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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH STRATEGY

GREENWICH HOSPITAL	(23-32656-CON)

CERTIFICATE OF NEED APPLICATION and PUBLIC HEARING

Re: THE TERMINATION OF INPATIENT OR OUTPATIENT SERVICES BY GREENWICH HOSPITAL

HELD BEFORE: ALICIA NOVI, ESQ.,
THE HEARING OFFICER

DATE: March 27, 2024

TIME: 9 a.m.

PLACE: (Held Via Teleconference)

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

APPEARANCES

For GREENWICH HOSPITAL (Applicant):

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(Begin: 9 a.m.)

THE HEARING OFFICER: Good morning, everybody. I would like to thank you all for being here. Greenwich Hospital, the Applicants in this matter are seeking a certificate of need for the termination of inpatient or outpatient services offered by a hospital pursuant to Connecticut General Statutes Section 19A-638(a)(5).

Specifically, the Applicant seeks to propose to transfer its adult and pediatric outpatient clinics to be operated by the Family Centers, Inc., a federally qualified health center.

Today is March 27, 2024, and my name is Alicia Novi. Dr. Deidre S. Gifford, the Executive Director of the Office of Health Strategy, designated me to serve as Hearing Officer for this matter to rule on all motions and recommend findings of fact and conclusions of law based upon completion of the hearing.

Public Act 21-2, as amended by Public Act 22-3, authorizes the agency to hold a hearing by means of electronic equipment. In accordance with this legislation, any person who participates orally in an electronic meeting shall make a

good-faith effort to state his, her, or their name and title at the outset of each occasion that such person participates orally during an uninterrupted dialogue or series of questions and answers.

We will 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 held pursuant to Connecticut General Statutes Section 19A-639a(f)(2) which provides that HSP may hold a hearing with respect to any certificate of need application submitted under Chapter 368z.

Although this will be a discretionary hearing, the manner in which OHS conducts these proceedings will be guided by Chapter 54 of the Uniform Administrative Procedures Act and the Regulations of Connecticut State Agencies, Sections 19A-9-24.

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

the spelling of their last name, and OHS title.

MR. LAZARUS: Good morning, Steven Lazarus. Last name is spelled L-a-z-a-r-u-s. I'm the Certificate of Need Program Supervisor.

MS. RIVAL: Hello, I'm Jessica Rival. I am an analyst assigned to this application for the Office of Health Strategy.

MS. McLAUGHLIN: Good morning, my name is Yadira McLaughlin; M-c-L-a-u-g-h-l-i-n, and I'm a planning analyst also assigned to this application.

THE HEARING OFFICER: Thank you. Also present is Faye Fentis who is assisting with hearing logistics, gathering names for public comment, and providing miscellaneous support.

The certificate of need process is a regulatory process, and as such the highest level of respect will be accorded to the Applicants, members of the public, and our staff. Our priority is the integrity and transparency of this process. Accordingly, decorum must be maintained by all present during these hearings.

This hearing is being transcribed and recorded, and the video will be made available on the OHS website and its YouTube account. All

documents related to this hearing that have been or will be submitted to OHS are available for review through our certificate of need CON portal which is accessible on the OHS CON webpage.

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

Lastly, as Zoom notified you in the course of either entering this hearing or right before I started speaking, I wish to point out that by appearing on camera in this virtual hearing you are consenting to being filmed. If you wish to revoke your consent, please do so at this time by exiting the Zoom meeting -- or leave by exiting the Zoom meeting.

I'm going to start by going over the exhibits and items of which I am taking administrative notice, and then I will ask if there are any objections. The CON portal contains the pre-hearing table of record in this case and exhibits were identified in a table from A to Q.

Mr. Lazarus, Ms. McLaughlin, and Ms. Rival, do we have any additional exhibits to enter into the record at this time?

MR. LAZARUS: Not at this time. Thank you.

THE HEARING OFFICER: All right, thank you.

The Applicant is hereby noticed that I'm also taking administrative notice of the following documents; the statewide healthcare facilities and services plan and its supplements, the facilities and services inventory, the OHS acute care hospital discharge data, the all payer claims database data, and the hospital reporting systems HRS financial and utilization data.

I may also take administrative notice of other prior OHS decisions, agreed settlements, and determinations that may be relevant in this matter but which have not yet been identified.

Counsel for Greenwich Hospital, can you please identify yourself in the record at this time?

MS. FELDMAN: Good morning, my name is Joan Feldman with Shipman & Goodwin, and I am outside counsel for Greenwich Hospital.

THE HEARING OFFICER: Perfect. Thank you.

All right. Are there any objections to the exhibits in the table of record or the administratively noticed documents or/and dockets?

MS. FELDMAN: We have no objection.

THE HEARING OFFICER: All right. Thank you.

All right. So all identified and marked exhibits are entered as full exhibits.

(CON Exhibit Letters A through Q, marked for identification and noted in index.)

THE HEARING OFFICER: Do you have any additional exhibits you wish to enter at this time?

MS. FELDMAN: No, we do not.

THE HEARING OFFICER: Thank you very much.

All right. We will proceed in the order established on in the agenda for today's hearing.

I would like to advise the Applicant that we may ask questions related to your application that you feel you have already addressed. We will be doing this for the purpose of ensuring that the public has knowledge of your proposal and for the purpose of clarification.

I want to reassure you that we have reviewed your application, your completeness responses, and pre-filed testimony and I will do so many times before issuing a decision.

As this hearing is being held virtually, we ask that all participants, to the extent possible, should enable the use of video cameras when

testifying or commenting during the proceedings. All participants and the public shall mute their devices and should disable the cameras when we go off the record or take a break.

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

Public comment taken during the hearing will likely go in the order established by OHS during the registration process, however I may allow public officials to testify out of order. I or OHS staff will call each individual by name when it is their turn to speak.

Registration for public comment can be done using the Zoom chat function. Please list your name and that you would like to make a public comment in the message. Public comment is scheduled to start at 12 p.m. If the technical portion of this hearing has not been completed by 12 p.m., public comment may be postponed until the technical portion is complete.

The Applicant's witnesses must be available after public comment as OHS may have follow-up

questions based on the public comment.

If anyone listening to this hearing would like to submit written comments in lieu of speaking today, you may do so by e-mailing your comments to CONcomment@ct.gov. Again, that is c-o-n-c-o-m-m-e-n-t @CT.gov.

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

MS. FELDMAN: No.

THE HEARING OFFICER: All right. Okay. Is there an opening statement from the Applicant?

MS. FELDMAN: Yes, there is.

THE HEARING OFFICER: All right. Go ahead.

MS. FELDMAN: Thank you. Thank you, Hearing Officer Novi, for this opportunity to present my opening remarks to you.

The decision by Greenwich Hospital to transition its outpatient adult and pediatric clinics to Family Centers was a deliberate and careful decision made over a period of several years with significant collaboration and planning with community stakeholders.

As you know, hospitals must regularly recalibrate to do what is in the best interests of

their patients and the community, and often reallocate limited resources in different directions.

In the instant case this is exactly what Greenwich Hospital is proposing by collaborating with Family Centers and finding a new pathway that would offer its patients more holistic services that meet the needs of this population.

The proposal before you is not a novel proposal. Hospitals all over the country collaborate with federally qualified health centers to create models of care that fully address the social determinants of health of this vulnerable population.

Through our testimony today we hope to demonstrate that the services offered by Family Centers are different and more wholesome primary care services than that which Greenwich Hospital currently provides; that it will not cost more for either our patients or payers simply because the services provided by Family Centers are reimbursed with an all-inclusive form of reimbursement.

The proposed model has demonstrated to result in a significant and positive impact with respect to reducing avoidable emergency department

admissions and inpatient stays. Greenwich Hospital continues to be committed to reducing healthcare disparities for patients so they attain the highest level of health and a fair and just opportunity to obtain their optimal health regardless of their race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, preferred language, or other factors that affect access to care and health outcomes.

Through this very collaboration, Greenwich Hospital will partner with an organization that has excellent quality care and has the expertise to work with Greenwich Hospital in caring for our joint patients.

Thank you.

THE HEARING OFFICER: Thank you very much.

All right. Attorney Feldman, would you please identify all individuals by name and title who are planning to provide opening remarks on your application so I can swear them in?

MS. FELDMAN: Yes. Diane Kelly of Greenwich Hospital, the president of Greenwich Hospital.

THE HEARING OFFICER: And since it's a large room, if I could ask the person who's being identified, just raise their hand so I can see -- okay, which one

you are. Thank you.

MS. FELDMAN: And Bob Arnold, the CEO of Family Centers.

THE HEARING OFFICER: Thank you. All right.

Okay. I'm going to ask you both to please raise your right hand?

B O B A R N O L D,

D I A N E P. K E L L Y,

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

THE HEARING OFFICER: All right. I just want to remind you, when giving your testimony please make sure to state your full name and spelling of either your first or your last name, if they're difficult, for the Court Reporter.

And after that, then state whether you would like to adopt your written testimony that you submitted on the record prior to your statement or prior to testimony. Okay?

The Applicants may now proceed with their testimony, and I shall ask all witnesses to define any acronyms you use for the benefit of the public and the clarity of the record.

THE WITNESS (Kelly): Okay, I'm happy to do that because acronyms drive me crazy after being in healthcare for 40 years. We keep resurfacing them.

So good morning, Attorney Novi, Dr. Gifford, and the entire staff of OHS. I'm pleased to be here with you today to provide my testimony. Before I start to do that, I would like to adopt my pre-filled testimony as my own.

My name is Diane. I go with a middle initial P. The last name is Kelly, K-e-l-l-y. And I will begin those.

So my testimony today will focus on how the proposal before you is in the best interests of the Greenwich Hospital patient and for those in the community of which we serve and depend on us. Most specifically, the proposal before you seeks approval for Greenwich Hospital to transition its outpatient clinic services to a Greenwich-based, federally qualified health center known as Family Centers, Inc.

I must start my testimony by stating that the Greenwich Hospital dedicated clinic, clinicians and staff who serve Greenwich Hospital outpatient clinic patients are exceptional, and they provide

care to this population with enormous grace, compassion, and devotion, and this I am very proud of.

Therefore, we are not here today before you seeking to transition our patients' care, because they will receive a much better medical care at Family Centers or elsewhere, but because we believe that they will receive a different and more holistic wraparound model of services offered by the Family Centers, the things around the primary care.

In fact, the Family Centers operates as a patient-centered medical home, and we know that there is evidence that that truly is the state of art, especially in populations where there can be some disparities in access to care.

Most of our outpatient clinic patients are living with many social determinants of health and they would benefit from the Family Centers', again, wraparound services. Greenwich Hospital wants to see that the patients receive the type of care they need and that is already available to them in the community.

Accordingly, Greenwich Hospital decided that providing something less than what the Family

Center provides is not the responsible pathway, nor is it to our patients' best interest. And Greenwich Hospital does not believe that it makes sense to try to duplicate services that are already available in the community, especially when resources are so limited to what we have in all of our communities throughout the country.

As a former practicing mental health clinician, I'm a registered nurse by background of 40 years. Much of my clinical experience was in the behavioral health psychiatric services. I would like to give you an example of one benefit of the proposal -- and admittedly, this is near and dear to my professional heart.

We are all undoubtedly aware of the mental health crisis we are experiencing in this country. On a local level, we also know that a substantial portion of our pediatric and adult patients would benefit from having timely access to behavioral healthcare services.

Currently, when our Greenwich Hospital clinical patients are referred to behavioral health services, there is much delay and care can become fragmented, and we know that is actually in access of having providers available to all of us

in the country. It's a national crisis, the amount of psychiatric services that we all have access to.

This is not something that Fairfield County or the State of Connecticut is struggling with alone. This is a national, really a national issue that we're all trying to solve for, whereas the Family Centers' model actually has gone above and beyond and has behavioral health services embedded in their primary care. Again, we know that that is best practice.

You may ask why the Greenwich Hospital cannot provide these same services which are provided by the Family Center. The answer is that we are an acute care hospital. We specialize in acute care services, and not the provision of the wraparound services which is already being provided by the Family Center.

So when we're able to recruit and attract psychiatrists and mental health care clinicians, we have them embedded in our emergency room. We are opening up an intensive outpatient program for people in crisis in interventional psychiatric services. So yes, we want to put it in our community practices, but we have to go with the

acute phase first -- which I wish I wasn't having that conversation, but that is -- that's the reality of what we're all struggling with.

And again, if we have the ability to provide this without duplicating it, it's the right thing to do.

I must also tell you that based on the Yale -- all right. I'm not going to use an acronym. So Yale New Haven Hospital's clinics experience with the transition coming from Yale New Haven Hospital to a federally qualified health center; patients who have moved their care to health centers receive a host of new services previously unavailable to make -- to them. And now they have fewer visits to the emergency room.

So sometimes things up front will give you savings down the road, as I know you know that. So I do apologize for that, but I can get very passionate about this.

I mean, we actually have the data that supports the national data, that in New Haven there was a 33 percent reduction in avoidable ED visits and a 16 percent reduction in inpatient admissions among those patients who actually transferred from the old -- old? From the

previous primary care clinics to the FQHC clinic. That is -- that is remarkable. And yes, I love the data, but every single data point is a patient who actually avoided an ED and avoided an inpatient experience that is most obviously -- costs where, where we want to go with. We all believe preventative care is far more, you know, affordable -- but to show that it can really change someone's life.

Moreover, the proposal will not negatively impact the patient from a cost perspective, or from any other perspective from that matter.

I will tell you -- I want to say this very clearly. This initial conversation with Mr. Arnold, my colleague that you are going to hear from, came from the place of wanting to do better for this population. It did not come from a cost perspective.

The Family Centers have a very generous financial assistant policy and is dedicated to serving the uninsured and underinsured, which I think is such a big part of our population. In addition to, patients who transition to Family Centers will benefit from having access to 340b pricing for their pharmaceutical needs. They do

not have that today in our clinic. Our cost of pharmaceuticals in this country are making it cost prohibitive for people.

In response to OHS query, Office of Health Services query about the effect that the proposal will have on the diversity of providers and patient choice, patients will be given the choice of transitioning their care to the Family Centers or another FQHC, if that is their choice.

There are some in Stamford. I know there's one over in New York. I have to tell you I don't know all of them. Providers along with their primary care providers, if they choose not to go to an FQHC, if we have patients in our clinic -- with all patients, and they decide this is not their path, we will help them find another primary care.

And if that's the case, if this proposal is approved, Greenwich will pivot and devote resources to make acute care services that are needed by the community we serve. They won't be the wraparound services. So the full menu of options will obviously be part of the patient's choice, but with everything we do patient choice is at the center because if it's not their choice,

then they're not going to access it in a way that it can be best helpful.

Also, I want to be very clear that Greenwich Hospital is not by any means abandoning this patient population it currently serves. We feel very strongly that as a community hospital -- and yes, we're fortunate to be part of the Yale New Haven Health System, but our mission is to serve the community of which we serve.

Greenwich Hospital will continue to offer the same patient population the acute care services it always has, including the access to specialty care that it needs, which underinsured and uninsured patients typically have difficulty accessing.

In addition, Greenwich Hospital will provide Family Centers with a community benefit grant which will include the donation of the medical equipment, the furnishings currently at the Holly Hill Lane location. So it has a turnkey operation.

In addition, there will be some funding for Family Centers' operational losses at the Holly Hill Lane location. We absolutely know that we -- we are committed to making sure that the environment of which our patients feel that this

is a true wraparound primary care services, and we share that goal with Family Centers.

I hope my testimony has been informative and responsive, and I'm happy to answer any questions that you may have for me.

THE HEARING OFFICER: All right. Thank you very much, Ms. Kelly. I appreciate your testimony.

Attorney Feldman?

MS. FELDMAN: Mr. Arnold would like to provide some testimony. Thank you.

THE HEARING OFFICER: All right.

THE WITNESS (Arnold): Good morning, Attorney Novi, Dr. Gifford and OHS staff. My name is Bob Arnold, CEO of Family Centers, and I would like to adopt my previously filed testimony as my own.

My testimony this morning will focus on the reasons why Family Centers supports the proposal of transition of Greenwich outpatient clinic patients to Family Centers.

At Family Centers we believe that a healthy community is one that thrives, and our extensive network of primary health, dental, mental health services, behavioral health, educational resources and support services breaks down barriers associated with accessing quality health care and

builds stronger communities.

Currently, our services are offered at 111 Wilbur Peck Court, which is located within Greenwich public housing; at 20 Bridge Street; Greenwich High School; 60 Palmers Hill Road in Stamford; and eight school-based health clinics based in Stamford Public Schools, and which is by the way a wonderful way to be extending access to young people in middle and high school who are first taking control of their own health care and their own bodies, and it makes it very easy for them to access the health care that they need.

Family Centers serves more than 24,000 Fairfield County residents each year through our primary medical and dental services, mental health, but also through preschools and early education programs for young children, bereavement and family counseling services and vocational self-sufficiency supports, English language and basic literary -- literacy assistance and education and parenting supports.

Family Centers, as does Greenwich Hospital, has numerous collaborations and partnerships with many community service organizations for the sole purpose of providing comprehensive and coordinated

health and support services often referred to as wraparound services.

If the application is approved, Family Centers will establish a new FQHC site at 75 Holly Hill Lane in Greenwich, the very same location at which Greenwich Hospital clinics currently operate, but will expand the service hours so that the basic hours now are nine to five-ish or eight to four, or something like that. We will have a few days where the services are open until nine and potentially some weekend services, recognizing that people work, and in order to have access.

And we do have a population many of whom work at jobs where if they take time off they're not paid for their time off. So they're a lot of hourly workers, so that's an important element for them.

Family Centers' primary care providers are in the best position to conduct preventative screenings and identify the healthcare needs of the patient because we are able to address the social determinants of health such as the language-related barriers, food insecurity, housing issues, unemployment or other potential barriers to the patient achieving good health

outcomes.

Integrated support services are necessary to enhance the overall patient experience and improve long-term health outcomes. For example, I'm a primary care physician caring for a newly diagnosed diabetic Spanish-speaking patient who lives at or below the poverty limits. We know for that patient to successfully manage their diabetes they will need nutritional counseling, care coordination and social services to assist them perhaps in purchasing healthy foods and address any language-related barriers to obtaining other needed specialty or support services.

If I'm a pediatrician and caring for a child who has been recently diagnosed with developmental and educational challenges, I will need a support team to arrange the needed services to address the patient's educational and developmental needs so the child can achieve a strong educational foundation and maximize their potential. This is exactly what Family Centers does and can do for the patients who are transferred from the Greenwich Hospital clinics.

As with respect to our clinicians, all are trauma informed and capable of identifying

individual experiences, unresolved trauma, so that they can receive services from our embedded trauma and bereavement program and experts.

And with respect to our patients who are children, we have a team of behavioral health clinicians who specialize in developmental issues including diagnosis, interventions and referrals to our collective community providers so that these issues get addressed in a timely fashion and aren't left to fester.

I'm excited to tell you that in February, Family Centers implemented Epic to enhance patient communications and coordination of patient care, to manage care transitions, and to prevent duplication of services.

In addition, once the Holly Hill site -- once we're located at the Holly Hill site, Family Centers will have the capacity to offer services to at least 900 more new patients. It is Family Centers' hope that with this additional volume, Family Centers will be eligible to participate in PCMH Plus.

Moreover, if the application is approved it will allow --

MS. FELDMAN: Dr. Arnold?

THE WITNESS (Arnold): Yes?

THE HEARING OFFICER: Can you define PCMH Plus? It's an acronym -- for the record.

THE WITNESS (Arnold): Sure. You know, I think that I'm going to ask our Chief Health Officer who we could swear in to talk a little bit about PCMH.

MS. FELDMAN: Just one clarifying point, Mr. Arnold is not a physician.

THE HEARING OFFICER: Oh, I'm sorry.

MS. FELDMAN: It's okay.

THE WITNESS (Arnold): I was giving an example of a physician. I myself am an LCSW.

THE HEARING OFFICER: Yes, I'm sorry, Mr. Arnold.

THE WITNESS (Arnold): Dennis Torres is our Chief Health Officer. Maybe we could swear him in just to give you.

THE HEARING OFFICER: Sure. Mr. Torres, if you could just state your name for the record, please?

DENNIS TORRES: Sure. Dennis Torres, T-o-r-r-e-s.

THE HEARING OFFICER: Sorry. All right. You could please raise your right hand?

D E N N I S T O R R E S,

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

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

Go ahead. What is PCMH Plus?

THE WITNESS (Torres): PCMH Plus is a program through the Department of Social Services that is -- that awards outcomes related to patient-centered medical home goals.

So they look at hospital admissions or readmissions, ED usage, and there's a group in the state currently of FQHCs that receive PCMH Plus recognition.

I'm -- I think it's great that we will probably qualify for this. I'm not so sure, having attended many meetings with OHS, that this program is -- is going to be around for very long. I hope it is. I think it's a great program, and I think it rewards what we all want to see, which is the value-based outcomes. And this is, in fact, focused on value-based and alternative payment models. So that's what we are talking about.

We did not before, looking at this coordination of care, qualify because of the number of patients required. You have to have at least 2,000, and we do not currently.

THE HEARING OFFICER: Thank you very much, Mr. Torres.

All right. Mr. Arnold, if you'd like to go on with your continued testimony?

THE WITNESS (Arnold): Yes. So I'd like to say that if the application is approved, it will allow Family Centers for the first time to have a medical residency program integrated into its care delivery model.

It's our hope that the medical residency program will serve as a cost-effective physician recruitment opportunity for physicians committed to Family Centers' mission.

Most importantly, I want to emphasize that by addressing the social determinants of health, Family Centers will, not only be positioned to improve health care outcomes, but it will also foster a community that is more just and inclusive.

In summary, Family Centers is in full support of this application because a holistic approach to offering healthcare services will improve the lives of all of our patients.

Thank you for hearing my testimony, and if you have any questions, I'd be happy to answer them.

THE HEARING OFFICER: All right. Thank you very much.

All right. Attorney Feldman, do you have any questions for either -- or actually all three of your witnesses before we turn to OHS?

MS. FELDMAN: I do not.

THE HEARING OFFICER: Okay. So at this point we're going to go ahead and turn to the OHS staff and their questions.

We'll start with Ms. Rival.

MS. RIVAL: Again, good morning. I have a few questions. Please feel free to have the person who is most capable of answering the questions speak. The first question is, explain in detail the public need for the proposed termination of outpatient services?

THE WITNESS (Kelly): This is Diane Kelly.

I can start with that.

MS. RIVAL: Great.

THE WITNESS (Kelly): So -- say the last part of your question, just because I want to make sure I'm answering it succinctly.

MS. RIVAL: Sure. Just to explain in detail the public need for the proposed termination of outpatient services, the services that Greenwich Hospital is terminating.

THE WITNESS (Kelly): Yeah. Okay. So you know, when

you say, public need to close, I don't look at this as closing as much as I look at this as creating a new relationship with the Family Centers. Because my goal here, and I speak on behalf of Greenwich Hospital, is to ensure the care of our patients is, continue to and enhance.

So yes, the technical word is "close" because we will -- we will be then transferring that care, but not abandoning that care. I think that's where I got a little tripped up on that word.

Our medical residents, our physicians that supervise those medical residents will be part of the everyday fabric in the -- and the foundation of that care. So we stay very connected to that care.

The closure to me is more of an administrative process, if you will. And I don't mean that disrespectfully, but I'm coming from organizing care from the patient perspective. So it would be a transferring and opening a new relationship and expanding what we can do based on that new collaboration.

I think that you'll see in healthcare that we all have an obligation to collaborate with our partners so we can offer more to our communities

without having overburdening of duplication of resources.

So I just got a little bit like, oh, when you say close -- because my heart is like, oh, I'm -- I'm not walking away from this.

So thank you for allowing me to speak.

MS. RIVAL: Thank you.

On page 5 of the CON application it states, the proposed transition of the outpatient clinics from Greenwich Hospital to Family Centers is a key strategy to extend Greenwich Hospital's ability to continue caring for the medically underserved in the local community.

Please explain how termination of outpatient services by Greenwich Hospital will extend its ability to continue caring for the medically underserved.

THE WITNESS (Kelly): This is Diane and I -- well, I shouldn't just jump in. Right?

MS. FELDMAN: Yes.

THE WITNESS (Kelly): Oh, okay. I want to follow the rules here, which is always my -- so it's absolutely true that we feel limited on the resources that we can provide to our community because we don't have access to some of the things

that the Family Centers would allow us to have it. So we actually feel that there are many more people that would be accessing this kind of care if they -- if they -- if we could offer more.

We're not offering behavioral health embedded in primary care. We don't have the dental service part of our program. We don't -- we aren't reaching out to the schools.

I have -- I should have the data on this, and I'm going to apologize that I don't -- but proportionately, we know we're not reaching the number of people we should be reaching based on the community health needs assessment that we partner with. With Family Centers we actually do a community health needs assessment and we have a community advisory committee with all of our nonprofits coming in together and saying, are we meeting the needs of the community?

We just think there's more people that need care. And if we had more services and we had more ability to expand that, we could do that. And this is two people come -- two organizations coming together to join in and expand that access.

THE HEARING OFFICER: Okay. Before -- Ms. Rival, before you ask your next question, Ms. Kelly, you

are moving out of the frame at times and sometimes only half of your face is --

THE WITNESS (Kelly): Oh, you know what? I'm sorry.

THE HEARING OFFICER: If you can come in just a little bit?

THE WITNESS (Kelly): Yes, I did that to not block my colleague.

THE HEARING OFFICER: Thank you. It's okay. I just wanted you to move in a little bit more. So sometimes when you move, half your face would leave the --

THE WITNESS (Kelly): No, I just pushed in.

Thank you for that.

THE HEARING OFFICER: Okay. Go ahead.

MS. RIVAL: Thank you. My next question, what are the benefits and risks of the proposal to both the Applicant and Family Centers, Inc?

THE WITNESS (Kelly): So the benefits, I think we are -- I'm going to let Mr. Arnold come in.

But I'll just say benefits for Greenwich Hospital is that we will expand what we're capable of doing from a patient perspective. I will also tell you that we are committed to the future physicians that our nation so dearly needs.

This program will expand the amount of

patients that our medical residents see. It is a key component of our commitment to education by having more patients and having expanded services, and being in a patient-centered medical home environment we feel will enhance the experience for the medical residents. And again, obviously the expansion, the benefits are for our patients.

The risk, I honestly will keep thinking about it. I'll turn it over to Mr. Arnold, because I can't really think about what the risk would be.

THE WITNESS (Arnold): So I -- I must say that off the top of my head, I don't really envision any risks. I see this collaboration partnership as full of advantages.

We -- we already are benefiting from specialty care for our current clinic patients at Family Centers that will extend and continue with all of -- all of the additional patients at the Greenwich Hospital clinics.

And for us, it's a big plus to be working with the residency program. We're excited about that. That will bring many new benefits to the total population.

And I also think that when Diane says that it will perhaps open up the opportunity for other

patients who are not currently utilizing the clinics, I would point out that all of our outreach programs, some of which extend to mothers giving birth for the first time, being assessed for risk factors there, and having services through the OECPAT program, that kind of program, along with a lot of our early education and two-generational programs, and programs where we work with victims of crime, many of whom are women, all of -- all of those programs open up the opportunity for referral into this bigger network of services.

Because I think really we'll have access to all of the services that Greenwich Hospital provides, and there are all of the outreach services and wraparound services that we provide.

So I -- I don't really see risks in this operation, in this partnership. I see it as a net-net plus for really everyone, but especially the patient population and the access to all of the different kinds of services that they will now have.

THE WITNESS (Kelly): I do want to say -- this is Diane -- that I, you know, had talked about this in my opening, but, you know, the benefits, I

think it would be important to say that, you know, we don't just feel like this is going to be a good idea.

We have data to support that we will have some outcomes that we will be looking for and decreasing, you know, our inpatient stays is not insignificant from -- from an acute care facility. That that's something we all are striving to do.

And also increasing ED utilization, especially when EDs often can be used as primary care for those that don't have embedded services. So I -- I feel like that has a real, both a socio and economic, and clinical benefit.

So I just wanted to add that.

MS. RIVAL: Thank you. What contingency planning is in place in case the FQHC is no longer able to continue providing services?

THE WITNESS (Kelly): So I can better understand your question -- so what would happen if for some reason they couldn't do this, and what would we do with this patient population? Just --

MS. RIVAL: Correct.

THE WITNESS (Kelly): So we always would have the ability to make sure that we open up and try to get people into some of our practices. It

wouldn't be the same wraparound, but remember we are a part of Yale New Haven Health System. And with that, we do have -- we have medical practices available to us.

So -- and again, we are -- and we are committed to the residency program. So again, we would -- we would just try to realign that. You know, I think it's -- now I shouldn't say it goes without saying. You know nobody in health care is willing to -- or I actually don't even think they legally can walk away from their patients.

If something were to happen, the contingency would have to be we would have to figure that out. I mean, that's -- that's part of our obligation to the community that we serve with any of our services. I don't think it's -- it's not limited to this service.

THE HEARING OFFICER: I have a follow up to that. Have you done any planning? Is there anything in place? You said you would like to have the ability -- we would have the ability to try and get people into your medical practices?

Is there a plan in place already?

THE WITNESS (Kelly): So we always have a plan in place for when we have an abrupt change in service. And

we actually go into what's called our emergency operations plan.

And you first do -- and so that kind of can -- anything can go into that. You go with what are the needs of the patients? What are your resources you have available? And then you get the decision makers and you start moving that.

If there was an abrupt closure with any services, including this service, we would be enacting that clinical emergency operations plan, which quite honestly has proven to be extraordinarily effective during COVID, where we were able to have closures of ICUs and expand ICUs in another part of the system.

So it wouldn't be different. It wouldn't be outside of that, but we would be taking that responsibility to work within our license under an emergency plan for patient care.

THE WITNESS (Arnold): Yeah. So the comment I would make to the question is that one of the things that is planned is that we're going to have a joint committee board of the Greenwich Hospital and Family Centers health care that will be ongoing and working on the delivery of services, and keeping abreast of the changing needs, et

cetera.

And so it's highly unlikely that there would be this kind of a problem where automatically or quickly Family Centers would have to exit this work. We don't -- that's a rare thing to happen in the FQHC world.

Earlier on, Diane mentioned there are other FQHCs in this region who are very close to us on the borders of Greenwich on either side who could also be called upon in an emergency to pick up patients. But we -- we certainly don't see any reason why Family Centers health care would exit precipitously, rapidly -- rapidly without any ongoing plan.

And the chances of it are very small, but I understand that you -- you raised the question. And I do think that we will address any issues that were coming up and see very far in advance if we were running into issues around delivery of service between our joint hospital and Family Centers committee.

THE HEARING OFFICER: Thank you.

Go ahead, Jessica.

MS. RIVAL: Thank you. Pages 11 and 12 of the first completeness letter responses dated September 29,

2023, refer to the community benefits grant that will be established by Greenwich Hospital to ensure the Family Centers have the resources it needs to maintain and expand access in primary care. However, there is little stated about what the grant will provide.

Please provide details about what this grant entails, how Greenwich Hospital will ensure that Family Centers has funds to continue to provide care.

MS. FELDMAN: May I just briefly interrupt?

MS. RIVAL: Yes.

MS. FELDMAN: Could you please refer to Bates page number so we could follow?

THE HEARING OFFICER: I have that. It's Bates page number 331 and 332.

And I think your camera has slightly moved, Attorney Feldman, because -- oh, sorry. That's the person in front of you. I can see you again. I thought that was you. I'm sorry.

MS. FELDMAN: We're going to take Mr. Kelly -- I mean, Arnold.

THE WITNESS (Arnold): Yeah, sure. Yeah. Well, what's happening with the community grant is that it's including both in-kind donations from the

hospital, but also working with us annually in our budget around projected operating losses.

So it's -- it's our anticipation, and of course it's, you know, pending your approval, there will be a grant that should really ensure that the patients are fully cared for and that Family Centers does not experience an operating loss, and will allow us to also access any additional national opportunities for specialty care and studies. And that those will also be taken into consideration on an annual basis as we adjust the community benefit grant.

But our understanding of the community benefit grant is that it is a strong commitment from Greenwich Hospital to ensure that the patient population is cared for adequately, and that's why we'll be working together with a joint board into the future monitoring the operating costs and the needs of the ongoing two clinics.

THE WITNESS (Kelly): And I -- I would just add -- this is Diane. I would just add from the Greenwich Hospital perspective is that we recognize that we will no longer be billing for these services on some of these patients. They obviously have been -- have billable insurances, and that revenue

will go over and that will go under the FQHC, federally qualified health center model.

And we also recognize there that some of the expenses will then be turning over to the FQHC. And with any new program there is often -- we all live this in healthcare -- a shortcoming, a growing, if you will, that not everything will cover that.

We feel an obligation to make sure that we are still part of ensuring that these patients are getting cared for in a way that they're accustomed to. So I feel very, very confident, and I take my responsibility as leading a not-for-profit, a judiciary responsibility, but feel very confident that having us be part of this new relationship, we'll be able to oversee that and maybe -- and make sure that that support is where it needs to go with our patients.

I'm going to give you a small example of this commitment. You know, it's nationally known that the more transparent -- we have with a shared medical record will enhance the care of patients. This was a significant expense that the Family Center took on in order to make this step even closer possibly.

It's not something that most FQHCs can do on their own, but they did that. But so there there's -- there's financials on both sides of it, but we want to make sure that we're still contributing to this care, the care of our patients.

So it will be a reckoning, if you will. There will be a reckoning of the balance sheet on a regular basis through this joint committee, if that's -- if that's helpful.

MS. RIVAL: Okay. And just to follow up, on page 4 of the pre-filed public hearing issues' responses reads, Greenwich Hospital will subsidize reasonable operating losses of the Family Centers.

Can you please define what the reasonable operating losses are, and who determines if the losses are reasonable? I'm assuming the board, but.

THE WITNESS (Kelly): So we've had, you know, we -- we've had a lot of experience running an operating loss with -- with our clinic. That's not new. It's not new for any organization. So we -- we know for this number of patient population what it is that we lose every year. So we have a history of reasonable.

It's not just an arbitrary number, and we've shared that very closely with the Family Centers. So we will be looking at that loss, like, this is what we're used to losing. And we will -- so that gives us a very good benchmark. So we're not going to be asking them to outperform that and turn that around by ten, nor are we in asking them to actually increase that loss by ten.

So we, you know, it's reasonable. It's based on our experience of what it costs to take care of our patients.

MS. RIVAL: So would it be Greenwich Hospital that was making that --

THE WITNESS (Kelly): Yes. I'm sorry, Diane Kelly for Greenwich Hospital.

MS. RIVAL: Okay.

THE WITNESS (Kelly): And we've shared that loss with the Family Center.

MS. RIVAL: Okay. Thank you. On page 11 of the September 29th completeness responses letter, Greenwich Hospital says that they will maintain clinically and financially involved unless either party withdraws from the agreement.

What would cause Greenwich Hospital to withdraw from the agreement? And how would that

affect the Centers' ability to function and serve patients?

THE HEARING OFFICER: Again, that's Bates page 331.

THE WITNESS (Kelly): I don't know. Let's see. What would -- may I just have one minute?

THE HEARING OFFICER: Of course.

THE WITNESS (Kelly): You know, this one is -- I can't imagine, you know, the only thing that if something came up that we hadn't discussed -- I actually don't even want to answer.

I -- I really can't come up with what would cause us to undo this relationship, because we will be part of the board that's governing it. So we would be early on in discussing any major changes. So what would a major change be?

Well, you know what? Let me answer this, and I hope my -- our attorneys don't get mad at me for this, but we are committed to being in Greenwich, Connecticut, the FQHC. Our board is very committed to having further beyond Greenwich, but we have to have a presence in Greenwich.

So that is -- that is important, which is why this is such a good relationship because their foundation is built in Greenwich. We, of course, serve beyond Greenwich and would be happy to

expand it -- but location, because it's part of the foundation and the bylaws that our medical staff function under is supporting in our community local access.

MS. RIVAL: Okay. Thank you.

How will the proposal improve access and quality for patients in the primary service area?

THE WITNESS (Kelly): Bob, do you want to take that?

THE WITNESS (Arnold): Yes. Well, I think it will. I think it will improve access because of the amount of -- I don't know, outreach, if you will, or tentacles that Family Centers' various programs have throughout the community.

And we know that we are dealing with often a population that is both income constrained and sometimes new to the area. And so finding and accessing health care is sometimes challenging around language, but also is something that is often based on word of mouth in certain communities and -- and based on trust.

And we have a great deal of programming and -- and professional relationships with people both in public housing and in people living in marginalized situations, where we have access to them and we have built a great deal of trust.

And it's been our experience that in building that trust, it does help them to access health care as well as other services that would be beneficial to them. So I do think just our extensive access to various potential patient populations is in and of itself going to be a great advantage.

MS. RIVAL: Thank you.

THE WITNESS (Kelly): I would like to just add to that, if I may?

MS. RIVAL: Please.

THE WITNESS (Kelly): So as Mr. Arnold just mentioned, the proposal will obviously allow for the primary care, and I can't express enough the need for embedded behavioral health services in the area.

Now in Greenwich alone, over 86 percent of the adult visits and over 90 percent of the pediatric visits are patients reside -- are people residing in the town of Greenwich. We actually serve many more people in our hospital than Greenwich residents.

So we really want to make sure we're expanding and have something to offer to people that live in Stamford and beyond that. It's, you know, it's -- again, we serve a much larger

community. And when we have -- you come into our hospital for emergency services or inpatient services, your transition to the next level of care is our responsibility.

And having access to an FQHC that can really expand, you know, services to a comprehensive program will help us fulfill that obligation. Especially if it's, you know, Stamford area or even if it's in the New York market.

MS. RIVAL: Okay. Thank you.

My next question goes to, how often do you expect specialists to be available in the family center?

THE WITNESS (Kelly): So the -- the specialists that we have access to now, it's a rotation that they work with us. So are they embedded in the -- they're not embedded in the clinic per se. They're available to our patients as needed. So we -- we wouldn't see that changing.

You know having access to specialty care is important. It's also an important part of our -- our resident program. So if the patient -- if the resident is seeing a patient that has a -- I don't know, a cardiology, has a heart issue, that resident also learns a lot by following the

patient and having rotations with our -- our cardiologists.

So they're not necessarily embedded on a day to day, but they're available as a consultation service, which honestly, that's how all of our -- all of our specialty care is provided, whether -- whether it's a clinic or it's, you know, the specialists are consultative.

All of our specialists that are part of the Yale New Haven Health System and down here in Greenwich as we are, the Yale School of Medicine, and then we also have some of our community specialists that, you know, they -- we treat people regardless of their ability to pay.

THE HEARING OFFICER: I have a follow up question. I'm just not clear.

So you have a patient at the Family Centers who needs to see a cardiologist. What is the expected wait time for that patient to get to see a cardiologist at the Family Centers?

THE WITNESS (Kelly): It would go as if they were any other patient. It would be based on the referring physician making contact with that cardiologist. If it's a routine, I don't even -- I can't even tell you what our routine wait time is. Maybe

it's two or three weeks.

If it's an emergency, they -- they use the tools they have today and they do direct contact with the office, with the heart and vascular program now. You know, it's not different because of it being clinic patients. It's -- it would be the same thing if Diane Kelly showed up at her primary care and needed a cardiology visit.

It's they have -- our practices are part of this program. Bob?

THE WITNESS (Arnold): Yeah. And I would add to that, that with our existing clinic operations, we already have special specialists scheduled and coming in to the clinics.

And actually, the Holly Hill Lane clinic was built and designed to have the space to bring in numerous specialty services on a weekly/monthly basis.

I don't know -- our chief health officer may want to add to comment about -- say your name again.

THE WITNESS (Torres): Hi. Dennis Torres, Family Centers. So for a little context, since we've been operating the FQHC, we've been collaborating with the hospital on specialty services from the

very beginning, most particularly with radiology, with OB, so that there's a seamless continuum from our clinic into those services that are needed for the patient.

There is, through the -- through the clinic at 75 Holly Hill, there are a number of -- and I don't have the schedule in front of me -- a number of specialists that come through monthly, as Bob said. So that includes podiatry, cardiology, OB.

We will be adding psychiatry. There's nutrition, diet.

THE WITNESS (Arnold): Gerontology.

THE WITNESS (Torres): Of course, gerontology. I'm drawing a blank, I don't have it, but you get it. Like the specialty of things that are typically hard to access in -- in an FQHC come with this collaboration, which we're really excited about for -- for patients.

Because as you said, you might go to your doctor today and find that you need a cardiology visit or you might need to see a GI. GI -- and GI comes through, too, and GI being the hardest, I'll say at this point.

But they have set up planned visits into the clinic space, and we're able to accommodate those

needs for specialty care.

THE HEARING OFFICER: To your clients who do need to sign up for those specialists, are they normally able to get in fairly quickly? Or what is their wait time to get in with that specialist?

THE WITNESS (Kelly): Are you asking from the FQHC, or from the Greenwich Clinic?

THE HEARING OFFICER: From the FQHC. They said that they have the rotating schedule of monthly specialists.

So I'm wondering, is it usually you can get in to see the specialist that month? Or do you have to wait until the next month, is more of my -- how far in advance does that specialist get booked up?

THE WITNESS (Torres): I just want to clarify that those monthly schedules are at the current clinic at 75 Holly Hill Lane.

THE HEARING OFFICER: Okay.

THE WITNESS (Kelly): Which is our clinic.

THE WITNESS (Torres): Which is the hospital.

THE WITNESS (Kelly): That's why I was asking.

THE HEARING OFFICER: Okay. I'm sorry. The Holly Hill Clinic that you were just telling me about, the monthly specialists, how often is it?

Can you get in for the specialist that's coming that month? Or do you normally have to wait until the month after?

THE WITNESS (Kelly): I'm going to ask, is Priscilla still --

A VOICE: She just stepped out.

THE WITNESS (Kelly): She just walked out.

There, Dr. Santucci might be able to answer that.

KAREN A. SANTUCCI: Good morning everyone. My name is Karen Santucci.

THE HEARING OFFICER: If you could come down to the front? Because it's a very long table and a very tiny screen. And I'll have to swear you in.

So please state your name for the record and your title.

KAREN A. SANTUCCI: Yes, my name is Karen Ann Santucci, MD. I am the Chief Medical Officer of Greenwich Hospital. Good morning.

THE HEARING OFFICER: Good morning. If you could please raise your right hand?

K A R E N A. S A N T U C C I,

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

THE HEARING OFFICER: Thank you. Go ahead.

THE WITNESS (Santucci): Thank you. And I apologize for being late. I just had an unavoidable conflict. My sincere apology.

To address the question, I think the reason our team has had a little bit of a difficult time answering it is because it's truly specialty specific.

It may be that for GYN where we have clinics on Friday and we have a dedicated maternal fetal medicine doctor who's board certified in OB/GYN and specialty trained in MFM, she's there and she's available. We can get a patient in pretty quickly. For a specialty where almost the world struggles, like dermatology, someone may need to wait a month or two.

Now certainly if there's an urgent issue, as our folks have stated, we will do everything to expedite that visit and we will arc up our concerns to our specialists and make sure that they're seen in a timely fashion.

And I think it's also important to share with the group that our medical staff, being on medical staff at Greenwich Hospital as well as being part of our academic health system, Yale New Haven

Health, we ascribe and comply with the vision, mission, and values of our health system. And our mission, our values are to take care of our community, our population.

And this medical staff is very dedicated and we're pretty fortunate having a team of people, dermatologists, podiatrists, many folks, ophthalmologists, as I mentioned, gynecology, neurology -- where folks dedicate either mornings or afternoons on a regular basis, pulmonologists to take care -- to take care of these patients.

And our patients that we see currently in our outpatient center are not treated any differently from the patients who may live two blocks away from the hospital and come from a very different demographic. Our patients are treated fairly, respectfully, and we make sure that they get the highest level of care in a timely fashion.

THE HEARING OFFICER: Thank you.

THE WITNESS (Arnold): Can I just add to that from -- so Dr. Santucci spoke about the clinics as they operate at Holly Hill. We've been working in partnership with Greenwich Hospital since we've opened up our FQHC, and our patients at the FQHC have been afforded the same access.

So I think that -- so the answer to the question is that whether they were coming from Family Centers' FQHC or Greenwich Hospital's clinic, they've been receiving the same level of access and they will continue all to receive the same level of access in the future.

And I will point out that just a little bit of a side benefit of -- of this transition is that some of the primary care that we're doing in the Wilbur Peck Clinic will transition over to the new Holly Hill site, which will free up space in the Wilbur Peck Clinic for us to expand dental care, which is sorely needed by this population and -- and very limited in terms of access.

We only have one chair at this point and this will enable us to expand to three chairs and really penetrate the population's need much greater.

MS. RIVAL: Thank you. If Family Centers decides to stop providing a specialist service or cannot find a specialist willing to see patients at the Family Center, what would happen to those patients?

THE WITNESS (Arnold): I'm sorry, I don't think I -- could you repeat that question?

MS. RIVAL: Sure, of course. If Family Centers decides

to stop providing a certain specialist service or cannot find a specialist who is willing to see patients at FC, what will happen to those patients?

THE WITNESS (Arnold): Well, it's -- it's sort of inconceivable that we're going to stop providing any specialty area, and that we will do whatever is necessary to acquire that specialty.

THE WITNESS (Kelly): Dennis wants to --

THE WITNESS (Arnold): Yeah, Dennis. State your name.

THE WITNESS (Torres): Dennis Torres. The -- our care managers, our end care managers, often if we can't find a specialist locally, we'll look into Stamford. We've sent patients up to New Haven.

We provide transportation. So with all -- all the barriers that might hinder someone from getting to a specialist up the line, we remove those and make sure that patients have access.

That's part of our joint commission philosophy that we close all these open -- loose ends and we make sure that that happens. It might not be overnight, because sometimes it does take -- as you know, specialty care is sometimes hard to access, but it's not impossible, and we -- we make sure that we make those connections.

THE WITNESS (Kelly): This is Diane from Greenwich. I would add that I actually think that this proposal actually solves for this and makes this more -- brings us closer together and that it no longer would just be their issue to help resolve.

That would be our issue as well, because we'd have a joint responsibility and we'd have the access of the Yale New Haven Health System, which is -- you just reminded me, Dennis, is that, you know, there is a pretty robust FQHC partnership up there in New Haven that we know we would be committed to ensuring that we don't hit that road bump.

MS. RIVAL: Great. Thank you. That concludes my questions for now. I believe my colleague Yadira has some questions for the Applicants as well.

MS. McLAUGHLIN: Yes. Good morning again. This is Yadira McLaughlin with OHS. And my first question is on page 20 of the application, the response to question F.

Are these patients not already receiving excellent and culturally competent care by Greenwich Hospital? And besides everything being in one place, what other improvements will family-centered patients benefit from?

THE WITNESS (Kelly): So can you just repeat the beginning of it? I'm sorry.

MS. McLAUGHLIN: Sure.

MS. FELDMAN: And can you give us the Bates number, please?

THE WITNESS (Kelly): Yeah.

MS. FELDMAN: The Bates number, please, for the question?

(Pause.)

THE WITNESS (Kelly): So why don't I take a stab while we're looking for the Bates number?

Is that what we're waiting for?

THE HEARING OFFICER: Yeah. My printed version did not come with Bates numbers on it. So I don't --

THE WITNESS (Kelly): Okay.

MS. FELDMAN: So can you please repeat the question.

MS. McLAUGHLIN: Do you want me to repeat the question?

THE WITNESS (Kelly): Yeah, I want to be succinct, if you don't mind?

MS. RIVAL: Sure. So in response to question F of the application, aren't these patients already receiving excellent and culturally competent care by Greenwich Hospital?

And besides everything being in one place, what other improvements will family-centered patients benefit from?

THE HEARING OFFICER: It's page 27, Bates number. And it's in response to discuss how low-income persons, racial and ethnic minorities, disabled persons, and other underserved groups will benefit from this proposal, F question.

MS. FELDMAN: Can you please give us a minute to find it?

THE HEARING OFFICER: Sure.

MS. FELDMAN: Because I believe we already answered the question in the application, but we'll review it.

(Pause.)

THE WITNESS (Kelly): Thank you. This is Diane, and I'll take this. And I'm glad to say it's what I was thinking you were asking, but I wanted to make sure. And thank you for the question.

So Yale New Haven Health System and Greenwich Hospital alike have actually been on a very deliberate mission and vision of ensuring that we are culturally competent in the care that we're providing, and that we're sensitive to cultural

differences, to equity.

We actually have created an entire division with leadership. In fact, I at Greenwich Hospital represents the leadership through the system along with one of our physician partners. So this is part of our strategic priorities for 2023, '4, and '5. That's about what we, you know, we'll reevaluate it after '5.

And it's based on the fundamentals of health equity and cultural competency of our caregivers. That is -- included in that is the CMS framework for health equity that we're using. What we're also using for the framework of that is the joint commission standards that we all are -- are building our programs on.

But how does that translate here locally?

We actually participate in our community needs assessment and looking at disparities of care, looking at things that may be barriers to access to care. That's with our community partners.

Through this journey of making sure that we are really embedding this in everything that we're doing, we've actually made our community action council part of our formal board governance

process, that we are monitoring the results of the community -- the community assessment results. And we are monitoring our actions and reporting it to the board on a consistent basis to make sure that we actually are performing into those priorities.

It's actually probably the biggest sea change I've seen in governance in a health system, and I've been doing this for a while. So how are we doing that? And how do we make sure that's important to the Family Centers?

I will tell you that was actually a question to make sure that our vision in this, this frame was aligned. The board wanted to make sure that this was a priority of the Family Centers, but it really was -- it was an easy answer because it's the hallmark of what they do. It's the framework of what they do, is making sure that all people have access to equitable and culturally diverse care.

So I will tell you that it's embedded in all of what we're doing. It's a board priority, and again social determinants are assessed at many levels within the organization of Greenwich Hospital, including the coming into the clinic,

coming into our emergency department. And we actually -- even if you're inpatient, we are doing that.

We have an entire population health team that are -- we are working to close these, these gaps and we are doing a lot of, which is why I'm really grateful that the Family Centers went ahead and be part of Epic. Because it is a big part of our data analytics -- is looking for data that's reporting on a big level.

Are we having disparities of care based on any socioeconomic or racial diversities? And are we seeing clinical outcomes with that? So it's also part of our quality program.

I hope that answers your question.

THE WITNESS (Arnold): So to the second part of your question, what would change with Family Centers? I would add two things to what Diane Kelly said, and that is that Family Centers has a majority of its board as consumers utilizing the services of the FQHC.

And we have a community advisory group comprised of patients as well making recommendations about their experience utilizing the services and any part of it. And those, that

input is taken and included in policy changes within the -- within the healthcare centers.

THE WITNESS (Torres): I would just add one more to that, that our staff is also reflective of the populations we serve.

MS. McLAUGHLIN: Okay. Thank you.

My next question, if Family Centers decides to terminate a service, please explain the process for the service to return to Greenwich Hospital.

THE WITNESS (Arnold): Yeah, as --

MS. FELDMAN: Can we have a minute, please?

MS. McLAUGHLIN: Sure.

(Pause: 10:23 a.m. to 10:24 a.m.)

THE WITNESS (Kelly): So I -- just to begin that --

MS. FELDMAN: Say your name.

THE WITNESS (Arnold): Bob Arnold. It's practically unthinkable to me that we would discontinue the service. I know this came up earlier. Something would have to be catastrophic because, again, we -- we are, you know, a part of HRSA and -- and the network of community health centers across the nation. And it's a very rare thing for an FQHC to discontinue service.

I -- we did mention earlier that we were going to have a joint committee from the hospital and Family Centers to oversee the ongoing work of these two clinics. And so it's -- if we run into issues, whatever issues we run into should very likely be resolvable through the work of the joint commission that we will have.

But there's -- there is a very infinitesimal possibility that we're going to exit the primary care area. And I think earlier there was a question that touched partially on this that Diane Kelly responded to in which she said that the hospital would be open through its many practices to absorb patients, and there are three other FQHCs within several miles who would probably also be available should there be something really catastrophic.

But we certainly are not anticipating anything along those lines, and we have no plans of closing any of our practice.

MS. McLAUGHLIN: Thank you. My next question, what will outreach efforts to advise of this change consist of for current patients of Greenwich Hospital and for any anticipated new patients of the Family Centers?

MS. FELDMAN: Can you restate the question, please?

MS. McLAUGHLIN: Sure. What will outreach efforts to advise of this change consist of for current patients of Greenwich Hospital and for any anticipated new patients of the Family Centers?

MS. FELDMAN: Why don't you start?

THE WITNESS (Kelly): So this is Diane from Greenwich Hospital.

And that we would, like we do with all of our patients, whenever there's a change in their practice or in their care provider, we notify them in writing. We also have a patient advisory council, where on that council we have some of our clinic patients, and have started talking about this possibility. So we get their feedback in the process.

So we would be doing that kind of a communication, but we -- we absolutely do a very formal written communication and giving people the opportunity to ask questions and discuss this. That's part of our process when we do any of this kind of change in services in provider.

THE WITNESS (Arnold): And likewise, we would also notify our patient population, although not all of our patient population would necessarily be moving

to the Holly Hill site.

However, the distance between the Holly Hill site and the Wilbur Peck site, for instance, is only a few miles and it's on the same bus route. So there wouldn't be any sort of hardship really for the patient population.

And in fact, another large public housing development that we draw quite a few patients from is -- it is very close to the Holly Hill location, and would be much more convenient for that cohort of our patient population.

MS. McLAUGHLIN: Thank you.

My next couple of questions are going to be related to cost and cost effectiveness of the proposal. How would the proposal affect the cost of services for patients?

THE WITNESS (Kelly): The cost to the patient, is that the question? Or just cost in general? Just -- I'm just trying to --

MS. McLAUGHLIN: The cost of services to the patients.

THE WITNESS (Kelly): So that one is -- and we thought a lot about this, because today we don't have the ability to provide a wraparound service. You don't pay one fee if you were to pay. You know there, you know we have a range of what people can

pay for.

But you know your medical visit is your medical visit, and if you need behavioral health, that's another visit. That's another cost. If you need to see a consult, that's another cost.

So when we look at it, and if you're going into a patient-centered medical home, the overall cost should be lower because you're not getting those separate, different bills, if you will. And we know there will be a reduction in inpatient, and we know there will be a reduction in ED, which are very costly.

So our goal is that this is -- this is an enhanced value for a lower cost, because we would be moving away from that episodic billing to a more wraparound service.

THE WITNESS (Arnold): Yeah, I agree and think that the -- the cost should not be an issue, because both Greenwich Hospital currently and Family Centers provides substantial financial assistance to the patient population. And we of course follow HRSA's regulations around financial assistance.

And as far as the fees that patients are paying currently at the Greenwich Hospital

clinics, they -- they would not change upon the transition to Family Centers.

MS. McLAUGHLIN: Okay. Thank you. And please explain why some patients who transition to the FQHC will end up with higher costs.

THE WITNESS (Kelly): We don't -- we don't believe they will, to the patient.

He just answered -- I think that --

THE HEARING OFFICER: You did actually mention that in your application. If I can draw your eye to --

THE WITNESS (Kelly): Yeah, that would be helpful.

THE HEARING OFFICER: Let's see, I believe it is -- and actually in the completeness letter as well, you mentioned it quite a few times.

Let's see. Charity Care.

MS. FELDMAN: Hearing Officer Novi?

THE HEARING OFFICER: Uh-huh?

MS. FELDMAN: May I just point out that Mr. Arnold, I believe, just answered the question regarding there will be the -- whether there will be any negative impact for the patient regarding costs.

I think we heard Ms. Kelly say that there were no -- these were different services. We're comparing apples to oranges. And then we heard Mr. Arnold say that we will honor the cost

structure that is currently in place at Greenwich Hospital for these patients.

So I'm not sure how we can answer the question any differently at this point.

THE HEARING OFFICER: Okay. I will be asking questions later. I think during the break, I would ask you to go over your -- I think it's the second -- I have a paper copy. Sorry.

Review the financial information provided, and especially the charts that start on Bates page 37 and the answer prior to 37, on Bates page 36.

But we can move on. I'll ask that question later after a break, so.

MS. McLAUGHLIN: Okay. Thank you.

Please explain the cost differences between Yale New Haven Hospital's assistance policy and the plan submitted by Family Centers.

THE WITNESS (Kelly): I'm sorry. Can you repeat that? I was reading something. I'm sorry.

MS. McLAUGHLIN: Sure. No problem.

Please explain the cost differences between Yale New Haven Hospital's assistance policy and the plan submitted for Family Centers.

THE WITNESS (Kelly): I think that's what we were just referring to. Right?

THE WITNESS (Arnold): Yeah.

THE WITNESS (Kelly): So we did recognize it, that we -- and the Family Centers is going to be honoring our policy of assistance.

MS. FELDMAN: For these patients.

THE WITNESS (Kelly): For this patient population, so there is no increase for that populate -- for the patients.

So is that the -- is what you're looking for? Like, we did recognize there was a difference, and we're closing that gap by making sure we're honoring what it is that our patients are used to.

THE HEARING OFFICER: So just so I can make sure I understand.

THE WITNESS (Kelly): Yeah?

THE HEARING OFFICER: All patients coming from the Greenwich Hospital will still continue under the Yale New Haven current payment, which goes up to, I believe that was 450 percent or 400 percent of poverty line?

MS. FELDMAN: I think it's very -- this is Joan Feldman speaking. It's very difficult to say all patients. We're talking about a payer mix that is Medicare, Medicaid, self insurance -- I mean, commercial insurance and self pay.

The answers are going to vary depending upon which payer you're speaking to. So if you could ask the question to us in a specific fashion?

I think we already testified that both providers have very generous financial assistance policies. They are different, but the bottom line is that both will have policies that allow accommodations for patients with financial need so that no patient is -- cost does not become a barrier for access to healthcare.

That's the bottom line.

And to the extent --

THE HEARING OFFICER: Joan, I can't quote you on this. It would be easier if the information came from them.

MS. FELDMAN: Right. I think my clients have already said that, and I'm just reiterating what the testimony already has been.

The question keeps coming up in various forms. I'm just trying to clarify. That's all. It doesn't have to be testimony.

THE WITNESS (Arnold): Yeah, I can speak to this. And to the Family Centers' policy, I can say that the cost of the service is never allowed to be a barrier for any patient service. So that we will,

you know, there's certain set costs, but if there's a demonstration that that's difficult, we have the capacity and do waive that service or reduce that fee greater for the patient.

So that -- and by the way, that is -- that is a standard procedure with HRSA related community health centers across the country. That's why community health centers exist. They exist for patients who have no other option, or can't pay anything for their healthcare. That's the whole premise behind it. And so we certainly stand by that completely.

MS. McLAUGHLIN: Okay. Thank you.

My next question, on page 8 of the September 29, 2023, first completeness letter responses it states that the FQHC will save $1,263 per patient per year. Please elaborate on this statement.

Is this saving to the individual? The Family Centers? Or to the insurer?

A VOICE: Page 328.

MS. FELDMAN: Can we have a minute, please, off the record?

THE HEARING OFFICER: Sure.

(Pause: 10:39 a.m. to 10:41 a.m.)

MS. FELDMAN: Okay. We're back.

THE WITNESS (Kelly): Hi there. Thank you for that moment. So we actually, as everybody in healthcare is -- works really hard to be evidence-based. And so the number that you're referring to, the 1,263 reduction in the cost per care, was actually used as a reference point on why we believe in this model.

And it was under an Exhibit E. It's called the Matrix Global Advisor, and also the NACHC, you know, the National Association of Community Health Centers. It's a community health center chart book that gave us -- just supporting this model and what we could expect to see as a reduction. So it was a reference, so to be clear about that.

And we do believe -- we -- we have evidence of that in our own homework, if you will, by taking that reference and then looking at the outcome of what Yale New -- up at New Haven, and they saw that reduction in inpatient and then ED care. So that would all reduce the overall cost of care.

So that's -- it was more of a evidence base to this practice, if you will. Thank you.

MS. McLAUGHLIN: In the same completeness letter

response letter, which was dated September 29, 2023, table 3 on page 9 -- taking a look on table 3 on page 9, please explain why the cost incurred by commercial patients were more than double on the first year, and then increased the second year by almost $80.

Will these increases remain common?

A VOICE: Page 329.

THE WITNESS (Torres): Could you repeat your question, please?

MS. McLAUGHLIN: Yes. So in the same completeness letter response letter, which was dated September 29th, if you take a look on table 3, page 9, please explain why the cost incurred by commercial patients were more than double on the first year, and then increased on the second year by almost $80? Will increases of this size remain common?

JOHN WUNSCH: My name is John Wunsch from the Family Centers. I'm prepared to answer the question.

THE HEARING OFFICER: Okay. Before you are allowed to answer your question, if you would just raise your hand so I know who you are? Thank you.

And then I'm going to swear you in.

J O H N W U N S C H,

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

THE HEARING OFFICER: And if you could say your name a little louder and spell your last name for the recorder, please?

THE WITNESS (Wunsch): My name is John Wunsch, W-u-n-s-c-h.

THE HEARING OFFICER: Go ahead.

THE WITNESS (Wunsch): The rates shown for fiscal year '23 for Family Centers have not been negotiated in ten years, and don't reflect what's currently offered in the market from insurance companies.

And we're currently renegotiating our rates right now and expect the bigger bumps to occur within the '24/'25 fiscal year. Then the '26 fiscal year only reflects an inflationary increase.

MS. McLAUGHLIN: Okay. Thank you. And please outline the steps that you will take to lower the burden on patients who will be facing higher charges.

THE WITNESS (Kelly): So it's just from a Greenwich perspective is --

MS. FELDMAN: I think from --

THE WITNESS (Kelly): Oh.

THE WITNESS (Arnold): Could you repeat that? Sorry.

MS. McLAUGHLIN: No worries. Please outline the steps that will be taken to lower the burden on any patients who will be facing higher charges.

MS. FELDMAN: Just for clarification, please? You mean with respect to commercial insurance? Is that what you're --

MS. McLAUGHLIN: Correct.

MS. FELDMAN: Yes. Okay. What he just said.

No, you.

THE WITNESS (Arnold): Yeah, I'm trying to. So the patient's charges from the -- the insurance covered patient shouldn't be affected at all. It's the increase from the reimbursement from the insurance companies themselves that we're renegotiating now, that the patient copay is not going to change.

So we don't anticipate there will be additional charges that patients need relief for.

MS. McLAUGHLIN: Okay. Thank you.

And how would the proposal affect the diversity of healthcare providers and patient choice in the region?

THE WITNESS (Kelly): How will the proposal affect?

MS. McLAUGHLIN: How would the proposal affect the diversity of healthcare providers and patient choice in the region?

THE WITNESS (Kelly): They'll have more choice. And I'm a little lost in this one, because I don't think that's a barrier for us. So I'm just -- just trying to think about how will it affect it.

I mean, we are going to continue with patient choice. Both organizations work to have diversity. So I -- I think it will be remaining with a high consistency of options for people. Actually, they're going -- they're going to have patients moving from the FQH -- from Greenwich to the FQHC will have access to more services. So there, in effect, more people will be providing those services. So they'll have more available to them.

And I know the FQHC has a strong commitment to diversity -- so I guess it could be improved, but I would have to say I think we do a nice job at it at Greenwich as well. So I'm -- I think we'll maintain that high standard.

I'm not sure that really answers your question.

THE WITNESS (Arnold): But I also think the diversity, you know, you could utilize the term "diversity" in many different ways. But earlier on, I think Diane Kelly said that along with this transfer, the hospital is providing some other very clearly identified needs of intensive outpatient care within the community. And so that's going to add diversity to -- to the range of care that we see the need for in the FQHCs.

So I do think that that form of diversity is a big step and is -- it's very helpful. But we do have other FQHCs who we may share patients with, depending on what kinds of specialties or things they offer. So there's a great deal of diversity, and it seems like it's -- it's increasing.

THE WITNESS (Torres): I would just add, if I'm understanding the question --

THE HEARING OFFICER: Oh, wait. I'm just going to pause you for a second, because you're the second person to start talking without saying your name first.

THE WITNESS (Torres): Oh, sorry. Dennis --

THE HEARING OFFICER: For the Court Reporter, name, then speak.

THE WITNESS (Torres): Got it. Sorry. Dennis Torres.

THE HEARING OFFICER: Okay.

THE WITNESS (Torres): I would just add that this, this collaboration, this is adding choices. It's not taking away choices because staff from the hospital are staying.

Patients that are used to seeing their same providers, that's not going away. Patients that are used to seeing the same providers at Wilbur -- at Wilbur Peck at Family Centers, that's not going away so that no choices are -- are being removed.

The only choice, that's -- is really an additional one. So there are going to be added services, added benefits of a combination of the two.

THE WITNESS (Kelly): This is Diane Kelly from Greenwich. And I just would add also that our clinic is relatively small. And we will increase the amount of people that we're reaching, which in effect has a greater impact on the equity and availability of equitable and diverse care.

MS. McLAUGHLIN: Okay. Thank you all for your answers.

My last question is, does Family Centers have the capacity to accept all of the patients that are served by Greenwich Hospital? And if not, what percentage of Greenwich's current patients

will be served by the Family Centers?

I'm sorry. Let me clear something up. The second part, if not, what percentage of Greenwich Hospital's current patients will be served by the Family Centers?

THE WITNESS (Arnold): We have the capacity -- Bob Arnold. We have the capacity to serve 100 percent of the patients who would be coming from the Greenwich Hospital clinics.

MS. McLAUGHLIN: Okay. Thank you.

And that concludes my questions.

THE HEARING OFFICER: All right. So at this point I'm going to suggest a 20-minute break. It is now -- we'll call it 10:55. And so we can come back here at 11:15, give everybody a chance. And then Steve and I will be asking some follow-up questions after the break.

Okay. I ask that everybody turn off your camera and mute yourself during your break. We are going to try to do that, but it is good if everybody does it as well.

So we'll take a 20-minute break now. Thank you for all being really patient through this long haul. All right.

(Pause: 10:53 a.m. to 11:15 a.m.)

THE HEARING OFFICER: Okay. So I'll give the warning now. As you just heard by Zoom, you are now being recorded. If you do not consent to being recorded, I ask that you leave the Zoom hearing at this time. If you remain in the hearing, you give your consent to being recorded.

All right. We have Attorney Feldman back. Good morning, everybody. It is now 11:16 a.m., and I'm going to resume the hearing.

I did just make the announcement about Zoom, so those of you who just walked in, you consent to being recorded by remaining in this hearing or on camera.

All right. At this point, we will continue with questions from OHS. We will next move to Mr. Lazarus.

MR. LAZARUS: Thank you, good morning. Steven Lazarus, L-a-z-a-r-u-s. I have a couple of questions to follow up. First of all, thank you so much for providing a lot of detail. That was very helpful regarding this proposal.

And I think we've heard a lot from the Applicants regarding the advantages for this

proposal when it comes from a patient perspective. And I think that was thoroughly discussed and we do appreciate that.

However, this is an actual termination by Greenwich Hospital, legally speaking, of these services. So to that point, can the hospital talk a little bit about the need for terminating this service beyond just the patient perspective?

And what are the advantages and the reasons that it's sort of a need for the hospital? I think that would be appreciated.

THE WITNESS (Kelly): This is Diane Kelly, President of Greenwich Hospital. And the need for this came -- it came from a patient perspective. It just -- and it has remained the focus.

It's a small clinic that we really are not able to expand, given the fact that we're not -- we don't have a patient-centered medical home model. We are not -- we are, you know, primarily an acute care and specialty care service. So we have always wanted to continue the partnership with the FQHC who works in this space.

We did not want to duplicate services at a time when resources are very scant. I think we talked about the primary resource that really

looked like it would be prohibited -- was we knew this population, based on our community assessment need, would benefit greatly from having more behavioral health embedded in their everyday care.

That is one of our biggest shortages, not just Greenwich or Fairfield County, or Connecticut, but it's the state. So we really lend -- and leaned towards the people that are already doing this work and doing it well.

So it really -- it really was building on a relationship. We've already had strong partnerships. We want to grow our services. We couldn't grow them to the way that is best optimal for this population. So it lends itself to look to the people that have already been doing this in an expert way and expanding on that with their collaboration.

So I -- I do understand and appreciate your question, because I -- I know that's the wording, the closing. It just bugs me, but that's not for this -- that's my own personal. Because we are not -- we are so committed to making sure that -- that we are involved in this, in this care going forward.

MR. LAZARUS: Thank you. And we appreciate, you know,

the concern for the patients, and I think that's a great thing.

Was there -- I mean, having said that, was there analysis performed to understand this? I know you gave some reasons why it would be advantageous for the patients and why Greenwich Hospital could not grow this as a patient need -- sort of was growing as part of the CHNA.

Was there, like, a financial analysis or some sort of a study done to get to this point?

THE WITNESS (Kelly): Yeah, so with every one of our departments we do do a financial analyst -- and reckoning every year. Actually, it's an ongoing process.

This department has always cost the organization more than it brings in. That's -- but that's true with most of our departments. As you may know, Greenwich Hospital had posted its first loss in -- I don't know how many decades. So that itself is not a driver.

It's an unfortunate situation, but all -- most healthcare are finding themselves in that situation. But what we -- so we, we knew that this would require more resources by the FQHC. So we knew that we would be continuing to spend money

in order to shore up the care for this group and expand it.

Our choice was, continue to lose money and not expand what we're able to do. So the idea is let's spend the money, which is the same as losing, if you're coming from a health -- from my seat, whether I spend it or lose it, it doesn't matter. It's both. It's a negative off your balance sheet. It doesn't matter how it got there.

But we knew if we spent the money with the FQHC, we would actually be able to expand what we were offering to that group of patients and -- and expand the number of people we could serve.

You know, in the community health needs assessment it actually showed that we are -- we really -- there were more people in this community that were eligible than we were reaching. So we really -- and the FQHC model, the Greenwich Family Center is -- is built to reach this. You know, they're in the schools reaching out to the children before they even graduate from high school.

That, you know, I always think it's really smart in healthcare -- is go to the people who are

doing something really well. You don't have to duplicate it. Go to them and partner with them. That's how we're going to solve these, these health costs, and that's how we're going to improve what we can offer.

So I don't believe that we have to be everything to everybody, but we have to be open to other people's expertise.

MR. LAZARUS: Thank you. So would you be able to provide a copy of the analysis that was performed in this as a late file so we can have evidence for the record?

THE WITNESS (Kelly): It would just be the P and L from our last -- our profit and loss statement from maybe the last year of the clinic, where it showed that we needed to support it by a couple million dollars. Right?

MS. FELDMAN: Right. Are you focusing, Steve, on the financial analysis? Or the planning, strategic planning analysis?

MR. LAZARUS: Well, I think both, but I think the strategic -- from a strategic perspective, it would be nice to see the analysis that was performed. And it can certainly be backed up by the find, you know, pointed towards the P and L as

evidence.

But we're looking for the actual plan that was utilized to develop this project, for the need for it.

THE WITNESS (Kelly): Oh, the needs part. Yeah, we have stuff from the white cap engagement.

MR. LAZARUS: Okay. And again, supported by the financial analysis that may be showing, you know, the losses from the previous year.

THE WITNESS (Kelly): Yeah.

MR. LAZARUS: That would be fine.

THE WITNESS (Kelly): No, we -- yeah. Yes, we definitely can do that. I'm just going to put a few things together, like, pieces of different -- yeah.

MR. LAZARUS: Terrific.

So Hearing officer, we would call that Late File 1?

THE HEARING OFFICER: Yes.

MR. LAZARUS: Thank you.

(Late-Filed Exhibit Number 1, marked for identification and noted in index.)

MR. LAZARUS: Is there an agreement that was a formal

agreement between Greenwich Hospital and Family Centers for this? And can we get a copy of that as a late file?

MS. FELDMAN: Yes.

THE WITNESS (Kelly): Yeah.

MR. LAZARUS: There's testimony a few times I think that came up, and I think we're talking about some of the future decision making and care for the patients, and the joint committee board was discussed.

And it obviously seems to be a very important part moving forward. So if you can provide some background, talk about the makeup of the board, the timing when it's going to be formed, and what type of role they're going to have would be helpful.

MS. FELDMAN: So Steve, just -- not to provide testimony here, Officer Novi, but it's all set forth in the collaboration agreement that is Late File 2, presumably.

MR. LAZARUS: Okay.

THE HEARING OFFICER: But we may want to have them testify so that the public who may not have read the Exhibit 2 can be informed of what's in there without having to go back and find the exhibit,

because we do have public here at this hearing as well.

MS. FELDMAN: Do you want to say that --

MR. LAZARUS: So you're going to give just an overview --

THE WITNESS (Kelly): So it will be in the late file. It will be in the Late-File Number 2 in outlining about how that structure will look.

That's Diane Kelly from Greenwich.

MR. LAZARUS: How many members do you expect to be on that board? And what would the makeup be between Greenwich Hospital and Family Centers?

THE WITNESS (Arnold): Well, it's -- I don't know that you would call it a board. It's a joint -- it's a joint committee to oversee the transition and ongoing care of that.

And the numbers I don't think have been determined.

MR. LAZARUS: Do you anticipate that the majority of Family Centers and/or would it be equal -- or one party, or would it be an equal board?

THE WITNESS (Kelly): We're going to be able to provide that information in the collaboration agreement.

MR. LAZARUS: All right. So I think it would be helpful as part of when you do submit that, if you

can highlight with an explanation, particularly to the board which may -- since we don't have that -- won't be able to have that discussion now, there may be additional followup once we receive the late file on more details on that. Because that appears to be the key moving forward.

(Late-Filed Exhibit Number 2, marked for identification and noted in index.)

MR. LAZARUS: Alicia, I think if you want to go continue with your followup?

THE HEARING OFFICER: Yeah. Okay. My first question is, are there any services that are available at Greenwich Hospital that would not be provided at the new FQHC?

MS. FELDMAN: For clarification, do you mean at the Greenwich Hospital outpatient clinic?

THE HEARING OFFICER: People who go to the Greenwich outpatient clinic now, will there be services that they could have gotten at that clinic that won't be at the new FQHC?

THE WITNESS (Arnold): No.

THE WITNESS (Kelly): No.

MS. FELDMAN: That was Bob and Diane.

THE HEARING OFFICER: Okay. I would like to ask for a late file on the explanation of what a reasonable loss will be, or how that will be decided.

MS. FELDMAN: Yeah.

THE HEARING OFFICER: We'll call that number three.

(Late-Filed Exhibit Number 3, marked for identification and noted in index.)

THE HEARING OFFICER: Earlier in, I believe it was Ms. Kelly's testimony, you talked about benefits from expanding the improved resident program that will be going into the new FQHC, and that you had data to support that.

I don't think any of that was submitted with the original application and I would like to see some of that data on how a resident program will help.

THE WITNESS (Kelly): So we'll give you the current number of patients that our residents see today, and then we can give you what we're hoping they will see with the expansion of having more patients to see.

THE HEARING OFFICER: Okay.

THE WITNESS (Kelly): I think that if --

MS. FELDMAN: We need some clarification because I -- Hearing Officer, I didn't hear Diane Kelly say there was data that demonstrates the benefits to the residents. I think she was talking generally about training physicians.

THE WITNESS (Kelly): Yeah, it's -- I was. And it's in our -- it's in our proposal that it's under one of the benefits, if that will enhance our residency program by having more patients to see.

So maybe that's an assumption that more patients is better for training than few patients.

THE HEARING OFFICER: Okay. So hold on. I just want to make sure I understand correctly. So the residency program benefits the residents in the program, the actual medical students who are doing the residency, more than the --

THE WITNESS (Kelly): Yes.

THE HEARING OFFICER: -- patients? Oh, okay.

THE WITNESS (Kelly): Yes, I'm sorry. Yes.

THE HEARING OFFICER: We will withdraw that as a late file.

MS. FELDMAN: Okay. Thank you for that clarification.

THE HEARING OFFICER: Did Greenwich Hospital put out an RFP for a partner for the FQHC?

THE WITNESS (Kelly): We did.

THE HEARING OFFICER: Okay. I would like for that to be submitted as a late file.

MS. FELDMAN: Okay.

THE HEARING OFFICER: We'll call that number four.

(Late-Filed Exhibit Number 4, marked for identification and noted in index.)

THE HEARING OFFICER: And then also I would like to ask for more information. It wasn't clear to me in your testimony about what the community benefit grant is, how it's going to work. And I mean, I know you mentioned in-kind services would be provided.

What are those services? How are they going to be -- what are they going to be looking at? What they, you know, exactly what goes into this community benefits grant. Because if you're providing, like, a box of band-aids, I would like to know if that's included in your community benefit.

MS. FELDMAN: Yeah, there is -- in addition to the collaboration agreement, there is also something called a community benefit grant agreement.

THE HEARING OFFICER: Perfect.

MS. FELDMAN: And we can provide that as Late-File 5.

THE HEARING OFFICER: Yes, please.

(Late-Filed Exhibit Number 5, marked for identification and noted in index.)

THE HEARING OFFICER: Also, just a follow up to my earlier one, if we could get the Family Centers' response to the RFP as part of number four?

MS. FELDMAN: Sure.

THE HEARING OFFICER: Okay. And then one last question that I'm still not clear on. On Bates page 36, midway down the page for the question, on question 20's response, it says to qualify for free care at FC, the patient's income must be at a hundred percent or below the federal poverty level, versus 250 percent or below at Yale, or Yale New Haven Hospital System.

That is a significant difference. How will those patients who fall within the 101 and the 250 percent of the federal poverty level that we're getting qualify for free care at Yale New Haven Hospital System -- what are you going to do for those patients?

THE WITNESS (Torres): First, I want to clarify that we

do not provide free care. First, it requires that we -- that's not something we do. However, if you're a hundred percent or lower, we can discount to zero.

Just -- I know it's wording, but it's important that we say it's not free care. It's just discounted care, sometimes to zero. So I -- I believe the second part was, what happens between the 101 and 200? Because we -- HRSA requires that we have a sliding scale for patients between 100 and 200 percent of the federal poverty level -- and we do.

We have that sliding scale and that's looked at every year. The federal poverty level changes annually, too. So we have to have our board review that and -- and approve. The plan is to maintain that, that cost for -- for patients who are already enrolled and have accepted this, this as their -- as the sliding scale.

I -- with respect -- could you just repeat the second part of that question?

THE HEARING OFFICER: Sure. This is actually -- I read directly from the application. I said, how are you going to help those patients who would have qualified for free care under the Yale New Haven

Hospital System because theirs goes up to 250 percent of the poverty line, those 101 through 250 percent of the federal poverty line patients?

THE WITNESS (Torres): Yes, we've already agreed, and I think it was said earlier we will honor those agreements with those patients that are currently enrolled in the -- in the Greenwich outpatient clinic.

THE HEARING OFFICER: What about future patients who come in who are at those, a brand-new person who just moves to Greenwich and they are at 150 percent of the poverty level. What will happen for that patient?

THE WITNESS (Torres): Well, if they're a new patient and they're coming into our FQHC, they would qualify for our discounts and -- and sliding scale based on their income.

THE HEARING OFFICER: So their payment might be more than the grandfathered patients that come over from Greenwich?

THE WITNESS (Torres): Correct, and they -- yeah.

THE HEARING OFFICER: Okay. And you're Mr. Torres? I just want to make sure.

THE WITNESS (Torres): Absolutely.

THE HEARING OFFICER: We get your name in at the end or

the beginning at some point.

THE WITNESS (Torres): All right. Yes, Dennis Torres.

THE HEARING OFFICER: All right, that's it for my questions.

THE WITNESS (Arnold): Can I just, if I might, comment?

THE HEARING OFFICER: Yes.

THE WITNESS (Arnold): On the end of Dennis's -- that yes, they would come in with the new structure required by HRSA. But again, we are absolutely and always have been committed to not getting a fee, not allowing a fee to deter the patient care.

And if the patient cannot afford the fee according to the sliding scale, we have the ability to and can waive that fee, and reduce it to zero, because we're just committed to this patient population.

And we're not going to have a fee ever be a barrier for patient care. So that's -- that's an underlying, girding our whole approach to patients.

THE HEARING OFFICER: Okay. All right.

MR. LAZARUS: Attorney Novi, I just have one follow up question.

So we had talked about earlier about the strategic plan and the financial analysis done by

Greenwich Hospital. This is more for the Family Centers. Was there analysis done on your side and how this would affect your business strategically as well as financially?

THE WITNESS (Arnold): Yes. Yes, we -- we have analyzed how the influx would impact us with -- with projections, of course. And projections are just that, so we don't know that the numbers will play out exactly, but given that there's a current patient base at Greenwich Hospital, we know what those numbers will be.

And so we have that projection, and we also are recognizing that it benefits us through economies of scale because we'll have a larger patient population.

And in terms of whether or not we could accommodate it, that's really where the community grant with the partnership of Greenwich Hospital comes in.

So our intention and the plan which Greenwich Hospital agrees with for the community benefit grant is for us to break even on the services that we provide to the clinic patients.

MR. LAZARUS: Terrific. Can we get that as a Late-File 6, your analysis and the explanation -- and the

explanation that goes along with that?

THE WITNESS (Arnold): Sure.

MR. LAZARUS: Thank you. That's very much appreciated.

(Late-Filed Exhibit Number 6, marked for identification and noted in index.)

MR. LAZARUS: Attorney Novi, I'm all set.

THE HEARING OFFICER: Attorney Feldman?

MS. FELDMAN: Yes.

THE HEARING OFFICER: Any follow-up questions that you would like to ask your witnesses?

MS. FELDMAN: No, I do not have any follow-up questions.

THE HEARING OFFICER: Okay. So at this point, I would like to just remind our public that may be with us on this Zoom meeting, that we will be having the public portion of this at 12 p.m.

And that if you would like to sign up to make a public comment, you may do so now either through our Zoom chat; you can put your name and that you would like to make a public comment in the chat. And our staff will take down your name and call you in the order in which you register. At 12 p.m. we will start taking those comments.

Or if you would like to make a comment but you don't want to do it on Zoom, you may also e-mail your comments to CONcomment@ct.gov. And that will be open for a week after I conclude this hearing. So you will have a week after I conclude the hearing today to get your comments in if you would like to submit written comments to us.

And with that, I would like to take a short recess until public comment time at 12 p.m.

If we do not have public comments or public comments run quickly, then we will go ahead directly to closing statements and just a reiteration of the late file.

With that, we will see you here back at 12 p.m. Thank you.

(Pause: 11:39 a.m. to 12 p.m.)

THE HEARING OFFICER: All right. Welcome back, everybody. As Zoom just notified you, you are being recorded. If you remain in this hearing, you consent to being recorded. If you would like to revoke your consent, please leave the Zoom hearing at this time.

All right. For those of you just joining us,

this is the public portion of today's hearing concerning the CON application filed by Greenwich Hospital, Docket Number 23-32656-CON. We had the technical portion this morning. Sign up for public comment has been ongoing.

Just to give everybody a sense of how long we can expect the public portion of today's hearing to run, I typically allow commenters to speak for three minutes, the elected officials and elected appointed officials being given some flexibility.

The order of comment, we had no one sign up online. So I will make a verbal offer now. If there's anybody that is currently in this hearing that would like to comment, would like to make a public comment, you can either put your -- enter your name into the chat right now, or unmute yourself and turn on your camera and state that you would like to make a comment.

All right. Hearing none, I will recommend that anybody that is listening to this and has not made a public comment and does not want to speak on camera today, but would like to file one via e-mail, you will have the ability to do that for seven days, starting right -- oh, we got one.

Terry Kaufmann. All right. Okay.

Mr. Kaufmann, if you could please unmute yourself and turn on your camera so that we can see you?

Faye, if you could remove myself and Mr. Lazarus from the screen, and actually everybody so that we can see the person speaking?

Mr. Kaufmann, are you there?

TERRY KAUFMANN: Good morning. I'm here. I'm speaking through my phone. I'm trying to get my image up on the screen.

THE HEARING OFFICER: That's fine. On the phone, we -- you just stated that, so we acknowledge that we probably won't see you.

TERRY KAUFMANN: Okay. Again, I'm trying to get the video going.

THE HEARING OFFICER: Just go ahead. You can give your comment without the video if you'd like to go ahead and start speaking.

TERRY KAUFMANN: Thank you. So, yes, my name is Terry Kaufman. Good afternoon. I am a Family Centers board member, but I actually wanted to speak today as the father of an 8-year-old boy.

Recently, my son watched his grandfather fight a long battle with cancer, and the experience left him confused, scared, and just really sad.

My wife and I reached out to Family Centers because we knew our son needed help, but didn't really feel capable ourselves of giving him everything that we needed. And while that, that help has been an absolute godsend for my son and has given incredible relief to my wife and to myself, but I felt really compelled to talk about sort of the seamless manner in which -- to get into the fold with Family Centers, to explain our concerns about our son, and just the way that we were handled.

We weren't exactly sure what he needed. So really it was a process of them saying, okay. Well, here's how we think we can help you, and really quickly finding somebody that was a good match for our son, but also, obviously, appropriate for him, but whose schedule matched up with an over-scheduled second grader.

So you know, it's really been very important to us, very important to our son, and I couldn't be more thankful for the way that we've been handled.

THE HEARING OFFICER: All right.

TERRY KAUFMANN: Thank you. I appreciate you letting me make my comment.

THE HEARING OFFICER: Thank you very much, Mr. Kaufman.

THE REPORTER: May I have the spelling of your name, Mr. Kaufman?

TERRY KAUFMANN: Absolutely. It's Terry, T-e-r-r-y; last name is Kaufmann, K-a-u-f-m-a-n-n.

THE REPORTER: Thank you very much.

THE HEARING OFFICER: All right. Thank you, Mr. Kaufman.

Do we have any other? Anyone else that would like to speak?

(No response.)

THE HEARING OFFICER: Okay. So, seeing as I do not have one, I will go ahead and just remind everybody that you can submit written comments for seven days from today on CONcomment@ct.gov. Again, that's C-o-n-c-o-m-m-e-n-t @ct.gov.

That will be open for seven days from today, so that will be open through Wednesday, April 3rd of 2024.

Okay. Seeing as we have no one else who would like to speak, I will go ahead and move us to the late files. Steve, would you like to read the list of documents submitted?

MR. LAZARUS: Sure. Steven Lazarus, OHS staff. So we have a total of six late files, and the first one is the strategic and the financial analysis done by Greenwich Hospital to support this proposal.

The second one is the agreement between -- that's the agreement between Greenwich Hospital and Family Centers.

Number three is a question, which is asking for an explanation of what a reasonable loss would be and how that will be decided.

Four is a request and copies of the RFP that Greenwich Hospital had put out and the responses that came back with it, along with the Family Centers' response.

Five is the community benefits grant.

I'm not sure exactly -- were there any details to that, Alicia?

THE HEARING OFFICER: They were going to submit any information they had on the community benefits grant. We haven't seen any explanation of what was going to go into that grant, and an explanation of any benefits given to the FQHC in that grant.

MR. LAZARUS: We'll include that detail.

And the last I have is Family Centers

analysis that was performed for strategically as well as financially related to this proposal. And that's all the six late files I have.

THE HEARING OFFICER: Okay. Thank you very much.

Attorney Feldman, when do you and your clients expect to be able to provide the submission?

MS. FELDMAN: I think three weeks would be an adequate amount of time for us to pull that together.

I just want to clarify that with respect to the collaboration agreement and the community benefit agreement, those agreements are in draft form. Obviously, they haven't been executed because they're subject to the approval of OHS clarification.

THE HEARING OFFICER: Okay. So three weeks from today would be April 17th. Now we are going into a holiday weekend. Would you maybe like to the end of that week so you're not losing that one day?

MS. FELDMAN: Sure. We can always get it in earlier if we're able.

THE HEARING OFFICER: Yeah. So let's give you until April 19th, 4:30 on that Friday.

MS. FELDMAN: Sure.

THE HEARING OFFICER: All right. So we'll put that as

a date. And as always, if you have trouble meeting that deadline or you need more time to get documents together, please let our office know, and we can work with you on getting you an extension if necessary.

MS. FELDMAN: Thank you.

THE HEARING OFFICER: All right. Are there any other questions or concerns about these late files?

MS. FELDMAN: No.

THE HEARING OFFICER: No. All right. So let's move to the closing argument.

Attorney Feldman, would you like to make a closing statement?

MS. FELDMAN: Sure, not too long.

I want to thank you, Hearing Officer and OHS staff, and Dr. Gifford for your attention to this matter.

I believe and I hope that you'll agree that the application and the testimony that you heard today is very compelling, and that Greenwich Hospital has demonstrated that the current services provided by Greenwich Hospital clinics are different from the services offered by Family Centers. They're more holistic, they're more inclusive, and they're greater in scope.

Family Centers has a long history of helping its patients address socioeconomic challenges, for instance, related to, as you've heard, education, vocation, housing, and parenting, and you just recently heard bereavement counseling.

It's well established in the literature that by addressing the social determinants of health, patient outcomes will improve, and that when patients have more access to more social support services that wrap around the medical visit, the medical portion of the visit, the patients will make less visits, avoidable visits to the emergency department, and management of their chronic conditions will result in low -- lower inpatient admissions.

And just to be clear, because it seemed to have been a focus of many of the questions, the current clinics that are operated by Greenwich Hospital are very small in terms of the amount of patients that they care for currently.

And with respect to the cost issues, we don't believe that there are going to be any detrimental impacts on the patients with respect to their incurring any additional costs.

Only 25 percent of the Greenwich Hospital

patients currently that Greenwich Hospital sees are self-pay, and honestly many of them have no financial need. Actually, they are financially very comfortable, but for those that are financially challenged, what you heard today was that Family Centers, which is notorious for making sure that payment is not a barrier to access health care, has very generous financial assistance policies, different than Greenwich Hospital, but equally good.

And you also heard Mr. Arnold say that in order to make sure that cost is not a barrier to health care, they have the flexibility to adapt and to adjust, to meet the patient's financial needs based on the facts and circumstances that present themselves.

You also heard Mr. Arnold say that they will, for this patient population that transitions to Family Centers, they will honor the same financial arrangements that they had when they frequented Greenwich Hospital outpatient clinics.

So we think, we believe -- and we say this quite confidently, that there is no downside or detrimental impact to patients from a financial standpoint as a result of this potential

transition.

So we believe that what we're proposing here is a more proactive system of care that is less reactive, as you heard just now, by way of example. Behavioral healthcare services and care coordination are embedded in everybody's care at Family Centers. This is a proactive approach to keeping people healthy.

You also heard and saw in question, you know, how does federally qualified health centers reduce overall healthcare costs? We have seen that in New Haven. We also know that there we cited for you a national study which demonstrated that to be true, too.

So we hope that we have demonstrated that the executives of both Greenwich Hospital and Family Centers have indeed taken a leadership role in their community by going outside of their institutional walls to collaborate together to address the diverse needs of the community. We believe this is truly transformative, desirable, and in line with public policy directives to more fully address the social determinants of health.

We firmly believe that Family Centers will not only improve the health of the patients, but

will help keep preventable healthcare costs down in both hospitals and the community as a whole.

Family Centers provides the community with a patient-centered medical home -- and this collaboration promises, especially with Epic in play, a more effective integration of health services. There will be seamless referrals between the two providers and coordination of services.

Given that they have care coordination and share an electronic medical record, there will be less delays with respect to patients accessing the care that they need. This in turn improves patient satisfaction.

By collaborating and working in partnership with Family Centers, Greenwich Hospital and Family Centers will both be better positioned to serve vulnerable populations and support the comprehensive delivery of patient-centered medical homes.

Thank you, and we look forward to hearing from you once we've submitted our late files.

THE HEARING OFFICER: All right. Thank you very much, Attorney Feldman, for your closing statement. I would like to thank everybody in your room and

everybody online for attending the hearing today.

This hearing is hereby adjourned at 12:17 p.m. The record will remain open until closed by OHS, and just for those of you who would still like to make a public comment via e-mail, you can submit those for seven days through CONcomment@ct.gov.

Thank you, everybody. And have a good afternoon. Goodbye.

(End: 12:17 p.m.)

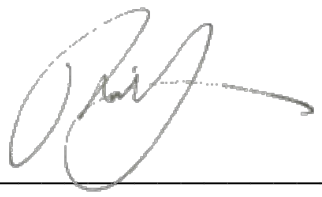
STATE OF CONNECTICUT

I, ROBERT G. DIXON, a Certified Verbatim Reporter within and for the State of Connecticut, do hereby certify that I took the above 114 pages of proceedings in the STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF HEALTH STRATEGY, APPLICATION & PUBLIC HEARING In Re: GREENWICH HOSPITAL, Docket No. 23-32656-CON; CERTIFICATE OF NEED APPLICATION, A HEARING REGARDING THE TERMINATION OF INPATIENT OR OUTPATIENT SERVICES BY GREENWICH HOSPITAL held before: ALICIA NOVI, ESQ., THE HEARING OFFICER, on March 27, 2024, (via teleconference).

I further certify that the within testimony was taken by me stenographically and reduced to typewritten form under my direction by means of computer assisted transcription; and I further certify that said deposition is a true record of the testimony given in these proceedings.

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

WITNESS my hand and seal the 15th day of April, 2024.



Robert G. Dixon, N.P., CVR-M No. 857

My Commission Expires 6/30/2025

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*CON EXHIBITS

*Exhibits available on CON portal.

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