STATE OF CONNECTICUT

OFFICE OF HEALTH STRATEGY

HEALTH SYSTEMS PLANNING UNIT

IN RE: GREENWICH HOSPITAL AND
YALE-NEW HAVEN HEALTH SERVICES CORPORATION
CERTIFICATE OF NEED APPLICATION
DOCKET NO. 20-32342-CON

VIA ZOOM

Hearing held on Wednesday, September 30, 2020,
Beginning at 10:31 a.m. via remote access.

H e l d B e f o r e:

MICHAELA MITCHELL, ESQ., Hearing Officer

Administrative Staff:

LESLIE GREER

Reporter: Debra Chasse, CSR #055

APPEARANCES:

FOR THE INTERVENER:
PARRETT, PORTO, PARESE & COLWELL
BY: PATRICK MONAHAN, ESQUIRE
One Hamden Center
2319 Whitney Avenue, Suite 1-D
Hamden, CT 06518

FOR YALE NEW HAVEN HEALTH:
MATT McKENNAN, ESQUIRE
JOHN ASHMEADE, ESQUIRE

BRIAN CARNEY, OHS
HANNA NAGY, OHS

**All participants were present via remote access.

HEARING OFFICER MITCHELL: Good morning, everyone. This is a public hearing before the Health Systems Planning Unit, HSP, identified by docket No. 20-32342-CON, being held on September 30th of 2020 to establish the elective percutaneous coronary intervention, or elective PCI, at Greenwich Hospital.

On March 14th of 2020 Governor Ned Lamont issued executive order 7B which, in relevant part, suspended in-person open meeting requirements. That executive order was extended on September 8th of 2020, via executive order 9A, to November 9th of 2020. To ensure the continuity of operations while maintaining the necessary social distance to avoid the spread of Covid 19, the Office of Health Strategy, or OHS, is holding this hearing remotely. We ask that all members of the public mute the device that they are using to access the hearing and silence any additional devices that are around them.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19A 639A, and will be conducted as a contested case in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Micheala Mitchell. Victoria Veltri, who is the executive director of the

Office of Health Strategy, has designated me to serve as the hearing officer for this matter. My colleagues, Bryan Carney and Hanna Nagy, are also here to assist me in gathering facts related to this application.

The Certificate of Need process is a regulatory process and, as such, the highest level of respect will be accorded to the parties, members of the public, and our staff. Our priority is the integrity and transparency of this process. Accordingly, we ask that you maintain decorum throughout the proceeding.

The hearing is being recorded and will be transcribed by BCT Reporting, LLC.

The documents related to this hearing that have been or will be submitted to the Office of Health Strategy are available for review through our sealed end core, which is accessible on the Office of Health Strategy CON web page.

In making its decision, HSP will consider and make written findings concerning the principles and guidelines set forth in Section 19A-639069 of the Connecticut General Statutes.

Yale-New Haven Health Services Corporation and Greenwich Hospital are the parties in this proceeding, and Stamford Health, Incorporated has been designated as an intervenor with full rights in

this matter.

At this time I'm going to ask Mr. Carney, if he wouldn't mind reading into the record the documents already appearing on out table of record in this case. Before you do that, I know that what we have uploaded to the portal may be slightly different than what you actually received in your e-mail. So, you know, we will make sure that we go through everything that we have received thus far and everything will be corrected in the final table of record, but I'll turn it over to you, Brian, for what you do have.

MR. CARNEY: Good morning. My name is Brian Carney of the Office of Health Strategy. At this time I would like to add to the Table of Record Exhibits A through V.

HEARING OFFICER MITCHELL: Are there any objections to the inclusion of these documents into the record? I'm going to go with the attorneys for counsel for Yale first.

MR. McKENNAN: Attorney Mitchell, no objections from Yale.

HEARING OFFICER MITCHELL: And then also counsel for the intervenor.

MR. MONAHAN: There are no

objections to the exhibits listed A through V. I do have a procedural question about a potential addition to the exhibits and the table of record. First, and I'm hearing a little echo, and I'm hoping that you can hear me okay.

HEARING OFFICER MITCHELL: I can. I'm wondering if maybe someone else that's in there with you may be connected to the hearing and also have their microphone turned on. Sometimes that will get rid of the echo.

MR. MONAHAN: In addition to one or two supportive letters, there was an additional supportive letter that may not have made it in by 4:30 yesterday but I have here. It is from Representative Patricia Miller. And she wrote a letter of support dated September 27th, submitted it yesterday but, for whatever reason, it has not made it to the record. I have it here, and I can certainly submit it later in the day. I don't know if it made its way after the 4:30 or 5 o'clock. That's one thing that I ask that be submitted to the record.

HEARING OFFICER MITCHELL: Right. So we are going to leave the record open for a week, as we customarily do, to allow for additional public comment if anyone wants to submit that in writing, so

even if we have not seen it yet or looked at it yet, we -- I would definitely advise you to take a look at the docket to make sure that it's there. We would usually put those in the public comment folder inside the docket, but if it's not there, you still have the opportunity to submit it at a later time. I also want to note that with the applicant, I believe it's their prefiled testimony, there were comments included from, I believe it's Neil Daily and I want to say it's Charles -- I don't know if it's Hugh. I did not that those were attached to the testimony, and I want to make it clear on the record that those are public comments and going to be given the appropriate weight, as they are not going to be given under oath, so we do note that those public comments were included with the prefiled testimony.

Anything else additional, Attorney Monahan?

MR. MONAHAN: The only other administrative question I will raise is in our submission of prefiled testimony, I did reference several docket numbers as seeking -- including the state plan, as well as seeking administrative notice. If they are referenced through the hearing, as opposed to submitting the entire statewide health plan or an

entire docket number. Several of them have already been referenced in many of the testimonies, and I was just wondering if, for the formality of the record, if administrative notice could be taken of CON docket numbers that are referenced testimony for throughout the course of the hearing. As opposed to submitting the --

HEARING OFFICER MITCHELL: The actual documents? So I will say that if they're mentioned in the prefiled testimony, if they're included in the record, you know, they would be something that we could look at in making our decision. So, yes, there would be notice taken of that, but then in addition to the plan, the plan is, as you know, I'm sure you know, Attorney Monahan, the plan of criteria that we look at, so by reference that is also included --

THE COURT REPORTER: You're frozen on my end.

HEARING OFFICER MITCHELL: I'm frozen?

THE COURT REPORTER: Yes. Once in awhile it's freezing. I don't know if it's on my end or what's going on.

HEARING OFFICER MITCHELL: Okay.

Can you still hear me well?

THE COURT REPORTER: I can hear you.

HEARING OFFICER MITCHELL: Just as long as you can hear me well. That's perfect. But let me know you can't hear me.

But the point that I was trying to make is that anything that is included in the record, whether it be a decision was noted in the prefiled testimony or discussed during the hearing, I'm going to take official notice of those. In terms of actually having a list of them, I don't, but once we start discussing those decisions and they're referenced and they're part of the record, then we can go back and take a look at them.

And then also with the statewide Health Care Facilities and Services Plan, it's one of our criteria that we look at, so you don't have to technically include the plan in there, but I do understand why you're making the statement, so you're covered.

MR. McKENNAN: Attorney Mitchell, I have a point of clarification. This is Matt McKennan, attorney for the applicants. It was my understanding that the administrative notice that the intervenor sought was to particular decisions and not the entirety

of the docket but the particular -- but the decisions themselves.

HEARING OFFICER MITCHELL: Right.

MR. McKENNAN: So I wanted to make sure that was clear for the record.

HEARING OFFICER MITCHELL: Attorney Monahan, you just mean the decisions that are referenced in those docket numbers; correct?

MR. MONAHAN: Yes. I have no intention of rehashing the decisions that were made in those documents.

HEARING OFFICER MITCHELL: And I do apologize if I mischaracterized your request.

MR. MONAHAN: No problem.

MR. McKENNAN: So, just to be clear, the decisions would be entered into the record but not the entirety of the docket that pertains to those decisions.

HEARING OFFICER MITCHELL: Right.

MR. McKENNAN: Thank you.

HEARING OFFICER MITCHELL: You're welcome.

Anymore that you wanted to mention, Attorney Monahan?

MR. MONAHAN: Not at this time.

Thank you.

HEARING OFFICER MITCHELL: And then anything else from applicant's counsel, whether that be Attorney McKenna or Attorney Ashmeade?

MR. ASHMEADE: Nothing at this time.

HEARING OFFICER MITCHELL: So here's how we're going to proceed. The applicants are going to present their direct testimony, then the intervenor will present their direct. We will have cross for both sides, and HSP will ask questions of the applicant. I don't know how long that's going to go. We'll see if we can manage the time. But from 3 to 4 this afternoon, that period of time is for signup for people from the public that want to give public comment. So from 3 to 4 the plan is to be off the record, and then to come back at 4 for public comment.

I'm going to reserve the right to allow public officials and members of the public to testify outside of the order of the agenda, if necessary. I do want to thank both Attorneys McKennan, Ashmeade, and also Attorney Monahan for getting all the the testimony that you had from the public officials that might not have been able to make it, you know, prior to the hearing. I appreciate that.

I heard someone say something. Was

someone going to say something?

THE COURT REPORTER: Yes. It froze again. I don't know what's going on.

HEARING OFFICER MITCHELL: If it freezes, it's okay, as long as you can hear me.

THE COURT REPORTER: Yes, and I don't. Everybody freezes when it freezes on me.

HEARING OFFICER MITCHELL: Can you hear me now?

THE COURT REPORTER: I can.

HEARING OFFICER MITCHELL: I would like to, at this time, advise the applicants that we may ask questions related to your application that you feel that you may have already addressed. We will do this for the purpose of ensuring that the public has knowledge about your proposal and for the purpose of clarity. I want to reassure you that we read your application, we've read your completeness responses, and we've read your prefiled testimony.

At this hearing, because it's being held virtually, we ask that all participants, to the extent possible, enable the use of video cameras when testifying or commenting during the proceeding. Anyone who is not testifying or commenting shall mute their electronic devices, including telephones, you know,

other devices not being used specifically to access the hearing. We're just going to ask that you turn the volume down on those.

We are going to monitor participants during the hearing and, to the extent possible, counsel for the parties should raise hands to make an objection, and the hearing officer will address you. If the hand raised function, if you use that, I understand it looks like you all don't have access to the hand raise function, so we won't do that, so just let me know if you're going to make an objection. If I don't acknowledge you within maybe 3 to 5 seconds, go ahead and make your objection virtually. Virtually. Go ahead and make your objection verbally.

Participants should mute their devices and disable their cameras when we go off the record because we're going to continuously record these proceedings. We don't want to make an error and not record something that needs to be recorded. So if you need to confer with your witnesses, then just make sure you mute your device, and you can disable your camera if you so choose.

I will provide, as I did this morning, a warning within like three to five minutes prior to going back on the record once we've gone off

the record. Public comment is going to be taken in the order established by OHS, and that's by registration in that 3 to 4 p.m. period. I will call each individual by name when it's his or her time to speak. We'll do another announcement about how public comment is supposed to proceed when we start that at 4 o'clock.

At this time I'm going to ask all of the individuals who are going to testify on behalf of the applicant and the intervenor to raise their hands and be identified by their attorneys so that I can swear you in.

MR. McKENNAN: Attorney Mitchell, are you asking that we go around the room --

HEARING OFFICER MITCHELL: And state your names.

MR. McKENNAN: And state our names.

HEARING OFFICER MITCHELL: Yeah, that's perfect.

MS. KELLY: Diane Kelly.

HEARING OFFICER MITCHELL: Miss Kelly, can you spell your full name for the court reporter?

MS. KELLY: D-i-a-n-e, K-e-l-l-y.

DR. HOWES: Dr. Christopher Howes; C-h-r-i-s-t-o-p-h-e-r, H-o-w-e-s.

DR. VELAZQUEZ: Dr. Eric Velazquez; E-r-i-c, V-e-l-a-z-q-u-e-z.

MS. LoRUSSO: Francine LoRusso; F-r-a-n-c-i-n-e, L-o-R-u-s-s-o.

MR. ROTH: Norman Roth; N-o-r-m-a-n, R-o-t-h.

HEARING OFFICER MITCHELL: That's it for the applicant; correct?

MR. McKENNAN: That's all the folks testifying for the applicant.

HEARING OFFICER MITCHELL: I'll move over to Stamford Health.

MR. MONAHAN: I'll now turn to the witnesses who will be testifying.

MR. BAILEY: Jonathan Bailey; J-o-n-a-t-h-a-n, B-a-i-l-e-y.

DR. MARTIN: Dr. Scott Martin; S-c-o-t-t, M-a-r-t-i-n.

HEARING OFFICER MITCHELL: I'm going to ask everyone that announced your names that will be testifying make sure you raise your right hand for me so I can swear you in.

D I A N E K E L L Y,

E R I C V E L A Z Q U E Z,

F R A N C I N E L o R U S S O,

N O R M A N R O T H,
J O N A T H A N B A I L E Y,
S C O T T M A R T I N,
called as witnesses, being first duly sworn (remotely) by the Hearing Officer, were examined and testified on their oaths as follows:

(All witnesses answered in the affirmative.)

HEARING OFFICER MITCHELL: So at this moment we are going to go forward with the testimony. I will start with the applicant. To make sure, when you're testifying, if you use any acronyms, that you clarify it for the purpose of the record and we shall begin.

THE COURT REPORTER: Can I ask just one question? It's the court reporter. What are the names of the attorneys in the box where it's TOPAOIJY?

MR. McKENNAN: Attorney for the applicants, Matt McKennan. M-a-t-t, M-c-K-e-n-n-a-n.

MR. ASHMEADE: And John Ashmeade, A-s-h-m-e-a-d-e.

THE COURT REPORTER: And maybe when you first speak, just say who you are because I can't see you in the big table -- the conference table with

your masks on and all.

MR. McKENNAN: Understood.

MR. MONAHAN: For the intervenor --

THE COURT REPORTER: Just so I get the right person who is speaking.

HEARING OFFICER MITCHELL: Right. I just want to make sure, for the purposes of your question, did you also need the name of the intervenor's counsel as well?

THE COURT REPORTER: Is that --

HEARING OFFICER MITCHELL: Patrick Monahan?

THE COURT REPORTER: Patrick Monahan, I have that.

HEARING OFFICER MITCHELL: You have him, okay. Are you all set?

THE COURT REPORTER: I am all set. Thank you.

HEARING OFFICER MITCHELL: You're welcome.

MR. KELLY: Good morning. For the purposes of social distancing, the speaker will remove their masks so you can hear us clearly, but the remainder of the people in the room will remain socially distant and will keep their mask on.

So, with that, my name is Diane Kelly. Good morning and thank you. I'm the president of Greenwich Hospital. I adopt my prefiled testimony.

It's my pleasure to be here to speak in favor of the Certificate of Need Application to establish elective percutaneous coronary intervention services at Greenwich Hospital. The 206-bed hospital cares for patients in regions of Westchester County, New York and Fairfield County, Connecticut.

It should be noted we played a significant role in caring for our New York neighbors during the height of the Covid pandemic. It is also worth noting how Connecticut hospitals, including both Greenwich Hospital and Stamford Hospital, worked together collectively and collaboratively to ensure the community's safety.

You will hear testimony this morning supporting in the following areas; the importance of patient choice will be noted. The patients at Greenwich Hospital have ranked their experiences consistently in the top 5 percent using both national and government measures. You will hear high quality comprehensive care. This proposal should enable physicians to perform both the angiogram and elective PCI in the same local community where the

patient originally sought care. Familiar cardiac specialists could manage and monitor patients prior to, during, and after the procedure, improving the continuity of patient care.

Another important factor is the cost of healthcare needs to be affordable for both systems and for the patient. There will be no additional costs incurred by the hospital or the system in implementing an elective PCI program here at Greenwich. The patients will personally avoid unnecessary costs associated with travel, including ambulance transfers.

In conclusion, we are committed to delivering patient-centered care by adding elective PCI to the advanced cardiac services already provided by Greenwich Hospital. It will further enhance cardiac care services to the patients in the communities we serve. I want to thank you for your time and attention. I encourage you to approve this CON application, and with that I would like to now turn this over to Dr. Eric Velazquez --

THE COURT REPORTER: Hold on a second. Hold on. She's reading really fast, but you froze again. So I got "The patients in the communities" --

MS. KELLY: At that point I just

wanted to thank the commission for the time and attention to this important matter and I wanted to turn it over to Dr. Eric Velazquez, our chief of cardiovasculare surgery at Yale School of Medicine.

HEARING OFFICER MITCHELL: Let me just interject really quickly. I just want to make sure that the court reporter is able to get all the information that she needs to properly transcribe.

THE COURT REPORTER: Exactly.

HEARING OFFICER MITCHELL: Let us know how we can help you.

THE COURT REPORTER: It keeps freezing and also she's reading really fast.

MR. McKENNAN: Attorney Mitchell, this is Attorney McKennan. If we could have a few more minutes beyond the 15 allocated in the agenda, I think that would be helpful with the court reporter understanding the testimony.

HEARING OFFICER MITCHELL: We talked about this in a prehearing conference, and you guys are going to have the time that you need. We usually just establish 15 minutes as the initial parameter, but you guys can slow down. Don't worry, we're going to make sure we get everything on the record. Just take your time and then, Debbie, just let me know if there's

anything that you need in terms of, you know, making sure you have everything complete.

THE COURT REPORTER: I don't usually have a problem with freezing. I do this all the time here. I don't know if it's something happened with the weather or what, but I keep freezing. And also I'm not familiar with what you guys are all talking and that's why when you're reading really fast, it's kind of like --

HEARING OFFICER MITCHELL: Difficult to keep up with.

THE COURT REPORTER: Yes. I have no idea what you're talking about.

MR. McKENNAN: Thank you, Attorney Mitchell.

HEARING OFFICER MITCHELL: Oh, you're welcome. So everybody just take your time, and we're going to speak slow and make sure the record is clear.

THE COURT REPORTER: So the last point we were at with her was "services already provided by Greenwich Hospital."

HEARING OFFICER MITCHELL: Would you mind repeating from that part, Miss Kelly?

MS. KELLY: I'm going to start with

"cost healthcare needs to be affordable." Will that help you?

THE COURT REPORTER: Yes. Thank you.

MS. KELLY: There will be no additional costs incurred by the hospital or the system in implementing an elective PCI program. Patients will avoid unnecessary costs associated with ambulance transfers and costs associated when travel is required.

In conclusion, we are committed to delivering patient centered care, and we believe adding an elective PCI to the advanced cardiac services already provided by Greenwich Hospital will further enhance cardiac services for the patients and the communities that we serve. Thank you for your time, your attention, and I encourage you to approve the CON application.

I would like to now turn this over to Dr. Eric Velazquez. He's our chief of cardiovascular medicine at Yale School of Medicine.

DR. VELAZQUEZ: Good morning and thank you. My name is Eric Velazquez. I'm the chief of cardiovascular medicine at Yale-New Haven Hospital, physician chief of the Heart & Vascular Center at Yale-New Haven Health, and the (not understandable)

professor of medicine cardiology at the Yale School of Medicine. I'm also a practicing cardiologist. I adopt my prefiled testimony.

My testimony regards the following two areas; one, research and clinical practice guidelines which offer clinical evidence in support of this proposal and, two, Yale-New Haven Health Heart & Vascular Center expertise and support of the proposed program.

The research on elective angioplasty without outside cardiac surgery led to a significant change to the 2011 American College of Cardiology, American Heart Association, Society of Coronary Angiography, and interventional combined clinical practice guidelines for angioplasty.

Specifically, the modification of elective angioplasty without onsite cardiac surgery from a class 3, which was not recommended, to a class 2B, which is recommended, and the benefit equal or greater than the risk recommendation.

In March of 2012 the American Heart Association issued a policy statement on PCI without surgical backup. They defined two major reasons for providing PCI without onsite surgery. No. 1, PCI without onsite surgery is a reasonable consideration

for providing local care to patients and families who do not want to travel significant distances or who have certain prefer local physicians. The policy statement emphasized that such centers should have mechanisms in place to ensure high quality care. There's a growing body of research which demonstrates that patient outcomes are essentially the same in hospitals with or without onsite cardiac surgery. Several changes in technology have improved the efficacy and reduced procedural complications of PCI procedures.

In 2014, the American College of Cardiology, American Heart Association, and the Society of Coronary Angiography Interventions combined expert consensus document updates, noted that when patients are appropriately selected, most public studies regarding the risks of elective PCI at facilities without onsite cardiac surgical backup have shown the procedure to be relatively safe.

The Society for Angiography Intervention proposed criteria to ensure patient safety focused on patient characteristics and lesion characteristics. Those meeting the criteria for high risk should not undergo elective PCI at a facility without onsite surgery. Greenwich Hospital will adhere to a rigorous clinical programatic requirement and

strict angiographic criteria, with protocols to identify in high risk patients and lesions prior to performance of an elected PCI procedure, and these cases would be referred to a center with onsite surgical backup.

The Heart & Vascular Center of Yale-New Haven Health is uniquely positioned in Connecticut to support the careful expansion of elected PCI without onsite cardiac surgery. The Heart and Vascular Center's medical staff encompasses physician experts in the areas of cardiology and surgery, including specialists in interventional cardiology, electrophysiology, cardiac surgery, transplant surgery, and vascular surgery. Our highly skilled board certified interventional cardiologists collectively perform thousands of procedures each year.

In 2019 alone, our Heart and Vascular Center interventional cardiology team, including 23 Yale faculty, performed over 480 primary PCIs for acute MI at over 2,000 nonprimary or elective PCI. Our faculty also performed procedures at Yale-New Haven Hospital, which is among the busiest cardiac cath labs in the state performing in excess of 1,400 angioplasty procedures in 2019.

The current proposal of elective PCI

program at Greenwich Hospital will operate according to the same policies, procedures, and protocols using the same faculty as our programs at Yale-New Haven Hospital. This consistency of care is very important for both physicians and patients alike and results in an optimal experience. The high caliber and experience of the clinical staff assigned to the program has been a major factor in the Greenwich Hospital primary angioplasty or MI program and its very excellent clinical results.

The Heart & Vascular Center and these faculty have demonstrated successful support of an elective PCI program without onsite surgical backup at one of our other affiliated hospitals in the Yale-New Haven Health system, Lawrence & Memorial Hospital. This program has been operational for over eight years producing outstanding results for patients. The Lawrence & Memorial program is supported by the same collaborative relationship of Yale-New Haven Health and Yale School of Medicine that we propose for the Greenwich Hospital program. This program has operated successfully and reflects a growing body of literature suggesting no differences in outcomes of patients who receive elective PCI at sites without onsite surgical backup versus those who do.

In conclusion, the proposed elective PCI program of Greenwich Hospital offers the residents of Greenwich Hospital and their service area the opportunity to receive the full continuum of cardiac services in their local community by one of the nation's leading cardiovascular providers. Based on the body of research sited and the demonstrated success of our program at the Lawrence & Memorial Hospital and the support of the Yale-New Haven Cardiovascular Center and Yale faculty, I strongly encourage the OHS support and approve this proposal.

I would like to now turn this over to Dr. Christopher Howes, assistant professor of medicine at Yale University and our chief of cardiology at Greenwich Hospital. Thank you.

HEARING OFFICER MITCHELL: Thank you.

DR. HOWES: Good morning, Attorney Mitchell, and the Office of Health Strategy. You guys can hear me okay?

HEARING OFFICER MITCHELL: We can hear you.

DR. HOWES: My name is Dr. Chris Howes and I'm medical director of the Yale Heart & Vascular Center at Greenwich Hospital, I'm the chief of

cardiology at Greenwich Hospital, and I've been the medical director of the angioplasty program at Greenwich Hospital since its inception in 2005.

At that time in 2005, Greenwich Hospital was the first hospital program in the state of Connecticut to provide emergent angioplasty without surgical backup, and we have been doing so ever since 24 hours a day, 7 days a week, 365 days a year since that time without interruption.

I am a practicing interventional cardiologist who's worked at Yale School of Medicine since 1997. Myself and my Yale interventional cardiology group have been working at --

THE COURT REPORTER: Okay. Hold on. You froze. So I got "cardiology group have been working at."

DR. HOWES: So I'm going to paraphrase.

HEARING OFFICER MITCHEL: Hold on one moment.

MR. CARNEY: Debbie, I would suggest maybe that you turn off your video, and that may help with your audio performance.

THE COURT REPORTER: Okay. That's no problem. Thank you for that.

MR. CARNEY: And then let us know if that helps.

THE COURT REPORTER: I will.

MR. CARNEY: Sorry for the interruption.

THE COURT REPORTER: I'm so sorry about this. It's highly unusual. Okay.

DR. HOWES: Since 2005, myself, along with my Yale cardiology group colleges, have been performing catheterization and emergent angioplasty at Greenwich Hospital and have continued to do so at Yale-New Haven Hospital. I adopt my prefiled testimony.

As part of the HPC, Greenwich Hospital provides extensive inpatient and outpatient services to the community of Greenwich and the surrounding areas. This includes echocardiography, nuclear imaging, stress testing, coronary angiography by C-T imaging, pacemakers, diagnostic catheterizations, and emergency or primary angioplasty.

Greenwich Hospital's primary angioplasty program, the first program in the state of Connecticut to provide PCI without onsite surgical backup, received permanent approval in 2008.

THE COURT REPORTER: It froze again.

Permanent approval in 2008.

DR. HOWES: We have provided highly successful and safe cardiac services since that time.

I'd like to speak briefly about the similarities and differences between primary angioplasty and elective angioplasty. At Greenwich Hospital we've been doing primary angioplasty for the last 15 years. These are patients that come in acutely to the hospital, they have a very characteristic ECG abnormality called an ST elevation MI, and they're having an acute heart attack at that moment. Typically, these are the sickest patients that cardiologists see. We've been taking these patients directly to the cath lab and treating them for the last 15 years, with excellent outcomes and saving people's lives.

Elective angioplasty is essentially the same procedure. A catheter is inserted into the patient's body, an angiogram is performed, blockage is identified, an angioplasty with a balloon is performed to dilate the blood vessels, and then a coronary stent is typically put in.

The difference is elected angioplasty is a slightly different group of patients. There's basically two subgroups that form elective

angioplasty. The one subgroup, which makes up the largest share of patients, patients that have what we call acute coronary syndrome. They have a new syndrome suggesting that they may be having a heart problem, shortness of breath, or chest pain. They come to the hospital, they get evaluated, they don't have the characteristic stemming EKG abnormalities, so they can't make it through our emergency coronary angioplasty protocol, but they're still in the throws of a heart attack or threatening heart attack.

Those patients typically need to have an angiogram and often coronary intervention, PCI, within the first 24 to 48 hours. They are called elective PCI patients, but it's really a misnomer. This isn't elective. This is urgent, life saving procedures that have to be done in a very time sensitive period.

The third group are a little bit more stable patients. These are sometimes outpatients that either have increasing symptoms or abnormal stress tests that warrant further evaluation, and these patients, too, may end up getting an angiogram, may require a PCI, and there would be elective angioplasties as well. Keep going?

HEARING OFFICER MITCHELL: Yes.

DR. HOWES: Lack of elective angioplasties at Greenwich Hospital results in a destruction of care for the patients. Most patients, almost all patients, prefer to be treated locally, close to their home, close to their families, and close to the physicians who know them best and have been caring for them. This has never been more paramount than during the current Covid pandemic. Nobody wants to be going elsewhere.

Currently, those patients in the two groups that I just described, the two coronary syndrome patients and the crescendo outpatients, increasing symptom patients, need to be transferred typically to larger hospitals.

Our experience in Greenwich is many of these patients are transferred or referred to Yale-New Haven Health System, either Yale-New Haven Hospital or Bridgeport Hospital. They choose to remain in the same health system with the same medical record. These hospitals are encountering high occupancy and demand for services, and patients often incur delays for their elective but truly urgent procedures. The delay to New York City hospitals can be even greater.

This community needs to assess the continuity of care, a concept which includes the

ability to seek care, from diagnosis to treatment, close to home from familiar, trusted physicians. Elective PCI in the local area will hope to alleviate the emotional and financial burden imposed on patients and their families who have to leave the service area for treatment.

This proposal would not increase healthcare costs. It offers potential savings to health systems and to families by promoting shorter lengths of stay, reduction of redundant work on transfer to a second institution, and eliminates travel costs for patients and families.

Dr. Velazquez spoke to this, but I want to mention the numerous studies and articles that were presented with this sealant application supporting the safety and quality outcomes preserved from PCIs performed at hospitals without cardiac surgery. Clearly, PCI is a much safer procedure in 2020 than it was in earlier times. Even in 2005, when I was the first physician in the state of Connecticut to perform an angioplasty without surgical backup, we have gotten better as an institution and as a community at what we do. It is now understood that same-day procedures and even PCIs at ambulatory surgical centers, not at hospitals, are being performed routinely throughout the

country.

Over the last 15 years this small primary angioplasty program at Greenwich Hospital has demonstrated high success and safety treating the sickest patients. We participate in national registries and benchmark our outcomes and continue to update our protocols to keep current with the guidelines as they are released.

As Dr. Velazquez alluded to, in the last 15 years studies have indicated that patient selection is a critical factor in outcomes and that volume measures alone may not be the best metrics to measure quality. In 2013 PCI (not understandable) concluded, in the current era, volume outcome relationships are not as robust as in the past when balloon angioplasty without stenting was the only treatment modality.

Greenwich Hospital will follow the protocols to identify high risk patients with high risk lesions prior to the performance of an elective PCI. The majority of patients can have their elective PCI in Greenwich safely and effectively, but the high risk patients will continue to be transferred to larger centers. These protocols have been successfully implemented at Lawrence & Memorial. Their elective PCI

has been performed for the last eight years successfully with outstanding outcomes. Not one patient in the L & M program has required emergent bypass surgery.

In conclusion, this is a demonstrated the need for PCI service in Greenwich, supported by the data showing (not understandable) to Yale-New Haven Health System and to New York Hospitals. Primary angioplasty and elective PCI are essentially the same procedure. The only difference is the acuity of the patients. We're currently taking care of the sickest, most acutely ill patients. In fact, the elective patients are much more stable and statistically lower complications are commonly seen, and many of these patients can go home the same day. Access to high quality, cost effective cardiac services will be enhanced for this approval promoting clinical continuity, patients under care in their local communities. For all these reasons, I strongly encourage you to consider this application.

I turn my remaining time over to Norman Roth, CEO of the Greenwich Hospital.

MR. ROTH: Good morning and thank you, Dr. Howes. My name is Norman Roth, and I am the chief executive officer of Greenwich Hospital and

executive vice president of the Yale-New Haven Health System, and I will be retiring on Friday, October 2nd, so I appreciate the opportunity to present testimony today.

It has been my privilege to be part of the Yale-New Haven Health System for 41 years, the last six of which I've spent at Greenwich Hospital, and it's my pleasure to be here today to speak in support of the Certificate of Need Application to establish elective PCI services at Greenwich Hospital.

Just this month the hospital garnered national attention when Press Ganey awarded the hospital with seven patient experience performance achievement awards, four clinical of excellence awards were received for maintaining top performance of excellence in patient experience over three consecutive years in the following areas; ambulatory surgery, inpatient services, outpatient services, and the Federal Hospital of Consumer Assessment of Health Care Providers and Systems, commonly known as HCAHPS, and three Guardian of Excellence awards were received for reaching the 95th percentile for four consecutive quarters this year in the following patient care categories; patient experience in ambulatory surgery, the emergency department and HCAHPS inpatient services.

It is noteworthy that the time period of these awards included April 1, 2019 through March 31, 2020, and we are especially proud of our staff in achieving national recognition, even as we face the formidable challenges presented by the Covid 19 pandemic.

For the remainder of my testimony, I would like to present three patient stories regarding their care at Greenwich Hospital. The first patient resides in West Harrison, New York, and Greenwich Hospital and Yale Medicine cardiologists are his providers of choice in this region and convenient for him to access cardiovascular care. This patient has undergone two elective PCI procedures on two separate occasions. Both times the patient had an angiogram at Greenwich Hospital and then was determined to require an elective PCI, which could not be offered at Greenwich Hospital, despite the patient's choice to receive cardiovascular care close to home and at this hospital.

In the first instance, the patient was transferred by ambulance to Yale-New Haven Hospital to undergo the procedure, despite the fact that this facility, staff, supplies, and equipment were available to provide the same services at Greenwich Hospital, but at this time we could only utilize those services for

emergency PCI procedures.

In the second instance, the patient went home after the angiogram, and the elective PCI was scheduled at Yale-New Haven Hospital several days later. The patient was subject to unnecessary stress, scheduling, and transportation issues, all of which could have been avoided if elective PCI were offered at the patient's facility of choice. The second patient also chose to receive cardiovascular care at Greenwich Hospital from Yale Medicine physicians as a convenient location with trusted clinicians, yet because the hospital does not offer elective PCI, although it does offer the same procedure in an emergency situation, the patient was required to travel from his home in Rye, New York on to Yale-New Haven for three elective PCI procedures. The patient choice should be a factor in healthcare decisionmaking.

The third patient is a 60-year old male patient who was brought by ambulance to the Greenwich Hospital emergency department after collapsing at a Greenwich Hospital club. CPR was initiated by bystanders and EMS was called. EMS arrived and the patient was asystolic requiring intubation and continued CPR with return of spontaneous circulation. EMS conducted EKG was positive for

myocardial infarction. An MI alert was called into Greenwich Hospital prior to the patient's arrival. The EKG in the emergency department showed ST elevations consistent with a significant heart attack, and the patient was sent for emergent C-T scan of the head, which was negative for bleed, and then the patient proceeded on to the cardiac cath lab. A coronary angiogram revealed 99 percent occlusion of the proximal circumflex of the left anterior descending artery, 90 percent occlusion of the proximal circumflex artery, and 95 percent occlusion of the right coronary artery. Percutaneous coronary intervention was performed on an emergent basis with placement of one drug alluding stent to the left anterior descending artery, which was the culprit lesion which caused the heart attack. By Dr. Christopher Howes.

The patient was placed on a hypothermia protocol in guarded condition pending neurologic recovery. Several days later the patient began opening his eyes spontaneously, was weaned off sedation, and we started the rewarming phase of the hypothermia protocol. Patient continued to show improvement and was alert and following commands appropriately. Patient was weaned and extubated from the ventilator but still had significant issues with

his other coronary arteries which were not stented at the time because they were not the culprit lesion.

Since Greenwich Hospital cannot perform elective angioplasty, we were only able to fix his LAD, which was the lesion that caused this heart attack, but not able to treat the right coronary artery and circumflex arteries. The patient was then transferred from PCI and placement of drug-eluting stents to the right coronary artery and FFR of the circumflex artery. The next day he was discharged to his home in Greenwich, Connecticut.

In conclusion, as discussed by my colleagues earlier this morning, Yale-New Haven Health System already has an extensive record of offering the same elective service within its health system at Lawrence & Memorial Hospital. Approval of this CON application ultimately results in eliminating the need for repeat procedures and hospitalizations, travel, and unnecessary stress for patients and their families and is cost effective for both patients and the state. The need is justified by the requirements and care of patients who choose Greenwich Hospital and Yale Medicine cardiologists. These patient examples and the experience of the Yale-New Haven Health cardiac services fully supports the submitted proposal, and I

strongly encourage OHS to approve this application. Thank you, and that concludes our formal testimony.

HEARING OFFICER MITCHELL: Thank you.

MR. MONAHAN: Can I raise a question? I thought there were five witnesses.

HEARING OFFICER MITCHELL: I thought there was one other person, as well. I just want to confirm with counsel.

MR. McKENNAN: Attorney Mitchell, in the interest of time, we have four people testifying. The fifth is available in the room, if necessary, for questioning. And the fifth would be happy, I believe, to adopt prefiled testimony, if necessary.

HEARING OFFICER MITCHELL: Yeah. So that's the usual procedure, so if she could just make a brief statement indicating that she adopts her prefiled testimony, that would be fine.

MS. LoRUSSO: Hi. Francine LoRusso. Good morning and thank you. As you heard, we were trying to watch our time. My name is Francine LoRusso, and I am the vice president and executive director of the Heart & Vascular Center at Yale-New Haven Health System, and I adopt my prefiled testimony.

HEARING OFFICER MITCHELL: Thank

you. Is there anything else that you wanted to add, counsel for the applicants, before we go to the intervenor? You still have time, if you want to.

MR. McKENNAN: Nothing further from the applicants.

HEARING OFFICER MITCHELL: I'm going to move over to you, Attorney Monahan. Thank you.

MR. MONAHAN: Our first witness is Jonathan Bailey.

MR. BAILEY: Can you see me and can hear me okay?

HEARING OFFICER MITCHELL: Yes, we can hear you.

MR. BAILEY: Good morning. My name is Jonathan Bailey. I'm the senior vice president and chief operating officer here at Stamford Health, and before I get into my remarks, on behalf of Stamford Health I want to express our appreciation and thank you for the opportunity to be here this morning to share our opposition, share some of the core points of why we do oppose the application that is before you, and to have our voice heard relative to these proceedings.

As I get started, I think it's really important to reiterate the fact that Stamford Health is deeply committed to meeting the needs of the

community that we serve. As you saw in my testimony and can read, we are -- Stamford Hospital includes a 305 bed Planetree hospital distinction. We are a major teaching affiliate of Columbia University, and we have a medical staff of more than 700 physicians of which over 50 percent of those physicians are independent providers caring for this community.

Most importantly, I think it's absolutely clear, Greenwich Hospital's proposed program fails to fill a void in community needs. There simply is no void to be filled. Stamford Health well-established program that has been recognized for our quality outcomes, for our incredible patient experience, is merely 7 miles from Greenwich Hospital. That's less than a 17-minute transfer, and we have ample capacity for meeting the needs of the community today and for any additional expansion or demand that may come out. There's also, as the applicant has mentioned in their application, other providers in Westchester as well.

We're also an organization that believes that where professional standards and clinical guidelines exist, they must be followed because they truly set the foundation for superior outcomes, for reducing harm, and what we see clear in this

application is that Greenwich Hospital's proposal does not follow the SCAI, AHA, ACC guidelines, and I truly think it's important that we all be reminded of what is actually included in the 2012 State Facilities and Services Plan and has also been included in the more updated version since then, and if I could actually just take a moment and actually read what is in that plan.

"Connecticut hospitals seeking authorization to initiate an elective PCI program without onsite cardiac surgery capabilities will be required to meet the conditions required in the guidelines and to demonstrate clear public need for the program. The guidelines state that it is only appropriate to consider initiation of a PCI program without onsite cardiac surgical backup if this program will clearly fill a void in the healthcare needs of the community. Further, the guideline notes that competition with another PCI program in the same geographic, particularly an established program with surgical backup, may not be in the best interest of the community."

We also believe that the applicant failed to address the potential adverse impact on providers in the existing area. At Stamford we have

and we continue to invest resources into our program to ensure that we can continue and meet the needs of the community. The only way for Greenwich Hospital to meet their volume threshold would be to capture volume from other providers. And this is particularly concerning to us because, as the applicant notes in their application, there is a national decline on PCI interventions across this country.

Additionally, this is not the first time that Greenwich Hospital has come forth with a seeking approval for providing elective PCI within their hospital. OHS has previously opined on these matters and has reached the conclusion to deny those previous applications. We do not see there to be any compelling reason stated in this application for OHS to reach any other conclusion than it has previously.

We also believe that the comparison that Greenwich Hospital has put forth relative to that of Lawrence & Memorial is both misleading and inappropriate. The CON application by Lawrence & Memorial, which they were awarded, was based on geographic isolation. They are 48 miles away from the closest full service cardiac program. Further, that application also sets forth threshold volumes that would be aligned with the overall guidelines.

Lastly, we believe that the OHS CON program goals are absolutely relevant for the proceedings here ahead of us. Ensuring and providing access to high quality care providers, minimizing the duplication of services, facilitating a stabilized market, and reducing overall healthcare costs deliveries are critically important to maintaining and continuing to have a strong healthcare delivery system in Connecticut, and we believe the application here does not achieve upon those goals, based on what I've just shared.

That concludes my remarks, and I'll be happy to turn it over to Dr. Martin to provide his input.

HEARING OFFICER MITCHELL: Thank you.

MR. MONAHAN: Doctor, just before we start, Attorney Mitchell, just so there's no oversight in the record, was it clear that -- if it isn't clear, I want to make clear that Mr. Bailey adopts his written testimony, and I don't know that that statement was made from the very beginning of his remarks.

HEARING OFFICER MITCHELL: I'm just going to have him step back over and just make that statement.

MR. BAILEY: My apologies, Attorney Mitchell. I did have that written in my notes and failed to do it. As Attorney Monahan said, I do adopt my prewritten testimony as previously submitted.

HEARING OFFICER MITCHELL: Thank you. Thanks, Attorney Monahan, for catching that.

DR. MARTIN: Thank you, Attorney Mitchell, for letting me speak. I would like to adopt my prefiled testimony. I'm Dr. Scott Martin, director of interventional cardiology at Stamford Hospital. I would like to adopt my prefiled testimony and add a few comments.

As a physician, a lot of what we do is guided by judgments and experience, because a lot of times we don't know what the right thing to do is.

MR. McKENNAN: Attorney Mitchell, could we request that Dr. Martin speak up? We're having a little trouble hearing him on our end.

HEARING OFFICER MITCHELL: All right. If you wouldn't mind speaking a little bit louder.

MR. McKENNAN: Thank you.

HEARING OFFICER MITCHELL: You're welcome.

DR. MARTIN: I'm Dr. Scott Martin,

director of interventional cardiology, Stamford Hospital. I'd like to adopt my prefiled testimony and add a few comments.

As a physician, a lot of what I do is guided by judgment and experience because there's not always a consensus on what the right thing to do is, which blood pressure medicine to start, which kind of stress test to order. You can go to get a second opinion and get an entirely different answer. But sometimes we do have a consensus on what the right thing to do is. And when those things are important to public health, our societies issue guidance and expert consensus documents. Guidelines tell us, for example, when to get a mammogram to prevent death from breast cancer, when to get a colonoscopy. In my world, we're told we have guidelines on taking an aspirin when you have a heart attack. They're important enough that institutions and physicians are graded on their adherence guidelines, often payments, and, in this situation, we have a guideline on the matter at hand.

In 2014 all of the societies involved in this field, the American College of Cardiology, which represents all cardiologists, the Society of Coronary Angiography Intervention, which represents interventional cardiologists, and the

American Heart Association, which represents the whole breadth of cardiac care, including patient advocates and researchers, as well as physicians, release the consensus guidelines, consensus document, the expert consensus document that's been cited already, for an update on percutaneous cardiac intervention without onsite surgical backup.

And I know that the applicants are aware of the documents and they selectively quoted from it, and it's very clear and I can read from it. "The operation of laboratories performing less than 200 procedures annually that are not serving isolated or underserved populations we question. Hospitals justify the creation of new PCI centers without onsite surgeries by saying they approve access for geographically underserved populations and allow patients to be cared for in close geographic proximity to their own families and physicians. However, multiple low volume and partial service PCI centers in the geographic area, PCI expertise, increase costs for the health system and have not been shown to improve access. The development of PCI facilities within a 30-minute emergency transfer time to an established facility is, therefore, strongly discouraged."

That was 2014, and there's been a

couple of related documents in 2016 and 2020, but they reaffirm that these standards should be continually met.

HEARING OFFICER MITCHELL: I just want to ask what page were you looking at on the 2014 document, just for the record.

MR. BAILEY: This is from page 2,619.

On the applicant's own volume estimates, they will not meet these guidelines, and that's the reason I'm opposing. That's all. Thank you.

HEARING OFFICER MITCHELL: Anything else? Thank you. Anything else, Attorney Monahan?

MR. MONAHAN: No. We have no other witnesses testifying. And I don't know what your next procedural plan is, Attorney Mitchell, but might we take a break before cross-examination begins, if you're not considering that at this point?

HEARING OFFICER MITCHELL: Actually, I was. I was hoping everybody wanted to take a break, too. So let me ask both Attorneys McKennan and Ashmeade and also you, Attorney Monahan, how long of a break do you want?

MR. McKENNAN: Attorney Mitchell, we

would be fine with 10, 15 minutes.

MR. MONAHAN: That is certainly fine with us and certainly need no more than that.

HEARING OFFICER MITCHELL: So we will come back at -- it looks like it's about 11:37. We'll come back at 11:50. Does that sound okay with everybody? Just make sure you mute your devices, minimally. You can turn off your cameras, if you want to. Thank you. We'll be right back at 11:50.

(Whereupon, a recess was taken from 11:38 a.m. until 11:51 a.m.)

HEARING OFFICER MITCHELL: I'm going to go ahead and turn it over to Attorneys McKennan and Ashmeade for cross of the intervenor's witnesses.

MR. ASHMEADE: Sure. I would like to cross Mr. Bailey.

THE COURT REPORTER: This is the court reporter. Which attorney is doing the cross?

MR. ASHMEADE: For Mr. Bailey, it will be John Ashmeade.

THE COURT REPORTER: Okay. Thank you.

HEARING OFFICER MITCHELL: Everybody ready?

MR. ASHMEADE: Yes.

HEARING OFFICER MITCHELL: You can proceed when you're ready, Attorney Ashmeade.

MR. ASHMEADE: Good morning, Mr. Bailey. This is John Ashmeade. I just want to clarify a few statements from your prefiled testimony. You noted that there are four full service cardiac programs in the geographic region. What are the four that you believe are in the geographic region?

MR. BAILEY: Can you reference which page you're on in my prefiled testimony?

MR. ASHMEADE: Sure. Let me just -- just a moment. I'm sorry about that.

HEARING OFFICER MITCHELL: That's okay.

MR. BAILEY: I think I found where you're talking about. I can answer your question.

MR. ASHMEADE: It is correct that there are only two, it's Stamford Hospital and Westchester Medical Center; correct?

MR. BAILEY: So in the geographic area --

MR. ASHMEADE: There are only two; is that correct?

MR. BAILEY: No, there are four existing cardiac surgical programs with onsite -- or

PCI programs with onsite surgical backup. That would be Bridgeport Hospital, St. Vincent's Hospital, Stamford Health, and Danbury.

MR. ASHMEADE: But they're not in the geographic region that we are talking about today; correct? Bridgeport Hospital and St. Vincent's.

MR. BAILEY: The ones that I've identified are all in Fairfield County in this geographic area.

MR. ASHMEADE: Moving forward, on page 3 of your prefiled testimony, you indicate that Stamford Health, and I quote, "supports the use of evidence-based guidelines in CON proceedings." Correct?

MR. BAILEY: Correct.

MR. ASHMEADE: In connection with that you -- in connection with that, you know, you have relied on the 2012 OHS Service Plan and the 2011 PCI Surgical Backup Policy Guidance published by the ACC and the AHA; correct?

MR. BAILEY: And the consensus guidelines, yes.

MR. ASHMEADE: And back then the primary concern in terms of volumes for facilities performing elective procedures, the concern was they

wanted the physicians there to have as many procedures as possible to protect patient safety; correct?

MR. MONAHAN: I'm going to object to the form. I think if the attorney's referring to a statement in the document that states that premie, I would like the witness to have the opportunity to review it.

HEARING OFFICER MITCHELL: Is that what you're doing, Attorney Ashmeade? I just want to make sure that's correct.

MR. ASHMEADE: Let me -- I'll withdraw the question and restate it.

HEARING OFFICER MITCHELL: Okay.

MR. ASHMEADE: Okay. Let me ask you this. In the 2012 guidelines adopted by OHS, there are certain minimum procedure requirements that are recommended; correct?

MR. BAILEY: Do you mind pointing to me where you are referencing, please?

MR. ASHMEADE: Okay. In the March guideline, this is in your prefiled testimony, the document that you attached. It says, page 2, "Programs should adhere to strict patient selection criteria." Do you see that bullet point? That's the second bullet point on the second half of the page.

MR. BAILEY: Are you talking about within the state facilities plan?

MR. ASHMEADE: Within the -- the attachment to your prefiled testimony.

MR. BAILEY: Sure.

MR. ASHMEADE: Okay. Do you see that second bullet point?

MR. BAILEY: Hold on one second. Let me make sure I have it, so I can read along with you here.

MR. ASHMEADE: Actually, it's the third bullet point. It says, and then I'm just reading the top sentence. "These policy guidelines apply to hospitals conducting both primary PCI and elective PCI. They should have an annual institutional volume of at least 200 to 400 cases." Do you see that?

MR. BAILEY: I do see that. You're referring to AHA, not the guidelines; is that correct?

MR. ASHMEADE: Right. And that's attached to your document as an exhibit to your prefiled testimony; correct?

MR. BAILEY: Yes.

MR. ASHMEADE: And this was a guideline from 2012; correct?

MR. BAILEY: I believe that is

correct.

MR. ASHMEADE: Okay. And your belief is that this -- you know, we should -- OHS should make decisions based on the evidence; correct?

MR. BAILEY: That is correct.

MR. ASHMEADE: And we now have, since 2012, we're now in 2020, we have 8 years of experience to review; is that correct?

MR. BAILEY: There are certainly 8 years between now and 2020, yes, I agree with that.

MR. ASHMEADE: Right. And since that point in time there have been other recommendations that have come forward; correct?

MR. MONAHAN: Object to the form.

MR. ASHMEADE: I'll restate the question.

MR. MONAHAN: Okay.

MR. ASHMEADE: Since 2012, in 2016, and I think this is attached as intervenor S.

MR. MONAHAN: May we have a moment to get that document?

HEARING OFFICER MITCHELL: Yes. Take the time you need. Yes.

MR. BAILEY: We've got the document.

MR. ASHMEADE: Do you have the

document?

MR. BAILEY: Yes, sir.

MR. ASHMEADE: In that document there is -- it states, "In addition, although clinical competence guidelines acknowledge only a moderate correlation between operator percutaneous coronary intervention volume and mortality, for each operator a minimum PCI volume of 50 per year is recommended averaged over two years."

MR. MONAHAN: Objection. Where are you reading from, and are you talking about an operator versus facility? Because the issue here is facility.

HEARING OFFICER MITCHELL: I'm going to allow that. Can you direct us to which page you're on?

MR. ASHMEADE: This is on the second page on the right-hand side of the first full paragraph.

HEARING OFFICER MITCHELL: Okay. Thank you.

MR. BAILEY: Would you mind restating your question?

MR. ASHMEADE: Sure. In the 2016 document in that paragraph -- it states, "In addition, although clinical competence guidelines acknowledge

only a moderate correlation between operator percutaneous coronary intervention volume and mortality for each operator, a minimum PCI volume of 50 is recommended." It's fair to say what this document is suggesting since 2012 is that there has been an improvement in the practice of performing elective PCI procedures; correct?

MR. MONAHAN: Objection.

HEARING OFFICER MITCHELL: What's the objection?

MR. MONAHAN: I have no problem with the witness answering that question about the words, but this is not a doctor. Dr. Martin may be able to address that.

MR. ASHMEADE: But he raised -- I'm sorry. Are you finished?

HEARING OFFICER MITCHELL: Let him finish his objection, and then we'll turn it over to you, Attorney Ashmeade. Go ahead, Attorney Monahan.

MR. MONAHAN: If there's a precise question about what the statement says and the witness is asked whether he understands what the statement says, I have no problem with that, but then to extrapolate and interpret a clinical interpretation from a non-clinician I believe is inappropriate.

HEARING OFFICER MITCHELL: And then Attorney Ashmeade, your response?

MR. ASHMEADE: So this witness has submitted this document in his prefiled statement and referenced it and used it as a basis to form some of the conclusions in his prefiled statement, so I'm simply asking -- I'm simply trying to understand or, you know, raise this issue with him because this is what he's relying on for his statements.

MR. MONAHAN: If I may just add before you rule, Attorney Mitchell, and can I kindly suggest that Attorney Ashmeade read the paragraph, the whole paragraph, that includes the statement before the words "in addition"? Would you read the whole paragraph?

MR. ASHMEADE: I can read the whole paragraph. That's fine.

MR. MONAHAN: Thank you.

MR. ASHMEADE: "Clinical competence guidelines state that in order to maintain proficiency while keeping complications at a low level and minimum volume of greater than 200 PCIs per year be achieved by all institutions. In addition, although the competence guidelines acknowledge only a moderate correlation between operator percutaneous coronary interventions,

volumes, and mortality for each operator, a minimum PCI volume of 50 per year is recommended." So it's fair to say that the guidelines are focusing on maintaining physician proficiency; correct?

MR. BAILEY: I don't agree with you. I believe in reading that paragraph, there are two aspects that are called out specifically in there. There is an operator affect, the physician's position, and there is an institutional, which you read there, the beginning part of that criteria, which still remains at greater than 200 cases per year.

MR. ASHMEADE: Right. But the focus, the reason why you want that is to maintain physician proficiency; correct? It says "clinical competence guidelines state that in order to maintain proficiency."

MR. MONAHAN: I think the witness has answered.

HEARING OFFICER MITCHELL: I didn't get that, so I'm just going to ask. Is that your thought about that, is that it is to maintain physician proficiency?

MR. BAILEY: Let me clarify that I'm not a physician or a clinician. I don't believe it's in my ability to opine on the proficiency and what is

required for clinical proficiency. But I can answer it is when you look at the ability to provide high quality care, it goes well beyond the physician to be able to do such, and it really requires the entire system working together with a high enough volume to be able to satisfy the clinical competencies, and that's why it's important to point out that there's a 200-case threshold for institutions because it does go beyond (not understandable).

HEARING OFFICER MITCHELL: Okay. Additional questions, Attorney Ashmeade?

MR. ASHMEADE: Sure. Just one moment.

Looking at the AHA document that you attached to your statement, the fourth paragraph, it indicates that a good reason -- a second reason for an elective -- let me know if you have it.

MR. BAILEY: I do.

MR. ASHMEADE: The second reason for elective PCI without surgical backup is to provide local care to accommodate patients and families who do not want to travel significant distances or have certain preferences with their local physicians. And so the argument that Greenwich Hospital is making in terms of -- the argument that Greenwich Hospital is

making in terms of a community need or requirement is based on the fact that our local Greenwich community -- their preference is to receive their treatment at Greenwich Hospital; correct?

MR. BAILEY: So I don't know if I can opine on the argument they're making specifically, but I think the important aspect here is on this guideline referenced on this paragraph is moreover that Stamford Health, as I stated in my opening remarks and included in the testimony, we are merely 7 miles away from Greenwich Hospital. That's a 17-minute transfer.

As I noted, as well, we have an open medical staff. So this statement calls out for being able to care for their local providers. We have an open medical staff, and we are happy to accept applications from any of those providers who wish to care for their patients here.

MR. ASHMEADE: The fact of the matter is, as you say, you're 7 miles away, but then the patients continue to come to Greenwich Hospital for their treatment, and we should respect their choices; correct?

MR. BAILEY: I don't believe I can speculate on certain things about what patient choices are or not and what is maybe driving patient choice. I

just come back to the fact of the matter is that we have an organization that meets the census guidelines with a minimum number of cases, and we have an open medical staff. We're satisfied that what is spelled out here within the guidelines, we are clearly able to ensure that such a requirement we'd be able to satisfy.

MR. ASHMEADE: Let's look at the statistics over -- strike that.

If we look at the choices being made by Greenwich Hospital patients, they are coming here and then they're -- they're being referred to Yale-New Haven Hospital and Bridgeport Hospital; is that correct?

MR. MONAHAN: I'm going to object. I object. If that's what you're repeating is in your application and in testimony, that is correct. You have stated that over and over. If you're asking him to acknowledge that, I don't have a problem with the question.

HEARING OFFICER MITCHELL: Was it just for acknowledgement purposes?

MR. ASHMEADE: Just for acknowledgement purposes.

HEARING OFFICER MITCHELL: Okay. Go ahead.

MR. BAILEY: I'm aware that that's what you stated.

MR. ASHMEADE: In terms of your application, your claim is that if Greenwich Hospital is able to perform elective procedures -- strike that.

In the last four years, how many patients have been referred from Greenwich Hospital to Stamford for elective PCIs?

MR. BAILEY: I do not have that information in front of me to be able to address your question. I'm happy to go ahead and follow up on that question. I don't have that data in front of me.

MR. MONAHAN: We can provide a link file on that if that's important to the hearing officer.

HEARING OFFICER MITCHELL: We can make that determination at the end if we need it. Go ahead, Attorney Ashmeade.

MR. ASHMEADE: Sure. It's your -- you've made the contention that if a program is -- becomes available at Greenwich Hospital, it will have a negative impact on the program at Stamford Hospital; correct?

MR. BAILEY: The assertion in my testimony is that any additional applicants who are

awarded the program in this geographical area will have an adverse impact on other local providers.

MR. ASHMEADE: But you don't know the numbers at this point in terms of the potential loss of volume at Stamford Health; correct?

MR. MONAHAN: I'm going to object to the extent that it calls for speculation.

MR. ASHMEADE: It didn't. I said he does not know the numbers.

MR. BAILEY: I do not know the numbers, and to answer your question would require me to speculate on something that I don't know the answer to.

MR. ASHMEADE: You are aware that, at least since 2013, L & M, a facility that we would agree is geographically isolated, has performed at least 670 elective procedures; correct?

MR. BAILEY: I would have to confirm that data. You're stating a number that I would not be familiar with necessarily.

MR. ASHMEADE: Okay.

MR. BAILEY: Do you have information in the file that we can reference?

MR. ASHMEADE: That's in our file documents. Let's assume that, for the moment, that

that number is correct. There's only been two referrals to YNHH during that time period of 2013 to 2019. That sort of information would suggest that the program itself has met all safety requirements; correct?

MR. MONAHAN: I'm going to object to the form of the question, because it delves into the clinical. If the question is asking what the guideline is, because of the preface in the question about L & M being an isolated geographic area, I have no problem with the witness answering whether it meets the guideline or not, based on his non-clinical understanding.

HEARING OFFICER MITCHELL: Any response, Attorney Ashmeade, before I make the ruling on the objection?

MR. ASHMEADE: The witness has testified that he -- in his prefiled testimony that we shouldn't consider L & M -- strike that.

HEARING OFFICER MITCHELL: Okay.

MR. ASHMEADE: The witness has testified in his prefiled testimony that -- let me strike the question all together and move on.

HEARING OFFICER MITCHELL: Okay.

MR. ASHMEADE: In your prefiled

testimony you raise concerns --

MR. McKENNAN: Attorney Mitchell, this is Attorney McKennan.

HEARING OFFICER MITCHELL: Yes.

MR. McKENNAN: While Attorney Ashmeade is identifying the next line of questioning, if I could ask a point of clarification with respect to the cross-examination thus far?

HEARING OFFICER MITCHELL: Yes.

MR. McKENNAN: One point, to be clear, and I thought I heard you answer this way, but, Mr. Bailey, I believe you identified that your testimony does not identify the number of patients that Stamford would lose as a result of Greenwich Hospital adding elected PCI; is that correct?

MR. BAILEY: That is correct.

MR. McKENNAN: And I believe that you said that you did not include that within your prefiled testimony because that would be speculative; is that correct?

MR. BAILEY: Can you please restate your question, and make sure I answer it appropriately and accurately?

MR. McKENNAN: I'm asking whether you stated previously upon cross-examination that you

did not include volume as to patients Stamford may lose as a result of this proposal because that would be speculative.

MR. BAILEY: No, I don't believe that's the way I answered the question. I believe the question answering was I don't have that information right now and to try to guess or speculate on any data that I don't have in front of me would cause speculation on the impact that I was being asked.

MR. McKENNAN: But your testimony does present or argue that our addition of elective PCI would impact Stamford; is that correct?

MR. BAILEY: I believe, to answer your question, adding any additional program in a situation where there's a declining national trend on PCI volume will have adverse impact on any provider in that geographic area. Regardless of the specifics on the volume, there's going to be adverse impact to the community that we serve because of the qualifications or the guidelines.

MR. McKENNAN: Yet you don't identify a precise number of patients Stamford may lose as a result of Greenwich Hospital serving its patients locally who have chosen Greenwich Hospital; is that correct?

MR. MONAHAN: I'm going to object. Asked and answered. This was raised as a point of clarification, and now it's becoming, in a way, going after an answer that apparently is not appreciated by counsel and has been asked and answered several times now.

HEARING OFFICER MITCHELL: Any response, Attorney McKennan, before I make the ruling?

MR. McKENNAN: No, I can move on.

MR. MONAHAN: Just for my benefit, are we dealing with two attorneys examining each of our witnesses?

MR. McKENNAN: Attorney Monahan, I'm asking questions while Attorney Ashmeade is gathering his thoughts to ask further questions. I believe that's entirely appropriate; correct?

MR. MONAHAN: I'm just asking if that's the procedure we're following. And I'm asking that of the hearing officer, not you.

HEARING OFFICER MITCHELL: So I'm going to interject and say that it's okay if Attorney McKennan is going to ask some additional questions of the witnesses.

MR. MONAHAN: Thank you.

HEARING OFFICER MITCHELL: You're

welcome, Attorney Monahan.

MR. McKENNAN: Mr. Bailey, you testified that it would be commonsense, I believe, that our addition of this program, or any other program, for that matter, would impact Stamford Hospital; is that correct?

MR. BAILEY: You used the word commonsense which I'm not sure it's a defined term that I can say this in answer to your question. You're talking about commonsense. What exactly are you defining as commonsense here?

MR. McKENNAN: Let me put it differently. Have you identified any market studies in your testimony to show there would be an impact on Stamford Hospital?

MR. MONAHAN: Asked and answered, but you can answer.

HEARING OFFICER MITCHELL: I was going to say I'm actually going to allow that. Can you repeat what your response was?

MR. BAILEY: I'd be happy to, Attorney Mitchell. So, no, in my testimony I do not include any market studies on impact to Stamford Hospital on the addition of this program.

MR. McKENNAN: Has Stamford Hospital

prepared any financial analysis to determine what the impact on its service would be if this service were offered at Greenwich?

MR. BAILEY: No, we have not prepared any financial statements related to this.

MR. McKENNAN: So it's accurate to say that there's no evidence in the record as to the role you -- or the financial impact on Stamford as a result of this proposal?

MR. BAILEY: I can state that the information that I submitted and can testify against and confirm that there is no specific volume impact included in my testimony related to Stamford Hospital.

MR. McKENNAN: Just to be clear, the question was there's nothing in the record to show either a volume or financial impact on Stamford Hospital; is that correct?

MR. MONAHAN: Wait a second.

HEARING OFFICER MITCHELL: Go ahead, Attorney Monahan.

MR. MONAHAN: I'm going to object to the form of the question, because the testimony -- the question involves more than just -- it could involve a broader definition of the financial impact on Stamford Hospital because the prefiled testimony talks about a

dilution of quality in relation to numerous below 200 PCI elective facilities being implemented in an area where there is a program like Stamford Hospital that satisfies the national guidelines. Now, how that bears out financially, I think there is a financial impact, but the way the question is being framed and the way the witness has candidly answered, there's been no dollars and cents, but there is indeed a potential financial impact. So we're spilling into interpretation --

MR. McKENNAN: Attorney Mitchell, I'm going to have to object. Attorney Monahan is testifying. I'm asking about what's in the record. And my point being, with Mr. Bailey, is that there's nothing in the record that indicates a number of patients lost or a financial impact, and I want clarification on that point.

HEARING OFFICER MITCHELL: I'm going to allow it, and then I just want a simple yes or no on that.

MR. BAILEY: To my knowledge, there is nothing that we have included in our testimony that would specify specifically.

HEARING OFFICER MITCHELL: At this point, can we move on from that point?

MR. McKENNAN: Just to clarify at that point, Mr. Bailey mentioned specific numbers as to numbers of patients and financial numbers; correct?

MR. BAILEY: That is correct.

HEARING OFFICER MITCHELL: I think that's clear. Can you move on to the next point?

MR. McKENNAN: Thank you. Mr. Bailey, you mentioned that national trends show declining PCI volumes; correct?

MR. BAILEY: Correct.

MR. McKENNAN: Are you aware of state trends in PCI volume?

MR. BAILEY: I am aware that there are state trends that would be -- I believe it was submitted in the application by Greenwich Hospital, the reference specifically to the national trend.

MR. McKENNAN: So you are aware of state trends; correct?

MR. BAILEY: I'm aware that there are state trends related to volumes and PCIs in the state.

MR. McKENNAN: Does your testimony cite state trends?

MR. BAILEY: My testimony does not cite state trends.

MR. McKENNAN: Would it be accurate to say that the trend in the state of Connecticut from fiscal year '18 to '19 shows an increase in PCI volume?

MR. BAILEY: Sorry, I cannot answer your question. I do not have that data in front of me.

MR. McKENNAN: But you are generally aware of state trends related to PCI volume?

MR. BAILEY: If I can clarify my answer to your question. I'm aware that there would be state trends because the data is available. I do not have the data in front of me.

MR. McKENNAN: You understand that this application is for approval by the State of Connecticut summarizing, in part, state trends.

MR. MONAHAN: I'm going to object to the -- I think it mischaracterizes the application.

HEARING OFFICER MITCHELL: Any response for that, Attorney McKennan?

MR. McKENNAN: I think the Office of Health Care access in the Health System Planning Unit is required to look at clear public need within a community, that community being the state of Connecticut, as well as the surrounding service area of Greenwich Hospital, and the intervenor is testifying that he's aware of state trends but is not testifying

as to where that trend is going, and it's difficult for me to understand how the intervenor can make the claim as to declining volume when the trends show the opposite.

HEARING OFFICER MITCHELL: I don't want you guys to go back and forth over that specific question. Let me just ask, Attorney McKennan, if you can restate the question.

MR. McKENNAN: We've established that you're generally aware of state trends related to PCI; correct?

MR. BAILEY: I'd like to clarify I'm aware there would be data available to understand state trends. I'm not aware and do not have the data in front of me to be able to speak to what those trends would be in the state of Connecticut or any state.

MR. McKENNAN: So prior to filing your testimony claiming there is a decline in volume, you did not review the statewide trends; is that correct?

MR. BAILEY: That is correct.

MR. McKENNAN: Would you also agree that state and local trends are more important or precise than national trends?

MR. BAILEY: Unfortunately, as a

non-clinician, that would really require me to speculate about clinical trends and clinical bases that I'm not well informed to be able to answer your question.

MR. McKENNAN: So I have to ask the question again, because I don't believe it's a clinical question, it's a market volume question, which your testimony speaks to. It should be a fairly straightforward answer.

Local and state trends are more precise than national trends; is that correct?

MR. MONAHAN: I'm going to object on two grounds. One is I don't think it's appropriate to admonish the witness about what you believe his answer and whether he should be straightforward or not. He's trying his best to explain an answer.

Second, when the application and the prefiled testimony of the applicants refers to national guidelines that contain data about a national decline in PCI volume, I think we're going now in a direction where you're trying to separate a state from a national guideline that has been utilized by the applicants themselves. The witness has answered that he's not aware of Connecticut trends. I don't know how much clearer he can be.

HEARING OFFICER MITCHELL: I'm going to sustain the objection.

MR. McKENNAN: Attorney Mitchell, that's not precisely my question. My question for the witness is whether local and state trends are more precise and accurate than national trends.

HEARING OFFICER MITCHELL: I'm going to ask, do you know the answer to that question?

MR. BAILEY: In this situation I do not know whether that would be applicable to be more precise or not. I don't feel comfortable enough to answer that question.

MR. McKENNAN: Attorney Mitchell, we have nothing further at this point with Mr. Bailey. We do have a few questions for Dr. Martin.

HEARING OFFICER MITCHELL: Okay. Perfect. Thank you, Mr. Bailey.

MR. BAILEY: Thank you.

MR. McKENNAN: Good morning, Dr. Martin. Attorney McKennan for the applicants. Thanks for joining us.

DR. MARTIN: Good morning.

MR. McKENNAN: You're an interventional cardiologist; is that correct?

DR. MARTIN: Correct.

MR. McKENNAN: You joined Stamford Hospital in 2015; is that right?

DR. MARTIN: Correct. Yes.

MR. McKENNAN: And you're an employee of Stamford Medical Group; is that right?

DR. MARTIN: Yes.

MR. McKENNAN: Could you tell me how many interventional cardiologists are employed by your medical group?

DR. MARTIN: There are two interventional cardiologists employed by our medical group, and there are two other interventional cardiologists on staff here who are not employed.

MR. McKENNAN: And you were not at Stamford Hospital when Greenwich Hospital filed its original CON application for elective PCI in 2012; is that right?

DR. MARTIN: Correct.

MR. McKENNAN: Since your time in Stamford your testimony highlights various improvements in technology, including the cath lab at Stamford; is that right?

DR. MARTIN: Yes.

MR. McKENNAN: You would agree that one of the reasons for making the improvements is to

improve safety and quality of patient care; is that right?

DR. MARTIN: Sure.

MR. McKENNAN: And you, personally, perform both primary PCI and elective PCI at Stamford Hospital?

DR. MARTIN: Yes.

MR. McKENNAN: Approximately how many procedures do you do a year?

DR. MARTIN: It varies but, on the average, 100 to 150 PCIs a year.

MR. McKENNAN: All of those procedures are performed at Stamford Hospital?

DR. MARTIN: Yes.

MR. McKENNAN: Would you agree that since you joined Stamford in 2015, quality has improved at the hospital over that period of time?

DR. MARTIN: That's a hard thing to measure. In terms of quality for -- PCIs have been reasonably safe. Our quality is measured in terms of emergency surgery and patient survival. Those numbers are varied year to year, so I don't know that I can cite a measurable change in quality over my time here, but I would say it's been really excellent throughout that time.

MR. McKENNAN: So you agree that quality hasn't significantly decreased at Stamford Hospital. That's correct?

DR. MARTIN: Right.

MR. McKENNAN: I'm assuming, but would like to confirm, you noted that all your procedures are done at Stamford Hospital. That would mean that you haven't performed elective PCI at a facility without cardiac backup since your time at Stamford?

DR. MARTIN: That's true.

MR. McKENNAN: So you have no personal experience over the past five years performing this procedure?

DR. MARTIN: Which procedure?

MR. McKENNAN: In a facility without cardiac backup.

DR. MARTIN: Right. It's the same procedure but, no, I've not performed it somewhere without cardiac surgery backup.

MR. McKENNAN: But you do agree that it's the same procedure?

DR. MARTIN: It's a reasonably safe procedure in that it -- routinely when I consent to patients for the procedure and it's elective, I tell

them less than 1 percent risk of some major complications; however, those major complications are things like emergency surgery, stroke, or death. It's all relative in terms of what you mean by same procedure.

MR. McKENNAN: It's the same procedure, you just happened to not have performed it in a facility without cardiac backup in five years; is that correct?

DR. MARTIN: Correct, I have not performed it at a facility without cardiac surgery backup.

MR. McKENNAN: Have you ever performed PCI without backup?

DR. MARTIN: No, all the PCIs in my career have been at centers with cardiac surgery.

MR. McKENNAN: You have no experience providing elective PCI without cardiac backup?

DR. MARTIN: Correct.

MR. McKENNAN: Your testimony sites certain national trends with respect to PCI. Would you agree that PCI at Stamford has declined over the past, say, three years?

DR. MARTIN: I think it's declined

in 2020, probably related to Covid, but prior to that I think there's been some variation year to year, but I wouldn't say it's a trend.

MR. McKENNAN: How many PCIs did you perform in fiscal year '17?

DR. MARTIN: I don't have that in front of me, but I think I have it nearby if you want me to find the numbers.

MR. McKENNAN: If you could provide the numbers showing the number of PCIs you performed in fiscal year '17.

HEARING OFFICER MITCHELL: I'm going to object. I'm not objecting. I'm going to interject. We will decide at the end which documents, if any, we need to make a decision, so we're going to ask you to hold off on making agreements about what should be provided for OHS.

MR. McKENNAN: Dr. Martin, did you happen to review the rebuttal testimony filed by the applicants?

DR. MARTIN: I read it this morning.

MR. McKENNAN: And do you have any reason to dispute that the volume, according to the Patient Census Report of the Connecticut Hospital Association shows a decline in PCI volume at Stamford

Hospital?

MR. MONAHAN: If you could refer the witness to exactly what you're referring to, just so we're clear on the language.

MR. McKENNAN: I'll actually withdraw that question and point the intervenor to page 436 of the Certificate of Need Application.

MR. MONAHAN: Are you talking about the original seal and application?

MR. McKENNAN: I'm referring to specifically to the Bates stamped number applied to the completeness question response.

MR. MONAHAN: If I may have a moment, Attorney Mitchell, I think I can pull that up.

HEARING OFFICER MITCHELL: Yes.

MR. MONAHAN: I'm sorry, Matthew. What page did you say?

MR. McKENNAN: Page 436. Do you have the page?

DR. MARTIN: I have that.

MR. McKENNAN: The table on this page identifies PCI volume, according to the Connecticut Hospital Association's Patient Census Report. Do you have any reason to dispute the accuracy of this table?

DR. MARTIN: Table 2 here?

MR. McKENNAN: Correct.

DR. MARTIN: I do. The numbers for Stamford Hospital, I believe, are inaccurate. Particularly the primary PCI numbers are significantly higher there, and I believe the total PCI volume numbers are also above what I have.

MR. McKENNAN: So the totals are too high, but the primary numbers are too low; is that correct?

DR. MARTIN: Primary PCI volumes are also higher than what I know to be accurate.

MR. MONAHAN: May I take a look at the graph, as well, just to understand what the questions are about?

HEARING OFFICER MITCHELL: Yes.

MR. MONAHAN: Attorney Mitchell, if I may make a comment before the question is presented or attempted to be answered by the witness about the graph that has been referred to.

HEARING OFFICER MITCHELL: Yes.

MR. MONAHAN: This is a graph, it's a Patient Census Report provided by the Connecticut Hospital Association. No. 1, it doesn't distinguish between primary and elective PCI. No. 2, it doesn't

apply in the terms with which it categorizes the various numbers in the columns for fiscal years. Those are important because the Stamford Hospital, Yale-New Haven Hospital, Greenwich Hospital may have internal numbers and definitions different than how the Connecticut Hospital Association methodology comes up with this graph. So to point to whether this is an accurate representation of what is internally accurate here I believe is beyond the scope of this witness's knowledge, unless we had someone who could actually understand what definitions were used to formulate this graph and how they correlate what definitions we use in turn. So, for that reason, I don't think this witness is qualified to comment on the accuracy of that graph.

HEARING OFFICER MITCHELL: Any response, Attorney McKennan?

MR. McKENNAN: Attorney Mitchell, I can restate my question.

HEARING OFFICER MITCHELL: Okay.

MR. McKENNAN: Dr. Martin, at this point in time you're not clear as to the number of PCIs you performed in 2017; is that right?

DR. MARTIN: Me, personally, or the institution?

MR. McKENNAN: The institution.

DR. MARTIN: I don't have an exact number for you.

MR. McKENNAN: You don't have an exact number for '18 or '19 either?

DR. MARTIN: Correct. I can get that. My number will be slightly different than what's in Table 2 here.

MR. McKENNAN: I understand. Do you have a general sense as to whether that number is increasing or decreasing?

DR. MARTIN: I think, as I stated, in 2020, this year, it's certainly decreased. In April and May and March, there were circumstances beyond our control that led to a near elimination of elective PCI.

MR. McKENNAN: Over the course of '17 to '19?

DR. MARTIN: Very little year to year. I would say overall, to me, the trend seemed flat.

MR. McKENNAN: And I believe your testimony states that volumes are declining.

DR. MARTIN: Nationally, volumes are declining. Certainly in local markets you'll see changes from one year to the next. Even in the national trend if you pick one year to another, there

could be a move in the opposite direction. That doesn't align with being a trend.

MR. McKENNAN: You would agree that the local trends are probably more predictive than national trends?

MR. MONAHAN: Objection. Predictive of what?

MR. McKENNAN: I'll withdraw.

Would it be accurate to say that, despite flat volume at Stamford Hospital, quality has increased?

DR. MARTIN: As I said before, quality is a hard thing to measure, but I would say, as before, it's remained excellent.

MR. McKENNAN: And quality is not always tied to volume; is that correct?

DR. MARTIN: When we look at the guidelines for 2014, they've reviewed all the available data, had a wide range of experts in the field who did correlate that there seems to be a drop-off in quality when less than 200 PCIs were performed at a facility a year and, to my knowledge, there's been no study or accurate consensus since then to say otherwise.

MR. McKENNAN: I saw that in your testimony. If I could refer you to the 2014 SCAI, ACC,

AHA consensus documents.

DR. MARTIN: I have that here.

MR. McKENNAN: A couple of questions related to that document. One, could you confirm for the record that that document was prepared in 2014; thus, it's six years old?

DR. MARTIN: It was published in 2014. I suspect the preparation went back a bit from that, but it was published in 2014.

MR. McKENNAN: So the data that's incorporated within the production is even more aged than the report itself; correct?

DR. MARTIN: Yes.

MR. McKENNAN: And you would acknowledge that that document states that in 2014 45 states allowed elective PCI without onsite surgery; is that correct?

DR. MARTIN: I believe you.

MR. McKENNAN: I can refer you to page 2,611, but if you're agreeing, we can move on.

DR. MARTIN: So agreed.

MR. McKENNAN: The statement also references a variety of studies and analyses, and I'm reading on page 2,612, which states that, "There are no indications of increased mortality or greater need for

CABG from either primary or nonprimary PCI at sites without cardiac surgery." Would you agree with that statement.

DR. MARTIN: I would agree that that's there, but I would also point to page 2,616 where the same document says, this is in paragraph, the first full paragraph, "An institutional volume threshold less than 200 PCIs annually appears to be consistently associated with worse outcomes." To be clear, worse outcomes, and what I do, are people having heart attacks and having cardiac surgery and die.

MR. McKENNAN: But you acknowledge that the bullets of evidence shows that there's really no difference in mortality or need for CABG or primary or nonprimary, regardless of the fact that they don't have onsite backup?

MR. MONAHAN: I'm going to object. The question calls for a condensation into a singular opinion about a very lengthy document that has been quoted in several instances by the -- by both the applicant and by the intervenor. The document does speak for itself, it's in the record, it will be reviewed by the Office of Health Care Strategy, and the doctor has just pointed out what he felt was an important part to answer that question.

MR. McKENNAN: I can move on, Attorney Mitchell.

HEARING OFFICER MITCHELL: Okay, Attorney McKennan. Thank you, Attorney Monahan.

MR. McKENNAN: Dr. Martin, you would agree that when the 2012 guidelines cite the 2011 guidelines, they stipulated new classification with respect to offering PCI without cardiac backup; is that right?

DR. MARTIN: You're just asking if offering a PCI without a cardiac backup was new? Yes.

MR. McKENNAN: And was that a significant change in the clinical practice at the time?

DR. MARTIN: Yes.

MR. McKENNAN: And is it also correct that the 2011 guidelines state that elective PCI might be considered in hospitals without onsite surgery if they have planning for program development, rigorous clinical and angiographic criteria for patient selection?

DR. MARTIN: Yes, and the institutional and procedural guidelines related to volume and other factors.

MR. McKENNAN: And your testimony

sites the 2012 consensus document which refers to the 2012 AHA policy statement on PCI. Are you familiar with that document?

DR. MARTIN: Which one?

MR. McKENNAN: The 2012 AHA policy statement on PCI. Page No. 2,615 of the 2012 statement.

MR. MONAHAN: Again, for clarification, you're referring to the AHA American Stroke Association document?

MR. McKENNAN: 2012 AHA Policy Statement on PCI. The reference is 2,615 of the --

MR. MONAHAN: It's dated March 7, 2012?

MR. McKENNAN: I'm referring to a statement in the 2014.

MR. MONAHAN: I apologize. May we have a moment to get to the right document?

DR. MARTIN: You're saying the 2014?

MR. McKENNAN: The 2014 consensus document, page 2,615.

MR. MONAHAN: In like three different documents?

HEARING OFFICER MITCHELL: Do you need a moment? That's okay.

MR. MONAHAN: Just to understand what document we're getting to.

MR. McKENNAN: If it's helpful, I'm referring the 2014 guidelines attached to Dr. Martin's prefiled testimony.

HEARING OFFICER MITCHELL: Thank you.

MR. MONAHAN: I appreciate the time and patience, and we're ready to proceed.

MR. McKENNAN: And that document provides two major reasons for elective PCI without cardiac backup; correct? I'm asking because it was attached to your testimony. I assumed you'd be familiar with the document.

DR. MARTIN: I'm familiar with the document.

MR. McKENNAN: And one of those reasons is that PCI without onsite surgery is reasonable for providing local care to patients and families who do not want to travel significant distances or who have certain preferred local physicians; is that correct?

DR. MARTIN: That's correct.

MR. McKENNAN: And do you agree with that statement?

DR. MARTIN: I do. I agree that patients should have the choice to stay local, if at all possible, if it can be done safely. For that reason, we're right here. Seven miles away. I could hit a golf ball from my office into Greenwich, and we're happy to allow Yale physicians to come here and perform PCI if they want to do so at a facility meets the gold standard guidelines for volume.

MR. McKENNAN: And just to be clear, that statement identifies two reasons; one being traveling significant distances, but also the importance of patients having the ability to receive care from quote, unquote "certain preferred" local physicians; right?

DR. MARTIN: Correct.

MR. McKENNAN: And you agree with the second part of that statement, that it's important that patients have access to preferred local physicians?

DR. MARTIN: Yes. I think that's part of the value of our having open medical staff, is that any physician can come here and provide care to their patients in need.

MR. McKENNAN: Right, but if a patient chooses a physician who is not on the medical

staff at Stamford Hospital, you would agree that the patient's choice of a preferred local physician is important?

DR. MARTIN: I think patient choice is one factor, but I don't think patient choice should override safety and best practices when it comes to meeting deadlines for care.

MR. McKENNAN: You would agree that care close to home is important? That's right?

DR. MARTIN: I think when possible, yes.

MR. McKENNAN: The 2014 consensus statement on page 2,616 attached to your prefiled testimony cites the 2013 guidelines. Those guidelines conclude, and this was in 2013, the current -- "In the current era, volume outcome relationships are not as robust in the past." Would you agree with that statement?

DR. MARTIN: Yes. And I said it previously in the next statement, which is "However, the institution of volume threshold of less than 200 PCIs annually appear to be consistently associated with worse outcomes."

MR. McKENNAN: On page 2,619 of that same consensus document you cited a statement that

speaks to operation of facilities with less than 200 procedures annually that are not serving isolated or underserved populations. Is it correct that that statement does not say these facilities cannot perform these procedures?

DR. MARTIN: I'm not a lawyer, but my understanding it's for this office to decide whether they can be performed here. The document provides guidance, but it doesn't say what you can and cannot do.

MR. McKENNAN: The document simply says that those programs shouldn't be questioned; correct?

DR. MARTIN: I see where it says "questions strongly discouraged."

MR. McKENNAN: And that those programs might need to be closed, but only if there's not satisfactory outlooks; right?

MR. MONAHAN: Objection. Are you asking if those words are in the document?

MR. McKENNAN: I'm asking if Dr. Martin agrees with the statement within the document.

DR. MARTIN: I agree that any laboratory that cannot meet satisfactory outcome should be closed. I think that's reasonable.

MR. McKENNAN: So if a laboratory performs less than 200 but could maintain satisfactory outcomes, that laboratory should remain open.

DR. MARTIN: In the guidelines they recommend that laboratories that can't meet 200 outcomes only be approved -- only be allowed to operate if they meet some other specific need. For example, for access, if they're far from any other facility, then -- in that certain circumstance, then, yes, they'd be allowed to stay open, if they meet all the standards.

MR. McKENNAN: So a low volume provider that meets quality outcomes should remain open?

MR. MONAHAN: Objection. It's the same question, and there was an answer given, and I do not appreciate the fact that the same question was answered when the answer was given. If the doctor wants to repeat the same answer to the same question and Attorney Mitchell wants that, then I have no objection.

HEARING OFFICER MITCHELL: Attorney McKennan, help me understand the distinction between those questions.

MR. McKENNAN: I believe my question

was a yes or no question, and the witness did not answer yes or no.

HEARING OFFICER MITCHELL: Repeat your question with regard to -- repeat one more time.

MR. McKENNAN: Would it be consistent with the guidelines for a low volume program to stay open as long as they meet satisfactory outcomes?

HEARING OFFICER MITCHELL: I'll allow that question.

DR. MARTIN: You want just a yes or no to that?

MR. McKENNAN: Correct.

MR. MONAHAN: If you can.

DR. MARTIN: Yes, the document does specify that patients that are serving underserved populations and don't meet the volume standard can remain open if they meet the satisfactory outcomes.

MR. McKENNAN: Thank you. And you would agree that quality outcomes are more important than volume?

MR. MONAHAN: I'm going to object.

HEARING OFFICER MITCHELL: On what basis, Attorney Monahan?

MR. MONAHAN: I don't understand the

relationship between a quality outcome and the word volume. There's no -- the question is which is more important, and there's no reasonable correlation between those two terms. I don't understand what the question means is what I'm saying.

MR. McKENNAN: Can I just clarify that the testimony of the intervenors, that there's no reasonable correlation between quality and volume; is that accurate?

DR. MARTIN: No.

MR. McKENNAN: So there's no correlation? Just to be clear.

DR. MARTIN: I'm sorry, repeat what I'm answering?

MR. McKENNAN: I believe I heard the intervenor state there was no correlation between quality and volume; is that right?

DR. MARTIN: I didn't say that.

MR. McKENNAN: Attorney Monahan, I believe I heard you say there was no correlation between quality and volume; is that right?

MR. MONAHAN: I stated an objection. You can ask a question to the witness.

MR. McKENNAN: Dr. Martin, do you believe there's a strong correlation between quality

and volume?

DR. MARTIN: I think -- that's a difficult question to answer. I think, for some things, there clearly is a strong correlation. For example, for heart transplant --

MR. McKENNAN: We're talking about elective PCI.

DR. MARTIN: For elective PCI, you have the documents, you know that there's correlation; once you've reached a certain threshold, it doesn't seem to be a strong correlation. Facilities that maintain over 200 PCIs, the relationship between volume and quality seems less strong than it has in the past, but it hasn't been studied well in facilities that don't meet that standard.

MR. McKENNAN: And you would agree that, and we may have covered this, but just to be completely clear, the 2013 guidelines, which were referenced previously, say the volume outcome relationship is not robust?

DR. MARTIN: Again, in a facility where over 200 PCIs are done, it does state that it's known that it's less robust than in the past.

MR. McKENNAN: Is there a particular statement within the guidelines you can point to that

shows the quality, volume, correlation is either more or less robust for low volume facilities, as compared to high volume facilities?

DR. MARTIN: In the 2013 document, it's on page 445, "It's important to note that a study exists suggesting that an institutional volume threshold less than 200 PCIs per year appears to be consistently associated with worse outcomes across the various studies."

MR. McKENNAN: What was the date of the document?

DR. MARTIN: This is from the 2013 guidelines you were asking about.

MR. McKENNAN: Attorney Mitchell, I have a few more lines of questions. I'm wondering whether we could take a brief break and come back. I see the time is now approximately 1:15.

HEARING OFFICER MITCHELL: All right. Any objection to that, Attorney Monahan?

MR. MONAHAN: No objection if a short break is necessary.

HEARING OFFICER MITCHELL: How much time do you want, Attorney McKennan?

MR. McKENNAN: Probably 30 minutes.

HEARING OFFICER MITCHELL: You want

to take an extended break, because we're probably going to be back on well after 4?

MR. McKENNAN: Yes, if the intervenor is agreeable.

MR. MONAHAN: There is not an objection at this moment but, Attorney Mitchell, if I just may ask because of scheduling and there are five witnesses that I guess I have an opportunity, I'm just curious if a half hour extended break is appropriate, as opposed to a 15-minute break or 20-minute break? Not to shortchange anybody, but just we are really looking at a schedule of finishing this this afternoon.

MR. McKENNAN: Attorney Mitchell, we we can do 15 minutes. That's fine.

HEARING OFFICER MITCHELL: So we'll take a 15-minute break and come back at 1:30. All right. I'll see you guys then.

(Whereupon, a recess was taken from 1:15 p.m. until 1:31 p.m.)

HEARING OFFICER MITCHELL: I give the floor to you, Attorney McKennan, to continue your questioning.

MR. McKENNAN: Thank you, Attorney Mitchell.

Dr. Martin, just a few more

questions.

Is Stamford affiliated with an academic institution?

DR. MARTIN: We have agreements with some academic institutions; for one, the teaching facilities for Columbia University Medical School, and we have a partnership also with the Hospital for Special Surgery.

MR. McKENNAN: With respect to the cardiac program, does Columbia provide support and oversight to the cardiology program?

DR. MARTIN: To a limited extent, yes. Columbia does provide oversight to the cardiac surgery program and, to some extent, to the cardiology program.

MR. McKENNAN: Is there an integrated staff between the facilities? Meaning do staff and physicians go back and forth between the facilities?

DR. MARTIN: As far as I know, there is a heart failure specialist from Columbia who works jointly between the two programs. He's not an interventional cardiologist. There are a couple of other physicians from Columbia who have privileges at our hospital but do not routinely perform procedures

here.

MR. McKENNAN: Is it correct that you do not routinely perform privileges at Columbia?

DR. MARTIN: No, not at all. I don't have privileges to work at their hospital.

MR. McKENNAN: The support that you receive from Columbia is an overall benefit to your program; is that correct?

DR. MARTIN: Yes.

MR. McKENNAN: And the integration between Columbia and Stamford is overall contributing to improvement of quality outcomes at the facility; is that right?

DR. MARTIN: Yes. That's why we participate in it. It's the benefit of their physicians.

MR. McKENNAN: Do you share the same medical record as Columbia?

DR. MARTIN: No.

MR. McKENNAN: Would you agree that the closer you are integrated with Columbia in an academic facility, the better your outcomes and quality may be?

MR. MONAHAN: Object to the form of the question.

MR. McKENNAN: I'll withdraw it, Attorney Mitchell.

HEARING OFFICER MITCHELL: Okay.

MR. McKENNAN: Are you aware that Yale-New Haven Health System has a fully integrated cardiac program across all hospitals and health systems?

DR. MARTIN: I'm not sure what you mean by that, but.

MR. McKENNAN: I'll take that as you're not aware of that.

Are you aware that the physicians that perform PCI here at Greenwich Hospital also perform PCI at other health system hospitals in our Yale-New Haven Health system?

DR. MARTIN: Yes.

MR. McKENNAN: Would you agree that Yale-New Haven Health System's relationship with its affiliated hospitals is more integrated than Stamford's relationship with Columbia?

MR. MONAHAN: I'm going to object to the form of the question.

HEARING OFFICER MITCHELL: Attorney McKennan, do you have any response to the objection?

MR. McKENNAN: I'll withdraw.

Are you aware that all Yale-New Haven Health System facilities are on the same Epic medical record?

DR. MARTIN: I was not aware of that, and I have no reason to doubt you.

MR. McKENNAN: Is it a benefit to patients choosing to receive care at a Yale-New Haven Health System facility, that no matter what facility they ultimately receive care from, those patient records are on the same medical record?

MR. MONAHAN: Objection, Attorney Mitchell. It seems to me that we're striking now into the benefits of a system or the benefits or pros and cons of being in a system that have nothing right now to do with the PCI elective program application before us.

HEARING OFFICER MITCHELL: Do you have a response, Mr. McKennan?

MR. McKENNAN: Yale-New Haven is also an applicant on the application, and I believe the intervenor made statements about the growth of health systems within the intervenor's prefiled testimony, and the point of this questioning is to assess the benefits of health systems with respect to quality improvement at the facilities in our state.

HEARING OFFICER MITCHELL: I'm going to sustain that objection.

MR. McKENNAN: A few more questions. Your testimony seems to suggest that White Plains Hospital and New York Presbyterian Lawrence Hospital offer full cardiac programs with onsite backup. You recognize that they do not have onsite backup at those facilities; is that correct?

DR. MARTIN: Yeah. In my testimony, page 4, it says for closer to PCI programs that they do provide full service PCI, but I recognize that they don't have cardiac surgery backup.

MR. McKENNAN: Would it be accurate or would you have any reason to dispute that White Plains opened its program in 2010 and Lawrence opened its program in 2015?

DR. MARTIN: I have no reason to dispute that.

MR. McKENNAN: There's nothing in your testimony that describes when these programs opened offering elective PCI without onsite backup, that there was any impact on Stamford Hospital; correct?

MR. MONAHAN: I didn't understand -- literally I didn't understand the words. I apologize.

I just didn't understand the words.

MR. McKENNAN: I can restate the question.

Does your testimony identify any impact to Stamford Hospital as a result of the opening of White Plains and Lawrence Hospital's program to offer elective PCI?

DR. MARTIN: I think any business type questions I would defer to Jonathan on my end. For what I do day-to-day, no, it has no impact.

MR. McKENNAN: Just to be clear, though, your testimony doesn't cite any statistics that show any impact with White Plains or Lawrence opening their programs; correct?

DR. MARTIN: Other than mentioning that they are local facilities, I don't think my testimony says anything about them.

MR. McKENNAN: Okay. Thank you.

How far would you say White Plains is from Stamford Hospital?

DR. MARTIN: That I don't know offhand.

MR. McKENNAN: Does about 15 miles sound correct? Can we stipulate to 15 miles?

MR. MONAHAN: I'm going to object.

I think there was testimony in the --

HEARING OFFICER MITCHELL: I'll just turn it over to you, Attorney Monahan. Are you willing to stipulate the 15 miles?

MR. MONAHAN: We're talking about the 15 miles between where to where? I'm sorry.

MR. McKENNAN: Between White Plains Hospital and Stamford Hospital.

MR. MONAHAN: I have no basis, candidly, for stipulating whether it's 15 or 14 or 13 or 17. I apologize. I have no objection to any type of late file that has an appropriately based mileage that we can agree on that comes off of the --

MR. McKENNAN: Attorney Mitchell, I can move on. Sorry.

HEARING OFFICER MITCHELL: Okay.

MR. McKENNAN: The question is are you aware of any impact to Stamford Hospital when White Plains Hospital opened it's elective PCI program without cardiac backup in 2010?

DR. MARTIN: I'm not aware of any such thing.

MR. McKENNAN: Is it accurate to say you're also not aware of any impact to Stamford Hospital as a result of Lawrence Hospital opening its

program in 2015?

MR. MONAHAN: I'm going to object. What kind of impact? Are you talking about impact on hospital finances, impact on quality of care, impact on -- I'm not sure I understand the question.

MR. McKENNAN: I can restate.

Are you aware of any impact in terms of lost volume to Stamford Hospital as a result of Lawrence Hospital opening its facility in 2015 to perform elective PCI without cardiac backup?

DR. MARTIN: I don't know the answer to that.

MR. McKENNAN: Are you aware of any financial impact?

DR. MARTIN: I don't feel able to answer that one.

MR. McKENNAN: I believe your testimony states that the only way for Greenwich Hospital to achieve its volume projection is to redirect patient volume from Stamford Hospital, and there would be no public benefit. Is that your testimony?

DR. MARTIN: I believe that was in Jonathan's testimony, but can you point out the part that we're referring to?

MR. McKENNAN: I can withdraw the question and move on.

Are you aware that the CON application does not project any shift in volume from Stamford Hospital to Greenwich Hospital?

DR. MARTIN: I believe that's in the application, yes.

MR. McKENNAN: And I believe I asked this question of Mr. Bailey, but to confirm with Dr. Martin, is it accurate that your testimony does not identify the number of patients that may be impacted and shipped from Stamford to Greenwich as a result of this proposal?

DR. MARTIN: Correct.

MR. McKENNAN: Your testimony also doesn't identify a financial impact either; correct?

DR. MARTIN: Correct.

MR. McKENNAN: Would you agree that there's a certain number of patients in our local geography that choose Greenwich Hospital and Yale for cardiovascular care?

DR. MARTIN: I think clearly there are patients who choose to see multiple different doctors, including Greenwich Hospital and Yale Cardiac Care.

MR. McKENNAN: And the only way for those patients to receive elective PCI from their chosen provider on the same medical record is to travel to Bridgeport or Yale-New Haven; is that correct?

DR. MARTIN: I don't think the patients really care about their medical record, but in the current environment, their doctors don't have privileges here because they haven't asked for them. And then, yes, to stay on the same medical record, if that's important for the patient, they'd have to go to Bridgeport or Yale.

MR. McKENNAN: And there's a benefit to academic affiliations; correct?

MR. MONAHAN: I'm going to object to "a benefit."

MR. McKENNAN: I believe earlier Dr. Martin stated that the affiliation with Columbia was intended to improve quality. You would agree that academic affiliations generally would improve quality of care?

DR. MARTIN: You know, as I mentioned multiple times, the quality for what I do is a difficult thing to measure because bad outcomes are rare but, yeah, the point of being affiliated with a surgery center, academic medical center, is to try to

improve quality.

MR. McKENNAN: Is it accurate to say that patients would benefit from being able to receive elective PCI from their physician of choice at their facility of choice?

DR. MARTIN: I think that's speculative.

HEARING OFFICER MITCHELL: I'm just going to -- at this point I'm going to interject, and the reason why I'm doing this is kind of in the interest of time, but when I'm listening to the line of questioning, it sounds like you're trying to get the intervenor to say some of the things that you said about quality and access and everything in your own application, and I have heard the testimony from your witnesses, I've read the testimony. You're probably not going to get them to admit that the same medical record is beneficial. You know, if there's anything else new or different that maybe you have in terms of questions that might alert us to new information, that would be helpful, but it kind of seems like, at this point, I don't know if the questions that are being asked are that productive in terms of helping us make a decision.

MR. McKENNAN: Attorney Mitchell,

just a few more questions and I can close. I have no issue doing that.

Dr. Martin, would you agree that it's a benefit to patients not to incur transfer costs as a result of receiving care locally?

DR. MARTIN: I would say avoiding any costs is a good thing for patients.

MR. McKENNAN: Okay. And you would also agree that patient choice is an important consideration as to where patients receive healthcare services?

MR. MONAHAN: I'm going to object. We did go over this ground before the break.

MR. McKENNAN: Attorney Monahan, I think it's in the record. We can move on. I agree.

HEARING OFFICER MITCHELL: Thank you both.

MR. McKENNAN: Attorney Mitchell, I believe that closes our cross-examination of the intervenor.

HEARING OFFICER MITCHELL: Okay. So I do thank you for your questions. I thank both of the intervenor's witnesses. I'm going to turn it over to Attorney Monahan for questions for the applicant's witnesses.

MR. MONAHAN: Thank you. I would like to ask questions of Miss Diane Kelly who was, I believe, the first witness.

MS. KELLY: I'm all set. Diane Kelly.

MR. MONAHAN: Hello, Miss Kelly. How are you? I'm Pat Monahan, as you know, and I represent Stamford health. I'm going to ask you a few questions about your testimony and then about the remarks you made here today.

In your -- first of all, I appreciated your comment in your opening and if I'm correct, and correct me if I'm wrong, you stated that you enjoy a good collaboration with Stamford Health, especially during this Covid 19 period that we've all unfortunately been going through.

MS. KELLY: Yes, I did. I was able to establish a very good working collaborative relationship with Jonathan. It was our first time that we worked together. As we all do in healthcare, we have very much a very common purpose, so.

MR. MONAHAN: I appreciate that, and you've taken the next question out of my mouth. The hospitals, in general, try to work together for the benefit of the patient good; correct?

MS. KELLY: Correct.

MR. MONAHAN: In your testimony, you have stated that your two primary areas are Fairfield County in Connecticut and Westchester County in New York; correct?

MS. KELLY: Yes.

MR. MONAHAN: And in both of those locations there already exists elective PCI programs with surgical backup; correct? One in Stamford Hospital and one at Westchester Medical Center; correct?

MS. KELLY: Yes.

MR. MONAHAN: You are aware of one of the critical elements of the office that the legislature has implemented in our CON statute of there being a clear public need before a new medical service would simply be placed in an area if there is no void to fill; correct?

MS. KELLY: I have read that.

MR. MONAHAN: Okay. So right now you do acknowledge that in your locale you have two elective PCI programs that do perform more than 200 PCI cases at their facilities in your service area; correct?

MS. KELLY: Correct.

MR. MONAHAN: In your written testimony you also highlight Greenwich Hospital's commitment to service excellence; correct?

MS. KELLY: Correct.

MR. MONAHAN: As the president of Greenwich Hospital, do you recognize and encourage that that commitment to service excellence involves continuing study and understanding of recommended best practices from authoritative sources in clinical areas, such as the American Heart Association, Society for Cardiovascular Angiography and Interventionalists, and the American College of Cardiology Foundation?

MS. KELLY: I do, especially with the emphasis on continuing. Every year we learn more and we have additional updates, so that is the Hallmark of what we do is continuously looking at the best practices. They're not always the same from one year to the next. We evolve, fortunately, in healthcare.

MR. MONAHAN: I couldn't help on the key word that you said that they're about best practices, because especially in the area of cardiac care, as we heard from, or at least as I heard in testimony, cardiac care, if you're heading toward a better outcome, you're heading toward a better outcome for the patient. If you're heading toward a worse

outcome, that, in many cases, that worse outcome could mean death; correct?

MR. ASHMEADE: Objection.

MS. KELLY: Can you -- I'm not sure what the question was.

MR. ASHMEADE: Objection to the form of the question. I don't know what that --

MS. KELLY: I don't even know what that was.

HEARING OFFICER MITCHELL: I'm going to ask -- do you have any response to the objection on the form of the question, Attorney Monahan?

MR. MONAHAN: I was just asking if the president of Greenwich Hospital recognizes that a worse outcome for a cardiac patient can lead to death.

MR. ASHMEADE: She's not a physician.

MS. KELLY: I'm not going to answer that.

(Unintelligible crosstalk.)

MR. MONAHAN: If you can't answer the question, I'll move on.

HEARING OFFICER MITCHELL: I'll move on. Just for future consideration, if there's anything that you don't know or you feel like you don't have the

expertise about, it's okay to say that.

MS. KELLY: Thank you.

MR. MONAHAN: Also, in your written testimony, you do refer to the program at Lawrence & Memorial Hospital; correct?

MS. KELLY: Yes.

MR. MONAHAN: Is that a yes?

MS. KELLY: Yes.

MR. MONAHAN: And, of course, Lawrence & Memorial Hospital is within the Yale-New Haven Health System?

MS. KELLY: Correct.

MR. MONAHAN: And you recognize, don't you, that the decision to permit Lawrence & Memorial Hospital was granted to allow them to do their elective PCI without surgical backup because of their geographic isolation from the closest hospital, which would be over 40 miles away, with surgical backup; correct?

MR. McKENNAN: Attorney Mitchell, I'm going to object. There are a variety reasons, and the form of the question identifies one reason, and I think the record speaks for itself.

HEARING OFFICER MITCHELL: Attorney Monahan, any response to the objection?

MR. MONAHAN: If I may, I'd like to read the exact reasoning in the discussion for the granting, if I may, to see if that helps the witness understand or refute my question.

HEARING OFFICER MITCHELL: I'll allow it. Hopefully, it's not over a page.

MR. MONAHAN: It's only a couple of sentences. It's one paragraph of three sentences, to be exact. I'm reading from the discussion in the final decision of the Lawrence & Memorial decision, Docket No. 1231768.

MR. McKENNAN: Stop. Attorney Mitchell, I'm going to object. Can you identify the page of the decision?

MR. MONAHAN: Page 12 of 16.

MR. McKENNAN: Is that within the prefiled testimony of Miss Kelly?

MR. MONAHAN: Yes. Well, it is -- Miss Kelly is referring to the Lawrence & Memorial program, and I am referring to the Lawrence & Memorial program, which has been asserted throughout your application, and if -- given what Attorney Mitchell has just said I may do, I'd like to proceed to read the three sentences.

MS. KELLY: Can I ask a clarifying

question, please?

HEARING OFFICER MITCHELL: Hold on one moment. Let's just back up. With regard to the objection, let me just ask, the purpose of the question, Attorney Monahan, is what?

MR. MONAHAN: The purpose of the question is to show that the Lawrence & Memorial situation is very different from the Greenwich PCI application that they keep referring to as a comparable situation. The purpose is to show that the decision in the Lawrence & Memorial decision was abiding by the guidelines where there was an isolated geographic area, and it is spelled out crystal clearly in the discussion of the L & M decision. So for the applicants to throw L & M in almost all the prefiled testimony throughout their application and yet object to my reciting the premise of that decision, to me makes no sense.

HEARING OFFICER MITCHELL: Let me just ask, Attorney McKennan and Attorney Ashmeade, is Miss Kelly, is she the best person to respond to any questions specific to the L & M decision?

MR. ASHMEADE: I don't think she is, and the fact is that you've taken administrative notice of the decision, so I don't know why he needs to read that decision to this witness.

HEARING OFFICER MITCHELL: All right. So let me just ask is there anybody that you have that's a witness that might be able to answer the question about the rationale for the decision and the distinction between that decision and the application that's before OHS?

MR. McKENNAN: Attorney Mitchell, I believe that would be a legal interpretation and not a clinical or operational interpretation, and that should best be left to the agency.

HEARING OFFICER MITCHELL: Let me just ask, throughout the -- because I did note it as well, so throughout the prefiled testimony, there are references to L & M and to their program, and to what extent are those references comparable to the facts in the application with regard to Greenwich? I'm asking, actually, counsel that question.

MR. MONAHAN: If you're asking --

HEARING OFFICER MITCHELL: Not you, Attorney Monahan.

MR. MONAHAN: I apologize. I'm sorry. With your face on the screen looking at me, I thought you were asking me. I'm sorry.

MR. McKENNAN: I think the point being if there are questions about the particular

program and it's relationship to Yale-New Haven, those are appropriate, and we are prepared to answer, but if it's a question as to the legal decisionmaking of the agency, those are outside the scope of the clinicians and operators here. Those are the agency's determination.

HEARING OFFICER MITCHELL: So here is the question I have again for counsel. I just want to make sure that I understand, and I just want to make sure that the record's complete.

There are a number of instances where there is some discussion about L & M's program and how well they've done since the inception of that program, and I think that what I'm hearing from Attorney Monahan is that he is basically saying that the reason why that program was granted to L & M is a little bit different than, you know, what's before us today. I'm asking counsel, you know, to what extent is there any agreement about that, so that we can proceed with the questioning on it.

MR. McKENNAN: I think the record speaks for itself.

MR. MONAHAN: Well -- I'm sorry. I don't want to speak out of turn.

HEARING OFFICER MITCHELL: I'm

actually going to allow it. Attorney Monahan, do you have a response to that?

MR. MONAHAN: I do. It is a clinical question, and if Miss Kelly truly cannot answer that question, then, as president of the Greenwich Hospital, I will ask the clinician, because that guideline is in every single guideline about the geographic isolation exception that applies to L & M. So to say that it's a legal conclusion when it is embodied in the very clinical guidelines cited by applicant, I believe is incorrect, and I can address it with the clinician.

HEARING OFFICER MITCHELL: Let me just ask one other question, just for the sake of just making sure that we keep the -- you know, that we don't, you know, muddy the water, so to speak.

Attorney McKennan and Attorney Ashmeade, are you asserting in any way that this specific application relates to the argument that Greenwich is geographically isolated?

MR. ASHMEADE: We have not made that argument. I think we are focused on L & M's experience to demonstrate low volume institutions can maintain their quality over a period of time, and that's the been the reference and not to the geographic isolation.

HEARING OFFICER MITCHELL: Attorney Monahan, does that assist in any way in terms of the questions that you were asking with regard to the comparison of the facts of that case and the outcome of that case and the facts of this case?

MR. MONAHAN: Yes. I see that as an admission that they -- that there is not a comparison to be made between L & M and this Greenwich application because the granting -- the premise of the L & M was the satisfying of the condition of isolation, geographic isolation, which, by the admission of the applicants here, does not apply to Greenwich. So with that stipulation, I'm prepared to move to the next question.

HEARING OFFICER MITCHELL: I just want to make sure that we have it very clear, attorneys for the applicants, what I asked was, specifically, are you asserting that there is geographic isolation in this specific application? That was the only thing. I wasn't talking about any of the other quality metrics. Is that what you're saying? Because I don't want to put words in your mouth that weren't in the application, so I want to make sure that that's crystal clear.

MR. McKENNAN: We are not asserting

geographic isolation, yet using Lawrence & Memorial Hospital as a primary example of a program that has great quality outcomes over many years without onsite backup proving changes in the evolution of a practice over time within the health system.

HEARING OFFICER MITCHELL: Attorney Monahan, any response to that?

MR. MONAHAN: I'm prepared to move on to my next question.

HEARING OFFICER MITCHELL: Sounds good. Thank you.

MR. MONAHAN: Miss Kelly, in your written testimony beginning at the bottom of page 3 and moving over to page 4, there is discussion of the track record of success offering elective PCIs without onsite cardiac surgery, at least what you're proffering is at L & M, Greenwich Hospital, the Heart Vascular Center, if I'm using that acronym correctly, the leadership developed careful analysis in a "clinical growth plan." Am I correct in referring you to your reference to "clinical growth plan," that encompasses this desire to get Greenwich Hospital to have an elective PCI without surgical backup?

MS. KELLY: I'm just looking. If you can give me one moment, please.

HEARING OFFICER MITCHELL: It seems they're confused about where that's located.

MR. MONAHAN: The top of page 4, the second line.

(Unintelligible crosstalk.)

MS. KELLY: I'm just looking to make sure, because what I prepared in writing today and what was submitted to you, I don't see the reference to clinical growth plan.

MR. MONAHAN: I'm looking at what you prefiled.

MS. KELLY: Yes, that's what I'm looking at.

(Unintelligible crosstalk.)

MS. KELLY: I want to make sure I'm answering to the right document. I'm pretty precise in remembering what I said, and I guess not. On page 2, on page 3?

MR. ASHMEADE: On page 2.

MS. KELLY: Are you looking at yours or mine?

MR. MONAHAN: If it helps you, I can -- it's dated September 30th, it's your prefiled testimony, it's -- there's a sentence that begins on the bottom of page 3 that says, "With this strong

infrastructure in place," and then it carries over to some more words, that include the Clinical Growth Plan that I referred to.

(Unintelligible crosstalk.)

MS. KELLY: I don't have it in front of me, but why don't you ask the question again and I'll use my memory as a reference.

MR. MONAHAN: Sure. I should have thought of that myself. In your testimony you do speak about the excellence and the significance of the Yale-New Haven Heart and Vascular Center, HVC, and you go on, as I read this, to interpret it as part of a strong infrastructure, and after careful analysis coming up with a Clinical Growth Plan that now involves including elective PCI at Greenwich Hospital without surgical backup. Am I correct that that is what you are imparting to the Office of Health Care Strategy as part of the Clinical Growth Plan of HVC?

MS. KELLY: That's correct.

MR. MONAHAN: Now, being aware that we are in Connecticut, which is a CON state, you recognize, don't you, or tell me if you disagree, that the fact that a successful system, like Yale-New Haven Health System, and its growth plans throughout the state, in whatever direction in the state, is not in

any way to compromise the statutory factor requirement of clear public need; correct?

MR. ASHMEADE: Objection. I mean, I think the use of the word "growth plan" is maybe different from financial growth.

MR. MONAHAN: I'll repeat the question and make it simple.

Per your public need, one of the primary requirements in our CON statute, it applies to Greenwich Hospital and it applies to Yale-New Haven Health System, no matter how expansive or excellent your growth plans may be; correct?

MR. ASHMEADE: Again, I don't know what you mean by "growth plans." Is this clinical growth or --

MR. MONAHAN: These are your words in your testimony.

MS. KELLY: May I give you an interpretation of Clinical Growth Plan from how we look at it?

MR. MONAHAN: If you can't answer the question I asked, you can go ahead. I'm willing to entertain what you have to say.

MS. KELLY: Thank you. The Clinical Growth Plan is built on expanding high quality care to

those that we are committed to, and in this particular plan what we are doing is trying to bring excellent providers to the community and being part of a comprehensive system where we have a shared medical record, positions of high quality, and manage through a continuum of care so it's not isolated to heart and vascular care. It's a continuum of care provided to our patients. Growth and enhancing our services, not so much growing in the idea of volume, if you will.

MR. MONAHAN: And with that plan in mind, you, Yale-New Have Health System and your Heart & Vascular Center, you all still are subject to the clear public need and requirement of the Connecticut statutes. You recognize that; don't you?

MS. KELLY: Yes, I do.

MR. MONAHAN: You also recognize that you are subject to the Connecticut statewide Health Care Plan Facilities and Services Plan; correct?

MS. KELLY: Correct.

MR. MONAHAN: And have you read that document as it pertains to cardiac conditions in preparation for this hearing?

MS. KELLY: No, I have not personally read that document.

MR. MONAHAN: In your testimony, and

if you end up getting your testimony, you can let me know that because, otherwise, I'll try to get you to --

MS. KELLY: I'm not sure which you're referring to.

MR. MONAHAN: Okay. I'm looking in your written testimony, near the end of your testimony where you state that, and I'll read the sentence for you, it says, "This service addition," and if the service addition you're talking about is the elective PCI program at issue here, "would benefit all Greenwich Hospital patients, patients of the relatively new Putnam facility mentioned previously, receiving treatment for advanced cardiac conditions that routinely require access to elective PCI could take comfort knowing that the care needed be pursued locally with the same physician in the same coordinated health system." Do you recognize that statement as yours?

MS. KELLY: I don't have it on what I submitted, but I certainly agree and recognize that statement as something that I would say. I think that's fair.

MR. MONAHAN: As you established at the very beginning of this, the -- if a physician were to choose to apply for medical staff privileges at Stamford Hospital -- I see you shaking your head,

but --

MS. KELLY: I'm just trying to listen.

MR. MONAHAN: Okay. If a physician, one of your successful and excellent operators, were to apply for privileges at Stamford Hospital, that elective PCI with surgical backup could be pursued locally by patients who want to choose that particular cardiac physician; isn't that correct?

MS. KELLY: Can you say it one more time? I'm sorry.

MR. MONAHAN: Sure.

MS. KELLY: I apologize.

MR. MONAHAN: A patient will often go to their cardiologist and say doctor, I want you to take care of me. A cardiologist applies for privileges at Stamford Hospital right now, which is 7 miles away from you, to do an elective PCI with surgical backup, isn't it so -- and is granted privileges, and isn't it so that that cardiologist could say to that patient, yes, we could do that locally right here in Stamford, 7 miles away from Greenwich Hospital. Isn't that the case?

MS. KELLY: It is the case, but they would not have the benefit of having all of their

information in one electronic medical record, and I know somebody stated that's not important, but it is important for healthcare professionals and actually for our government to see that it's a priority, so I couldn't answer without adding that.

MR. MONAHAN: Okay. Assuming that we were to, if the hospitals that you say collaborated so well in connection with Covid, could collaborate as well in communicating appropriate medical records with each other for the best interest of a patient, assuming that you are capable of doing that with Stamford Hospital, isn't it the case that you can still provide a patient local service with a PCI elective program with surgical backup at Stamford Hospital?

MS. KELLY: That's correct, but it's a big assumption, and at the end of the day I do believe patients have choice, and I think that matters. So if the patient said no, Doctor, I want to go to Stamford, not Greenwich, we would not object to that. But I do believe it's a choice, and we do have patients that say I prefer to stay here at Greenwich. It does matter, and I think it matters clinically. Patients, how they're perceiving and receiving their care is very important, and we should not minimize it.

MR. MONAHAN: And, believe me, I'm

not a doctor and I'm not diminishing patient choice, and I heard Dr. Martin talk about how patient choice is certainly an important factor, but in the interest of the clinical guidelines that have been quoted over and over, which I'm not going to repeat, and the benefit of having surgical backup, even in that very rare instance where it could mean the difference between life and death, I believe that my question is would a patient normally, who entrusts this serious condition in the cardiac physician of their choice, typically follow the recommendation of that cardiologist?

MR. ASHMEADE: Objection. I mean -- objection.

MS. KELLY: I can't really --

HEARING OFFICER MITCHELL: Hold on one moment, Miss Kelly. What's the objection, Attorney Ashmeade?

MR. ASHMEADE: He's asking a clinical question to a non-clinician. How would she know what a patient would normally do?

HEARING OFFICER MITCHELL: It may be best for you to ask that to another witness, Attorney Monahan.

MR. MONAHAN: Certainly. I'll move on. Yes.

Well, we know, based on your application, Miss Kelly, that you don't send patients to Stamford Hospital, that you -- patients who are in need of an elective PCI, you transport them, very often, to Yale-New Haven Health in New Haven, which is sometimes, depending on traffic, 60 minutes away; correct?

MR. ASHMEADE: Objection. There's no factual predicate for the assumptions in the question. 60 minutes away. You know, he's not established how we transport patients.

HEARING OFFICER MITCHELL: I'm going to sustain that, Attorney Monahan.

MR. MONAHAN: Okay. I'll just, without getting into the minutes and everything, but it's clear that you've made it clear in your application that the patients are transferred within the Yale-New Haven system to either Bridgeport Hospital or to Yale-New Haven Hospital; correct?

MS. KELLY: Correct.

MR. MONAHAN: I have no other questions of Miss Kelly.

HEARING OFFICER MITCHELL: Thanks, Miss Kelly.

MR. MONAHAN: May I question Dr.

Howes?

MR. ASHMEADE: Yes.

MR. MONAHAN: Hello, Dr. Howes. My name is Patrick Monahan, and I'm also going to ask you some questions about your testimony.

MR. ASHMEADE: Before you proceed, it seems like Miss Mitchell's Zoom picture has gone off. Is she still present?

HEARING OFFICER MITCHELL: I'm still here. I just had to stand up for a second.

MR. MONAHAN: One of the points made in your testimony, Doctor, is the, and I'm looking at the page 7 of your testimony, your prefiled testimony, that the lack of elective angioplasty --

DR. HOWES: Maybe your printer and our printer is different. I only have five pages in the prefiled testimony.

MR. MONAHAN: Fair enough. That does happen. I am looking at the -- you have bullet points of 1, 2, and 3?

DR. HOWES: Yes.

MR. MONAHAN: And then after that you have a paragraph, and the next paragraph that starts with "The lack of elective angioplasty at Greenwich Hospital is also" -- do you see that

paragraph?

DR. HOWES: Yes.

MR. MONAHAN: Yes. You say that currently Greenwich Hospital patients must be transferred or referred to other hospitals for elective angioplasty procedures, even though there are, and I'm paraphrasing, cardiologist and catheterization lab staff support on site, and Greenwich Hospital is available 24 hours a day providing needed care.

As I mentioned before in Miss Kelly's testimony in one of my questions, you say many of those patients are transported to Yale-New Haven Hospital or Bridgeport Hospital for their treatment by the same Yale School of Medicine's physicians from whom they would have received the care at Greenwich Hospital; correct? Do you see that?

DR. HOWES: Yeah, I see it.

MR. MONAHAN: Is there anything preventing those physicians who are performing those procedures at Yale-New Haven Hospital or Bridgeport Hospital from applying for privileges at Stamford Hospital where there is, 7 miles away from Stamford, the emergency backup?

DR. HOWES: Yes. I feel very strongly that there is and that's the quality of care

of an HVC system. We are a fully integrated health system. Dr. Velazquez, the chief of Yale School of Medicine, is at Yale overseeing 100 physicians. I speak with him on a daily basis. We communicate every week as the chief of the satellite hospital in his program. The staff at the Yale cath lab works under the exact same protocols that they work at L & M, St. Raphael's, which we haven't discussed, and Greenwich. It's a fully integrated system. To ask me or one of my colleagues to go to do a procedure at Stamford Hospital is, you know, asking someone to drive someone else's car. You know how to drive, but you never drive it as well as you drive the things that you're familiar with. I think to think that we just jump to another hospital and another system and be able to do the same care is fundamentally flawed, and this gets to your point about the guidelines talking about institutional volume and operator volume, and there is nuance between those two things, but our institutional volume is maintained by these connections. Our nursing staff in Greenwich Hospital are Yale-New Haven heart and vascular nurses. They go to Yale-New Haven for routine proficiencies and upgrades on training. It's a very different system than having a loose affiliation with Columbia. It's a completely different program.

MR. MONAHAN: Is it your position that you will refuse to allow your physicians to apply for privileges at Stamford Hospital?

MR. ASHMEADE: Objection.

MR. MONAHAN: That's a fair question, based on that answer.

MR. ASHMEADE: That was not his testimony.

MR. MONAHAN: But it's a question.

In your position, are you saying --

HEARING OFFICER MITCHELL: I'm going to let him answer.

DR. HOWES: Please restate the question.

MR. MONAHAN: Are you stating on the record that you refuse to permit Yale-New Haven Health System cardiologist physicians to apply for privileges at Stamford Hospital to perform elective PSI with surgical backup when they may believe they have the best interest of their local patient involved?

DR. HOWES: No. 1, I don't employ any cardiologists, and I have no control over who works where or who applies where, and I certainly would not restrict anybody, any physician to choose where they want to work or practice.

MR. MONAHAN: In your testimony you state that "No impact is expected on existing provider volumes at other Connecticut hospitals in the Greenwich Hospital service area due to the established referral patterns for those patients." Do you see that sentence?

DR. HOWES: Point it out to me again? Which paragraph?

MR. MONAHAN: It's in the same paragraph we were reading.

DR. HOWES: Repeat the question?

MR. MONAHAN: I'm asking if you see the sentence that says, "No impact is expected on existing provider volumes at other Connecticut hospitals in the Greenwich Hospital service area due to the established referral patterns for these patients." Do you see that sentence?

DR. HOWES: I do.

MR. MONAHAN: Okay. In the Greenwich Hospital service area, Doctor, 7 miles away, Stamford Hospital is in your service area; correct?

DR. HOWES: Correct.

MR. MONAHAN: And a referral pattern is not set in stone; is it? Referral patterns can change; can't they?

DR. HOWES: They can.

MR. MONAHAN: Unless they are restricted or mandated that they can't change. Am I understanding from you that there is no mandate in the Yale-New Haven Health System or the Greenwich Hospital system that prohibits a cardiologist from applying for staff privileges at Stamford Hospital if that physician decides that it is in the best interest of their patients to stay local?

DR. HOWES: I can't speak to other people. I've been working through the Yale system for 23 years, I believe, and no one has told me that I cannot apply to another program, and I've had no interest in applying to another program.

MR. MONAHAN: Okay. So it's a physician by physician choice is what you're telling me?

DR. HOWES: I'm acknowledging I don't know. I don't know everybody's work agreement. I'm not involved on that level.

MR. MONAHAN: Now, later in your testimony you talked about -- you selected a quote from the 2012 ACCF, FCAI expert consensus document and the quote that you inserted was, "When without onsite cardiovascular surgical backup" -- excuse me, I skipped

a sentence. "When patients are appropriately selected, most published studies regarding the risk of elective PCI at facilities without onsite cardiovascular surgical backup has shown the procedure to be relatively safe," closed quote. Am I correct about that?

DR. HOWES: I see that, yes.

MR. MONAHAN: That's only one quote in the whole document; correct?

DR. HOWES: Yes, of course.

MR. MONAHAN: In fact, quotes that you did not include in your testimony on page Bates stamped 450 in your own application that are not -- as I said, not in the testimony, refer to the statement, "It is generally believed that elective and primary PCI are permissible in sites without cardiovascular surgery if there's strict adherence to national guidelines."

And then in the same paragraph it says, "Any national volume guidelines must be strictly followed." Have I correctly read those sentences?

DR. HOWES: I don't know. I don't have that page right in front of me.

MR. MONAHAN: Well, if you don't -- I can represent to you that I did, but if you would like me to point you to it so you can confirm that I am

reading them correctly, I'll read them again.

MR. McKENNAN: Which page in the sealant application?

DR. HOWES: In the document, which section is it? 2-2, 2-3, 2-4?

MR. MONAHAN: To answer, first of all, your attorney's question, it's on 000450 is the Bates stamp, and the section that is in the executive summary under the heading "Cardiac Catheterization at a Facility Without Cardiovascular Surgery." My point is you selected one statement in your testimony, but you didn't include it all; right?

DR. HOWES: Okay. To respond to that, obviously I didn't quote the entire document, which is --

MR. MONAHAN: Thank you.

DR. HOWES: I'd like to add that this is an expert consensus document given as a guideline. It's not a mandatory statement. There is no required protocol mandated from it. This is a guideline. Guideline means to give advice, and to think that any of these documents is the holy word is to overstate the power of these documents.

In fact, in this document's preamble, it says this document -- "Best attempt of the

ACC and document cosponsors to inform and guide clinical practice in areas where rigorous evidence may not yet be available or evidence, to date, is not widely applied to clinical practice." My interpretation of that is they acknowledge it's a living document, and it changes by the time they publish it.

MR. MONAHAN: Doctor, it was authoritative for you to quote it; wasn't it?

DR. HOWES: It's quoted throughout all of this CON application by both sides. We use these guidelines, but my personal perspective is that they never dictate the care that we provide. They help to --

MR. MONAHAN: Fair enough. As I understand it, fine institutions like Yale-New Haven Health System, Greenwich Hospital, and Stamford Hospital all consider peer review guidelines to try to reach best practices, to put all the best thinking together to come up with the best outcomes for their patients; correct?

DR. HOWES: To try to come up with the best practices, absolutely.

MR. MONAHAN: You're not dismissing this as a sort of an article that appears in some less

than authoritative file; are you?

DR. HOWES: Quite the contrary. I think it's a very useful and important document. It is a guideline. It gives advice. It doesn't mandate.

MR. MONAHAN: Okay. Would it be helpful to you to recognize, or do you recognize that the State of Connecticut specifically has demonstrated, in its statewide health plan, that it follows or encourages following these guidelines? Are you aware of that?

DR. HOWES: Do you guys want to answer that legal question?

MR. MONAHAN: Do you know the answer? I'm asking the witness.

HEARING OFFICER MITCHELL: Hold on one moment. It's okay for him to ask his attorney for assistance. I was going to say, in addition to that, if you're unaware of it, it's okay to say, you know, that you haven't read it or you're unaware and that you have to defer to counsel. It's okay. Do you know the answer to it? If you don't know it, just say it.

DR. HOWES: I'm aware of it, and I don't agree with it.

MR. MONAHAN: Okay. So that -- just so I'm clear, the Statewide Health Care Facilities and

Service Plan, which is an integral part of the CON factors to be considered in the expansion of CON service, as you are applying for here, is certainly a critical part of the consideration, and in the cardiac section of the Statewide Health Plan, which you said you are aware of, you disagree with what the authors and the stakeholders put together to form that section of the document. Is that my understanding of your testimony?

DR. HOWES: I know nothing about the process of how that document and those conclusions are come to. I don't agree that the guidelines should be viewed as mandatory or as the absolute word.

MR. MONAHAN: That's not my question. I understand you don't read them as mandatory. My question is you stated to me, unless you misspoke, you disagreed with the Statewide Health Plan. Is that your testimony, or are you saying that it should not be mandated?

MR. ASHMEADE: Before you answer, Attorney Mitchell, I've let this go two or three times, but Attorney Monahan continues to interrupt the witness before he finishes his answer, so I just ask that he allow the witness to respond before he interjects.

HEARING OFFICER MITCHELL: I'm going

to agree. And then, in addition to that, do you understand, not understand because I don't want you to feel like I think that you don't understand, but I just want to make sure do you understand the distinction that he's making in terms of the question?

DR. HOWES: I don't think I do.

HEARING OFFICER MITCHELL: Attorney Monahan, can you just specifically state, when he says -- you're asking him what he disagrees with, and I just want to make sure he understands specifically what you're asking in terms of what he disagrees about.

MR. MONAHAN: Okay. Thank you for that clarification.

I understand you disagree, and if I understood you correctly, Doctor, that you disagree with the Statewide Health Care Facilities and Services Plan as it pertains to PCI. Can you explain to me what you disagree with?

DR. HOWES: No. Your original question said something else about the way they incorporate and interpret the guidelines.

HEARING OFFICER MITCHELL: I want you to just stick with the question that he asks, though. In terms of what you disagree with, help us understand what that is.

MR. ASHMEADE: I think he's just explained it. He's explained that he disagrees with how OHS has incorporated the guidelines. He's testified that the guidelines are -- they give some guidance, but we shouldn't rigidly follow them.

HEARING OFFICER MITCHELL: Is that what you're saying, Doctor? I just want to make sure those are your words.

DR. HOWES: That is what I'm saying, the guidelines.

MR. MONAHAN: Thank you. I have no other questions of Dr. Howes.

HEARING OFFICER MITCHELL: All right. Thank you, Dr. Howes.

MR. MONAHAN: May I have just one moment, Attorney Mitchell?

HEARING OFFICER MITCHELL: Yes.

MR. MONAHAN: I just want to go over something with one of my colleagues.

HEARING OFFICER MITCHELL: Sure. Sure.

MR. MONAHAN: Thank you, Attorney Mitchell.

HEARING OFFICER MITCHELL: You're welcome.

MR. MONAHAN: I would like to call Dr. Velazquez. I would like to ask some questions of Dr. Velazquez.

Hello, Doctor. Doctor, I know there's been a lot of talk and, needless to say, I'm not a doctor, but there's been a lot of talk about the clinical guidelines and the various guidelines that have come into play in this proceeding and how they have evolved over time and, in fact, that's how guidelines do evolve. They evolve over time; correct?

DR. VELAZQUEZ: That is correct.

MR. MONAHAN: And as was brought out by your attorneys, the intervenors have referenced guidelines from 2012 and 2014 and in both rebuttal testimony and in additional exhibits. In fact, there are additional guidelines for these -- one or more of these same organizations in 2016 and 2020; correct?

DR. VELAZQUEZ: I cannot speak to the dates of the updates, but they are updated on a regular schedule by the societies that you referenced, the American College of Cardiology, the American Heart Association, the Society of Coronary Angiography Interventionalists always have an updated schedule that they adhere to to review the status of the evidence as it evolves.

MR. MONAHAN: If we -- you know, we had talked -- there had been talk about the 2014 consensus statement, and I can represent to you that I am now looking at an SCAI Expert Consensus Statement, 2016 Best Practices in the Cardiac Catheterization Laboratory, and it was published in 2016 by Wiley Periodicals. Is that something you're familiar with?

DR. VELAZQUEZ: I'm familiar with it. I do not have it in front of me.

MR. MONAHAN: I'm sorry, did I understand that you have that, or you don't have that?

DR. VELAZQUEZ: I had said that I'm familiar with it and that I did not have it in front of me, but I do have a document that was published in Catheterization and Cardiovascular Intervention in 2016 which represents an endorsement by several cardiac societies, including India, Latina America and Canadian. It's important to highlight that the American Heart Association and the American College of Cardiology did not, obviously, agree to put their names on this because they did not endorse these guidelines, to our understanding. And to be frank, if this is the reference, this is identified as a teaching document on part of the core curriculum series that this group puts out, so it's meant as an educational document for

people in training and/or who want to update training.

I'm ready to answer any questions. I have it in front of me if you want to speak to a component of it.

MR. MONAHAN: Let me understand. The SCAI organization is an organization that you, in the course of your career, have viewed as authoritative. Have you?

DR. VELAZQUEZ: I'm not an interventional cardiologist, so the answer is it's one of multiple societies that are considered components of -- a way for a clinician to gather, and I intend to -- I'm am not someone who belongs to this society personally, but I have no reason to suspect that they would have any intentions. They typically would write things that would be considered authoritative in collaboration with larger organizations like the American College of Cardiology and the American Heart Association.

So, again, each society certainly has a right to put out information. We just wanted to give you a sense of the variability in opinion and in process that these societies utilize, so it's always stronger when they come together.

MR. MONAHAN: Okay. Well, just with

all of that explanation, if we just turn the page to the second page of the document at least, again, moving through the time period of 2012 to 2016, at least in this document, with all the caveats you just gave, on the second column of the first full paragraph, it begins with the lead sentence, and I quote, "Clinical competence guidelines state that in order to maintain proficiency while keeping complications at a low level, a minimum volume of greater than 200 PCIs per year be achieved by all institutions." Did I read that correctly?

DR. VELAZQUEZ: Correctly, yes, and it does --

MR. MONAHAN: Thank you.

DR. VELAZQUEZ: -- highlight an opportunity that I've been wanting to correct. At the Heart & Vascular Center it's an integrated and coordinated system approach that provides, you know, one care signature across of all of Yale-New Haven Health. It is misconstrued to think of Greenwich Hospital which is part of the Heart & Vascular Center as a single institution when, in fact, it works in coordination as part of the same Heart & Vascular Center with Yale-New Haven Hospital, with L & M and Bridgeport.

So our care signature, our staff, our faculty operators are part of that institution, and so that institution, as I shared in my testimony, has volumes that are, you know, far in excess of 200 per year; in fact, in the thousands per year.

So I do want to add that to the record because it is -- I think it's misconstrued to think of the Greenwich Hospital cath lab as operating in isolation from the fully integrated cardiovascular center.

MR. MONAHAN: Well, I appreciate that explanation. Am I to understand from that that you feel that Yale-New Haven Health System, with all of its integration, is somehow immune from the application of the CON factors that talk about primary service areas of individual institutions such as Greenwich Hospital?

DR. VELAZQUEZ: The answer to that is clearly no. I have tremendous respect for the legislature. That's why I'm physically here in the room and willing to take any questions. We're not immune. We are part of the solution for healthcare in Connecticut.

MR. MONAHAN: Okay. I just wanted to make sure because I didn't want to misunderstand

you, that somehow you thought that because of what you described as the signature and the integration, that that somehow made you -- your organization, including Greenwich Hospital, somehow exempt from some aspect of CON.

MR. ASHMEADE: Objection. This question has been asked and answered.

HEARING OFFICER MITCHELL: I'm going to sustain.

MR. MONAHAN: Okay. Thank you.

Now, you did, in your testimony, quote from an American Heart Association document, I believe. Am I correct?

DR. VELAZQUEZ: Yes. In several occasions I quoted from the American Heart Association documents. You have to be specific about which one and whether it's in my written testimony or what I provided today.

MR. MONAHAN: Okay. The document I'm referring to is a document that -- well, in your testimony the quote, which is bolded on the first page of your testimony -- prefiled testimony states that, and it's giving reason, you know, you're explaining your reasons in support of the application. It says, "The second reason was PCI," and this is quote, "PCI

without onsite surgery is a reasonable consideration for providing local care to patients and families who do not want to travel significant distances or who had certain preferred local physicians," closed quote, period. Did I read that correctly?

DR. VELAZQUEZ: That is correct. I agree with that statement.

MR. MONAHAN: Okay. Now, you did not quote other portions of that same document, and I'm referring to page 2 of the document where under the heading, and this is the American Heart Association and American Stroke Association, which you had referenced before as being absent from one of the other documents that I was quoting from. They are under a heading that says, "Recommended policy guidance for states wanting to address the issue of PCI without surgical backup through regulation for legislation," and in that statement it says, and if you have it in front of you, you please tell me if I'm reading this correctly. I'm reading at the bottom where it introduces the bullet points. "This policy guidance applies to hospitals conducting both primary PCI and elective PCI," and when you go to the third bullet, it says, "Have an annual institutional volume of at least 200 to 400 cases." Did I read that correctly?

DR. VELAZQUEZ: I'm looking at the same document that you are, yes, and you read it correctly.

MR. ASHMEADE: This is a document from 2011. Would you please confirm?

MR. MONAHAN: Understood.

MR. ASHMEADE: Thank you.

MR. MONAHAN: And I apologize, Doctor, I know you have a very impressive CV and, without me going through it now, what is your specialty?

DR. VELAZQUEZ: I'm the chief of cardiovascular medicine at Yale. My clinical subspecialty has been focused on coronary disease and heart failure, as well as cardiovascular imaging. That's what I have done clinically in my career.

MR. MONAHAN: Now, you were -- I appreciate that. Does that mean in your day-to-day work you do or do not do elective PCIs?

DR. VELAZQUEZ: Absolutely, I was trained as a cardiologist. During my training, I was trained to do cardiac angiography and intervention, but in my day-to-day activities as chief of cardiovascular medicine, I do not practice, nor have I ever practiced, as an interventional cardiologist.

MR. MONAHAN: And, lastly, you don't dispute that Stamford Hospital and Greenwich Hospital are in the same local community; correct?

DR. VELAZQUEZ: I do want to comment on that. I think the same local community is not a -- and there's no right answer to that. I guess that's the answer that I would ask patients. From my perspective, a geographic mile distance, yes, they are very close by to each other. Whether an individual who lives in Stamford would identify Greenwich as their community or whether an individual who lived in Greenwich would identify Stamford as part of their community, I would leave to the community residents who make those choices. I don't live in either community, so I can't speak to that question. I think that is a question that can only be answered by patients.

MR. MONAHAN: And what about the Office of Health Strategy?

DR. VELAZQUEZ: I have tremendous respect for the legislation, and if that's how they define it, I don't have a working knowledge of the legislation, so I will leave that to the individuals of OHS to define.

MR. MONAHAN: I have no further questions for this witness.

HEARING OFFICER MITCHELL: Thank you, Dr. Velazquez.

MR. MONAHAN: I have just a few questions for Miss LoRusso.

HEARING OFFICER MITCHELL: Okay.

MR. MONAHAN: Hello, Miss LoRusso.

MS. LoRUSSO: Hi, how are you?

MR. MONAHAN: I'm doing okay. Thank you for asking. So, Miss LoRusso, you submitted prefiled testimony for this matter in support of the application and, as I understand it, you are the vice president and executive director for the Heart and Vascular Center for Yale-New Haven Health; is that correct?

MS. LoRUSSO: That's correct.

MR. MONAHAN: I take it from your prefiled testimony, Miss LoRusso, that you are familiar with the Statewide Health Care Facilities and Services Plan?

MS. LoRUSSO: Yes.

MR. MONAHAN: In fact, you quoted it in part, section 1.4; correct?

MS. LoRUSSO: If you show me what page, I will review it.

MR. MONAHAN: Sure. On your last --

in your last paragraph you quoted -- you said, "This proposal" --

MS. LoRUSSO: Yep.

MR. MONAHAN: -- "is consistent with the guiding principles in section 1.4 of the Statewide Health Care Facility & Services Plan to ensure access to quality healthcare, facilitate access to preventive and medically necessary care, maintain and improve the quality of healthcare services offered to the state's residents, promoting planning that helps to contain the cost of delivering healthcare services to its residents, and promotes planning that will achieve the appropriate allocation of healthcare resources in the state." Am I correct?

MS. LoRUSSO: Yes.

MR. MONAHAN: Now, that was quoted from section 1.4, "Guiding Principles." In that lengthy description of your quote, you omitted the introduction, or at least a portion of the introduction, if I'm correct, of 1.4 Guiding Principles that says, "The goal of all this planning and regulation activities is to improve the health of Connecticut residents, increase the accessibility to continue with continuity and quality of healthcare services, and prevent unnecessary duplication of health

resources." Do you see that?

MS. LoRUSSO: I don't have it in front of me, but I'm going to trust what you're telling me.

MR. MONAHAN: Did you purposely not include those words? In other words --

MS. LoRUSSO: No.

MR. MONAHAN: So that was inadvertent?

MS. LoRUSSO: There were several statements I felt were important to this document, this being one of them, but there was no specific intent.

MR. MONAHAN: Well, are you aware in your role that one of the CON factors that the legislature has set forth as important determinations is whether the proposed service will create unnecessary duplication of health services?

MS. LoRUSSO: I understand what you're saying, but I do not think this is unnecessarily duplicating services.

MR. MONAHAN: So you disagree with that?

MS. LoRUSSO: I don't think that what we're requesting is a duplication of unnecessary services.

MR. MONAHAN: And is that why you omitted it?

MS. LoRUSSO: I didn't intentionally omit it.

MR. MONAHAN: Okay. How about the other portion of the Statewide Healthcare Plan that pertains particularly to this very service, the PCI elective service in the statewide healthcare plan? Did you purposely omit that?

MR. ASHMEADE: Objection. We don't know what he's referencing.

HEARING OFFICER MITCHELL: Hold on. I didn't hear the objection. I just want to make sure I hear it. What was the objection? Because I didn't hear it.

MR. ASHMEADE: He's asking the witness, Miss Mitchell, if she intentionally omitted something, and we don't know what he's referencing. He's not told us what the statement is he's referring to.

MR. MONAHAN: I'll be very clear. Thank you.

You chose to quote a preamble with an inadvertent omission of one of the wordings related to the factors in the statute. My question is now did

you -- when you decided what you were going to include in your health -- in reference to your pretrial testimony in relation to the healthcare plan, did you make a decision to ignore or not include on purpose the cardiac services section of the health plan? And in particular, I will -- the statement that says, "Connecticut hospitals seeking authorization to initiate an elective PCI program without onsite cardiac surgery capabilities will be required to meet the conditions required in the ACCF/AHA/SCAI practice guidelines and to demonstrate clear public need for the program. The guideline states that it is only appropriate to consider initiation of a PCI program without onsite cardiac surgical backup" --

MR. McKENNAN: Attorney Mitchell --

MR. MONAHAN: May I please finish?

HEARING OFFICER MITCHELL: Let him finish, and then I'll let you make your objection. Go ahead, Attorney Monahan.

MR. MONAHAN: "This guideline states that it is only appropriate to consider initiation of a PCI program without onsite cardiac surgical backup if this program will clearly fill a void in the healthcare needs of the community. Further, the guideline notes that competition with another PCI program in the same

geographic area, particularly an established program with surgical backup, may not be in the best interest of the community." My question is did you purposely omit that from your prefiled testimony?

HEARING OFFICER MITCHELL: Hold on one second. Before you even answer that, I'm going to turn to you, Attorney McKennan. What's your objection?

MR. McKENNAN: I object. The accusation that we are somehow intentionally misleading the agency is inappropriate. We, at this point, agreed that those guidelines and the State Health Plan are part of the record, and it's up to OHS to make a decision based on the evidence in the record. I don't, quite frankly, see the relevance of accusing our leadership of making intentional omission to mislead you.

HEARING OFFICER MITCHELL: All right. Just to -- I do hear your objection. Attorney Monahan, before you even respond, I'm just going to go ahead and ask the witness. Did you intentionally omit anything from the Statewide Healthcare Facilities and Services Plan?

MS. LoRUSSO: No, nothing was intentional.

HEARING OFFICER MITCHELL: Attorney

Monahan, you can continue with the remainder of your questions.

MR. MONAHAN: I think that answered my question. Thank you. I don't think I need to pursue that. I have no other questions, and I believe there were no other witnesses, so intervenor has completed his questions.

HEARING OFFICER MITCHELL: Thank you, Attorney Monahan. Thank you Miss LoRusso, as well, for her testimony.

Is there anything else that you'd like to present, Attorney Monahan, before we go to break? Because we need to register anybody who's going to be doing public speaking, and also we need to convene -- OHS needs to convene to discuss our questions. Is there anything else new or different that you wanted to present?

MR. MONAHAN: No.

HEARING OFFICER MITCHELL: Also, attorneys for the applicant, anything new or different before we go off the record for about an hour -- about 50 minutes.

MR. McKENNAN: Nothing further from the applicants.

HEARING OFFICER MITCHELL: We are

going to go off the record for the purpose of registering anybody from the public that may want to speak and then also for the purpose of discussing OHS's questions. We'll see you back here 4 o'clock. Sound okay?

MR. MONAHAN: Can I ask one question?

HEARING OFFICER MITCHELL: Yes.

MR. MONAHAN: Are the questions that you may ask to each -- to potentially each of the witnesses?

HEARING OFFICER MITCHELL: So I do think so. If people want to stick around or make themselves available, I think so.

MR. MONAHAN: Thank you.

HEARING OFFICER MITCHELL: Just when you walk away, walk out of the room, just make sure you mute everything before you exit. Thanks.

(Whereupon, a recess was taken from 3:12 p.m. until 4:01 p.m.)

HEARING OFFICER MITCHELL: We've been notified about three people that want to speak. I just want to make a brief announcement about that. I'm going to ask all participants should enable the use of video cameras when commenting during the proceeding.

Anyone who's not commenting should mute their electronic devices and the also mute telephones, televisions, other devices that are in the vicinity that are not being used to access the hearing so we can make sure that we hear you nice and clear. We will call the names who signed up to speak in the order in which they registered. If we miss anyone, please just make sure you utilize the raised hand function to let us know, and we will get to you as soon as we can.

Before giving your comments -- we're now transcribing not only testimony, we're transcribing public comments. Before giving your comments, please state and spell your name for the purpose of accurate transcription. We're going to limit speaking time to 3 minutes. Don't be dismayed if we stop you at the conclusion of your time. We just want to make sure that we give everybody the opportunity to speak, and we want to make sure that we're fair to everyone. We don't want to give some people more time than others. We just want to make sure that we keep everything uniform.

We strongly encourage you if you'd like to submit any further written comments to the Office of Health Strategy by e-mail, or mail, no later than October 7th of 2020. Our e-mail address is

CONcomments, all one word, dot gov. Did I get that right, Leslie?

MS. GREER: Yes. But, I mean, we will still get that e-mail address, but we're no longer using that. So it's either that one or OHS@CT.GOV.

HEARING OFFICER MITCHELL: Okay. Thank you. OHS@CT.GOV. And then our mailing address is P.O. Box 340308, 450 Capital Avenue, Hartford, Connecticut, 06134-0308. If you didn't get all of that, it's okay. We're going to post the hearing video in a couple of days, so if you need to catch that, then you can go ahead and fast forward to this part, right immediately after the break, and you'll be able to capture the address, or you can also e-mail us for the address or call us. Our contact information is also on the website, and I just want to thank you in advance for taking time to be here and for your cooperation.

We're now ready to hear statements from the public, and the first person that I have that I want to unmute themselves is Mr. Roland Morris.

MR. ROLAND MORRIS: Good afternoon. My name is Roland Morris, R-o-l-a-n-d, M-o-r-r-i-s, Junior. I live in Greenwich, Connecticut.

Almost four years ago I had a serious cardiac event. I went into cardiac arrest

outside of the hospital. Fortunately, I was with people that knew CPR, and there wasn't an AED machine there, and Greenwich Emergency Services was there within about 8 minutes. I then was taken to Greenwich Hospital. I, of course, don't know any of this or remember it. And it did take 40 minutes to stabilize me, but waiting for me at the hospital was Dr. Howes. He literally saved my life. He was inside my heart within minutes, I'm told, and unclogged a fully blocked, I don't know the technical term for it, but I think they refer to it as the widow maker.

I was then put in a coma for a couple of days. My first memory was being put into an ambulance and transferred up to New Haven for a follow-up procedure. This ended up being fairly stressful on me because I was barely understanding what had happened to me. It took me a long time to get this memory, and it was quite stressful on my family. It seemed to me at the time that the most dangerous thing that had happened was taken care of fantastically at Greenwich Hospital. It seemed odd that we had to transfer up to New Haven.

My care there was fabulous, the doctors were great. They put in one more stent. I had an unfortunate experience the night of, but that was

just an unlucky room, I guess. But I think Greenwich was just an amazing result, and life moves along quickly for all of us and in the last three years, fortunately I've been there for two weddings, two grandchildren, and a third grandchild on the way. I have all of that to thank Dr. Howes and Greenwich Hospital. So thank you.

HEARING OFFICER MITCHELL: Thank you, Mr. Morris. I appreciate your comment.

We'll move on to Mr. Robert Berkley.

MR. ROBERT BERKLEY: Yes. Good afternoon. Thank you for the opportunity to participate. As you said, my name is Robert Berkley, R-o-b-e-r-t, B-e-r-k-l-e-y. I'm a resident of Greenwich, Connecticut and I'm currently the chair of the board of trustees of Greenwich Hospital.

I would like to offer my support for the proposed addition of PCI services to exist in the way of cardiac services currently offered at Greenwich Hospital. This proposal represents a unique opportunity to improve access to high quality care locally, the concept, which is of utmost importance in the post Covid 19 health care environment. With safety a top priority, an elective PCI program at Greenwich Hospital would adhere to the monitoring and standards

set forth by the Yale-New Haven Heart and Vascular Center.

Implementation of elective PCI at Greenwich Hospital would enhance the overall quality of the cardiology program and more fully utilize the expertise of the local cardiac specialists. With these physicians able to perform both angiogram and elective PCI, familiar providers will continuously monitor patients prior to, during, and after the procedure improving the continuity of patient care.

It's my understanding that there are some concerns, perhaps, that if this was expanded at Greenwich Hospital, it could somehow adversely impact other practices in the area. From my perspective, it's quite to the contrary. This type of procedure is a serious procedure that people look for healthcare outside of the immediate area. They look to major medical centers, teaching hospitals, and as a result of that, they're drawn to places such as New Haven or New York City.

In the event that we found ourselves in a position to offer this type of care in Greenwich, we could then be offering world class care when it comes to this type of procedure, not requiring people to travel more than an hour in order to get this level

of care by this level of healthcare provider.

As both the chair of Greenwich Hospital and, more importantly, a lifelong resident of Greenwich, Connecticut, I ask that you review these considerations from a perspective of enhancing services to our community or our several communities that we serve while honoring the importance of choice of healthcare. Thank you for your consideration of Greenwich Hospital Certificate of Need Application to add elective PCI services to continue with the cardiac services already provided by the hospital. I strongly encourage you to approve this application. Thank you.

HEARING OFFICER MITCHELL: Thank you, Mr. Berkley.

Then we are going to move on to Mr. -- is it VanHoesen? Is that how you say it? I don't want to make a mistake there. Take your time. That's okay.

MR. DAVID VanHOESEN: So I just wanted to share my experiences similar to Mr. Roland's experiences, or Roland's experiences, at Greenwich Hospital and then at Yale-New Haven.

In 2015 I had a cardiac arrest on a paddle court at Millbrook in Greenwich. They kept me alive through use of a pump on my chest, a mechanical

pump. I went into the hospital. I don't remember any of this. But apparently I was stented with two stents and cleared blockages within emergency at Greenwich Hospital, and my family was there and they were all rejoicing. They had me in an induced coma, I guess, for a couple of days. They kind of woke me up just enough to make sure I was okay to then put me back under and say okay, there's another minor one. We need to send him up to Yale-New Haven to get fixed.

I don't remember any of that, but I do remember waking up at Yale-New Haven at 2 in the morning not knowing where I was, why I was there, and what was going on, and there were some strangers in the room. I was totally taken back by it. I was very upset, and it may have had to do with the medications, I don't know, but anyway, they found my family, who was busy checking into a hotel at 2 in the morning, and they came and kind of settled me down and explained what had happened and so forth.

Then they -- once things got settled, they explained I needed to have another stent put in; not a major one, but a stent put in, and that was fine and that was straightforward. Doctors I had never met before, doctors I have never seen them, nor seen since, but it all worked out fine and then I went

home.

I'm very thankful, thankful to be alive, but I really feel it was due to the work at Greenwich Hospital and Dr. Howes and his crew.

I'd then like to fast forward five years, which was this past summer. Through Covid I was feeling discomfort, I wasn't able to get in and see a doctor and so forth. Then I was able to see -- I finally got in and did an echocardiogram. They're like, oh, it's time for an angiogram. I went into the hospital. They take a look and they're like oh, there's an issue here. One of the old stents is clogging up. We're not allowed to do it right here and right now. I'm like, "You can't do it? It's not an emergency?" It's doesn't really qualify as an emergency. Then I get put into an ambulance, shipped to Yale-New Haven.

HEARING OFFICER MITCHELL: One moment, Mr. VanHoesen. Am I the only person that's experiencing difficulty hearing? Try one more time. I think it was just me. I heard you say that you were transported in an ambulance, and then that's when it started.

MR. DAVID VANHOSEN: So then they transferred me up by ambulance to Yale-New Haven again,

and I was put into a room with other sick people with different issues. It was kind of in the height of Covid. I thought oh boy, I'm getting exposed again all over again in a place I don't know anybody. Nobody can visit me, I can't visit anybody. I'm far from home.

Anyway, the next day I go down, and eventually they say it's time for me to get my stent done again, and these are doctors I've never met before, I've never seen since. I'm here, I'm happy, I love being alive, but it was a little distressing for sure. Then I get to go home. I really feel that, and given the risks, rewards, and that sort of thing, had I been able to have that done in Greenwich at the time, I wouldn't have had to go through medication again, I wouldn't have been exposed to different germs and potential viruses, that sort of thing. It would have been much better to be at Greenwich.

That's what I have to share, and to be with your own doctors, there's a value to that, and there's a value to having your family around you and so forth. I forgot to spell my name for you in the beginning, so should I do that now?

HEARING OFFICER MITCHELL: If you wouldn't mind. I think it's actually underneath your name. Thank you so much.

Is there anybody else from the public that wants to make a comment? Just unmute yourself and let me know. I don't think I hear any comments for now, but we'll still leave it open for people to make comments until -- we're going to stay until about 6 o'clock.

But in the interim we will go to the Health System's Planning Unit's questions for the applicants and for the intervenor. I actually am going to start, but before I go to the questions that Brian and Hanna and I discussed, I just want to ask a question that, you know, just kind of came to me after hearing Mr. VanHoesen's comments. I guess that would be with regard to the precautions that are being taken to protect patients from exposure to Covid 19 and whether or not those are implemented at every hospital that's affiliated with Yale-New Haven Health Services Corporation, if there's anybody that can answer that.

MS. LoRUSSO: I can speak to that. This is Francine LoRusso. Yes, we do adhere to Covid requirements and restrictions at all of the health systems hospitals. We have the same standards and practices across all the delivery network.

HEARING OFFICER MITCHELL: Can you talk a little bit about what those standards are? If

somebody presents maybe in an emergency situation, for example, if they need, you know, emergency it would be PCI. If they need PCI, how does that look like? How are they separated from people that have other situations going on?

MS. LoRUSSO: Dr. Howes is interfering in my response. I'll let him go ahead.

DR. HOWES: In the Covid era we try to do preprocedural testing screening for Covid infection. So, for example, Mr. VanHoesen's second experience when he was seen in the office, was having increasing symptoms, had an abnormal noninvasive image, we had the luxury of a couple of days. We scheduled him for a Covid test. The next day when it was negative, he had his angiogram. Then we had to get him up to New Haven kind of still on that same negative angiogram. We have about a 48-hour window to kind of think that they still have a negative Covid test.

That's very different than like what goes to these patient's stories would have been in 2020. I believe Greenwich Hospital was the first patient -- first hospital in the state to do a STEMI intervention on a Covid patient, and I'm sorry to say that patient did not survive, but we had to do it, there was no time or waiting. We put on our full

protective PPE, and we take care of the patients. And, fortunately, with that protective behavior, we did not have staff that got infected from that interaction.

All of these unstable patients that come in through the emergency room now, if they get admitted, they will all be tested. Again, the STEMI patients, we don't have the time to wait, so we always assume they're Covid positive. We treat them with a mask and we treat the entire staff with full protective gear. It does, honestly, add time and delay, and it's never as easy to take care of these patients in the current environment.

DR. VELAZQUEZ: And those precautions are uniform and universal across every cardiovascular site. So it would not be different at Yale-New Haven Hospital or Bridgeport Hospital or at L & M.

HEARING OFFICER MITCHELL: Thank you.

So the next questions are for the purpose of ensuring the accuracy and completeness of the record. Is there anybody in the room on the applicant's that can name all the towns that comprise Greenwich Hospital's primary service area?

MR. ROTH: This is Norm Roth

speaking. In the file of page 13 is the service area towns, and the primary service area of Greenwich Hospital is Greenwich, Portchester, Rye, and Stamford.

HEARING OFFICER MITCHELL: Thank you.

The next question that I have is are there any other hospitals that are rotated within the actual physical hospital located within Greenwich Hospital PSA that provides either primary or elective PCI?

MR. ROTH: Obviously, Stamford is in that, but in the other areas there's no other hospital at all in those other towns, and the residents of those towns do get the majority of their healthcare services here at Greenwich Hospital. In fact, over 50 percent of patients -- inpatients admitted to Greenwich Hospital reside in Westchester County. So we have a very strong draw in eastern Westchester County to Greenwich Hospital.

HEARING OFFICER MITCHELL: That kind of leads into my next question somewhat, and I think that the application talks about it, as well. Are there any, and this is just again for ensuring accuracy for the hearing records, are there any additional hospitals that provide primary and elective PCI

services to patients residing within your PSA, aside from Stamford? So that's not if the hospitals are located in the PSA, but are there any other hospitals that provide services, that you know of, to residents within the PSA?

MR. ROTH: Well, the White Plains Hospital does provide primary and elective PCI, and they may draw patients from eastern Westchester, but then their referral for cardiac surgery and other advanced cardiac services will be to Montefiore in the Bronx.

HEARING OFFICER MITCHELL: And the next question I have, and thank you for that response, is regarding improvements and quality within the region. So the question has a number of parts to it, and I'll try to make sure that I break it down so that whomever is answering remembers what I'm asking, but this is based upon projected PCI volume that's in Exhibit E on page 436 of the application, and in that volume it basically indicates that Greenwich Hospital is not expected to meet the institutional minimum of the 200 PCI procedure threshold through fiscal year 2020.

You talk a lot about your perspective, that the volume is kind of part of a

larger picture of what one should look at when you look at quality. It's not the end all, be all. The question that I have is how will this proposal improve the quality of healthcare delivery in the region if the minimum volumes required to support better patient outcome are not met?

DR. HOWES: I'll give it a try. Again, part of quality metric is patient satisfaction, and I don't think there's any question that both of the patients that testified in this hearing, and what their testimony has borne is that the patients like to stay locally, in the Covid era more than ever.

I think Dr. Velazquez argued the point that although the physical side of Greenwich Hospital would not achieve 200 patients, and I actually believe we would not achieve 200 patients, our HVC system and our HVC protocol achieves much more for the function in the lab, the people in the lab and, therefore, the patients that experience an intervention at a hospital like this, which is very different than a small isolated hospital that has no support to it.

And then one other point that I think is worth spending time is talking about improving patient outcomes. We're a primary care -- primary angioplasty program and we take great pride in how

serious we take this job and how good we think we do our job, but at the end of the day we're doing 40 to 50 interventions a year, and if we got an elective program, we might not achieve 200 procedures a year, but if we get to 150 or 175, that's actually exposing our staff to more local intervention, so we're actually increasing our, you know, patient volume directly by offering more services, and that may translate into some improved procedural care. I don't know, but it's not going to hurt us by doing more.

MS. LoRUSSO: If I might add, too, again going back to the concept we talked about, being an integrated health system and the Heart & Vascular Center. We do have a very cohesive performance improvement team, and we are part across all of the of DMs the same registry around ACC and CVR registry, which is really a comparison across our quality metrics, and we actually track our position performance, as well as interventions that we can improve on as a team, and we adjust protocols and interventions based on that.

Again, I think that is something that is a significant offering for the community here at Greenwich that perhaps they would not have.

DR. VELAZQUEZ: Miss Mitchell, could

I add an additional comment if you have time?

HEARING OFFICER MITCHELL: Absolutely.

DR. VELAZQUEZ: I would say Dr. Howes is probably underestimating the impact of the care that he provides and the three stories from the individuals who joined us this afternoon. My sense is we can't speak to exactly what the draw will be when we have an elective angioplasty program here that could be one that could engage above and beyond the thresholds that are identified as a guidance. But I then go back to the specific perspective that we -- in terms of quality improvement, I would stipulate that we -- the Greenwich community benefits from the extensive, you know, in the thousands of procedures that are performed by the same staff, same faculty, operators of the same quality metrics and reporting standards, and the sharing of those quality standards and that experience is something that is directly applicable to the residents of the Greenwich service area, and that, in many ways, outperforms the capacity for that kind of experience for others.

So I do think that when you talk about the impact on quality, quality is an important component and we raised it and we certainly have to

agree. I don't see any reason why we would not be able to meet that volume that is stipulated in the guidance, but what I think we bring beyond that is the fact that all our patients, Mr. VanHoesen, Mr. Morris, all of them, have the benefits of being cared for by the staff and faculty who are part of a larger organization and benefit from the combined expertise of that organization. I think that's very important to highlight.

HEARING OFFICER MITCHELL: Thank you. I think you touched on this next question and answered it, but do you expect to ever reach that 200 PCI procedure threshold at the Greenwich facility?

DR. VELAZQUEZ: Maybe If I can take the first stab at that.

You know, what we know about cardiovascular disease is it is already the No. 1 cause of morbidity and mortality in the U.S. and growing as the population ages and increasingly as the population gathers, multiple risk factors, like diabetes or obesity, the Connecticut population of patients who are injured, particularly in the Greenwich region is also growing. So I don't see any reason we would not expect, due to population trends that have been published, that the need for a program that could serve

more to our patients, I suspect that would be met very quickly, just because of the population expectations we have for, not only the nation, but by age and population as a whole and in Greenwich County.

MR. ROTH: This is Norm Roth. I would like to add some further information to that.

Exhibit J of the Table of Records responds to hearing issues. We identified that Greenwich Hospital sends approximately 50 patients per year directly from Greenwich Hospital to Yale-New Haven for elective PCI services, and we have identified that nearly 150 patients who reside in the primary Greenwich service area travel on their own to Bridgeport Hospital or Yale-New Haven for elective PCI services. So I believe it is in the realm of possibilities that in the future Greenwich Hospital will independently be at that 200 case threshold.

HEARING OFFICER MITCHELL: If I were to ask you to just make an educated guess, do you know about when that would be?

MS. LoRUSSO: I'm going to just mention that if we were not transferring these patients and we were able to provide those services here, then you would reach that threshold immediately. I think that was part of the supposition, is that right now we

know, as we heard from our two patients who testified, if they didn't have to go to an alternate facility, they would have gotten their services here.

HEARING OFFICER MITCHELL: The next question pertains to the guidelines, and it is basically that is there anything specifically in the cardiac guidelines that would support the operation of an elective PCI program at Greenwich Hospital if the institutional volumes remain below 200 PCI threshold, so we're looking for specific criteria that we could look at.

DR. HOWES: Could you repeat the question?

HEARING OFFICER MITCHELL: What specifically in the cardiac guidelines would support the operation of an elective PCI program at Greenwich Hospital if the institutional volumes remained below the 200 PCI threshold. So we're looking for specific criteria that we could use to evaluate.

DR. HOWES: So using the 2014 document that's an expert consensus from the three governing bodies; the SCAI, the ACC, and AHA, and I made the point that his is a consensus expert opinion. It's a guidance. It's not an end all, be all. They point out in that document that in 2008, we're talking

prehistoric history in the world of PCIs, in 2008 26 percent of the hospitals in this country that performed PCI perform less than 200 PCIs, and of the 33 -- approximately 33 percent of facilities had no onsite surgery and, on those, 65 percent, so 282 facilities had less than 200 PCIs and didn't have surgical backup. Hundreds of hospitals.

Obviously, they all have different locations and different stories, but they did not say these programs should close. What they said is, and it's a couple of pages later in the document, "Laboratories performing less than 200 cases annually must have stringent systems and process protocols in place with close monitoring the clinical outcomes and additional strategies that promote adequate operator and catheterization laboratory staff experienced through collaborative relationships with larger volume facilities. The existence of laboratories performing less than 200 PCIs annually that are not serving isolated or underserved populations should be questioned, and any laboratory that cannot maintain satisfactory outcomes should be closed."

We would argue, or have tried to make that point, that we are already actually an existing PCI program. We are not creating a new

service. We're asking for access to a new population of patients for a procedure we've already been doing for 15 years, and we already have these systems that process protocols, we participate in the NCER, we participated in the C core registry when that study was being done that created all this body of literature, and we discussed in a systemwide view of the individual operators and the cath lab's operators.

As the director of the cath lab, I meet regularly with the cath lab directors of Bridgeport, of Yale-New Haven, and L & M and we talk about what's working, what's not working, what's new in development. So we're constantly pushing forward with development, and I'm the first to admit if we're not doing a good job, we shouldn't keep doing it, but I feel quite the contrary. We do an excellent job providing excellent care to our patients that reflects in the patient's satisfaction and the fact that they should keep coming back to us.

I'm not sure that answered the exact question.

DR. VELAZQUEZ: The other comment I would add, Eric Velazquez, is that in the document and I'm referring to -- I'm referring to the document that's a 2014 update on PCI without onsite surgical

backup that's published in circulation and I'm specifically referring to page 2,615, which I believe was mentioned in the record during the questioning, and I'll read, "Second, PCI without onsite surgery is a reasonable consideration providing local care to patients or families who do not want to travel significant distances or have surgery with other local physicians. This is an important consideration of the policy statement emphasized and evolving evidence that such centers should have mechanisms in place to ensure high quality care," which is why I continue to refer to the fact that as an integrated system with Greenwich Hospital and our cath laboratory at Greenwich Hospital only providing 15 years of primary angioplasty, within an integrated system there are measures in place to ensure high quality care and ongoing review with a volume of procedures for our institution and the system that approaches more than 2,000 a year, and we have those quality metrics and quality measures in place.

So I think, to your question, you know, it is stated clearly in the guidelines that what we are proposing should be acceptable.

HEARING OFFICER MITCHELL: Thank you for your response on that. The next question is explain what a high risk patient is for PCI and

describe the process that Greenwich Hospital would use to determine if a patient is in the high risk category and, thus, requires a procedure to be performed at a facility with onsite surgical backup.

DR. HOWES: This is Dr. Howes. So there is a document that's really ancient history and just so -- it's a 2006 document about PCI without surgical backup, so that is before the 2011 document that talked about elective angioplasty, and certainly before 2012 and 2014 but that document, even then, acknowledged that primary angioplasty without surgical backup was happening in the nation. And they characterize two different separate things that need to be conceptualized when looking at a patient and looking at where the appropriate place to do that, that intervention is. It's a list, we may have included it in our application that -- the two charts are there.

One of them is describing patient characteristics; how sick are they, do they have malignancy, do they have dementia, the characteristic things of what the patients have, and then there's a second list about more technical aspects of what the angiogram looks like, what the coronary circulation looks like, what's the specifics of that actual patient's coronary disease.

And I think -- primary angioplasty, where you kind of have to make the decisions in the moment, not this second. Mr. Morris had triple vessel coronary disease, but we had to say this is the culprit. Let's fix it. Do we keep fixing other stuff, or have we kind of bought him time to see if he recovers. That's all on the fly.

We have been doing that for 15 years, and Dr. Martin testified that clinical decisionmaking is a big part of what we do, and I agree with him 100 percent. Clinical decisionmaking is integrating that clinical patient and their coronary angiogram to decide what's safe, what's appropriate, what's reasonable, but in the elective PCI situation and, obviously, some of these patients aren't truly elective, they could be having a heart attack, they could be sick, but you do have the grace of time to stop and actually think about this systematically, and I think this is where Dr. Cambi, the cath lab director at L & M, has been so successful is his patient selection is incredible, and that's a testament of how complications and emergency events have occurred.

This, again, goes to the beauty of the health system. When I do an angiogram at Greenwich Hospital, our films immediately download into the

electronic medical record, and I can call any one of my partners that I've worked with for the last 25 years and say hey, can you take a look at this angiogram, what do you think? He could be at home in Woodbridge or Dr. Cambi could be in New London, and as part of that electronic medical record, you can get consultive care and say you know what? That LAD looks pretty calcified. I think we should hold off, let's transfer them up to Yale. We do that all the time.

On most of these patients, not the primary angioplasties, because it's clear, you've got to do something. But on the elective ones, you stop, you pause. You know, if it's totally straightforward, if it's a stable patient, it's a single vessel disease, it's a clean lesion, most of those are going to be pretty promptly. But if it's two vessel disease and their ejection fraction is 40 percent, let's also stop, let's think about it, and make sure we don't put the patient in harm's way.

That's very well characterized in the documents. We would utilize those kind of flow chart predictive things of what a high risk patient and/or a high risk lesion would be. And we have the luxury of consulting our colleagues.

HEARING OFFICER MITCHELL: I think

you actually answered kind of my next sub question, especially when you talked about being able to consult with your colleagues using the electronic medical records.

The other question, if you can just kind of touch upon it a little more, is what safeguards would be implemented to make sure high risk patients are properly identified?

DR. HOWES: Again, I -- you know, it's clinical decisionmaking and we have very experienced clinicians. We openly encourage communication amongst ourselves. We have not here, as an elective -- as a primary angioplasty protocol, required a physician to stop and ask someone what they think. I might be wrong, but I think when Dr. Cambi started his program back in 2012, 2013, he used to show all of his films to another senior operator in the system just to make sure he had a second opinion, and getting two people together is usually better than -- there's a lot of thought process goes into that.

DR. VELAZQUEZ: Every outcome for every case that is performed for every patient that we provide a service to, all that information is summarized and reviewed as part of our cardiovascular center performance and quality improvement process.

It's not different for Greenwich than it is for L & M than it is for -- they're all the same -- the same faculty, the same operators, so I would argue that our process is that we -- it's universal to you, not only because we enter data into the entity or registry and the agency, cath registries but because that's part of our process internally, that we review all cases, particularly if there's an outcome that we can learn something from.

DR. HOWES: Dr. Howes again. I was talking almost preemptively reviewing it before you've done the intervention. Postintervention, every procedure done at this hospital is reviewed by me. We have a quality control board, we review all the cases. Obviously, more of the cases that seem to have some kind of question get more scrutiny. We review every diagnostic catheterization and every PCI, and we continue to review all of those cases.

HEARING OFFICER MITCHELL: Thank you. I'm going to turn it over to my colleague, Hanna Nagy, who's going to ask a few more questions.

MS. NAGY: Thank you. So my first question is please discuss Greenwich Hospital's emergency transfer plan for PCI patients in need of urgent cardiac surgery.

DR. HOWES: I think that's me again. Again, Dr. Howes. We've been doing this since 2005. We actually have a very well ascribed flow chart of how to transfer patients emergently, and I believe that was included --

MR. McKENNAN: We did not include that. But we could, if necessary.

DR. HOWES: We can show you that flow chart. It's a little more complicated than one would think because there are options to sometimes fly a patient by helicopter, there are options for ground transportation, and it turns out that we have an ambulance onsite here at Greenwich Hospital always with the capability to transport a patient with, not only a ventilator, but big enough to transport a balloon pump.

Ideally, those patients can be transferred with emergency medical services medics, but that is not always available, so on rare occasions we've had to transfer patients with either an ICU nurse or a physician going with the patient. That's a staffing issue, but there's always the opportunity to have the ambulance or the helicopter.

It turns out it depends on time of day and the weather on what's going to be the quickest and promptest transportation. Yale-New Haven Health

System has its own helicopter staff, and that is a highly trained staff, very comfortable to use the equipment, so that is a preferred method of transportation, but that, again, depends on weather and those sorts of things. Some patients do transfer by ground transportation and, like I said, we have a flow chart of how we work through that.

We not only work with, obviously, Yale-New Haven Health transport system, we do transport patients to New York City and to Valhalla, and they have their own transportation connections, as well, and we know how to interface and integrate with all of those.

MS. NAGY: Going along those same lines in terms of the different modes of transportation that you have at your disposal, what is the maximum amount of time acceptable for this type of emergency transfer?

DR. HOWES: Again, it kind of depends on what the clinical scenario is. Most patients that need to transfer emergently don't actually need to go to the operating room that minute. It's usually they need to get to a higher level tertiary care center and can either be stabilized or be reevaluated, but they can go directly to the cath lab.

I think a more pressing issue is a patient with an aortic dissection. That has nothing to do with anything that we're talking about here today, but those are patients that do come to Greenwich Hospital currently and, obviously, it is a common catastrophic illness, and we have been transferring those patients out emergently for years, and that would be the most pressing thing, to get those patients transferred out within 20 to 30 minutes, and then the transportation time, 30 to 40 minutes, if it takes that long for an operating room to get activated.

In the modern era, and this might be interesting to some people, during the Covid epidemic with all the respiratory failure that was involved, ECMO, the extracorporeal membrane oxygenator became more of a pressing issue, and we have now been able to get patients on ECMO in Greenwich Hospital by bringing the services down in a mobile unit from the Yale-New Haven Health System via the ambulance or the helicopter. So we're actually providing the supportive care at the site almost emergently. We've never had to do that for a cardiac patient.

MS. LoRUSSO: This is Francine LoRusso. I have to comment on that, because during the Covid era there were several patients that we had to

transport and we were very, very fortunate, and those patients actually were able to be discharged from the hospital. But it is a mechanism that we were able to insert here and transport immediately, and it's a skill set that is quite unique.

MS. NAGY: So typically the expected emergency transfer time from Greenwich Hospital to Yale-New Haven Hospital, can you provide me with averages with regards to both ambulance transfer, as well as helicopter transfer?

(Unintelligible crosstalk.)

MR. McKENNAN: Attorney Mitchell and Miss Nagy, could we request that that be filed as a late file document? I'm not sure we have that at our fingertips right now.

MS. NAGY: That would be great. I'll defer to Attorney Mitchell to see if we can allow that as a late file, but I have no objection.

HEARING OFFICER MITCHELL: We'll discuss all the late files at the end.

MS. NAGY: Now I'm going to ask you a couple of questions about the PCI quality measures that are currently being utilized at Greenwich Hospital for its primary PCI program. Can you talk a little bit about that and explain if there are additional measures

or what additional measures that you take specific to elective PCI?

DR. HOWES: So probably the starting point for quality assessment for the cath lab is this voluntary data registry called the NCDR, and that's sponsored through the American College of Cardiology, and it's a very low dataset, and they try to group your data -- you submit your data, your outcomes, and try to group you with other hospitals of a similar guide and what you perform, and then you can kind of benchmark yourself with other hospitals that are doing theoretically similar behaviors, and that data entry set actually has the ability to separate, unlike apparently the State of Connecticut couldn't separate primary angioplasty from other acute MIs, and that's why I think some of that data that was discussed earlier today all mixed together and looked like so many MIs. You can separate this in the dataset, what's a STEMI, what's an ACS patient, what's a more stable patient.

The dataset is much more robust than just looking at mortality and, obviously, mortality is, at the end of the day, one of the most powerful and worrisome statistics, but really when we're looking at our process, we're interested in giving care, giving it

on the right patients, renal outcomes, bleeding outcomes, stroke outcomes, and all of that can be isolated and separated down on a case-by-case basis, and that data is available to us on a rolling quarter basis. We do review that every quarter. And fundamentally it wouldn't change. We would, obviously, have more patients to put into the dataset, and the data would be a little different because right now all of our patients are primary patients, and we'll always have two groups of patients, the primary and elective.

That does get teased out a little bit differently because of like kidney dysfunction, which is actually the most common complication in cath lab based procedures. That's very hard to measure in primary angioplasty because none of these patients have known kidney function at the time of the procedure. They're coming in emergently, whereas elective angioplasty, all those patients have a kidney test beforehand. So there are nuances and differences in the dataset, but the acquisition and the inputting of the data would be more or less the same.

In addition to that NCDR thing, as I alluded to earlier, we look at every angiogram. I know the physicians that are doing all these procedures. We talk about every case. Sometimes that's as useful as

an outcome thing, what did you think of that angiogram, you know, should we have taken another picture of the right coronary artery. There's always room for improvement for all of us.

MS. NAGY: Do you anticipate that, based on the quality metrics, were the proposal to be approved, being changed or the way that you offer these procedures being changed in terms of the quality metrics at all, based off of the results of the elective PCI?

DR. HOWES: Can you restate the question? I'm not sure I got it.

MS. NAGY: Sure. So you were alluding to the fact that there would be kind of two datasets, basically; the primary dataset that you have currently and then going forward you would also have an elective dataset. Do you anticipate or will you be willing to look at the results of the elective PCI dataset and change your quality metrics, if necessary, or to address those metrics through quality?

DR. HOWES: Absolutely. I think it will actually make our quality dataset better, it will be more robust, and I actually think in the elective angioplasty population, a lot of those data points are more relevant.

The primary angioplasty, a lot of what happens is a little bit out of our control. The horse is let out of the barn. The elective angioplasty group, we're kind of saying that this is an appropriate patient to do, this is an appropriate time to do it, this is an appropriate location to do it. So we definitely have to look in the mirror and make sure we're doing it correctly and appropriately, so absolutely.

DR. VELAZQUEZ: Miss Nagy, I would say that currently all our procedures are entered into the NCDR registry across the cardiovascular center, all elective and all primary angioplasties. So we would -- as part of our leadership role, we would require that to happen, the idea of elective PCI, was granted to Greenwich Hospital because it would be consistent with the standard we apply in all our programs.

MS. NAGY: So I'm going to shift a little bit and talk about the cost. As far as the financial feasibility going forward, given the current climate, will Yale-New Haven Health Services experience operating losses in fiscal year 2020 due to Covid 19? And, if so, could you project how much?

MR. ROTH: This is Norm Roth. Yale-New Haven Health System will experience operating

losses in fiscal 2020 as the result of the impact of Covid 19 and that amount, if you exclude the federal stimulus money, is approximately 400 million dollars. With the stimulus money added in right now, it is looking like the anticipated loss will be between 40 and 50 million dollars, and as we look forward to fiscal '21, we are seeing a strong recovery of patients, both inpatients and outpatients, in all of the healthcare facilities of Yale-New Haven Health, and in fiscal '21 we are expecting a break, even to perhaps up to three-quarters or one percent positive operating margin.

MS. NAGY: Would you be able to answer the question again in terms of Greenwich Hospital? And I can repeat the question. Will Greenwich Hospital experience operating losses in fiscal year 2020 due to Covid 19? And if you would be able to project an amount.

MR. ROTH: Yes. So Covid 19 hit Greenwich Hospital extremely hard and very early. Our first patient was on March 14, 2019. We peaked in mid-April at 120 -- 2020, March 14, 2020, and then in April we peeked at 126 inpatients and 26 ICU patients testing the very limits of this organization. Naturally, when we knew that that volume was coming, we

discontinued outpatient services, elective services, created additional bed capacity and Diane Kelly worked with our staff, got us to a bed capacity approved by the Department of Public Health up to 284 beds. We were able to segregate non-Covid patients from Covid patients, and throughout the entire Covid 19 period, we have now seen nearly 740 patients at Greenwich Hospital, a very significant number of patients.

So in fiscal 2020, without federal stimulus dollars, Greenwich Hospital will lose approximately 35 million dollars, but when we are able to add in the stimulus funds for lost revenue provided by the federal government and FEMA, we are actually forecasting a slight operating gain at this organization of approximately 5 million dollars.

Looking ahead at fiscal '21's operating budget, and I will make the clarifying statement, assuming no major resurgence of Covid 19 at the levels that we saw in March, April, and May and into June, we are forecasting that Greenwich Hospital will end the year with a favorable operating margin of about 9 million dollars for the year for fiscal '21.

MS. NAGY: Great. Okay. Thank you. Do you anticipate the projected losses by the system will affect this transaction? And, if so, how?

MR. ROTH: We don't anticipate any impact on this proposal, and there's no impact on Greenwich Hospital. In fact, from a healthcare cost perspective, we think that it is actually favorable for both the state and the patients, because all the services that are required for elective PCI already exist at Greenwich Hospital. All the supplies, staff, physicians are all here, so rather than incurring additional expense of ambulance transportation, sometimes occasionally repeat examinations and second procedures, it all can be done here. So from a healthcare cost perspective, we believe this would actually be an improvement in overall healthcare costs.

MS. NAGY: And can you speak to the losses to the system, as well, if that will have an impact? You spoke about the hospital, specifically.

MR. ROTH: The health system totally supports this. They are co-applicants. This is Greenwich Hospital and Yale-New Haven Health System, and the Yale-New Haven Health System is going to have the same experience going into '21 as we have today, and volumes at Yale-New Haven and Bridgeport Hospitals are such that they are frequently in a surge alert, meaning that there are so many inpatients in the facility, that it creates significant delays in the

emergency department. In fact, prior to Covid, Yale-New Haven was experiencing 80 or so, sometimes even higher, patients waiting for inpatient beds. So actually, from a health system perspective, performing more of the elective PCIs here would relieve some of the burden on the busiest angiography program in the state of Connecticut at Yale-New Haven Hospital.

MS. NAGY: Okay. Great. Thank you. So I'm going to hand it off to my colleague, Brian Carney, to finish up the questions.

MR. CARNEY: Thank you. Thanks, Hanna. Good afternoon, everyone. I have several questions for the intervenor, Stamford Health.

The first question is, in your words, if elective PCI is approved at Greenwich Hospital, what do you think would be the impact on Stamford Hospital's cardiac program?

MR. BAILEY: Could you clarify the question? Impact meaning -- could you be a little more specific what you're talking about from an impact perspective?

MR. CARNEY: Sure. As you're saying, the clinical piece of it, the financial impact of the hospital, clinical impact for the program, the volume impact for the program.

MR. BAILEY: Sure. So I can address, again, some of the questions from the business side, and I'll let my colleague, Dr. Martin, talk a little bit more about it from a clinical side.

The questions were asked during the cross-examination about whether we've done any volume protection, have we done any cost financial indication. We have not done that. And that's truly not the basis of our argument here. We do believe there's going to be an adverse impact across all providers throughout the geographic area when another program would be implemented at the level of specificity that that may entail.

There's a lot of speculation that would be caused with that, but we think it would have some impact to us and that, as I mentioned before, there is a national decline happening across the country, and that is something that would cause potential additional degradation of overall case filings, and we're concerned that we meet the gold standards from a clinical standpoint.

DR. MARTIN: Clinically, I think if this program went through, we wouldn't see any dramatic change. Our volume is such that we're not in danger of closing. We're not in danger of becoming a low quality

program. I think that, day-to-day, my job wouldn't change.

What I do worry about is, aside from working at Stamford Hospital, I have patients and colleagues and friends that live in Greenwich, and I -- we just hope, for their sakes, that we continue to uphold the gold standards and provide care as the best available as guided by our guidelines.

MR. CARNEY: Does Stamford Hospital have available capacity to increase the number of PCI procedures performed and, if yes, how many additional PCI procedures could you do?

DR. MARTIN: We certainly have the capacity. I would say we nearly doubled our capacity, nearly doubled the number of procedures we're doing now to provide quality care. We're reasonable busy. We have three cath labs, they're running all day, and they're definitely openings -- I read in some of the testimony from the applicants about patients having to wait days to get procedures. That certainly would not be the case here. When we do get transfers from Greenwich or Norwalk, those procedures, we're typically waiting for the patient to get here to take them to the procedure immediately.

MR. CARNEY: Can either of you three

gentlemen name the primary service area towns served by Stamford off the top of your head?

MR. BAILEY: I can address that question for you. So we look at Stamford and Darien as our immediate primary service area and our additional service area and, pardon me, because I am still fairly new to the geography if I don't capture all the names. I will get it to you in followup. That would include Greenwich, New Canaan, Wilton, Norwalk, and Westport. Let me -- to give you clarity, let's give you that information in a followup, if you're okay with that.

MR. CARNEY: Sure. You're saying basically the primary service area is two towns; Stamford and Darien?

MR. BAILEY: We consider that our immediate area, our immediate primary service area.

MR. CARNEY: Our definition is like top 85 percent of discharges.

MR. BAILEY: I don't have that information readily available, to my knowledge.

MR. CARNEY: A couple of other things I'm interested in knowing, which I'm sure you're not going to have that at the top of your head. We can address them as late files, but I'll just mention if you could provide us the annual historical volumes for

primary and elective PCI at Stamford Hospital for the past three fiscal years, also providing us the yearly totals by patient town of residence for primary and elective PCI. So we're going to ask you for that.

And, lastly, we'd like to have sort of an idea of where you think the program's going, so we'd like you to provide us with the annual projected volumes for primary elective PCI anticipated over the next three years and what you would anticipate if this proposal goes through, so with or without the proposal. So, to kind of quantify that, that impact on volume.

MR. BAILEY: Understood. I'd be happy to provide that.

MR. CARNEY: As of now, that's all of the questions that I have. Michaela?

MR. McKENNAN: Attorney Mitchell, with respect to the late files, we'd like an opportunity to respond to the documentation, if that's okay.

HEARING OFFICER MITCHELL: I'll give you a brief amount of time to respond after we receive them. In addition to that, we had a couple of requests for late files for your client, as well. So we -- you know, it probably will make better sense for me to issue it in a written order so everybody has

everything.

But we were looking for, from you, updated financials, from 2019 to 2022. We wanted to get the estimated distance between Greenwich Hospital and White Plains, and then we also wanted to get, if you can, I was asking for the average time for an emergency transfer from Greenwich to both Bridgeport and Yale-New Haven Hospital, either by ambulance -- I think I said by ambulance, but by ambulance and by helicopter, so these are the things that we'd be looking for. We only verbally talked about them.

I'll probably, not probably, I will issue an order tomorrow requesting everything in writing so that you have that handy so you don't have to remember everything now, but since we've gone over them verbally, I wanted to ask how much time you need to produce the documents that we discussed. I'll start with the applicants.

MR. McKENNAN: Was the question how long it would take to respond to the late files?

HEARING OFFICER MITCHELL: Yes.

MR. McKENNAN: I would request at least a week and a half through the end of next week to gather the updated financials. That's probably the most time consuming of each of these tasks, so looking

at a calendar -- can we set the 9th as a date?

HEARING OFFICER MITCHELL: Okay. Are you amenable to that, Attorney Monahan, for the production of the information that we need from your client?

MR. MONAHAN: Yes.

HEARING OFFICER MITCHELL: I will give a little bit of additional time for a response from the applicants to the intervenor's information that they provide, their additional evidence. I don't want this to drag on too long. I'm thinking -- do you need three full business days?

MR. McKENNAN: I think that's reasonable. So three full business days, so Monday, Tuesday, Wednesday following the 9th.

HEARING OFFICER MITCHELL: The 12th is Columbus Day. Are you all working on the 12th?

MR. McKENNAN: That's a good point.

MS. LoRUSSO: That's not a holiday at Yale-New Haven.

MR. McKENNAN: That's reasonable.

HEARING OFFICER MITCHELL: So you want to say close of business on the 14th?

MR. McKENNAN: Agreed.

HEARING OFFICER MITCHELL: I will

issue an order on that.

I don't know if there's anybody else from the public that is on listening. If you are, I'm going to ask you to unmute yourself and kind of let us know that you're there if you want to speak.

Hearing nothing, I'm going to go ahead and adjourn the hearing. We'll issue the order for the additional documentation tomorrow with the agreed upon dates. It will have the specificity that you need to make sure that you produce everything that we're asking for.

In addition to that, I just want to thank everybody for convening virtually. It is not easy for everybody to sit in the same room for as long as you did, especially under the current circumstances, so I just really appreciate it. I appreciate all the people who are participating from the public just giving us your time and letting us know what you think about this application, and if you have any questions or concerns, please feel free to reach out to us. Attorneys know to copy one another on correspondence.

Other than that, we're going to go ahead adjourn the hearing for today. The record, as it stands, is going to remain open until October 9th for any additional comments or submissions. So we're all

set at this point.

(Whereupon, the Hearing was adjourned at 5:21 p.m.)

CERTIFICATE FOR REMOTE HEARING

STATE OF CONNECTICUT

I, Debra A. Chasse, CSR 055, a Notary Public duly commissioned and qualified, do hereby certify that there appeared before me on September 30, 2020, at 10:31 a.m., at a hearing taken by remote means for The OFFICE OF HEALTH STRATEGY IN RE: GREENWICH HOSPITAL AND YALE-NEW HAVEN HEALTH SERVICES CORPORATION, CERTIFICATE OF NEED APPLICATION, to wit: DIANE KELLY, CHRISTOPHER HOWES, ERIC VELAZQUEZ, FRANCINE LoRUSSO, NORMAN ROTH, JONATHAN BAILEY, and SCOTT MARTIN, who were duly sworn by the Hearing Officer to testify to the truth and nothing but the truth touching and concerning the matters in controversy in this cause; that they were thereupon carefully examined upon their oath and their testimony reduced to writing under my direction by computer-aided transcription; that the proceedings are a true record given by the witnesses.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which these proceedings were taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

In witness whereof, I have hereunto set my hand this 21st day of October 2020.

Debra A. Chasse, CSR 055
Notary Public
My Commission Expires:
June 30, 2021