19 **did in her letter that Nuvance's Putnam**
20 **Hospital closed maternity and recently**
21 **reopened it based on the efforts of the state**
22 **to increase -- the willingness of the state**
23 **to increase reimbursement, and the**
24 **willingness of the community to increase**
25 **charitable contributions and rather than**

1 leave these -- leave this community in the
2 lurch, as has been suggested by all of its
3 leaders, we ask that the hospital work with
4 us to find a palpable solution that leaves
5 the hospital's core services intact and
6 allows the development of a plan that would
7 address the financial concerns that they
8 have.
9 HEARING OFFICER CSUKA: Thank you,
10 Attorney Knag.
11 Attorney Tucci, are you prepared to
12 deliver your closing argument?
13 MR. TUCCI: Yes. Thank you, Mr. Csuka.
14
15 (Closing argument of Mr. Tucci.)
16
17 MR. TUCCI: The first thing. I'd like
18 to do is thank you, Mr. Csuka, and all of the
19 OHS staff for all of the hard work that you
20 put into the this application and the public
21 hearing to ensure that the process ran as
22 smoothly as possible and that all of the
23 facts fast data came out. We appreciate that
24 very much.
25 I've been involved in certificate of

1 need proceedings for longer than I care to
2 admit on the public record. I have to say
3 I've never quite heard anything like or
4 experienced anything like what I have
5 experienced in these last two hearings
6 involving to Sharon Hospital.
7 Typically when there are interveners,
8 interveners bring to the table facts, data
9 expertise, specific information relating to
10 the merits of the CON application that are of
11 assistance to OHS in evaluating whether or
12 not the CON criteria are met.
13 What we have experienced in these last
14 couple of sessions is intervener
15 participation that consists of speculation,
16 fear, innuendo, accusations against the good
17 faith of the hospital, not facts, not data,
18 not reliable information.
19 In fact in the face of data, in the
20 face of facts, in the face of reliable
21 information, we get, as you just heard from
22 interveners counsel, we don't care, we just
23 don't agree with that, it isn't true, we
24 don't accept that. I respectfully suggest
25 that none of that has been of any use or any

1 help to OHS in the work that you need to do
2 to determine whether or not this CON
3 application is in the best interest of the
4 citizens of the state of Connecticut.
5 More fundamentally, what you've heard
6 is not only information that isn't helpful
7 but actually advances theories and themes
8 that frankly appear to be without any
9 rational basis whatsoever, and I don't mean
10 this -- I don't know any other way to say
11 this, but in many respects untethered to
12 reality.
13 The notion that Sharon Hospital's
14 operational difficulties are going to be
15 solved and have not been solved because we
16 haven't worked hard enough to get
17 contributions, I will state now for the
18 record if there is anyone out there who is
19 willing to write a check for 20 million
20 dollars and contribute it to Sharon Hospital,
21 we will gladly accept it.
22 If -- if -- the notion that the
23 legislature of the state of Connecticut is
24 going to write a 20 million dollar check to
25 cover operating losses at Sharon Hospital. I

1 can tell you that the latest headline out of
2 the executive branch is that there will be
3 further cuts to hospitals and hospital
4 operations.
5 This is not some vague hope that there
6 will be a financial bailout that comes to the
7 aid of rural hospitals like Sharon that are
8 struggling. And quite frankly, even if there
9 was any realistic possibility of that ever
10 happening. It absolutely is not good
11 healthcare policy, and has nothing whatever
12 to do with the CON factors that you're
13 required to apply to suggest that the way to
14 solve our problems about how to make rural
15 hospitals like Sharon most effective and most
16 financially self-sustaining and to create the
17 care that is in demand and is appropriate for
18 their service area, is by continually bailing
19 them that out.
20 The definition of insanity is to
21 continuing to do the same thing over and over
22 again when it produces the same negative
23 result.
24 So let's talk about when we started
25 this process I think one of my introductory

1 comments to you, Mr. Csuka, is this is
2 relatively straightforward to relocate the
3 critical care services that the hospital
4 currently offers to a new physical space on
5 the second floor of the hospital to be called
6 a progressive care unit.
7 I think we've actually proved that
8 through all the facts and the data and the
9 testimony that you heard, so I think my
10 comment was largely accurate, but it's
11 incomplete because really what this
12 application represents is -- and coupled with
13 the prior application that was submitted -- a
14 referendum on the future of Sharon Hospital,
15 and what has been proposed here is a
16 transformation plan that not only satisfies
17 all of the factors that you've identified as
18 the critical factors for CON approval, but
19 will actually insure that this hospital has a
20 viable future in the community for the next
21 10, 15, 20, 25 years.
22 When you opened hearing, you talked
23 about the key critical CON factors that need
24 to be evaluated and that would be tested her
25 in the technical portion of the public

1 hearing, and they're well known: Need,
2 quality, access, cost effectiveness.
3 So what have we proved? I'm not going
4 to go through a catalog of all the evidence
5 because it would take too long to do it, but
6 just briefly what have we proved with respect
7 to each of those factors?
8 With respect to the need for critical
9 care services in the Sharon service area,
10 we've absolutely demonstrated that that need
11 will not only continue to be met but will be
12 met in a higher quality increased access
13 manner through relocation of our critical
14 care services to the second floor with the
15 PCU unit.
16 The consolidation of this critical care
17 function and creation of a mixed-acuity unit
18 is not only more cost effective because, as
19 you heard from the testimony today, we're now
20 paying nurses who sometimes are sitting in a
21 unit with where there are no patients to
22 serve is not only more cost effective but
23 will actually increase access of critical
24 care services and the quality level of those
25 services which is already very high. So how

1 **will that happen? Well, you've heard me**
2 **explain in great detail when you're able to**
3 **pool your resources so that all of the**
4 **inpatients that are being cared for in the**
5 **hospital are all at a single location, all of**
6 **the nurses, all of the attending healthcare**
7 **professionals, all of the service staff will**
8 **all be in the same location, that unit could**
9 **be flexed up or down meaning that if there's**
10 **a higher number of patients who require**
11 **critical care services, they will be able to**
12 **the accommodated because there's a 28-bed**
13 **unit.**
14 **With respect to the staffing ratio,**
15 **you've heard of lot of fear and speculation**
16 **about that. Again, fear and speculation**
17 **about whether medical-surgical nurses are**
18 **going to be adequately trained is just that:**
19 **Fear and speculation.**
20 **Of course they're not going to be**
21 **adequately trained. What is the converse of**
22 **what on intervener is suggesting? Apparently**
23 **the intervener is suggest that what we are**
24 **proposing is to establish a new physical**
25 **space on the second floor of this hospital**

1 that is going to be less safe for patients
2 and is going to the expose us to more
3 questions and potentially create harm to
4 patients.
5 Why in world would we ever do such a
6 thing? The facts completely belie that fear,
7 that speculation, that innuendo. You heard
8 from Miss McCulloch, you heard from
9 Dr. Marshal the physical space on 2 North
10 meets the quality level of standard of care
11 to deliver critical care services.
12 You've heard described excruciating
13 detail every type of monitor, alarm, system,
14 and the increased level of staff that will be
15 in place on 2 North so that they're are more
16 eyes on patients, more interaction with
17 patients who require critical care services,
18 not less but more. The increase in access is
19 apparent on its face.
20 Why has there been -- the intervener
21 would ask you to believe that in some form or
22 fashion, there is a critical care shortage of
23 ICU beds, not only in Sharon Hospital but
24 throughout the system.
25 The facts and the belie that. We're

1 limping along here with a IC -- a physical
2 ICU that is basically half empty every day
3 that it's open, and for 50 percent of those
4 four patients who were in the unit in most
5 other hospitals they would be in a
6 medical-surgical unit because they don't even
7 met the necessary standard to be in an ICU of
8 the nature of Danbury Hospital.
9 Let's talk about the financial picture
10 here that was -- that was -- that has been
11 addressed briefly by Mr. Knag and his
12 comments and also through the testimony of
13 Mr. Germac. The theme and theory that's
14 being advanced, which again I respectfully
15 suggest has no basis in reality, is that the
16 grand plan here is for the Sharon Hospital to
17 turn away patients that it could otherwise
18 profitably serve and to intentionally take
19 business away from the Sharon Hospital in
20 order to get this CON approved.
21 How could that possibly make any sense
22 whatsoever? What's been going on over the
23 last several years is every attempt to find a
24 way to find a way to keep this hospital
25 financially viable, and it makes no sense

1 that the patients are in any by being turned
2 away when they could be cared for here.
3 You heard the evidence. The evidence
4 is overwhelming. The reason why Sharon
5 Hospital transfers patients is because they
6 need to be transferred for their own safety
7 because they require care that they can't get
8 here.
9 What we're walking about when we have a
10 system like Nuvance is actually quality and
11 access and better care results when those
12 patients are able to be transferred to a
13 hospital that's part of the Nuvance system
14 because the clinician at Vassar or the
15 clinician at Danbury who takes a patient at
16 Sharon Hospital is actually able to look in
17 realtime at that patient's medical record to
18 understand what the history of that patient
19 was, what care they need to provide the
20 specialized level of care that that patient
21 needs at Danbury or at Vassar or at some
22 other hospital of the patient's own choosing
23 which is another ^ that's propagated by the
24 interveners here, that somehow Sharon
25 Hospital has the power to dictate where a

1 **patient goes. That's absolutely false. The**
2 **evidence doesn't support that.**
3 **And so why is this the right model for**
4 **a hospital like Sharon because it makes**
5 **perfect sense to have Sharon Hospital be the**
6 **lifeline for patients who need critical care,**
7 **the lifeline for patients who need emergency**
8 **care.**
9 **They get that lifesaving care at Sharon**
10 **Hospital. If they need equipment, if they**
11 **need a specialist that isn't available at**
12 **Sharon Hospital, they need to go to, they**
13 **should go to other hospitals where they can**
14 **get that care.**
15 **If it so happens that the patient**
16 **elects to get that care at another Nuvance**
17 **hospital so much the better because the**
18 **quality of their care will be enhanced**
19 **because the clinicians are part of the same**
20 **something, they look at the same medical**
21 **records, they talk to each other, and you**
22 **heard testimony from Miss McCulloch and other**
23 **witnesses about how when those patients come**
24 **back to Sharon Hospital, they're able to get**
25 **that continuity of care that they need at**

1 Sharon without any interruption or any need
2 to look at records that are generated by
3 another hospital.
4 Much was made of the supported public
5 officials, politicians, and so forth who, you
6 know, oftentimes want to weigh in on these
7 sorts of things. I understand that, but as
8 long as we're talking about public comment,
9 let me just briefly refer back to the witness
10 after witness who testified about why the PCU
11 model who weighed in during the public
12 comment session, who talked about why the PCU
13 model made clinical sense, made economic
14 sense, was in the best interest of patient
15 care.
16 You heard from witness after witness
17 affiliated with and connected with Sharon
18 Hospital, emergency department physicians,
19 other medical doctors who are on staff,
20 people who were in charge of the EMS part of
21 the emergency transport program, all coming
22 out and speaking in favor of this because
23 they know it's the right thing to do in order
24 for Sharon to be able to deliver cost
25 effective and quality critical care services

1 going forward.
2 In terms of the financial aspects of
3 this, you heard very detailed and very clear
4 testimony from Dr. Mercy -- Dr. Murphy about
5 how the beauty of this proposal to really
6 save Sharon Hospital and make it a vital
7 resource for the community going forward is
8 that the sum of the transformation plan is
9 greater than its parts, and when you put it
10 all together, that's what's going to allow
11 the hospital to have any realistic hope of
12 remaining financially viable as it goes
13 forward to try to provide the care that
14 patients need.
15 What have you heard in response from
16 the intervener besides speculation, innuendo,
17 and fear? Well, what you heard from
18 Mr. Germac was essentially a made-up
19 calculation that somehow there's a magic 13
20 million dollars of revenue out of there that
21 if the hospital didn't transfer patients
22 somehow the hospital would be able to garner
23 that revenue.
24 Well, I don't think anything more needs
25 to be said about that so-called calculation

1 because it's clear on its face it that has
2 absolutely no merit of basis on its own.
3 The other myth that I think has been
4 exploded here today is the notion that
5 somehow if this application is approved
6 something is going to be taken away, there's
7 a termination, there's a closure, there's a
8 deprivation of some service, product, or
9 medical care that the community would
10 otherwise need. That myth has been
11 completely exploded over and over again by
12 every witness you heard testify under oath.
13 Let me state this as clearly as it can
14 be stated. The critical care services that
15 are currently offered at Sharon Hospital
16 today will be of the same level and quality
17 and intensity when the PCU is up and running
18 if you approve this application. There's no,
19 ifs, ands, or buts about that. It's just a
20 fact.
21 When I thought about how to conclude
22 this I think I do need to ask you to just
23 briefly consider what will happen if OHS
24 decides that this application shouldn't be
25 granted? Well, essentially what you will be

1 doing is dooming Sharon Hospital to be stuck
2 in the past. We'll continue to limp along
3 with an ICU unit on the first floor that is
4 staffed by two nurses who may or my not have
5 anything to do, and when patients are
6 there and nurses are not available, we won't
7 be able to deliver the care.
8 The unit is outdated. It's going to
9 require a significant capital investment if
10 it has to continue in its current form. And
11 for what purpose? All that will be happening
12 is that we will continue to maintain the
13 status quo, which is a half empty unit where
14 we're struggling to staff it appropriately,
15 and when we do staff it, there's actually
16 less demand than is otherwise needed to keep
17 that unit financially viable.
18 You know, I think there's really
19 nothing more to be said about why approving
20 this application makes sense other than the
21 words that Dr. Murphy used to help describe
22 why this is so essential for the future of
23 Sharon Hospital.
24 The 20 million dollar deficit that's
25 been talked about here, that's really not the

1 problem. That's a symptom of the problem.
2 If the hospital is able to re-engineer itself
3 so it's able to offer care that is
4 financially self-sustaining, care that
5 community needs and wants locally, that will
6 go a long way to ensuring the future of
7 Sharon Hospital.
8 The single biggest threat, as
9 Dr. Murphy said, to Sharon Hospital is the
10 status quo. We respectfully ask you change
11 the status quo, grant this application, allow
12 Sharon Hospital to continue to provide high
13 quality need critical care services in the
14 new PCU unit at the hospital. Thank you.
15 HEARING OFFICER CSUKA: Thank you
16 Attorney Tucci.
17 That concludes the hearing. Thank you
18 to everyone has attended both last week and
19 today. Thank you especially to counsel and
20 their witnesses.
21 Just a reminder that written public
22 comment can be submitted up to seven days
23 from today. That is March 1st, 2023. After
24 that it will not be included as part of the
25 hearing record. I believe that is

1 **everything, so this hearing is hereby**
2 **adjourned the record will remain until closed**
3 **by OHS following its submission of late files**
4 **that were discussed earlier in the**
5 **proceeding.**
6 **Thank you again and take care of**
7 **yourselves.**
8
9 **(The hearing was adjourned at**
10 **approximately 4:45 p.m.)**
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1 **CERTIFICATION**

2

I, ANNETTE F. BROWN, LSR and Notary
3 Public within and for the State of
Connecticut, do hereby certify that I took
4 the foregoing proceeding on February 22,
2023.
5

I further certify that the proceeding
6 was taken by me stenographically and reduced
to typewritten form under my direction by
7 means of COMPUTER-ASSISTED TRANSCRIPTION, and
I further certify that said transcript is a
8 true record of the proceeding.

9 I further certify that I am neither
counsel for, related to, nor employed by any
10 of the parties to the action in which this
deposition was taken; and further, that I am
11 not a relative or employee of any attorney or
counsel employed by the parties hereto, nor
12 financially or otherwise interested in the
outcome of the action.
13

I WITNESS my hand and my seal this 13th
14 day of March, 2023.

15

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19

20 Annette F. Brown, LSR No. 00009
Notary Public
21 My Commission Expires:
November 30, 2024
22

23

24

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