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1 STATE OF CONNECTICUT

2 OFFICE OF HEALTH STRATEGY

3

4 DOCKET NUMBER 22-32612-CON

5 A HEARING REGARDING THE TERMINATION OF INPATIENT LABOR & DELIVERY SERVICES BY
6 JOHNSON MEMORIAL HOSPITAL

7

8 Hybrid Hearing held at the Public Utilities Regulatory Authority, 10 Franklin Square, New Britain, Connecticut, and via Zoom, on Wednesday,
9 July 12, 2023, beginning at 9:02 a.m.

10

11 H e l d B e f o r e:
ALICIA J. NOVI, ESQ., Hearing Officer
12

13 Administrative Staff:
STEVEN W. LAZARUS, CON Program Supervisor
14 ANNALIESE FAIELLA, Planning Analyst
YADIRA MCLAUGHLIN, Planning Analyst
15 LESLIE GREER, Consumer Information
Representative
16 MAYDA CAPOZZI, Administrative Assistant (remote)

17

Representing Johnson Memorial Hospital:
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21 ANNA R. GUREVICH, ESQ.

22 Witnesses:
ROBERT ROOSE, M.D., M.P.H.
23 SUSAN PETTORINI-D'AMICO, DNP, RN, NEA-BC

24

25

Reporter: Lisa L. Warner, CSR #061

1 (Whereupon, the hearing commenced at 9:02 a.m.)
2 HEARING OFFICER NOVI: Good morning.
3 It is now 9:02 a.m. This is the hearing for
4 Johnson Memorial Hospital, Incorporated, Docket
5 Number 22-32612-CON. I'd like to thank everybody
6 for being here. This is Johnson Memorial
7 Hospital, Incorporated, the applicants in this
8 matter, seek a Certificate of Need for the
9 termination of inpatient or outpatient services by
10 a hospital pursuant to Connecticut General
11 Statute, Section 19a-638(a)(5). Specifically, the
12 applicant seeks to terminate inpatient labor and
13 delivery services.
14 Today is July 12, 2023. My name is
15 Alicia Novi. Dr. Deidre Gifford, the executive
16 director of the Office of Health Strategy,
17 designated me to serve as hearing officer for this
18 matter to rule on all motions and to recommend
19 findings of fact and conclusions of law upon
20 completion of the hearing.
21 This is a hybrid hearing. By that I
22 mean, it is being held both in person and
23 electronically via Zoom. Public Act 21-2, as
24 amended by Public Act 22-3, authorizes an agency
25 to hold a public hearing by means of electronic

1 equipment. In accordance with this legislation,
2 any person who participates orally in an
3 electronic meeting shall make a good faith effort
4 to state his, her or their name and title at the
5 outset of each occasion that the person
6 participates orally during an uninterrupted
7 dialogue or series of questions and answers.
8 For anyone attending remotely, unless
9 you are actively participating in the hearing
10 either as one of the applicant's witnesses or as a
11 member of the public providing comment at the
12 designated time, I ask that you mute the device
13 that you are using to access the hearing and
14 silence any additional devices that are around
15 you.
16 This public hearing is being held
17 pursuant to Connecticut General Statute, Section
18 19a-639a(d). As such, this matter constitutes a
19 contested case under the Uniform Administrative
20 Procedures Act and will be conducted in accordance
21 herewith. The Office of Health Strategy staff is
22 here to assist me in gathering facts related to
23 this application and will be asking the
24 applicant's witnesses questions.
25 At this time, I'm going to ask each

1 staffperson assisting with questions today to
2 identify themselves with their name, the spelling
3 of their last name, and their OHS title.
4 I'll start to my right.
5 MR. LAZARUS: Good morning. My name is
6 Steven Lazarus, L-a-z-a-r-u-s, and I am the CON
7 program supervisor.
8 HEARING OFFICER NOVI: To my left.
9 MS. FAIELLA: Good morning. My name is
10 Annie Faiella, F-a-i-e-l-l-a, and I am a planning
11 analyst for the CON.
12 MS. McLAUGHLIN: Good morning. My name
13 is Yadira McLaughlin, M-c, capital L,
14 a-u-g-h-l-i-n, and I'm a planning analyst for the
15 CON.
16 HEARING OFFICER NOVI: All right. Also
17 present are Mayda Capozzi online and Leslie Greer
18 in the room who are OHS staff members that are
19 assisting with the hearing logistics, gathering
20 the names for public comment, and providing
21 miscellaneous support. As I stated earlier, Mayda
22 is providing support electronically, and Leslie is
23 present in the hearing room with us.
24 The Certificate of Need process is a
25 regulatory process and, as such, the highest level

1 of respect will be accorded to the applicants,
2 members of the public, and our staff. Our
3 priority is the integrity and transparency of this
4 process. Accordingly, decorum will be maintained
5 by all present during these proceedings. This
6 hearing is being transcribed and recorded, and a
7 video will be made available on the OHS website on
8 its YouTube account.
9 All documents related to this hearing
10 have been -- have been or will be submitted to
11 OHS -- or will be submitted to OHS will be
12 available for review through our Certificate of
13 Need portal which is accessible on the OHS CON
14 webpage.
15 In making my decision, I will consider
16 and will make written findings in accordance with
17 Section 19a-639 of the Connecticut General
18 Statutes.
19 Lastly, as Zoom notified you in the
20 course of -- prior to the recording -- or prior to
21 this hearing starting, I wish to point out that by
22 appearing on camera in this virtual hearing you
23 are consenting to being filmed. If you wish to
24 revoke your consent, please do so at this time by
25 exiting the Zoom meeting or this hearing room.

1 All right. I'm going to start by going
2 over the exhibits and items which I am taking
3 administrative notice of. Then I will ask if
4 there are any objections. The CON portal contains
5 the prehearing table of record in this case.
6 Exhibits were identified in the table as A through
7 S.
8 Mr. Lazarus, Ms. McLaughlin and Ms.
9 Faiella, do we have any additional exhibits to
10 enter into the record at this time?
11 MR. LAZARUS: Good morning, Steve
12 Lazarus. Yes, we have one additional letter that
13 was sent in by Senator Jeff Gordon yesterday
14 afternoon to our legislative liaison. It's not in
15 the record. We just received it this morning, so
16 we are in the process of trying to upload it and
17 then we'll share it.
18 HEARING OFFICER NOVI: Okay. Attorney
19 DeBassio, do you have any objections to that?
20 MR. DeBASSIO: Good morning, Madam
21 Hearing Officer. Just for the record, my name is
22 David DeBassio of Hinkley Allen on behalf of
23 Johnson Memorial Hospital. With me today is my
24 associate, Anna Gurevich.
25 And the only addition we had -- we have

1 **no objections to the record as it is right now.**
2 **The only addition we have is before the hearing**
3 **began we presented you with an appearance for my**
4 **associate, Ms. Gurevich. And her pro hac vice**
5 **application was just granted by the New Britain**
6 **Superior Court, so we'll be uploading that to the**
7 **OHS portal as soon as we can.**
8 **HEARING OFFICER NOVI: Do you have any**
9 **objection to my listing that as Exhibit T once it**
10 **is uploaded?**
11 **MR. DeBASSIO: No. Thank you.**
12 **MR. LAZARUS: Hearing Officer, do you**
13 **want to do that, Senator Gordon --**
14 **HEARING OFFICER NOVI: We will**
15 **eventually make it an exhibit. Let's see if we**
16 **get any more elected officials.**
17 **MR. LAZARUS: Sure. We can address it**
18 **by the end of the day.**
19 **HEARING OFFICER NOVI: Yes.**
20 **MR. DeBASSIO: Okay. I was just going**
21 **to say, maybe it would make sense to not actually**
22 **give it an exhibit number yet since there will**
23 **probably be documents uploaded before we get a**
24 **chance to upload the appearance of Attorney**
25 **Gurevich.**

1 HEARING OFFICER NOVI: Yeah. We'll
2 make sure that -- it may go in as a different
3 exhibit. However, you have no problem with this
4 going in as a full exhibit into the record. All
5 right.
6 MR. DeBASSIO: No problem.
7 HEARING OFFICER NOVI: If I could ask
8 you, Attorney DeBassio, if you could click,
9 there's a button on the front of your microphone,
10 if you could click that on. It's around the back.
11 There you go.
12 MR. DeBASSIO: There you go.
13 HEARING OFFICER NOVI: You might need
14 to -- it clicks, it toggles.
15 MR. DeBASSIO: The green light came on.
16 HEARING OFFICER NOVI: Oh, good. Okay.
17 All right. So you're all set then. All right.
18 Sorry, I just got notified that they couldn't hear
19 you as well.
20 All right. So I would also like to
21 note that the applicant is also hereby noticed
22 that I'm taking administrative notice of the
23 following documents: The statewide Health Care
24 Facilities and Services Plan and its supplements;
25 the Facilities and Services Inventory; the OHS

1 **Acute Care Hospital Discharge Database, the**
2 **All-Payer Claims Database claims data, and the**
3 **Hospital Reporting System's, the HRS, financial**
4 **and utilization data. I may also take**
5 **administrative notice of other prior OHS**
6 **decisions, agreed settlements and determinations**
7 **that may be relevant in this matter which have not**
8 **yet been identified.**
9 **All right. So because we've already**
10 **identified you, Attorney DeBassio, I will go ahead**
11 **and skip over a few of these. Sorry. All right.**
12 **So we will proceed in the order established in the**
13 **agenda for today's hearing. I would like to**
14 **advise the applicant that we will ask questions**
15 **related to your application that you may feel**
16 **we've already addressed. We will be doing that**
17 **for the purpose of ensuring that the public has**
18 **knowledge of your proposal and for the purpose of**
19 **clarification. I want to assure you that we have**
20 **reviewed your application, the completeness**
21 **responses, and prefile testimony, and I will do so**
22 **many times before issuing a decision.**
23 **As this hearing is being held in hybrid**
24 **fashion, we ask that all participants attending**
25 **via Zoom, to the extent possible, enable the use**

1 of video cameras when testifying or commenting
2 remotely during the proceedings. All participants
3 and the public shall mute their devices, should
4 disable their cameras when we go off record or
5 take a break. Please be advised that, although we
6 try and shut off the hearing recording during
7 breaks, it may continue. If the recording is on,
8 any audio or video that has not been disabled will
9 be accessible to all participants.
10 Public comment taken during the hearing
11 will likely go in the order established by OHS
12 during the registration process. However, I may
13 allow public officials to testify out of order. I
14 or OHS staff will call each individual by name
15 when it is their turn to speak. Registration for
16 public comment has already begun and is scheduled
17 to start at 3 p.m. If you would like to register
18 for public comment, please do so in the chat
19 function of the Zoom, or, if you are in person and
20 you would like to give public comment, you may
21 sign up with us.
22 If the technical portion is not
23 completed by 3 p.m., the public comment may be
24 postponed until the technical portion is complete.
25 The applicant's witnesses may be available -- must

1 be available after public comment as OHS may have
2 follow-up questions based on public comment.
3 Are there any other housekeeping
4 matters or procedural issues that we need to
5 address before we start? Attorney DeBassio?
6 MR. DeBASSIO: No, Madam Hearing
7 Officer.
8 HEARING OFFICER NOVI: Thank you. All
9 right. So, Attorney DeBassio, would you like to
10 make an opening statement?
11 MR. DeBASSIO: Thank you, Madam Hearing
12 Officer. I'll be brief because I want to be
13 respectful of OHS's time and the schedule we have
14 here and reserve most of my comments for the
15 closing statement other than I'd just like to
16 introduce our two witnesses. With us we have Dr.
17 Robert Roose, who's the chief administrative
18 officer of Johnson Memorial Hospital, and we have
19 Ms. Susan Pettorini-D'Amico, who's the chief
20 nursing officer of Johnson Memorial Hospital.
21 They'll both be adopting their prefile testimony
22 and testifying largely in accordance with that.
23 And as you just may have mentioned, we are
24 respectful of the time constraints here, but as
25 this is a public hearing, we don't intend to be

1 repetitive, but they are going to be going over a
2 lot of the same information as contained there
3 just for the benefit of the public and the record
4 and the hearing here today.
5 HEARING OFFICER NOVI: Okay. So at
6 this point, I would like to swear in your
7 witnesses. Actually, do you want to also mention
8 your assistant counsel's name again as well.
9 MR. DeBASSIO: I apologize. My
10 colleague is Anna Gurevich.
11 HEARING OFFICER NOVI: Could you spell
12 her last name for the court reporter.
13 MR. DeBASSIO: You're going to put me
14 on the spot here.
15 THE COURT REPORTER: I've got it
16 already. I'm all set.
17 HEARING OFFICER NOVI: All right.
18 Thank you so much.
19 At this point, I would like to ask your
20 witnesses, Dr. Roose and Ms. Pettorini-D'Amico, to
21 please raise your right hand so I can swear you
22 both in.
23 R O B E R T R O O S E,
24 S U S A N P E T T O R I N I - D ' A M I C O,
25 having been first duly sworn by Hearing

1 Officer Novi, testified on their oaths as
2 follows:
3 HEARING OFFICER NOVI: Thank you. I do
4 see that they both said yes. Thank you very much.
5 All right. So when giving your testimony, I would
6 like to remind both of you to please state your
7 full name and adopt any written testimony you have
8 submitted prior to starting your testimony today.
9 The applicants may now proceed with their
10 testimony. And I ask that for my benefit and the
11 benefit of everybody up here, please define any
12 acronyms for clarity of record that you use.
13 THE WITNESS (Roose): Thank you. Good
14 morning. Thank you for the opportunity to provide
15 testimony. I'm before you this morning in support
16 of Johnson Memorial Hospital's Certificate of
17 Need. May I just confirm that I'm able to be
18 heard okay?
19 HEARING OFFICER NOVI: Yes. I have not
20 gotten a -- I haven't gotten a --
21 THE WITNESS (Roose): Okay. Very good.
22 As we start, I just want to adopt the prefile
23 testimony.
24 My name is Dr. Robert Roose, and I
25 serve as the chief administrative officer for

1 **Johnson Memorial Hospital, which is a role that**
2 **serves as the chief executive officer for the**
3 **hospital, to which I recognize and accept the**
4 **responsibility to position the facility to provide**
5 **services to meet evolving community need but to**
6 **never sacrifice quality or safety in doing so.**
7 **I've been part of the system that is**
8 **known as Trinity Health of New England for now**
9 **more than ten years. Trinity Health is unique as**
10 **a large not-for-profit faith-based system. From**
11 **2013 to 2017, I was the chief medical officer and**
12 **vice president of Addiction and Recovery Services**
13 **for the Sisters of Providence Health System,**
14 **consisting of Mercy Medical Center, Providence**
15 **Behavioral Health Hospital and Brightside for**
16 **Families & Children, all of which was later named**
17 **Mercy Medical Center and affiliates.**
18 **From 2017 to 2018, I served as the vice**
19 **president for Behavioral Health at Mercy Medical**
20 **Center and its affiliates serving as the chief**
21 **executive for Providence Hospital, a 131-bed**
22 **facility in Holyoke, Massachusetts with a**
23 **continuum of inpatient and outpatient programs.**
24 **In 2018, I became the chief of**
25 **Addiction Medicine & Recovery Services for Trinity**

1 Health of New England. And then in 2019, I was
2 asked to take on the position of chief medical
3 officer for Mercy Medical Center in Springfield,
4 Massachusetts. I served as the chief medical
5 officer through the pandemic serving as incident
6 commander in leading efforts to transform care and
7 respond to changing needs and pressures in health
8 care until 2022 when I took on my current position
9 of chief administrative officer for Johnson
10 Memorial Hospital and its affiliates and Mercy
11 Medical Center and its affiliates.
12 Prior to coming to New England in 2013,
13 I served in director, medical director and other
14 teaching and faculty roles at Albert Einstein
15 College of Medicine in the Bronx, New York. I was
16 also an attending physician at Montefiore Medical
17 Center on the inpatient medicine service since
18 2008, which is where I completed my family
19 medicine residency.
20 I have been honored throughout my
21 career to serve on several commissions in
22 Connecticut and Massachusetts with a real focus on
23 public health outcomes and on community services,
24 including Massachusetts' Harm Reduction
25 Commission, the Treatment Subcommittee of the

1 Alcohol & Drug Policy Commission here in
2 Connecticut, and Massachusetts Governor Charlie
3 Baker's Working Group on Opioid Addiction in the
4 Commonwealth of Massachusetts. And my CV is
5 attached as Exhibit A.
6 I would like to state that I provide
7 that clinical, professional and leadership
8 background as a context and a testament to the
9 fact that I've experienced addressing some
10 difficult complex issues in public health and in
11 community care. Perhaps the behavioral health and
12 opiate addiction crisis has been the most striking
13 that we faced over the past decade. And never
14 have we seen a more profound example of how models
15 of care must change in response to the changing
16 needs in the community and where access to the
17 right type of services and treatment and where
18 it's delivered matters, and it's not a
19 one-size-fit-all.
20 And so I have done my own analysis on
21 this issue as I recognize that I am a relative
22 newcomer to Johnson Memorial Hospital having taken
23 my position in April of 2022. My colleague, Sue
24 Pettorini-D'Amico, who is testifying here today,
25 has more direct and firsthand experience of the

1 **circumstances leading to Johnson's decision to**
2 **close its labor and delivery unit. And while I do**
3 **not have that lived experience at Johnson, per se,**
4 **I have become very familiar with the history and**
5 **the facts and the information in the record, and I**
6 **agree unequivocally with quality and safety first**
7 **in mind and community needs second with the**
8 **findings that the labor and delivery unit should**
9 **be closed.**
10 **As I'll discuss in my testimony, the**
11 **declining utilization of Johnson's labor and**
12 **delivery unit, the availability of hospitals in**
13 **the service area, and the difficulty in recruiting**
14 **nursing staff and the numbers necessary to safely**
15 **operate the unit make the operation of the labor**
16 **and delivery unit at Johnson unfeasible and not in**
17 **the best interest of women that seek reproductive**
18 **health care in the community. I will always start**
19 **with quality.**
20 **There is a clear and critically**
21 **important correlation between volume and quality**
22 **of services provided when it pertains to labor and**
23 **delivery and maternity care. Johnson is**
24 **considered to be a low-volume birthing hospital at**
25 **less than 200 births per year. For obstetrical**

1 services, closure of the labor and delivery unit,
2 as counterintuitive as it may seem to some, will
3 actually improve the quality of labor and delivery
4 services that patients are able to receive by
5 transferring them to facilities that have higher
6 birth volumes, more staff resources, and
7 additional specialized care for the mother and
8 baby should complications arise.
9 An example of that are neonatal
10 intensive care units which are specialized spaces
11 with highly trained staff to care for babies with
12 extra needs. And we know in labor and delivery
13 care, the clinical situation can change at a
14 moment's notice. The statistics show actually
15 that mothers and their physicians in the service
16 area of Johnson have already been selecting to
17 deliver at these other area hospitals for many
18 years.
19 In the community itself, Trinity Health
20 of New England, the network that we have of
21 obstetrics and gynecology providers, will have and
22 have remained active and will continue to
23 coordinate patient care, including working with
24 the patient to determine where they will deliver.
25 This includes utilizing Saint Francis Hospital and

1 Medical Center or Mercy Medical Center or other
2 facilities as their pre-selected location for
3 delivering their baby. Johnson is also
4 simultaneously expanding the women's health in the
5 prenatal and postnatal period and those services
6 that are available in the community thereby
7 actually increasing access to more routine care.
8 And that is where access matters for
9 the dozens of visits that are needed to prevent,
10 identify and treat the risks or the conditions
11 that can impact a woman's mortality or morbidity.
12 Because while the labor and delivery experience in
13 a unit is a defining moment and defining
14 experience, it really carries the potential to
15 harm if not safely delivered. It's what's done
16 before that visit and what's done after that visit
17 that holds the greatest potential to heal.
18 And so for any patients that do arrive
19 at Johnson's emergency department for emergency
20 delivery care, Johnson has established emergency
21 department protocols that promote the
22 well-coordinated care of the patient whether or
23 not they end up transferring to another facility.
24 In looking at the community needs and
25 the primary service area for the community that

1 **Johnson treats, we know Johnson is located in**
2 **Stafford Springs, Connecticut. It's close to the**
3 **border with Massachusetts. Johnson's labor and**
4 **delivery patients primarily come from the towns of**
5 **Enfield, Stafford, Union, Windsor Locks and**
6 **Somers. In fiscal year 2020, over 75 percent of**
7 **Johnson's labor and delivery patients came from**
8 **those towns which we define as the primary service**
9 **area. Yet, it's important to recognize**
10 **historically over 80 percent of all of the**
11 **maternity patients of all the deliveries amongst**
12 **patients residing in those towns, Enfield,**
13 **Stafford, Union, Windsor Locks and Somers, have**
14 **already been choosing to deliver their babies at**
15 **other area hospitals. That has led to a low**
16 **utilization, low-volume birthing center.**
17 **In 2008, 15 years ago, there were 302**
18 **deliveries at Johnson Memorial Hospital. Fast**
19 **forward ten years later, in the years between 2017**
20 **and 2019, Johnson delivered, on average, only 172**
21 **babies per year, representing a 43 percent decline**
22 **in total deliveries. Looking at fiscal years 2017**
23 **to 2019, the last three years for which full**
24 **statistics are available that were unaffected by**
25 **the pandemic, an average of about 80 percent of**

1 **patients in that primary service area consistently**
2 **chose, or they were directed by their**
3 **obstetricians, to deliver at a hospital other than**
4 **Johnson. They primarily chose to instead deliver**
5 **at Saint Francis Hospital and Medical Center,**
6 **about 40 percent or more; Hartford Hospital 20**
7 **percent or more; and Manchester Memorial Hospital,**
8 **10 to 15 percent, as shown in the CHIME data. And**
9 **this trend was and is expected to continue.**
10 **The decision on where to deliver, of**
11 **course, is made by the patient with advice from**
12 **their obstetrician or provider based on**
13 **characteristics of the pregnancy as well as the**
14 **interests and desires of the woman. These**
15 **hospitals may be further away, but at least two of**
16 **them offer additional resources to care for the**
17 **mother and baby should the pregnancy be**
18 **complicated, considered high risk, or if**
19 **complications arise during the labor process,**
20 **including having a neonatal intensive care unit.**
21 **As referenced in the Certificate of**
22 **Need application, the proportion of high-risk**
23 **pregnancies is increasing as well driven in large**
24 **part by obesity-related complications such as**
25 **hypertensive disorders of pregnancy and**

1 gestational diabetes. This is a top trend. As
2 stated in the articles that are included in the
3 response to the Certificate of Need application,
4 it's clear that Johnson's labor and delivery unit
5 has not and would not deliver high-risk
6 pregnancies, and those patients in consultation
7 with their physicians would continue to deliver at
8 those other facilities, meaning fewer and fewer
9 women in future years would even be suitable
10 candidates to deliver at a lower-acuity low-volume
11 facility like Johnson.
12 The article that I referenced also does
13 highlight the growing need for providers to invest
14 in upstream or prevention earlier on in the course
15 of the pregnancy to address the rising acuity and
16 complexity that's occurring in maternal and
17 neonatal care. This ensures and includes ensuring
18 maternal and fetal medicine care and developing
19 programs for patients with such comorbidities,
20 including diabetes and hypertension. And as I
21 will continue to address throughout the testimony
22 and later on, while Johnson recognizes that its
23 labor and delivery service is not able to meet
24 those needs, as evidenced by its low utilization
25 and its low volume, Johnson is therefore investing

in the community to provide access to those services prenatally and postnatally instead.

Focusing on the low birth rates, in particular. Compared to fiscal year 2017, the fiscal year 2022 annualized number of deliveries from Johnson's primary service area declined 6.2 percent -- 6.3 percent from 543 deliveries in 2017 to 509 deliveries in 2022. Again, this figure comes from the CHIME data. Deliveries in Johnson's primary service area are continued and projected to decline by an additional 3.2 percent over the next five years between 2022 and 2027, as measured by Sg2, a national health care trend solutions company.

In taking that into consideration, the low birth rates, in looking at the demographics of the primary service area, it follows the number of females that are of child-bearing age is also projected to decline slightly over the next five years. This decline, of course, corresponds with the projected decline in deliveries in that same service area. Specifically, females between the ages of 18 and 44 numbered 12,549 in Johnson's service area in 2022, and that same age group is projected to decrease to 12,358 by 2027. Again, a

1 reduction of 1.5 percent over the next five years.
2 Additionally, the age group of females
3 that has the highest projected population growth
4 in the primary service area is the 60 and older
5 age group. This age group is outside of child
6 bearing age, will be the largest category of women
7 by age within the next five years, and categorizes
8 the community overall as one with an aging
9 population of both men and women. Females aged 60
10 and older numbered 11,255 in Johnson's service
11 area in 2022 and is projected to increase to
12 12,534 in 2027. That's a projected increase of
13 11.4 percent over the next five years. The
14 demographic information regarding these trends was
15 also collected by Sg2.
16 While it is clear from the projections
17 there will continue to be some community need for
18 delivery services, albeit it's declining over
19 time, patients do have a choice where they
20 deliver, and the vast majority historically have
21 already chosen to do so at a hospital other than
22 Johnson Memorial.
23 So after focusing on quality and safety
24 being a top concern, thinking about the
25 community's impact is our next priority. And

1 since the majority of patients from within the
2 service area are already delivering at other
3 hospitals, this proposal is not expected to
4 significantly alter access to care. Since 2017,
5 an average of 80 percent of patients in Johnson's
6 primary service area have delivered at Saint
7 Francis Hospital and Medical Center, Hartford
8 Hospital and Manchester Memorial, supported by the
9 CHIME data.
10 These and some other area hospitals are
11 already accessible to patients, as demonstrated by
12 patient choice to deliver there. By car, Saint
13 Francis Hospital is 35 minutes and 27.8 miles from
14 Johnson. Mercy Medical Center is 32 minutes and
15 17.7 miles from Johnson. Manchester Memorial
16 Hospital is 30 minutes and 20.1 miles from
17 Johnson. And Day Kimball Hospital is 51 minutes
18 and 32.9 miles from Johnson. Patients usually
19 have planned in advance in choosing a hospital for
20 their labor and delivery with the advice of their
21 physicians, and driving times will have been
22 considered in that decision and may even be
23 faster, of course, from their own home.
24 Importantly, and also as mentioned,
25 patients will typically travel to a hospital only

1 once during their pregnancy, and the care that
2 they more frequently require is the prenatal and
3 the postnatal care to support a healthy pregnancy
4 and newborn development. These services will
5 continue to be available and are being enhanced at
6 the current locations in Enfield which includes
7 access to services such as OBGYN physicians,
8 obstetrics and gynecology physicians, and women's
9 health specialties, including breast surgery, as
10 well as primary care services, pediatrics, imaging
11 and lab services.
12 The need for postnatal care in the
13 community is also supported by the expansion of
14 the Medicaid and Children's Health Insurance
15 Program coverage for 12 months after pregnancy.
16 And for the deliveries themselves, hospitals such
17 as Trinity Health's Saint Francis and Mercy will
18 continue to be available for deliveries as well as
19 the other surrounding community hospitals. The
20 decision on where to deliver is based on the
21 patient's choice and the pre-delivery plan
22 arranged between the physician and the patient.
23 And Johnson will continue to be a place
24 with emergency protocols in place to care for any
25 patients that arrive to the hospital and may be in

1 **labor, and the physicians and the staff are well**
2 **trained in those emergency delivery procedures,**
3 **were they necessary.**
4 **In regards to financial questions,**
5 **there is expected to really be little to no**
6 **financial cost to the overall health care system**
7 **from this proposal. Cost effectiveness of health**
8 **care delivery is dependent on many factors,**
9 **including balancing the overall expenses relative**
10 **to patient demand. In the case of labor and**
11 **delivery services, the cost to retain and**
12 **continuously recruit the staffing that's needed to**
13 **fully run the unit far outweighs the annual demand**
14 **for those inpatient services. Rather than**
15 **expending already-limited resources to keep the**
16 **unit afloat, the cost effectiveness of health care**
17 **delivery in the region can actually be improved if**
18 **Johnson were permitted to allocate those resources**
19 **to the services with higher community demand that**
20 **directly impact outcomes far more so.**
21 **As mentioned, the enhancements of the**
22 **prenatal and postnatal delivery services will be**
23 **what really increases health outcomes and health**
24 **equity in the region. Studies show that the value**
25 **of having access to a well-organized, high-quality**

1 array of resources and programs is how we decrease
2 health disparities. Care for patients starting
3 prior to conception and through a child's early
4 development can greatly improve the health
5 outcomes of the child. The incorporation of the
6 additional services into Johnson's Enfield campus
7 supports just that, the improvement of health
8 outcomes and health equity and the reduction of
9 disparities, and will continue to be a focus of
10 Trinity Health of New England.
11 Of note, the Enfield campus was
12 specifically chosen for that reason as a large
13 portion of Johnson's population lives in that
14 area. Based on the Connecticut town profiles, the
15 Town of Enfield is more ethnically and racially
16 diverse compared to Stafford and Union with a
17 greater percentage of racial and ethnic minorities
18 living in the town. Enfield also has more than
19 three times the population of the other two towns
20 combined. And as a town, it is more diverse and
21 populated than both Stafford and/or Union, is more
22 easily accessible due to the availability of major
23 roads and highways, and adding services there will
24 actually increase access to care for a larger
25 number of people.

1 As noted in the Office of Health
2 Strategy Table 9 in the application, almost
3 two-thirds of the labor and delivery patients had
4 a government payor, meaning Medicaid or Medicare,
5 made up mostly of Medicaid patients. And it is
6 anticipated that for those patients the cost to
7 deliver at other area hospitals would remain
8 essentially the same as they have the same
9 coverage throughout the state regardless of the
10 facility.
11 Specifically for the proposed
12 termination of the labor and delivery unit, the
13 cost of retaining and recruiting for the minimum
14 staffing coverage needed to run the unit would be
15 removed, and it would actually aid in the
16 controlling of the overall costs of health care.
17 Since the unit was already seeing low volumes of
18 patients, the cost to staff and maintain the unit
19 was very high relative to the larger programs that
20 see higher annual volumes.
21 Minimum staffing levels can't be
22 adjusted for this type of care without
23 compromising patient safety and quality of
24 service, especially since labor and delivery
25 nurses cannot be covered by nurses from other

1 units due to very specific competencies that are
2 required and specific training needed, which
3 results in incurring a minimum level of cost
4 regardless of the fluctuations in the patient
5 census from day to day.
6 If Johnson were to continue this
7 service, contract labor would certainly have to be
8 engaged, if it's even available, as the
9 recruitment and retention of local staff has been
10 unsuccessful. On average, hospitals' per patient
11 labor expense increased by 37 percent over the
12 last two years, which is an unsustainable
13 trajectory. And the high host of contract labor
14 expense would ultimately affect patient costs as
15 they directly impact the cost of providing that
16 health care.
17 Instead, the overall cost to the
18 state's health care system would be anticipated to
19 improve with this application because there's
20 concurrent initiatives in place to transform
21 Johnson to address the changing needs in that
22 area. By addressing other select services, one of
23 the goals is to care for and work with patients to
24 maintain or lower the overall acuity of their
25 needs in aggregate. This type of approach is

really oriented towards lowering the overall cost of health care for patients in the health care system by providing those services in the community closer to where the patients need them before and after labor and delivery.

In regards to the cost of care to the patients themselves, patient health costs for Johnson Memorial patients with this proposal is not anticipated to be materially affected as a result. For Medicaid patients, their cost to deliver at any hospital is not anticipated to increase, as they have the same coverage throughout the state. For patients with commercial insurance, the individual patient premiums are not subject to the cost of the service provided by the hospital, so there should not be an impact to their insurance premiums. The out-of-pocket costs for an individual patient may be affected and it may be variable depending on their health plan and their insurer based on which alternate delivery hospital they select.

As a Medicaid provider, Johnson Memorial Hospital, Saint Francis Hospital and Medical Center and the other area providers will continue to provide services always to patients

1 seeking care, including the underserved and the
2 underinsured regardless of their ability to pay.
3 Costs to the uninsured should not be affected by
4 this proposal, as the same charity care and
5 financial assistance policies that Johnson
6 Memorial Hospital maintains is available at the
7 other Trinity Health of New England facilities,
8 including Saint Francis Hospital and Medical
9 Center.
10 Specifically our financial assistance
11 policy provides a 100 percent discount for
12 medically necessary services to patients earning
13 below 200 percent of the Federal Poverty Level,
14 and a partial discount to patients earning up to
15 400 percent of the Federal Poverty Level. Under
16 this policy, patient copays and deductibles also
17 can be reduced if a patient qualifies for
18 financial assistance. And Trinity Health of New
19 England also makes discounts available to patients
20 experiencing catastrophic costs for their medical
21 care. As a mission-driven organization, Trinity
22 Health of New England is committed to working with
23 patients to make health care accessible. All of
24 Trinity Health of New England's hospitals will
25 continue to care for individuals with high-quality

1 **care regardless of their ability to pay.**

2 **Now, in regard to hiring, Sue will**

3 **speak in more detail to this in regards to our**

4 **efforts. But over two years in the fall of 2020,**

5 **right during the COVID pandemic, Johnson**

6 **experienced high turnover of nursing staff and was**

7 **unable to continue to maintain the necessary**

8 **staffing levels for nurses trained in labor and**

9 **delivery. Since October 2020, Johnson has had**

10 **insufficient staffing to meet the staffing**

11 **standards to reopen the unit and provide the safe,**

12 **high-quality nursing care. This is not**

13 **withstanding the fact that over several years**

14 **Johnson instituted a very successful training**

15 **program to train new nurses in labor and delivery.**

16 **Those fully trained nurses after that period of**

17 **training ultimately chose to work in busier other**

18 **labor and delivery units at other hospitals. My**

19 **colleagues can provide more detailed testimony on**

20 **this point and the efforts that were made to**

21 **achieve the required staffing levels necessary for**

22 **the service.**

23 **Additionally, I want to highlight that**

24 **there are no obstetrician gynecologists in the**

25 **community of the primary service area who are on**

1 Johnson's medical staff or who refer patients to
2 Johnson. Historically, there had been only one
3 individual physician in the community who
4 delivered patients at Johnson even prior to the
5 COVID pandemic when the labor and delivery unit
6 had enough staff to be operational.
7 And so to conclude. As a physician, I
8 would like to emphasize the most important
9 consideration here is patient safety and whether
10 Johnson is able to continue a labor and delivery
11 service in a manner that provides safe and
12 high-quality care to patients who would trust us
13 to do so. In a low-volume environment with
14 consequently an inability to retain the qualified
15 labor and delivery nursing staff with the
16 appropriate competencies and providers, we cannot
17 provide those services safely.
18 On the other side, the impacts to the
19 community of closure at this point is minimal, due
20 to low utilization resulting from patient choice,
21 but rather, the expansion of access into the
22 prenatal and postnatal care in the community can
23 be a very positive outcome. Accordingly, in
24 regards to inpatient labor and delivery units for
25 women that are seeking care, I want to emphasize

1 that more inpatient units does not mean better
2 outcomes and closer does not mean safer.
3 Thank you again for the opportunity to
4 speak in support of this Certificate of Need
5 application.
6 HEARING OFFICER NOVI: Thank you very
7 much.
8 Attorney DeBassio, would you like to
9 have both of your witnesses testify first and then
10 we'll do questions?
11 MR. DeBASSIO: Madam Hearing Officer,
12 if I may. What we were going to do, if it was
13 acceptable to you, is have Mr. Roose begin his
14 testimony, then we were going to have Ms.
15 Pettorini-D'Amico, and then both of them would
16 address the questions that OHS has posed to us. I
17 just didn't want Dr. Roose to have to speak --
18 HEARING OFFICER NOVI: That's perfect.
19 MR. DeBASSIO: -- for an extended
20 period of time without a break.
21 HEARING OFFICER NOVI: Yes, that's
22 perfect. That's what I was hoping to do as well.
23 MR. DeBASSIO: Yeah. So if that's
24 acceptable, we'll go Dr. Roose, Ms.
25 Pettorini-D'Amico, then they'll both return to

1 answer the specific questions you asked in the
2 hearing notice, and then we can take questions
3 from OHS.
4 HEARING OFFICER NOVI: I think, because
5 you have submitted the specific questions in the
6 hearing notice, we can go straight to questions by
7 our staff. We do have quite a few of them. What
8 we'll do is we'll do both of them, we'll take a
9 quick break, and then we'll go into staff
10 questions.
11 MR. DeBASSIO: Okay. That's fine. I
12 just didn't know if you wanted to get those
13 responses to the questions sort of on the record
14 for the public's benefit. I know, I have the
15 utmost confidence you've all reviewed our written
16 submissions.
17 HEARING OFFICER NOVI: So why don't we
18 go to Ms. Pettorini-D'Amico's testimony and then
19 we'll take a quick break and then we'll come back
20 and start with our questions. If there's anything
21 that we don't address that you would like to add
22 onto the record, you can add that in after our
23 questions as well.
24 MR. DeBASSIO: No, just that when we
25 submitted the responses to the questions, they're

1 not sort of formally adopted by any of the --
2 they're not formally adopted the same as witness
3 testimony, but the witnesses were going to
4 substantially adopt the responses to those
5 questions as their testimony. So to the extent we
6 needed to do that to complete the record and you
7 didn't want them to address those questions, I'd
8 just ask that we be given an opportunity to do
9 that.
10 HEARING OFFICER NOVI: I have read the
11 response. I probably will cite to it. And any
12 decisions that are made, it has been thoroughly
13 reviewed by both me and the analysts up here. If
14 there's anything additional you feel that you need
15 to add, we'll give you time to do that, but it has
16 been -- it is part of the record and has been
17 considered and will be thoroughly considered.
18 MR. DeBASSIO: That's fine. Thank you.
19 HEARING OFFICER NOVI: All right. If
20 you would like to -- I'm sorry?
21 THE WITNESS (Pettorini-D'Amico): My
22 glasses will have to come off to read.
23 HEARING OFFICER NOVI: No problem. I
24 have to leave mine on to read everything. Hello.
25 If you would like to state your name and title for

1 the record and then adopt your testimony. You can
2 begin.
3 THE WITNESS (Pettorini-D'Amico): Good
4 morning. My name is Susan Pettorini-D'Amico. I'm
5 the chief nursing officer and vice president of
6 patient care services at Johnson Memorial
7 Hospital. And I'm also the chief nursing officer
8 and vice president of patient care services at
9 Mercy Medical Center in Springfield, Mass.
10 HEARING OFFICER NOVI: Do you adopt
11 your testimony?
12 THE WITNESS (Pettorini-D'Amico): I
13 want to adopt my testimony. Thank you.
14 Johnson and Mercy are member hospitals
15 of Trinity Health of New England, which is an
16 integrated health care delivery system that is a
17 member of Trinity Health based in Livonia,
18 Michigan.
19 Thank you for the opportunity to
20 testify in support of the Certificate of Need
21 application for the closure of Johnson's labor and
22 delivery service. My testimony today will focus
23 largely on the issues with staffing and coverage
24 that led to the decision to suspend Johnson's
25 labor and delivery service and seek approval from

1 **OHS to close this service. In my capacity as**
2 **chief nursing officer and vice president of**
3 **patient care services for Johnson, I was involved**
4 **firsthand in staffing and recruitment efforts**
5 **around labor and delivery services. I was also**
6 **consulted and participated in the decision to seek**
7 **permission to close Johnson's labor and delivery**
8 **services.**
9 **As I will discuss further in testimony,**
10 **it was a difficult decision that was ultimately**
11 **driven by quality of care and patient safety**
12 **concerns arising from steadily declining births at**
13 **Johnson.**
14 **I've been a registered nurse since 1992**
15 **and also have a Master of Science in Nursing and**
16 **Doctor of Nursing Practice. I've been the chief**
17 **nursing officer and vice president of Patient Care**
18 **Services at Johnson since 2019. I am responsible**
19 **for nursing practice and outcomes as well as**
20 **overall hospital and outpatient operations. And**
21 **I'm also responsible for quality outcomes for**
22 **patient care services.**
23 **I was the director of Patient Care**
24 **Services for Johnson from 2018 to 2019, and had**
25 **responsibility for departments including emergency**

1 **services, medicine, surgery, perioperative**
2 **services, both inpatient and outpatient, intensive**
3 **care, physical therapy, occupational therapy,**
4 **speech therapy, inpatient and outpatient,**
5 **obstetrics, sleep center, radiology, again, both**
6 **inpatient and outpatient, behavioral health and**
7 **patient experience, float pool, laboratory,**
8 **quality, and regulatory and care management. I**
9 **directed over 250 full-time equivalents including**
10 **managers, assistant nurse managers, direct care,**
11 **and ancillary staff. I created quality dashboards**
12 **and programs for seamless care delivery of**
13 **patients to post-acute providers. In this role, I**
14 **achieved patient experience, observed over**
15 **expected ratio, decreased readmissions, and**
16 **throughput goals at Johnson, and also helped**
17 **Johnson to achieve the 93rd percentile nationwide**
18 **in emergency room likelihood to recommend.**
19 **Between 2015 and 2018, I was the**
20 **director of nursing at Saint Francis Hospital and**
21 **Mount Sinai Hospital Rehabilitation Services where**
22 **I directed, again, over 200 full-time equivalents,**
23 **including managers, assistant nurse managers, and**
24 **direct care and ancillary staff for all medicine**
25 **and surgical and rehab medicine units at Saint**

1 Francis and Mount Sinai Hospitals.
2 Between 2014 and 2015, I was the
3 director of education and professional practice at
4 Saint Francis Hospital and Medical Center. I
5 oversaw all clinical education initiatives for
6 nursing and clinical support staff, and also
7 created programs that enabled nurses to develop
8 skills in a safe environment. Among other things,
9 I also oversaw a new registered nurse residency
10 program that onboarded over 200 nurses in the last
11 couple years.
12 I was a nurse manager for critical
13 care, telemetry, the staffing office, and float
14 pool at Middlesex Hospital from 2010 to 2014, and
15 nurse manager for the intensive care unit and
16 step-down units at Midstate Medical Center from
17 2008 to 2010. And prior to that between 2005 and
18 2008, I was a nurse recruiter for Masonicare and a
19 nurse manager for the cardiac intensive care unit
20 at Saint Francis Hospital. And I believe my
21 resume has been submitted to you.
22 I also want to mention that between
23 1992 and 2005, I was a staff nurse and then a
24 patient care manager at Yale New Haven Hospital.
25 As I will discuss further in this

1 testimony, the decision to close the labor and
2 delivery unit was a difficult one, a difficult
3 decision that was ultimately driven by the quality
4 of care and patient safety concerns arising from
5 steadily declining births at Johnson and a
6 sustained period of unsuccessful recruiting to the
7 staff labor and delivery unit adequately.
8 Until 2022, there was only one OBGYN
9 obstetrics doctor, as Dr. Roose referred to, who
10 referred patients to be delivered at Johnson and
11 who was on the medical staff. From the fall of
12 2020 until the decision was made to submit this
13 application and apply to close the labor and
14 delivery unit, Johnson did not have the required
15 number of nurses on staff to be able to safely
16 operate the unit. Johnson's declining rate of
17 deliveries, approximately 172 births annually
18 prior to 2020, and a substantial decrease from a
19 height of 302 deliveries in 2008, impacted
20 Johnson's ability to recruit more nurses.
21 Since fiscal year 2017, an average of
22 about 80 percent of patients in Johnson's service
23 area have delivered at Saint Francis Hospital and
24 Medical Center, Hartford Hospital, and Manchester
25 Memorial Hospital. Year over year, the delivery

volumes have been declining in the area which mirrored the national decline of births. Also, low-delivery volumes exacerbate recruitment and retention of labor and delivery staff who then leave for employment in hospitals with higher volumes to retain their competencies. Without sufficient nurses, a labor and delivery unit simply cannot operate.

Labor and delivery is a staff-intensive service and is distinct from other services. Patients may go into labor at any time of the day, and a labor and delivery unit must be ready with an obstetrician gynecologist physician to perform the delivery as well as the required number of other clinical and nursing staff. Even with low volumes and low utilization of the labor and delivery services, a hospital must maintain full staffing coverage of the labor and delivery unit around the clock to provide the services safely and effectively.

In the summer of 2020, Johnson resumed labor and delivery services following a short suspension due to the COVID-19 pandemic. On April 6, 2020, Johnson informed OHS by letter that as of April 12, 2020, it would temporarily suspend

1 services in its labor and delivery department.
2 Along with the letter, the hospital filed a
3 notification form pursuant to the CON waiver
4 established by Executive Order 7B. On July 1,
5 2020, the hospital filed a letter notifying OHS of
6 its intention to resume all services, including
7 labor and delivery services, on or about July 6,
8 2020. All services previously suspended were
9 returned to full operation.
10 In the fall of 2020, Johnson
11 experienced a high turnover of nursing staff and
12 was unable to maintain the necessary staffing
13 levels for nurses trained in labor and delivery.
14 And since October of 2020, Johnson has had
15 insufficient staffing to meet staffing standards
16 to reopen the unit and provide safe, high-quality
17 nursing care. Three labor and delivery nurses
18 remained on staff, and this number is drastically
19 short of the number needed to provide safe labor
20 and delivery services. Johnson began to actively
21 recruit staff, but since 2020 has been unable to
22 reach the staffing levels necessary to safely
23 continue to provide labor and delivery services.
24 In terms of recruiting efforts. For
25 two years since the fall of 2020 until the filing

1 of this CON application, Johnson made concerted
2 and significant efforts to advertise its open
3 labor and delivery positions and recruit qualified
4 nurses. We offered hiring bonuses, we utilized
5 our regional First Choice staffing pool to
6 advertise for and recruit for labor and delivery
7 positions and attempted to work with our contract
8 labor vendors and staffing agencies to advertise
9 and recruit nurses for the open labor and delivery
10 positions. Unfortunately, given the current
11 regional and national staffing shortages,
12 competing contract labor contracts, and the
13 current level of community need for labor and
14 delivery RNs, there was very little interest in
15 our open positions from qualified labor and
16 delivery nurses.
17 Given the difficulty in recruiting
18 trained labor and delivery nurses, Johnson had to
19 pursue other options. A decision was made to hire
20 nurses that were responding to Johnson's
21 recruitment efforts even if they had limited or no
22 experience in labor and delivery. We would then
23 train them at our cost, time and effort. We were
24 successful in hiring eight nurses with limited or
25 no labor and delivery experience.

1 **To train these nurses, Johnson sent the**
2 **newly-hired nurses to take part in a thorough**
3 **orientation and training program in labor and**
4 **delivery at Saint Francis Hospital and Medical**
5 **Center in Hartford. The training program was**
6 **tailored to each nurse, depending on that nurse's**
7 **prior labor and delivery experience, and lasted**
8 **between 8 and 16 weeks. Training was available in**
9 **the full continuum of care provided in a labor and**
10 **delivery unit, including obstetrics, labor and**
11 **delivery, and post-partum care, as well as**
12 **emergency procedures and nursery.**
13 **As I stated, the training was**
14 **specifically tailored to each nurse. In training,**
15 **the nurses worked the schedules they had been**
16 **hired to work, but worked with a preceptor and**
17 **shadowed nursing staff at Saint Francis Hospital**
18 **and Medical Center. The goal was to bring these 8**
19 **nurses back to Johnson with experience in labor**
20 **and delivery and to be able to resume the labor**
21 **and delivery service by June or July 2021.**
22 **At the same time, Johnson continued to**
23 **actively recruit and advertise for nursing**
24 **positions as Johnson was still short of the target**
25 **full-time equivalent needed to safely staff and**

1 operate the labor and delivery unit. Given the
2 current regional and national staffing shortages,
3 competing contract labor contracts and the
4 community need for labor and delivery RNs, we have
5 seen very little interest in our currently posted
6 labor and delivery positions despite active
7 recruitment. The target to operate a labor and
8 delivery unit is 12.6 full-time equivalents which,
9 taking into account shift schedules, effectively
10 translates into having three trained labor and
11 delivery nurses on staff at all times 24 hours a
12 day, 7 days a week.
13 With all the hiring and recruiting
14 efforts, Johnson achieved an 8.4 full-time
15 equivalent. This effectively translates to having
16 two nurses around the clock. To reach the
17 targeted full-time equivalent, Johnson needed one
18 more nurse available 24/7 either on site or on
19 call. Unable to recruit anymore providers, the
20 remaining option was to ask labor and delivery
21 nurses to cover additional on-call shifts as well
22 as their scheduled shifts. This meant the nurses
23 would work five shifts per week, three shifts on
24 site and two on-call shifts. Even so, there was a
25 further concern that if one of these nurses was

1 sick or otherwise unavailable, the labor and
2 delivery unit would again fall short of the
3 required staffing levels. Following the COVID-19
4 pandemic, Johnson had less nurses in other
5 departments that it could pull from in the event
6 the labor and delivery unit needed emergency
7 staff.
8 Initially, our labor and delivery
9 nurses agreed to take extra call shifts, but
10 shortly thereafter they reconsidered. All area
11 hospitals had larger nursing staffs and were not
12 asking their nurses to take call on such a short
13 rotation schedule as Johnson was.
14 I do want to emphasize that our labor
15 and delivery training program was very effective.
16 Although unfortunately, after experiencing the
17 higher birth volume and the robust support
18 services at Saint Francis, the newly hired nurses
19 chose not to work at Johnson and instead took
20 labor and delivery positions at Saint Francis and
21 other hospitals with higher growth rates and more
22 robust staffing. Newly-trained nurses want to
23 work in a setting with greater staffing and more
24 experienced staff available which creates more
25 learning, more clinical support, and professional

1 **mentorship. The nurses were aware that at a**
2 **hospital like Johnson they would be responsible**
3 **for a larger continuum of care in labor and**
4 **delivery and would need to be proficient and**
5 **self-sufficient in labor and delivery skills that**
6 **in other hospitals might be taken over or**
7 **delegated to other providers.**
8 **The decision to take jobs at other**
9 **hospitals instead of Johnson was also influenced**
10 **by the fact that to meet the target full-time**
11 **equivalent, nurses would have had to take more**
12 **call shifts at Johnson than they would have to**
13 **take at other hospitals. Being a part of a**
14 **smaller staff at Johnson meant more time on call**
15 **and less freedom for nurses in their personal**
16 **life.**
17 **We remain committed to providing**
18 **services to the community, the Johnson community,**
19 **and in collaborating with our OB providers have**
20 **continued to safely serve obstetrical patients at**
21 **our ministry hospital, Saint Francis Hospital and**
22 **Medical Center. Furthermore, Johnson does not**
23 **want to leave our vulnerable populations,**
24 **including Medicaid and indigent residents, without**
25 **access to such vital services. The birth plan is**

1 discussed with each patient, and to date we have
2 not received negative comments or untoward patient
3 outcomes for this temporary process in providing
4 labor and delivery services. Our emergency
5 department physicians are qualified to treat
6 obstetrical patients for routine emergency
7 department visits, and there are also processes in
8 place that ensure safe transfers of obstetrical
9 patients who present to the ED in the rare event
10 that occurs.
11 We acknowledge that emergencies do
12 occur and that patients may not be able to deliver
13 at their planned delivery hospital. As always,
14 Johnson will continue to prepare for, accept and
15 evaluate women presenting to the Johnson emergency
16 department. All patients will receive an
17 emergency medical screening and will either be
18 stabilized or appropriately transferred to Saint
19 Francis Medical Center or another hospital with
20 full labor and delivery services. For mothers who
21 require emergency deliveries, Johnson's
22 board-certified emergency medicine physicians are
23 trained to provide emergency obstetrical care to
24 to obstetric and delivery patients who need
25 emergency services. Furthermore, all equipment

1 and supplies needed to perform an emergency
2 delivery are still located and stored within
3 Johnson's emergency department to ensure that
4 appropriate and timely care is provided.
5 Johnson is also committed to improving
6 and ensuring access to the care that is
7 expected -- that expecting mothers and their
8 newborns need in the community. Johnson is
9 currently expanding access for women's health
10 generally and specifically pre and post-delivery
11 care in the community and specifically at its
12 location in Enfield. The Enfield services include
13 access to services such as OBGYNs, women's health
14 specialties, primary care, pediatrics, imaging and
15 lab. This is the type of wraparound care that
16 will make a difference to patients as they will
17 have to travel a shorter distance to receive care
18 in their community. Through the prenatal period,
19 Johnson will continue to provide and coordinate
20 care for patients, create birth plans, and select
21 a delivery hospital, and following delivery will
22 be able to provide follow-up care in the
23 community.
24 I want to emphasize that our staffing
25 challenges are related to low volume of deliveries

1 that we have had in recent years at Johnson. From
2 302 deliveries in 2008, in the years 2017 and 2019
3 we have delivered only an average of 172 babies
4 per year. That is less than one baby every two
5 days. Taking into account shift-based staffing,
6 this number could be even lower for a nurse who is
7 scheduled to work just a few shifts a week. I am
8 a nurse by training and have practiced in clinical
9 settings for many years. I can understand the
10 concerns of the nurses we try to retain who
11 expressed their desire to work in busier hospitals
12 where they would have more access to more
13 deliveries, more staff, and more opportunities for
14 more clinical experiences. The low volume of
15 births is therefore related to our ability to
16 recruit and retain qualified staff in the numbers
17 needed to safely run a labor and delivery unit.
18 On a personal note, I want to mention
19 that I am a board member of the Tolland County
20 Chamber of Commerce since 2018, and I'm invested
21 in the health and success of Tolland County and
22 its residents. I believe granting this CON for
23 termination of labor and delivery services at
24 Johnson is the best way to ensure residents have
25 access to the high-quality and safe labor and

1 delivery inpatient care they deserve.
2 In conclusion, the decision to apply
3 for this CON to close the labor and delivery unit
4 was taken with much consideration and as a last
5 resort due to low volume and protracted lack of
6 adequate staffing to reach the required nurse
7 staffing levels. In my professional opinion, this
8 decision is necessary to ensure patient safety.
9 Thank you for the opportunity to
10 testify here today in support of this CON
11 application.
12 HEARING OFFICER NOVI: Thank you. I'm
13 going to allow Attorney DeBassio to ask any
14 questions for your witnesses that you would like
15 to ask, and then we'll take a break. So do you
16 have any questions for your witnesses?
17 MR. DeBASSIO: I have no questions at
18 this time. Thank you.
19 HEARING OFFICER NOVI: Okay. So at
20 this point, we'll take a quick ten-minute break.
21 It is now 10:06. A 20-minute break, let's make it
22 a 20-minute break. We'll be back here at 10:30.
23 So that way everybody has enough time to use the
24 bathroom and do whatever they need. We will now
25 break until 10:30. Thank you, everybody.

1 (Whereupon, a recess was taken from
2 10:06 a.m. until 10:31 a.m.)
3 HEARING OFFICER NOVI: Good morning
4 still, everybody. It is now 10:30. As Zoom has
5 just notified you, your remaining in this hearing
6 is your consent to being recorded. If you do not
7 consent to being recorded or videotaped, please
8 remove yourself from the Zoom hearing or this
9 hearing room at this time.
10 All right. Since nobody has removed
11 themselves from our hearing room, we'll go ahead
12 to our questions. I believe we are starting with
13 Yadira.
14 MS. McLAUGHLIN: Yes, we are. Okay.
15 Thank you.
16 In the first completeness letter
17 responses, Exhibit D, PDF page 6, shows the number
18 of births originated from JMH's primary service
19 area, the PSA, at JMH, and PDF page 8 shows the
20 historical utilization by service. However, the
21 primary service area presented is only 66, .66
22 percent in 2017, 68 percent in 2018, 71 percent in
23 2019, 75 percent in 2020 of the historical use.
24 Does that mean that one-third of the 25 percent of
25 the deliveries are coming from outside the primary

1 service area?

2 THE WITNESS (Roose): So --

3 HEARING OFFICER NOVI: I'd just ask you

4 to identify yourself by name first before

5 answering questions.

6 THE WITNESS (Roose): Of course. Good

7 morning again. Dr. Robert Roose, chief

8 administrative officer for Johnson Memorial

9 Hospital.

10 To the best of my recollection, when

11 looking at the primary service area of the five

12 towns of Enfield, Stafford, Union, Windsor Locks

13 and Somers, they represented upwards of around 75

14 percent of the deliveries. So I'd have to refer

15 to the specific notes, but yes, as they represent

16 between 68 to 75 percent, then there would be 25

17 to 33 percent that would be coming from outside

18 that area.

19 MS. McLAUGHLIN: Thank you. When did

20 JMH begin experiencing a decrease in volume?

21 THE WITNESS (Roose): By looking

22 historically in regards to inpatient labor and

23 delivery services, in 2008 there were 302

24 deliveries, and over the period of the ten years

25 that followed they had declined to an average of

1 172 deliveries between the years of fiscal year
2 '17 to fiscal year 2019. So during that 10-year
3 period there was an over 40 percent decline in
4 deliveries during that time that was consistent
5 and was expected to continue beyond that time.
6 MS. McLAUGHLIN: When did JMH begin
7 referring patients out to other facilities?
8 THE WITNESS (Roose): Can you clarify
9 that question?
10 MS. McLAUGHLIN: So at what point did
11 the hospital begin referring the labor and
12 delivery patients to other facilities, other
13 hospitals?
14 THE WITNESS (Roose): So I just want to
15 clarify and respond to the question in the best
16 way that I can. Johnson Memorial Hospital had
17 operated as a birthing center for a lower volume
18 maternity labor and delivery unit, and so through
19 its existence would triage and at times transfer
20 patients to appropriate levels of care if the
21 presenting woman needed a higher acuity level
22 service. In regards to the operation of the unit,
23 that was in full operation under those clinical
24 guidelines up until 2020.
25 HEARING OFFICER NOVI: Can I rephrase

1 **that question?**

2 **THE WITNESS (Roose): Yes.**

3 **HEARING OFFICER NOVI: When did the**

4 **unit stop taking patients or incoming patients?**

5 **THE WITNESS (Roose): Just a moment,**

6 **I'll refer to the dates that I believe that that**

7 **occurred. (Pause) It was in April of 2020 that**

8 **we initially temporarily suspended with the**

9 **attempt to reopen those services in July of 2020,**

10 **and then further notification in October of 2020**

11 **where those services were not able to be staffed**

12 **and operational. The data presented regarding the**

13 **declining births was in the fiscal year prior to**

14 **the impact of the onset of the COVID pandemic as**

15 **well as that initial temporary suspension in April**

16 **of 2020.**

17 **HEARING OFFICER NOVI: I would just**

18 **like to ask a follow-up question. When did the**

19 **last practicing OBGYN at your hospital terminate**

20 **their affiliation?**

21 **THE WITNESS (Roose): He had ceased**

22 **deliveries in 2020, but had removed himself from**

23 **the medical staff in October 2022.**

24 **HEARING OFFICER NOVI: What month in**

25 **2020 did he cease to deliver?**

1 **THE WITNESS (Roose): It correlated in**
2 **line with our temporary pause in April of 2020. I**
3 **would have to refer back to clinical records to**
4 **know when exactly the last date a delivery was**
5 **done at the hospital. I don't have that date here**
6 **at present.**
7 **MS. FAIELLA: Sorry, I do have a quick**
8 **follow-up question regarding the decrease in**
9 **volume. You had mentioned in 2008 you had roughly**
10 **around, in the 300s, correct? You had mentioned**
11 **though, Dr. Roose, that 200 was the magic number**
12 **for a safe and quality high-volume birthing unit.**
13 **When did JMH start to hit the 200s?**
14 **THE WITNESS (Roose): So I want to**
15 **speak about the data a little bit in regards to**
16 **the studies that have looked at volumes in**
17 **maternity units and overall outcomes and quality.**
18 **As you pointed out, there is an article that is**
19 **referenced that speaks and categorizes low-volume**
20 **centers as those under 200 deliveries per year.**
21 **It may not be a magic number. There is going to**
22 **be some relative impact potentially at lower**
23 **levels versus higher levels because of the impact**
24 **that it has on the ability to sustain true**
25 **clinical competencies from a nursing and provider**

1 perspective when deliveries are so infrequent and
2 therefore the exposure to those moments, and I'll
3 say moments because it truly can just be moments
4 sometimes where the risk can be introduced,
5 particularly in a high-risk setting like
6 obstetrics. And the level of awareness,
7 engagement or experience to identify those moments
8 can be impacted when one is not encountering those
9 on a regular basis which is what can relate to
10 having higher maternal mortality specifically.
11 I'd have to refer to the record in
12 terms of our application to see at which point,
13 but it was certainly as we approached the 2000
14 teens when that number started to continue to
15 decline more significantly.
16 MS. McLAUGHLIN: My next question, if
17 the application is not approved, what is the
18 projected volume for the remainder of this year
19 through 2026?
20 THE WITNESS (Roose): Projected volume?
21 MS. McLAUGHLIN: Yes.
22 THE WITNESS (Roose): So a question to
23 the projected volume. So I'll answer that in a
24 couple of ways based on experience, the reality,
25 and the trends that have been projected by

1 national companies. We talked a bit about how we
2 had seen that volume decline at Johnson
3 specifically from the 300s to less than 200 with
4 an average of 172. Because the services were not
5 operational, it's hard to exactly identify what
6 the demand for those services would have been in
7 sort of the same situation, but what we do know is
8 the pandemic changed many things, and we also know
9 that the trends have continued such that the
10 population of child bearing age women in those
11 communities has decreased, not increased. Birth
12 rates have decreased, not increased. And what we
13 know, which I think is likely one of the most
14 important relevant factors, is the one provider
15 who was utilizing Johnson Memorial Hospital as the
16 facility for patient choice relinquished his
17 medical staff privileges and assumed his care of
18 patients into a health system that uses another
19 hospital as well.
20 So that physician's patients are now
21 also being directed to other hospitals, other area
22 hospitals that provide services, and therefore
23 there is not one obstetrician or obstetrical
24 provider in the service area right now that would
25 use Johnson. So you could project theoretically

1 that there would be very few, if not close to
2 single or double digits, of a demand for services
3 at the hospital itself.
4 HEARING OFFICER NOVI: I have a
5 follow-up question to that. The doctor that was
6 practicing at the hospital stopped delivering in
7 April of 2020. Who was delivering the babies that
8 were born at JMH between July of 2020 and October
9 of 2020 when you ceased again?
10 THE WITNESS (Roose): It was the -- any
11 of the deliveries that were performed in 2020, so
12 I'll clarify, any of the deliveries that were
13 performed in 2020 were performed by that
14 physician.
15 HEARING OFFICER NOVI: And who has been
16 delivering since?
17 THE WITNESS (Roose): Nobody has been
18 delivering since. There have not been any babies
19 delivered at Johnson since.
20 HEARING OFFICER NOVI: So even
21 emergency there's been none?
22 THE WITNESS (Roose): Excuse me.
23 (Pause) There have been, after consultation with
24 Sue, there have been a small number of deliveries.
25 We believe that is two that have occurred, and

1 those would have been delivered by emergency room
2 physicians at Johnson Memorial Hospital that were
3 trained in the ability to deliver in emergency
4 situations, and then arranged for follow-up care.
5 HEARING OFFICER NOVI: Thank you.
6 MR. LAZARUS: Excuse me, this is Steve
7 Lazarus. Just a follow-up when we're talking
8 about the OBGYNs. We've talked a little bit today
9 about recruiting of the nursing staff. Can you
10 talk a little bit about the actual recruiting of
11 OBGYN physicians. How many did you have back in,
12 say, for example, 2008 when you had 302 deliveries
13 and over the years, if you can give a little
14 background that would be helpful, and any
15 recruiting efforts you can talk about.
16 THE WITNESS (Roose): (Pause) So after
17 conferring, it's our understanding and belief that
18 it was the one physician that was doing deliveries
19 at Johnson Memorial Hospital from 2008 until at
20 which point he had stopped delivering at Johnson
21 Memorial and had begun referring these patients
22 elsewhere which did include Saint Francis Hospital
23 and Medical Center. And our focus during that
24 period of time, because we had an obstetrician on
25 staff during that time, was to focus on the

1 **recruitment of the nurses as the priority.**
2 **It was not until 2022 when he**
3 **relinquished his privileges where we then were**
4 **left with a situation without a physician with**
5 **privileges to deliver babies at Johnson Memorial**
6 **Hospital. And so our priority in terms of**
7 **recruitment had always been on nursing. With the**
8 **physician, we couldn't operate unless we had the**
9 **nurses, and that was the focus. And we, as**
10 **mentioned in the testimony, ostensibly struggled**
11 **and were unsuccessful in creating a sustainable**
12 **plan for nursing care 24/7 to meet those**
13 **requirements, and it wasn't until after that point**
14 **in which the physician shortage became another**
15 **primary concern.**
16 **MR. LAZARUS: And the physician, one**
17 **physician, was he part of a medical practice,**
18 **single medical practice or was it multiple OBGYNs?**
19 **THE WITNESS (Roose): At that time, my**
20 **understanding is part of a single medical**
21 **practice. It was not until more recently that he**
22 **became part of a larger medical practice. And he**
23 **was not an employee of Trinity Health of New**
24 **England but an independent member of the medical**
25 **staff.**

1 MR. LAZARUS: All right. Thank you.
2 MS. McLAUGHLIN: Thank you. My next
3 question is, given that JMH had closed its labor
4 and delivery services and then reopened these
5 services, has JMH experienced an increase in
6 volume?
7 THE WITNESS (Roose): No, we have not
8 seen an increase in volume.
9 MS. McLAUGHLIN: Thank you. Next
10 question, what locations were these patients going
11 to when JMH was closed?
12 THE WITNESS (Roose): Prior to, as
13 mentioned in the testimony, prior to the closure
14 these patients were already identifying and
15 delivering at other area hospitals from the
16 service area in preference to Johnson Memorial
17 Hospital. After the closure, that same trend
18 continued and the predominant hospital which those
19 patients delivered was Saint Francis Hospital and
20 Medical Center, Hartford Hospital, followed by
21 Manchester Memorial Hospital, and they were likely
22 but less delivering also at Day Kimball Hospital
23 or potentially at Mercy Medical Center in
24 Springfield, Massachusetts.
25 MS. McLAUGHLIN: Thank you. And how

1 **does JMH know that these other provider locations**
2 **are willing and able to accept these patients?**
3 **And the other part to that question is, have there**
4 **been conversations or agreements in place between**
5 **these providers and JMH?**
6 **THE WITNESS (Roose): So we can speak**
7 **directly about the hospitals within Trinity Health**
8 **of New England network as there has been much**
9 **dialogue and specific agreements in place with**
10 **Saint Francis Hospital and Medical Center, which**
11 **operates a high-level maternity unit as well as a**
12 **neonatal intensive care unit, to accept all**
13 **patients from the community and any emergent**
14 **transfers that would arise from Johnson's**
15 **emergency department.**
16 **MS. McLAUGHLIN: Is there any evidence**
17 **to support the inpatient obstetric capacity of**
18 **these hospitals and the number of deliveries for**
19 **the most recently completed fiscal year?**
20 **THE WITNESS (Roose): Can you just**
21 **reask the question one more time just to make**
22 **sure?**
23 **MS. McLAUGHLIN: Is there any evidence**
24 **to support the inpatient obstetric capacity at**
25 **these hospitals, the ones that you just mentioned,**

1 and the number of deliveries for the most recent
2 completed fiscal year?
3 THE WITNESS (Roose): Excuse me just
4 for one moment. (Pause) So the data regarding
5 the utilization at the other hospitals was not
6 part of our application, but we'd be happy to
7 provide that data. We have never encountered a
8 situation where Saint Francis Hospital and Medical
9 Center has expressed any capacity concerns
10 regarding the patients from the primary service
11 area or transferred from Johnson Memorial Hospital
12 during this time at all.
13 MR. DeBASSIO: Just as a point of
14 clarification, the data for the last fiscal year
15 which I believe is what you asked about. I didn't
16 want it to sound like there was an admission there
17 was no data included.
18 THE WITNESS (Roose): Data for the last
19 fiscal year for those hospitals, yes.
20 MR. DeBASSIO: And if that data is
21 available, we'd be happy to produce it and
22 supplement the record, if that would be helpful.
23 HEARING OFFICER NOVI: Yes, we'll make
24 that a Late-File.
25 MR. DeBASSIO: Okay.

1 (Late-File requested, noted in index.)
2 MS. McLAUGHLIN: Thank you. Does JMH
3 have any existing relationships with other
4 obstetrical or prenatal providers in the
5 community?
6 THE WITNESS (Roose): Johnson Memorial
7 Hospital has a robust array of services and
8 relationships with prenatal care providers in the
9 Enfield community that are part of Trinity Health
10 of New England and have been part of other
11 practices, both midwives and obstetrics. There
12 has been a robust effort over the past several
13 years to continue to expand and enhance those
14 relationships and to provide those prenatal and
15 post-delivery services in that community within
16 that service area so that women of reproductive
17 age, those that are pregnant, are able to receive
18 that care and then work with their providers on a
19 location for their inpatient labor and delivery
20 services.
21 MS. McLAUGHLIN: And my final question,
22 how will these relationships to other facilities
23 be affected by the closure?
24 THE WITNESS (Roose): I think, in
25 thinking about the closure of these services,

1 there's been an active and robust investment in
2 relationships and services for women in the
3 prenatal and post-delivery period. And so as a
4 result of the ability to allocate resources in a
5 different way, I would uphold that those
6 relationships are actually stronger. There has
7 been an investment of resources for clinical care,
8 specifically in Enfield, to have obstetricians
9 there, have midwives there, to have breast
10 surgeons there, to have primary care there to
11 provide access and strengthen those relationships,
12 as well as the relationships with the inpatient
13 labor and delivery units at both Saint Francis
14 Hospital and Medical Center and other hospitals,
15 including Mercy.
16 MS. McLAUGHLIN: Thank you. That's it
17 for my questions.
18 THE WITNESS (Roose): Thank you.
19 HEARING OFFICER NOVI: I have a
20 follow-up question. JMH suggests transfer to
21 other hospitals who you said because of your low
22 birth rate you would recommend transfer. But
23 Manchester also has a low birth rate. Why would
24 you suggest transferring patients there when it's
25 a similarly-situated hospital?

1 THE WITNESS (Roose): We would --
2 patients are left -- from the perspective of where
3 a patient decides where to deliver, that's a
4 decision for them and their obstetrician or
5 obstetrical provider to decide. From a
6 transferring perspective, we have always
7 preferentially transferred patients to Saint
8 Francis Hospital and Medical Center specifically
9 those for which there was a high-risk condition or
10 a comorbidity that required a level of maternal
11 and then potentially neonatal care that would
12 be -- it would be needed that could include
13 specialized services including having a NICU
14 present or neonatal ICU present. Our protocols
15 and transfer protocols out of the emergency
16 department have included Saint Francis as our
17 receiving destination for those patients, not
18 Manchester.
19 HEARING OFFICER NOVI: But you list
20 them as one of the possibilities for people who
21 want to have a baby to go to that hospital, but
22 they have similar levels and similar services. So
23 why should you be allowed to discontinue yours
24 while they should be expected to keep and pick up
25 your overflow?

1 THE WITNESS (Roose): So, I won't
2 comment on the specifics of their situation in
3 regards to this because I don't know the specifics
4 of Manchester Memorial Hospital in the context for
5 which they provide those deliveries and the
6 resources they may have. In regards to the
7 volume, I think there is a -- there's evidence to
8 suggest that facilities that have more resources
9 and that provide more births would lead to better
10 outcomes with those resources. And so in an
11 environment where there are limited resources
12 potentially, there could be some logic to ensuring
13 that care is delivered in settings for which the
14 volumes are higher. And so I can't speak to them,
15 but to facilities for which there are more
16 deliveries happening, I uphold the statement I
17 think that's better for patient care and
18 sustainable for the long term.
19 HEARING OFFICER NOVI: That's it.
20 MS. FAIELLA: Hi. This is Annie
21 Faiella. I'm going to begin my questioning. So
22 who is going to be in charge of the emergency
23 department and what are the credentials of the
24 emergency department physicians that would be
25 required to deliver a baby in an emergency

1 **situation?**

2 **THE WITNESS (Roose): Our emergency**
3 **department is led by a medical director, who is a**
4 **board-certified emergency medicine physician, and**
5 **a nurse leader to oversee the services delivered**
6 **in the emergency department. Not being an**
7 **emergency medicine physician myself, but certainly**
8 **as a family physician have some experience with**
9 **what training is like, emergency medicine**
10 **physicians and those that are board certified are**
11 **trained in the range of conditions that can**
12 **present to an emergency room which could and often**
13 **includes obstetrical complaints which could be a**
14 **woman in labor to be able to competently deliver**
15 **an uncomplicated newborn in such a situation.**

16 **They're also highly trained to**
17 **understand and identify when risks may be present**
18 **and may be more beneficial to transfer a patient**
19 **to another location or a higher level of care. We**
20 **specifically engaged in an educational program**
21 **with the emergency room providers that focused on**
22 **obstetrical emergencies to ensure that, in**
23 **addition to their medical training, which those**
24 **competencies are upheld through their Board**
25 **certification process just like with other**

1 physicians, to give additional education in
2 obstetrical emergencies so that we could
3 facilitate and support and ensure that that
4 requisite level of recent education and training
5 was present at the time in which we were going
6 through the process as we are now to close the
7 inpatient labor and delivery services.
8 MS. FAIELLA: So the nurses in the
9 emergency department then who have been trained,
10 are they or have they been compensated for this
11 training to perform these additional services?
12 MR. DeBASSIO: I'm sorry, just to
13 clarify. I thought your last question was about
14 the ER doctors, and then you -- so now you're
15 asking about the ER nurses?
16 MS. FAIELLA: Both. I mean, so yes, I
17 was asking about the credentials for the ED
18 physicians to be required to deliver a baby in
19 emergency situations. And then you were
20 discussing the training that had taken place. I'm
21 assuming nurses were also involved in this
22 training, yes?
23 THE WITNESS (Roose): Yes.
24 MS. FAIELLA: So my question then is,
25 has anyone been compensated for this training to

1 **enhance their services, the ability?**

2 **THE WITNESS (Roose): (Pause) So I'll**
3 **clarify this. I'll answer this in maybe a couple**
4 **ways. As an organization when we train staff, we**
5 **arrange for and pay for that training and provide**
6 **that training during a time in which they are**
7 **working which is paid time. So then from that**
8 **perspective, yes, the training is fully covered**
9 **and compensated to the staff that are undergoing**
10 **that training, if that's something that is a**
11 **requirement of their employment.**

12 **Training emergency medicine physicians,**
13 **PAs or nurses in obstetrical emergencies is not an**
14 **expansion of their scope of work. This is part of**
15 **what their competencies would be working in an**
16 **emergency department because at any point in an**
17 **emergency department an obstetrical emergency**
18 **could come in whether you're at Saint Francis, at**
19 **Mercy, Hartford, at Johnson, et cetera. We felt**
20 **like it was in the best interest of connecting**
21 **with our providers, with our nurses, with our**
22 **community ensuring that we had provided that, but**
23 **that's not additionally, an additional scope of**
24 **work that would need an additional responsibility,**
25 **for example.**

1 MS. FAIELLA: Thank you. How many OB
2 physicians are currently credentialed by JMH?
3 THE WITNESS (Roose): Zero.
4 MS. FAIELLA: So what was the staffing,
5 labor and delivery staffing like in the past three
6 years, so how many physicians, nurses, et cetera,
7 and then what are the staffing numbers like now?
8 THE WITNESS (Roose): (Pause)
9 MS. FAIELLA: If this needs to be a
10 Late-File, that's also fine.
11 THE WITNESS (Roose): Thank you. We
12 want to make sure we have the numbers right
13 because it's a detailed ask about a three-year
14 period and a variety of different disciplines.
15 Perhaps that would be best for us just to gather
16 that information and provide it to you.
17 HEARING OFFICER NOVI: Let's make that
18 as a Late-File. And the answer to be responded to
19 in the Late-File is what was the labor and
20 delivery staffing like in the past three years,
21 how many physicians, nurses, et cetera, and what
22 are the labor and delivery staffing numbers like
23 now, same question.
24 THE WITNESS (Roose): Okay. Thank you.
25 MS. FAIELLA: We might want to add this

1 **one to the Late-File. So what are the appropriate**
2 **staffing levels for the labor and delivery**
3 **department at JMH?**
4 **MR. DeBASSIO: Are you talking about**
5 **both for physicians and for nurses broken out**
6 **separately?**
7 **MS. FAIELLA: Yes.**
8 **MR. DeBASSIO: Okay.**
9 **THE WITNESS (Roose): We can add that**
10 **to the filing. I know we had provided in**
11 **testimony 12.6 FTEs of nursing would be required**
12 **for a minimum.**
13 **MR. DeBASSIO: Minimum.**
14 **THE WITNESS (Roose): Minimum staffing**
15 **for 24/7 coverage. Physician coverage also must**
16 **be 24/7 availability. And so we can determine**
17 **what that would be, but it would be more than one.**
18 **MS. FAIELLA: So the applicant actually**
19 **quotes an FTE of 12.4 in the application but 12.6**
20 **in the prefile testimony.**
21 **THE WITNESS (Roose): Okay. Let's**
22 **clarify those numbers then. We can clarify.**
23 **HEARING OFFICER NOVI: And can you also**
24 **explain what an FTE is in the Late-File because I**
25 **was unable to find that at any point where you**

1 **explain what FTE meant.**

2 **THE WITNESS (Roose): Yes, absolutely.**
3 **So we can include that into the Late-File as well.**
4 **And conferring with Sue, my colleague, here, I**
5 **believe it is 12.6. FTE refers to a full-time**
6 **equivalent. And so that is a representation of a**
7 **40-hour staff member employee.**

8 **MS. FAIELLA: In addition, in the**
9 **answers to the hearing issues, the applicant**
10 **states that they hired 11 individuals, but Ms.**
11 **Pettorini-D'Amico says that they only hired eight.**
12 **So just to clarify, which number is accurate?**

13 **THE WITNESS (Roose): We can provide a**
14 **detailed schedule of the staff that were hired.**
15 **The difference between those numbers, we believe,**
16 **is relating to non-permanent hires, so contract**
17 **labor staff that had been engaged to try to**
18 **supplement and provide the required number of**
19 **staff but were not actually hired for long-term**
20 **employment. But we can clarify that in a**
21 **Late-File.**

22 **(Late-File requested, noted in index.)**

23 **MS. FAIELLA: Sure. Thank you. PDF**
24 **page 8 on the completeness letter response, the**
25 **average cost of deliveries per self-pay patient**

1 **does not look accurate for C-section deliveries**
2 **and vaginal deliveries. So just a clarification**
3 **for that.**
4 **THE WITNESS (Roose): Okay, I will**
5 **refer to the data, and we can clarify that to**
6 **ensure that's accurate.**
7 **MS. FAIELLA: Just so you see --**
8 **THE WITNESS (Roose): I do see the**
9 **numbers for fiscal year '16.**
10 **MS. FAIELLA: Yes.**
11 **THE WITNESS (Roose): And so we will**
12 **return to our financial data and update that**
13 **accordingly.**
14 **MS. FAIELLA: Also, the cost is not**
15 **provided for fiscal year 2017 and 2019. And also,**
16 **even though JMH closed for 2020, the cost, I'm**
17 **assuming, still would have been established, so we**
18 **would need to have that information as well.**
19 **THE WITNESS (Roose): So for '17, '19**
20 **and '20?**
21 **HEARING OFFICER NOVI: Yes.**
22 **THE WITNESS (Roose): Okay.**
23 **MR. DeBASSIO: I'm sorry, just a point**
24 **of clarification. I believe you're asking for**
25 **'17, '19, '20, '21 and '22 --**

1 MS. FAIELLA: Yes.
2 MR. DeBASSIO: -- projected costs even
3 if it was closed?
4 MS. FAIELLA: Yes, please.
5 MR. DeBASSIO: Thank you. I just want
6 to make sure we submit the right materials.
7 (Late-File requested, noted in index.)
8 MS. FAIELLA: Do Saint Francis
9 Hospital, Mercy and JMH all accept the same
10 insurance companies?
11 THE WITNESS (Roose): Yes.
12 MS. FAIELLA: Do you happen to know
13 what the cost for services at Mercy Hospital are
14 for labor and delivery?
15 THE WITNESS (Roose): We could, if that
16 is a request, we could provide that. All the
17 hospitals in Trinity Health of New England have
18 the same financial assistance policy, but we can
19 provide the cost of services at the other
20 hospitals.
21 (Late-File requested, noted in index.)
22 MS. FAIELLA: So Saint Francis
23 Hospital's cost is almost double that of JMH. Who
24 will be responsible for that increase in cost?
25 THE WITNESS (Roose): So one of the --

1 we can provide some additional look into that, but
2 one of the potential explanations for that
3 increase in costs at Saint Francis compared to
4 Johnson is that it's not comparing like-for-like
5 services. And so Saint Francis Hospital and
6 Medical Center does care for a more complex,
7 higher level, higher acuity population which would
8 carry higher costs, but for the same level of care
9 we would expect that the costs at the different
10 facilities are much more similar. So we could,
11 upon request, look to compare the costs for like
12 services at the different facilities to be able to
13 more specifically answer that question.
14 MS. FAIELLA: Yes.
15 THE WITNESS (Roose): Does that make
16 sense?
17 MS. FAIELLA: Yes.
18 (Late-File requested, noted in index.)
19 THE WITNESS (Roose): So a service
20 provided at Saint Francis that could not be
21 provided at Johnson because a mother needed a
22 higher level of care or a baby needed a neonatal
23 intensive care unit would considerably drive up
24 the overall cost for labor and delivery services
25 at Saint Francis which wouldn't be a comparison to

1 Johnson because those mothers would always be
2 delivering at Saint Francis and not Johnson.
3 MS. FAIELLA: So if the cost comes back
4 as though it's more, for example, would that then
5 increase the cost of the copay to the patient?
6 THE WITNESS (Roose): If the costs are
7 discrepant?
8 MS. FAIELLA: Yes.
9 THE WITNESS (Roose): That would depend
10 upon the commercial insurer's guidelines regarding
11 the plan that the patient had. We know that a
12 significant percentage of patients that deliver
13 from the primary service area or at Johnson in the
14 past had a government payer. So in our
15 understanding and estimate, that would not change
16 the patient responsibility because those patients
17 have a similar responsibility regardless of the
18 facility. It would actually then in turn be --
19 would go to the hospital as unreimbursed care, for
20 example. It would be -- it would only apply if
21 there was a commercial payer that had a different
22 arrangement. So that would have to be looked at
23 by the patient's insurance plan.
24 HEARING OFFICER NOVI: I have a
25 follow-up. So while the majority do, there are

1 some self-pay patients or people with
2 out-of-pocket costs if, and now that you aren't
3 delivering a birth, a birth that would have been
4 handled at JMH could get transferred to Saint
5 Francis. Would there be more out-of-pocket costs
6 for a consumer with commercial coverage that goes
7 to Saint Francis versus JMH?
8 THE WITNESS (Roose): It's hard for me
9 to comment because it is possible but not
10 necessarily true.
11 HEARING OFFICER NOVI: Could there be a
12 higher cost for someone who is a self-pay patient
13 who maybe wouldn't qualify under your financial
14 assistance program?
15 THE WITNESS (Roose): Again, I think we
16 have to assess the services that were provided.
17 And cost is really, costs for a self-paid patient
18 who doesn't meet guidelines that would be
19 completely out-of-pocket costs would be driven by
20 the array of services that they provided. And if
21 the services were more so, then that cost would go
22 up. If the services were less, then the cost
23 would be less.
24 MS. FAIELLA: Is JMH considered at risk
25 of closure financially?

1 THE WITNESS (Roose): It's not a
2 question that I was thinking about answering
3 today, I'll be honest. The sustainability of
4 hospitals in the current health care environment
5 is one that is being considered. Right now there
6 are many hospitals, Johnson Memorial Hospital
7 included, that for which the financial
8 sustainability is a concern.
9 MS. FAIELLA: Would you say that's
10 solely due to labor and delivery?
11 THE WITNESS (Roose): No.
12 MS. FAIELLA: Does JMH anticipate
13 closing any other departments?
14 THE WITNESS (Roose): I don't have any
15 comment on that at this time.
16 MS. FAIELLA: If a patient is
17 transferred to a hospital out of network due to
18 proximity and emergency status, who will cover the
19 cost to and from or sent out of state?
20 THE WITNESS (Roose): So one of the
21 ways in which we have looked to address this and
22 in partnership with the Office of Health Strategy,
23 have recently opened up an emergency medical
24 service branch location at Johnson Memorial
25 Hospital for EMS service. So if the patient does

1 require a transfer out of the facility and we
2 utilize our service, that is something that is
3 covered within their episode of care. That is
4 once -- I'll just leave it at that, covered within
5 their episode of care regardless of the facility
6 which they are transferred to.
7 HEARING OFFICER NOVI: I have a
8 follow-up. How do they get home?
9 THE WITNESS (Roose): We would arrange
10 for transportation.
11 HEARING OFFICER NOVI: At your cost or
12 their cost?
13 THE WITNESS (Roose): So our discharge
14 planners -- I'll bring up a couple points.
15 Discharge planners at the hospital will always
16 seek to make sure that patients have safe
17 discharge plans to return to their primary
18 residence or the location of their choosing and
19 will assess if that is something that they would
20 be qualified for to receive assistance whether
21 that's taxi services or ambulance services or
22 otherwise.
23 In the case of the primary service area
24 for Johnson, specifically labor and delivery, in
25 looking at the statistics, we know that, as we've

1 mentioned before, prior to closure 75 to 80
2 percent of patients were already opting
3 voluntarily to deliver at other hospitals, and in
4 that primary service area more than 90 percent had
5 access to private transportation and presumably
6 utilized that to go to their health care services
7 whether within Trinity Health of New England or
8 elsewhere. So that would be a decision that we
9 would make based on the judgment of our discharge
10 planners and care coordinators in making sure that
11 somebody has a safe place to return to.
12 MS. FAIELLA: While en route to JMH,
13 has the EMS diverted any patients to another
14 hospital in the past three to four years?
15 MR. DeBASSIO: Specifically for labor
16 and delivery?
17 MS. FAIELLA: Yes.
18 THE WITNESS (Roose): (Pause) I'm not
19 sure. We can look to try to find that
20 information.
21 (Late-File requested, noted in index.)
22 MS. FAIELLA: My next question is a
23 batch of questions that kind of go together. So
24 when a woman shows up at the hospital to deliver a
25 baby, how will JMH determine if ER nurses will

1 deliver the baby or if there's time to transfer
2 the patient to another location?
3 THE WITNESS (Roose): That decision is
4 within the clinical judgment of the provider in
5 assessing the situation and what level of risk and
6 emergency it is.
7 MS. FAIELLA: So the second part of
8 that question is who's going to make that call?
9 THE WITNESS (Roose): The provider.
10 MS. FAIELLA: If the decision is to
11 transfer a patient via ambulance, what staff
12 members will be present in the ambulance?
13 THE WITNESS (Roose): (Pause) I'm just
14 conferring with Sue to ensure that -- so EMS,
15 emergency medical services, staff are always
16 present, of course, during a transfer, and the
17 level of acuity of that transfer dictates who
18 accompanies the patient. In higher acuity
19 situations, a registered nurse would accompany the
20 patient. Depending on the clinical situation,
21 that may or may not be clinically indicated. It
22 really would depend upon the situation. And that
23 would go for labor and delivery services but any
24 medical transfer out of any facility.
25 MR. LAZARUS: This is Steve Lazarus.

1 Do you have any protocols related to OBGYN
2 services that are provided in the ED setting?
3 THE WITNESS (Roose): We do have policy
4 and protocols on the triage and evaluation of
5 obstetrical patients in the emergency department,
6 yes.
7 MR. LAZARUS: Can we get a copy of
8 that, please.
9 THE WITNESS (Roose): Yes, we can
10 provide that.
11 (Late-File requested, noted in index.)
12 MR. LAZARUS: Are there any guidelines
13 at a national level that are utilized and what
14 association for guidance that is being used?
15 MR. DeBASSIO: Again, specifically for
16 emergency department?
17 MR. LAZARUS: OBGYN.
18 MR. DeBASSIO: OBGYN generally or
19 emergency department?
20 MR. LAZARUS: Well, generally and in
21 emergency cases. I'm assuming it may be the same
22 organization, for example. I'm not sure.
23 THE WITNESS (Roose): We can ensure
24 that we provide the references. I don't want to
25 misspeak. I believe that there are guidelines for

1 this, for emergency obstetrical care that would
2 arise from the medical professional societies of
3 obstetrics and gynecology which would be the
4 American College of Obstetrics and Gynecology or
5 the American College of Emergency Medicine, as
6 well as the professional society for obstetrical
7 nurses, referred to as AWHONN. We can ensure
8 that's validated and included with the policy and
9 procedure, if that would be helpful.
10 MR. LAZARUS: Yes. Thank you. We'll
11 take it as a Late-File.
12 (Late-File requested, noted in index.)
13 MS. FAIELLA: So continuing on, so when
14 a woman shows up at the hospital to deliver a
15 baby, when would JMH allow someone to drive
16 themselves versus ambulance?
17 THE WITNESS (Roose): It's our
18 understanding that if a patient is presenting to
19 the emergency department and they are in need of a
20 transfer to another facility, then we arrange that
21 transportation. They would not drive themselves
22 unless they were ready for discharge and then they
23 choose to transport themselves to another
24 facility.
25 MS. FAIELLA: With that being said,

1 will transportation be provided to the patient and
2 their families or just the patient?
3 THE WITNESS (Roose): That is a
4 consideration that we can look to make. I'm not
5 sure we've had a decision on that at this point.
6 Certainly to the patient themself, and we can
7 evaluate that.
8 MS. FAIELLA: I think I might have
9 already asked this one, but I'm going to ask it
10 one more time. If transportation is provided, who
11 will cover the cost of transportation, what if the
12 patient does not have insurance?
13 THE WITNESS (Roose): We cover the
14 cost. I want to be very clear about that. For
15 the record and just to clarify, if a patient
16 presents at the hospital and they need transfer to
17 another facility, we will provide and cover that
18 transportation. It will not go to the patient.
19 MS. FAIELLA: Sorry. I'm just going to
20 backtrack also. You had mentioned an article with
21 that 200 number. Would you be able to provide
22 that article?
23 THE WITNESS (Roose): I believe it is
24 referenced in the application, and we can
25 certainly provide that.

1 (Late-File requested, noted in index.)
2 MS. FAIELLA: That's all for me.
3 MR. LAZARUS: I have a couple of
4 questions. A couple of the questions I have are
5 in the area of quality, but before I get there I
6 just have a couple of follow-ups. Going back to
7 recruiting, can you talk about what role is
8 Trinity playing with the hospital in recruiting
9 staff to bring it to appropriate levels?
10 THE WITNESS (Roose): I'll answer this
11 in a few ways. Speaking about nursing staff or
12 staff in general?
13 MR. LAZARUS: Uh-huh.
14 THE WITNESS (Roose): Trinity Health --
15 so everything that happens at Johnson Memorial
16 Hospital happens within the context of utilizing
17 the support and resources within the larger
18 organization that it's a part of. Trinity Health
19 being a large national not-for-profit faith-based
20 system has done some innovative recruitment, many
21 innovative recruitment initiatives and has talent
22 acquisition and recruitment support that is a
23 robust department to help fill positions. That
24 includes things as innovative as creating its own
25 internal travel nurse agency, referred to in the

1 the testimony as First Choice, which creates a
2 network of nurses that are able to provide
3 services at hospitals, including at Johnson
4 Memorial Hospital. And Johnson has been the
5 benefit to that and it has sustained some services
6 over the past several years, specifically, for
7 example, in our emergency department.
8 Trinity Health has also leveraged much
9 support from a recruitment perspective in the
10 departments in terms of marketing, in terms of
11 providing support for outreach, for innovative
12 programs to bring in new types of nurses or staff
13 into the organization, including in places where
14 we can hire graduate student nurses to create a
15 pipeline to recruit and retain. And I may be
16 forgetting things, but there's a whole host of
17 other activities. Trinity Health is very much
18 engaged, as we all are part of the same
19 organization, to help staff any of the different
20 areas of the hospitals.
21 MR. LAZARUS: So how does that
22 translate into OBGYN, in particular, at JMH?
23 THE WITNESS (Roose): So all of the
24 resources and programs were looked to be maximized
25 and utilized to its full extent to try to address

1 **the staffing gap but still led us to this**
2 **unsustainable place in which we found ourselves.**
3 **That goes for nursing as well as other staff.**
4 **MR. LAZARUS: So you talked about the**
5 **eight nurses that were hired and were trained,**
6 **went through the training program, and only two**
7 **stayed through the program, and the last one I**
8 **think that was like around 2020, 2021, and then**
9 **the program was paused in like April of 2020.**
10 **THE WITNESS (Roose): Uh-huh.**
11 **MR. LAZARUS: Have there been any**
12 **recruiting efforts ongoing since then or has the**
13 **focus been on moving the patients to other**
14 **facilities for access of care?**
15 **THE WITNESS (Roose): (Pause) So I**
16 **want to -- what we want to stress, and what we've**
17 **been discussing is that we want to -- the**
18 **recruitment of nurses was vigorous and robust**
19 **during 2020 and then into 2021 when the training**
20 **program was implemented and nurses were recruited**
21 **and then trained. We may need to confer a little**
22 **bit on specifically your question about the exact**
23 **timelines of efforts. But there remained**
24 **positions posted and recruited for during that**
25 **period of time when the training was occurring and**

1 then after when those nurses that were hired, and
2 they were fully trained, elected to not continue
3 with their employment at Johnson but actually go
4 to other hospitals, all of whom remained employed.
5 Nobody's jobs were eliminated, but those nurses
6 were employed in other areas for their choice
7 after that training period. Recruitment continued
8 for a period of time during and then after that.
9 HEARING OFFICER NOVI: I just have a
10 follow-up. When was their training completed?
11 MR. DeBASSIO: We would have to get an
12 exact date for you for that because there were
13 some nurses that were -- and I know I'm not
14 testifying, but we need an exact date because some
15 nurses were part-time and that's why they were fit
16 into a program that took longer than nurses that
17 were full-time, you know, and were available to do
18 the training. So we do know it was eight nurses
19 in that period of time, but when, we would need to
20 follow up with a specific date for when the
21 training program was completed.
22 HEARING OFFICER NOVI: Thank you.
23 (Information requested, noted in
24 index.)
25 HEARING OFFICER NOVI: Thank you.

1 MR. LAZARUS: Going back to the OBGYN
2 physician piece, was there ever an option or
3 something, anything discussed with Saint Francis,
4 your sister hospital, if a physician could be
5 shared or be brought to JMH to help provide that
6 service?
7 THE WITNESS (Roose): Yes. And that's
8 something that had been a discussion for all
9 throughout this period of time and continuing.
10 The challenge there are the physicians that are
11 working at Saint Francis Hospital and Medical
12 Center that are providing services in the
13 community want to work at Saint Francis Hospital
14 and Medical Center, not at Johnson Memorial
15 Hospital. And in addition, the context there is
16 in a circumstance for which there are limited
17 resources and those physicians are needed at Saint
18 Francis Hospital, it would not be serving the
19 community to move them out and then leave
20 challenges in capacity elsewhere. And so that has
21 not been a viable strategy by exploring that.
22 And what has been a -- what we have
23 felt like was in the best interest of serving
24 patients in the community was shifting some of
25 their care and recruiting into positions to

1 continue to provide inpatient services at Saint
2 Francis, which is a place that obstetricians and
3 gynecologists are working and want to work, but
4 having their outpatient care being delivered in
5 the service area of Johnson, Enfield in
6 particular, to be able to care for those patients
7 in the ways before and after delivery that could
8 help support overall health outcomes and health
9 equity. It was not a viable strategy to relocate
10 those physicians without creating other challenges
11 for those physicians leaving the network.
12 MR. LAZARUS: Is that something that's
13 isolated to the OBGYN program? That seemed like
14 it could be translated to many other services for
15 a community hospital.
16 THE WITNESS (Roose): I'm specifically
17 speaking now because of OBGYN because of the way
18 in which we may have been able to invest in
19 Enfield to provide those outpatient services. But
20 I think you are attending to a relevant point that
21 is a challenge for physicians, particularly where
22 there are physicians in specialties that are
23 dealing with significant shortages, there's not an
24 abundance of providers in virtually all
25 specialties these days. And many times they are

1 focusing their care on in settings that are in
2 hospitals with more resources and more patient
3 volume, more complexity, and a team of more
4 providers.
5 MR. LAZARUS: And does Trinity have --
6 I know they have a plan for recruiting and all
7 that stuff that you mentioned earlier, but is
8 there a plan to specifically help to bolster
9 community hospitals that are outside cities, for
10 example, or further out in the community that --
11 (AUDIO INTERRUPTION)
12 HEARING OFFICER NOVI: I'm going to ask
13 you to repeat that question. It looks like we may
14 have gone down for a second.
15 MR. LAZARUS: Sure.
16 HEARING OFFICER NOVI: Just before you
17 do that, I would just like to remind everybody --
18 did the hearing stop?
19 MS. GREER: Yes.
20 HEARING OFFICER NOVI: All right. I
21 apologize for the temporary delay in this hearing.
22 I think we're muted. Let's pause for a brief
23 second.
24 (Pause.)
25 HEARING OFFICER NOVI: All right. Is

1 everybody back?
2 MS. GREER: It should be fine.
3 HEARING OFFICER NOVI: I apologize. We
4 briefly lost Zoom. This is the public hearing for
5 Johnson Memorial Hospital, Docket Number
6 22-32612-CON. As you were informed upon us
7 restarting this hearing, this hearing is being
8 recorded. By remaining in this Zoom or in this
9 room you consent to being recorded. If you do not
10 consent to being recorded, please exit the Zoom or
11 the hearing room at this time.
12 I'm going to go ahead and resume the
13 question that was being asked by Mr. Lazarus, and
14 he will repeat the entire question for everyone.
15 MR. LAZARUS: Sure. And the transcript
16 has been going all along so the record is intact.
17 It was just a Zoom recording pause momentarily.
18 So going back to the question. I
19 guess, you know, I think we were talking about a
20 community hospital losing staffing and, you know,
21 especially to a hospital that's in the city or
22 more of a mainstream tertiary care hospital. So
23 these reasons that you sort of talked about,
24 provided, they're not specific to -- I mean,
25 obviously you're talking about specifically OBGYN,

1 but they're not isolated just to OBGYN, it could
2 be for other services as well.
3 MR. DeBASSIO: I'm going to object to
4 that question. We're here on the closure of labor
5 and delivery with regard to Johnson Memorial --
6 MR. LAZARUS: Right.
7 MR. DeBASSIO: -- not to the overall.
8 This isn't a hearing on the overall community
9 network and what's going on with other departments
10 and other divisions. I don't think that's an
11 appropriate question for Dr. Roose in the context
12 of this hearing.
13 MR. LAZARUS: True. However, my
14 question wasn't about other, in other contexts.
15 This same reason could be beyond just the OBGYN.
16 So it's not exclusive -- I guess my question, this
17 is not exclusive to OBGYN, the reasons why they're
18 recruiting for this particular service, or are you
19 saying this is only solely related to OBGYN?
20 THE WITNESS (Roose): I'll state what I
21 think is likely something that's recognized by
22 health care systems across the country.
23 Recruitment is a challenge everywhere. Shortages
24 in nursing and in providers impacts communities
25 differently, but there are rare exceptions to

1 where it is not presenting challenges. Johnson
2 Memorial Hospital has felt that extremely acutely
3 in the obstetrical labor and delivery service, but
4 it is not isolated to being the only service for
5 which we have been challenged in staffing and for
6 which being part of a system leverages us
7 benefits. And so, despite all of those efforts
8 and benefits, labor and delivery services continue
9 to challenge, but perhaps we likely have more
10 investment in staffing recruitment than perhaps a
11 like hospital without similar connections to a
12 system.
13 MR. LAZARUS: Thank you. What is the
14 annual cost of the labor and delivery for Johnson
15 Memorial program financially?
16 THE WITNESS (Roose): As that program
17 has not operated in the last few years, I don't
18 have that number right now.
19 MR. LAZARUS: Would you be able to
20 provide as a Late-File the last full year that it
21 was functioning?
22 THE WITNESS (Roose): I believe we
23 could. That would have been fiscal year '19.
24 MR. LAZARUS: Probably 2019, right?
25 MR. DeBASSIO: I believe it would be

1 fiscal year 2019. I thought that was included in
2 the CON submission, but to the extent it isn't,
3 we'll either highlight where it is in the
4 submission or we'll do that as a Late-File.
5 MR. LAZARUS: Great. Thank you.
6 (Late-File requested, noted in index.)
7 MR. LAZARUS: So what is the minimum
8 volume level needed to provide inpatient OB
9 services at the hospital and having a quality and
10 safe program?
11 THE WITNESS (Roose): I don't think
12 that there is a magic number to that answer.
13 Having a quality and safe program requires having
14 clinical competencies amongst all of the staff
15 that are ready and prepared to meet the needs of
16 the patients 24/7/365. That becomes more and more
17 challenging to do the lower the volume, but there
18 is not one number where I would say safe or not
19 safe. It is a continuum of risk, and it's really
20 based upon the ability to safely operate the
21 services, although lower deliveries makes that
22 more challenging.
23 MR. LAZARUS: The 200 number that was
24 mentioned earlier, is that related to a
25 professional guideline or is that something for

1 **your program?**
2 **THE WITNESS (Roose): No, I believe**
3 **it's in reference to the scientific article that**
4 **looked at low volume or varying volumes of**
5 **obstetrical units, maternity units, and labor and**
6 **delivery units relative to maternal mortality in a**
7 **variety of different settings. And the study**
8 **categorized types of hospitals based on the number**
9 **of births, and that looked at those under 200 as**
10 **being a category of a low-volume hospital that**
11 **carried higher risk or worse outcomes.**
12 **MR. LAZARUS: Are there any**
13 **professional guidelines that -- we talked about**
14 **earlier possibly submitting some -- that would**
15 **provide a minimum level of volume for OB?**
16 **THE WITNESS (Roose): I would have to**
17 **reference to see if that is specifically mentioned**
18 **as a number in any of the professional guidelines.**
19 **MR. LAZARUS: We may request that as a**
20 **Late-File.**
21 **THE WITNESS (Roose): Okay.**
22 **MR. LAZARUS: At least if you could**
23 **look into that.**
24 **THE WITNESS (Roose): Absolutely, we**
25 **can look into that. And I believe it's likely not**

1 to be the case to have a specific number, but one
2 in which talks about the services that are
3 provided. And the scientific analysis and the
4 articles in the peer review literature has looked
5 at that and what the impact is on outcomes.
6 (Late-File requested, noted in index.)
7 MR. LAZARUS: Thank you. How will JMH
8 provide the PSA population with relevant
9 information regarding the labor and delivery
10 services to allow patient choice?
11 THE WITNESS (Roose): As with any
12 service changes, we would engage in a
13 communication plan that would involve both
14 external and internal communications and ensure,
15 as we have, that the population is aware of the
16 existing prenatal services and the options for
17 delivery at other area hospitals and the services
18 that Johnson Memorial Hospital provides were they
19 needed.
20 Recently one example of that was
21 directly educating and training and communicating
22 with the local EMS companies in the surrounding
23 towns where we did some direct training from a
24 board-certified obstetrician regarding obstetrical
25 emergencies that EMS can encounter in the field.

1 And that was well received and part of ongoing
2 communication and engagement with our community to
3 let them know what services we provide and how we
4 can help arrange it to get to the right services
5 for all their needs.
6 MR. LAZARUS: Thank you. As far as
7 patient choice, as part of this education, are the
8 patients educated on which hospitals, for example,
9 Saint Francis is a Catholic hospital that may not
10 offer all the health services that another
11 hospital might offer, is that part of that
12 education and part of the choice? Are they made
13 aware of that prior to the transfer or, you know,
14 providing delivery there?
15 THE WITNESS (Roose): I appreciate that
16 question. And the answer to that is yes they
17 should be made aware of that, and we can ensure
18 that that is something that is done.
19 I want to highlight, you know, working
20 within a Catholic health care system, one of our
21 core values is reverence, and so we honor the
22 dignity and the decisions of every patient and
23 would ensure that every patient who has a desire
24 for a certain type of care or needs a service that
25 we provide and deliver that or we arrange for that

1 service to be delivered. And so therefore options
2 are always available and would be included in
3 patient education and provider-patient discussions
4 regarding their care so that the full range of
5 reproductive health options would be arranged for
6 if indicated or desired.
7 MR. LAZARUS: Thank you. As far as
8 going back to a couple of the Late-Files, can we
9 get a Late-File that updates the financial
10 attachment to the most recent completed or year to
11 date and as well as any of the tables that are
12 within the CON application that could be updated,
13 if we could get that as a Late-File.
14 MR. DeBASSIO: By the financial
15 application, do you mean the workbooks?
16 MR. LAZARUS: The financial worksheet,
17 yes, the attachment, the Excel.
18 MR. DeBASSIO: Yes.
19 MR. LAZARUS: That, and then I think
20 there's some tables with the application, if we
21 can get those, anything that needs to be revised
22 for year-to-date numbers.
23 (Late-File requested, noted in index.)
24 MR. LAZARUS: And I think I'm all set.
25 HEARING OFFICER NOVI: Okay. I

1 actually put my questions into everybody else --
2 actually, no, I have one last question left. The
3 closest hospital to JMH is Mercy Medical Center
4 which is in Massachusetts.
5 THE WITNESS (Roose): That's correct.
6 HEARING OFFICER NOVI: How would the
7 recommendation that a person who needs labor and
8 delivery go to an out-of-state hospital possibly
9 affect the labor and delivery charges to an
10 expectant mother?
11 THE WITNESS (Roose): One of the things
12 that we've worked on tremendously as an
13 organization, Trinity Health of New England, with
14 hospitals in Connecticut and Massachusetts is the
15 seamlessness to the extent possible of care
16 transitions between one facility or another. And
17 we regularly have patients that reside in one
18 state and receive care in another or transition
19 from an emergency department at Mercy Medical
20 Center, for example, and receive care at Johnson
21 Memorial Hospital, for example, particularly I'll
22 use an example of the geriatric psychiatry unit
23 that was opened. And it has been our philosophy
24 and our actions such that both facilities will
25 accept as many of the insurances as possible so

1 that that experience is one that does not impact
2 their cost of care with the same contracts being
3 managed by Trinity Health of New England.
4 I can't -- you know, there are going to
5 be individual situations within that where there
6 may be some variation to that. Because if there
7 is an insurer that may have a different philosophy
8 or not be accepted in one hospital in a different
9 state or another potentially, but we have made
10 efforts where we will accept even Medicaid
11 patients across state lines and certainly all of
12 the commercial payers and Medicare across those
13 with similar contracts.
14 So it's difficult to answer with 100
15 percent certainty for every payer, but the intent
16 and the actions is that would not be impacted.
17 And if there was any impact, it would be explained
18 to the patient prior to any transfer or any
19 discussion regarding that being the primary
20 preferred location for care.
21 HEARING OFFICER NOVI: And how are you
22 notifying the patients? You said you were, but
23 what are you doing to notify them, is it given in
24 a writing or is it just a discussion?
25 THE WITNESS (Roose): Yes, it would be

1 given in writing. If there was a calculation of
2 the expected out-of-pocket costs that would be
3 calculated in advance of receiving the service,
4 then that would be provided in writing.
5 HEARING OFFICER NOVI: Okay. Any
6 follow-up questions?
7 MR. LAZARUS: Just one question I have.
8 I know you had talked about, you had referenced
9 earlier the Sg2 report or publication that it was
10 projecting a decline over the next five years.
11 THE WITNESS (Roose): Yes.
12 MR. LAZARUS: Would you be able to
13 provide us a copy of that?
14 MS. GUREVICH: That's been attached as
15 attachment 3 to the CON application.
16 MR. LAZARUS: Attachment 3?
17 MS. GUREVICH: Yes.
18 MR. LAZARUS: All right. Thank you.
19 MS. GUREVICH: Sorry, just to clarify.
20 That's the same article that references the 200
21 number for a lower birthing volume hospital.
22 HEARING OFFICER NOVI: Do you know what
23 page attachment 3 starts on?
24 MS. GUREVICH: It is page 73 of the CON
25 application.

1 HEARING OFFICER NOVI: I have it right
2 here. Thank you.
3 MR. LAZARUS: Thank you very much.
4 HEARING OFFICER NOVI: All right. So
5 that is it for the questions from us. I'm going
6 to allow Attorney DeBassio to go ahead and ask any
7 questions based off ours, if you have any at the
8 moment, or if you'd like a brief recess before
9 that.
10 MR. DeBASSIO: Can we take a brief
11 recess?
12 HEARING OFFICER NOVI: Sure. Let's
13 take five minutes, ten minutes, what do you need?
14 MR. DeBASSIO: I'm cognizant that we're
15 coming up on the lunch hour, so why don't we take
16 ten minutes, if that's possible.
17 HEARING OFFICER NOVI: We'll come back
18 at 11:55, at which point you can begin with
19 questions.
20 MR. DeBASSIO: Thank you.
21 (Whereupon, a recess was taken from
22 11:45 a.m. until 11:56 a.m.)
23 HEARING OFFICER NOVI: All right. Good
24 morning again. It's now 11:56, as we were just
25 informed by the Zoom voice. Your being in this

1 hearing is consent to being recorded. If you
2 would like to revoke that consent at this time,
3 please leave the room or the Zoom hearing.
4 All right. At this point, I will go
5 ahead and go to follow-up questions by Attorney
6 DeBassio.
7 MR. DeBASSIO: Thank you, Madam Hearing
8 Officer. I have no questions at this time. Thank
9 you.
10 HEARING OFFICER NOVI: Okay. Follow-up
11 from us as well?
12 MR. LAZARUS: No, I think we're good
13 for now.
14 HEARING OFFICER NOVI: Okay. So at
15 this point, we will go ahead and move to our lunch
16 break. Before we go to lunch break, let's
17 discuss. Do we want to come back at a certain
18 time to see what sign-ups are going on?
19 MR. LAZARUS: So sign-up will begin at
20 2 o'clock online, and then we will take public
21 comment at 3 p.m.
22 HEARING OFFICER NOVI: All right. So
23 before I adjourn this hearing, I would just like
24 to remind people online that if they -- they can
25 start now actually.

1 **MR. LAZARUS: They can start doing it**
2 **now.**
3 **HEARING OFFICER NOVI: Okay. If you**
4 **would like to make a public comment at 3 p.m.**
5 **today, you can either in the chat function send a**
6 **chat to either Mayda -- just in the chat function**
7 **or do they have to send it to --**
8 **MR. LAZARUS: Just put it in the chat.**
9 **HEARING OFFICER NOVI: In the chat**
10 **function they can state their name and their phone**
11 **number so that we have contact information for**
12 **them, and then we will put them onto the list and**
13 **call them in order, otherwise, they can sign up**
14 **between 2 p.m. and 3.**
15 **I do apologize. Apparently, I turned**
16 **my mic off and it was difficult to hear me. All**
17 **right. Since there are no questions from the**
18 **applicant's witness, we will be adjourning for**
19 **lunch. But before we do, I'd like to remind the**
20 **public that you can sign up to give public comment**
21 **starting at 3 p.m., or public comment will begin**
22 **at 3 p.m., but you can sign up now for that public**
23 **comment. If you would like to go online into the**
24 **chat feature and provide your name and phone**
25 **number and state that you would like to make a**

1 public comment, we will call the comments in order
2 of sign-up. We may allow public officials who
3 registered to speak first, but then we will move
4 in order of the registration online. All right.
5 It is now 11:58, and I will go ahead --
6 MR. DeBASSIO: Madam Hearing Officer, I
7 apologize.
8 HEARING OFFICER NOVI: No problem.
9 MR. DeBASSIO: We are entitled to
10 closing arguments.
11 HEARING OFFICER NOVI: We will do that
12 after public comment.
13 MR. DeBASSIO: Okay. I just want to be
14 clear because on the agenda -- I thought it always
15 came after public comment, but on the agenda it's
16 listed --
17 HEARING OFFICER NOVI: I do apologize
18 if it was listed that way. I always, on mine I
19 always do the public comment, the public portion,
20 then we will list Late-Files for you, and then we
21 will do closing arguments.
22 MR. DeBASSIO: Perfect. That's my
23 preference as well. I just wanted to make sure
24 before we broke for lunch I wasn't waiving my
25 closing argument.

1 HEARING OFFICER NOVI: I do apologize.
2 MR. DeBASSIO: That's okay.
3 HEARING OFFICER NOVI: We will take
4 public comment first so you can comment on that
5 before we adjourn for the day. So if we don't
6 have public comment in the room or online that may
7 determine our timetable.
8 MR. DeBASSIO: Absolutely. That's
9 fine.
10 HEARING OFFICER NOVI: Okay. So at
11 this point, it is 11:59, and we will go on lunch
12 break now. We will see you all at 3 p.m. for
13 public comment, but if you'd like to sign up now,
14 feel free.
15 (Whereupon, a recess was taken from
16 11:59 a.m. until 3 p.m.)
17 HEARING OFFICER NOVI: Welcome back,
18 everybody. It's 3 p.m. For those of you just
19 joining us, this is the second portion of today's
20 hearing concerning a CON application filed by
21 Johnson Memorial Hospital, Incorporated, Docket
22 Number 22-32612-CON. We had the technical portion
23 this morning. As a reminder, this hearing will
24 end at 5:15 p.m., at the latest. All parties
25 should be exiting the parking garage before 6 p.m.

1 At 6 p.m., the parking garage is closed for the
2 night and no cars are able to exit the garage
3 after that time. Sign-up for public comment has
4 been all day in person and on Zoom in the comment
5 section.
6 At this point, I would like to ask if
7 we have any sign-ups from Leslie.
8 MS. GREER: No.
9 HEARING OFFICER NOVI: Do we have a
10 person on camera?
11 MS. GREER: There is someone on camera.
12 She did not sign up. Let me unmute her.
13 HEARING OFFICER NOVI: Hello, ma'am.
14 My name is Hearing Officer Novi. Are you on
15 camera because you would like to make a public
16 comment?
17 What is her name?
18 MS. GREER: Brenda Buchbinder.
19 HEARING OFFICER NOVI: Hello, Brenda
20 Buchbinder. Can you hear me?
21 BRENDA BUCHBINDER: I can hear you,
22 yes. I submitted written testimony. I am here to
23 witness the process.
24 HEARING OFFICER NOVI: Okay. So if you
25 are here to just, to view the hearing, we are

1 going to ask that you turn your video camera off
2 so that the people who are making public comment
3 can be seen.
4 At this point, I don't think we've had
5 anyone sign up. We do have another person who's
6 on camera. Can someone tell me the name?
7 MS. GREER: Representative Tammy
8 Nuccio.
9 HEARING OFFICER NOVI: Representative
10 Tammy Nuccio. Hello, Representative Nuccio, can
11 you hear me?
12 REP. NUCCIO: I can hear you. Can you
13 hear me?
14 HEARING OFFICER NOVI: Yes, I can.
15 Would you like to make a public comment?
16 REP. NUCCIO: I would, ma'am.
17 HEARING OFFICER NOVI: All right. Go
18 ahead.
19 REP. NUCCIO: Hi. I am Representative
20 Tammy Nuccio of the 53rd District. I neighbor
21 Stafford where Johnson Memorial Hospital is. And
22 I have been in talks with the hospital for, I want
23 to say, over a year now, in regard to their
24 services and specifically in regard to their
25 closing of maternity services.

1 I've been following along with the
2 meeting today, and I will also be supplying
3 written testimony for this. As an elected
4 representative, I am here to express my concerns
5 that -- I'm very worried and concerned about
6 Johnson Memorial closing maternity. We've seen a
7 very troubling trend of hospitals buying these
8 small rural hospitals, and unfortunately the very
9 first thing that they do is they close or look to
10 close the maternity sections in these hospitals.
11 If you do a quick search, the towns
12 that Johnson represents are a lot of small rural
13 towns, lower-income towns, towns that do not have
14 a lot of resources and do not have a lot of
15 availability to medical care as it is. The
16 shrinking of their services to exclude maternity
17 is going to mean a lot of women and a lot of
18 families are going to be pushed to have to travel
19 to Hartford or to Mercy Hospital in Massachusetts,
20 which is an entire different state than ours, just
21 putting that out there, for maternity services,
22 and I do not think that is fair.
23 I want to give Johnson the credit that
24 is due, and they have done a lot of work to
25 improve their services. At one point, the

1 conversation was they were closing all of their
2 intensive care and their inpatient beds, and we
3 really challenged them to dig deep and to find a
4 way to bring these services back post-COVID.
5 I think a lot of the arguments that
6 have been made by Johnson in regard to not having
7 staffing and such are self-created problems which
8 we've seen happen in Windham Hospital and now
9 we're seeing it again in Johnson. And I know
10 there are other hospitals that are experiencing
11 the same thing. When you say that you're going to
12 close a unit, there is no stability for that
13 workforce, and you're not going to get people who
14 are going to dedicate themselves to working in a
15 hospital where their jobs might be on the line.
16 Johnson used to do a good amount of
17 deliveries, and I think with investment they can
18 do it again. And I'm asking you to please
19 consider the moms who are going to be thrust into
20 an ambulance and told they have to drive 30 to 40
21 minutes before they're in a facility to give
22 birth, those women, especially lower-income women,
23 not having the resources around to have family
24 there to help them in their most vulnerable time.
25 And just think, if they don't have transportation,

1 how they're getting home from a hospital in
2 Hartford to a town like Union or Stafford or
3 Willington when those towns don't even have bus
4 services. They don't have Uber, they don't have
5 bus services, they don't have public
6 transportation. And these are the women that we
7 are going to be putting out by closing maternity
8 at Johnson Hospital.
9 I don't feel like there's been a good
10 enough case to show that we should not have
11 maternity there. And I think this hospital, this
12 small hospital has been bought by a larger
13 hospital who, quite frankly, can afford to put the
14 money in to make a nice state-of-the-art maternity
15 ward where women can continue to get service.
16 So that's a lot there, but I'm just
17 asking you to think about this CON and who is
18 going to service these women and how far we're
19 going to be putting them out by closing these
20 services, and asking that we do the right thing
21 and make sure women's health is a top priority for
22 our hospitals. And if they're not willing to do
23 it on their own, then we make sure that they know
24 it's a top priority for us. Thank you for your
25 time.

1 HEARING OFFICER NOVI: Thank you,
2 Representative Nuccio. We do appreciate your
3 comments today.
4 All right. Is there anybody else who
5 would like to make a comment? I'm going to
6 have -- Leslie, if you could unmute everybody for
7 a second. We'll just ask if there is anybody who
8 is currently listening to this hearing who would
9 like to make a public comment. We'll give you a
10 chance to speak up right now.
11 (No response.)
12 HEARING OFFICER NOVI: Is everyone
13 unmuted?
14 MS. GREER: It's not showing it. I've
15 given them permission to unmute themselves.
16 HEARING OFFICER NOVI: Okay. If you
17 would like to make a public comment, you may
18 unmute yourself and say your name.
19 (No response.)
20 HEARING OFFICER NOVI: All right.
21 Hearing no one who has stated their name, we will
22 go ahead and remute everybody again. Thank you.
23 I would like to let everybody know that, if you
24 would like to make a written comment, we will be
25 taking written comments for a week. If you would

1 like to submit a written comment, you may do so to
2 CONcomment@ct.gov. And again, that is
3 C-O-N-c-o-m-m-e-n-t@ct.gov. We will be accepting
4 written comments for seven calendar days from
5 today. And so, if you would like to, please go
6 ahead and submit that in writing, and it will be
7 uploaded into the record. Our contact information
8 is also on our website and the public information
9 sheet that was provided or the agenda that is
10 posted online.
11 MS. GREER: Two more people have
12 joined, so maybe make that announcement again
13 about public comment.
14 HEARING OFFICER NOVI: All right. I
15 would like to make another announcement about
16 public comment that we are accepting written
17 public comment for seven days through email. Our
18 email address is CONcomment@ct.gov. Again, that
19 is C-O-N-c-o-m-m-e-n-t@ct.gov. We will be taking
20 public comment for seven calendar days from today.
21 If you would like to submit one online, we do
22 welcome that.
23 All right. Now that we have heard from
24 our representatives and there's no additional
25 public comment, I would like to move on to -- are

1 we ready to go to Late-Files?
2 (Pause.)
3 HEARING OFFICER NOVI: Okay. Normally
4 we would list the Late-Files. However, because
5 there were substantial Late-File requests, what we
6 would like to do is put those together into a
7 letter, send that to you, and then give you ample
8 time to respond. Is that okay with you, Attorney
9 DeBassio?
10 MR. DeBASSIO: That's totally fine,
11 Madam Hearing Officer. And I think that approach
12 makes sense given how quickly we were going
13 through the questions and back and forth about
14 what was being requested.
15 HEARING OFFICER NOVI: There's a lot of
16 Late-Files. We do want to make sure that we will
17 give you enough time. We will also give you ample
18 time to respond to that, and if you do need more
19 you can always, I would suggest contacting Mr.
20 Lazarus if the time that we suggest is not enough
21 for you to get those answers to us. You can
22 easily contact him. I would request to not be
23 sent that email just because of ex parte
24 communications; however, Mr. Lazarus can help with
25 that.

1 MR. DeBASSIO: Understood. Thank you,
2 Madam Hearing Officer.
3 HEARING OFFICER NOVI: Thank you very
4 much.
5 All right. So at this time, are there
6 any additional questions from the analysts?
7 MR. LAZARUS: No, not at this time.
8 HEARING OFFICER NOVI: All right. So I
9 will go ahead and allow the applicant's attorney
10 to ask any additional questions he may have of his
11 own witnesses and then proceed to a closing
12 statement.
13 MR. DeBASSIO: I have no additional
14 questions at this time. Thank you, Madam Hearing
15 Officer.
16 HEARING OFFICER NOVI: Would you like
17 to proceed to your closing statement?
18 MR. DeBASSIO: Yes. Would you prefer
19 if I stand or is sitting okay?
20 HEARING OFFICER NOVI: Either is fine
21 with us.
22 MR. DeBASSIO: Thank you. Madam
23 Hearing Officer, members of OHS, I want to thank
24 you for the opportunity that you've given Johnson
25 Memorial Hospital and my colleagues here today to

1 address any questions and provide their written
2 testimony with regard to their application to
3 close labor and delivery services at Johnson
4 Memorial.
5 I hope one thing has come across very
6 clearly in Dr. Roose and Ms. Susan
7 Pettorini-D'Amico's testimony in that this
8 decision to close labor and delivery was not -- or
9 to seek permission to close labor and delivery was
10 not undertaken lightly and was undertaken with the
11 quality of services in mind and eventually the
12 care that the women who would be visiting Johnson
13 Memorial were going to receive. That was the
14 number one concern of Johnson Memorial throughout
15 this entire decision-making process.
16 And it became clear in their efforts in
17 the last couple of years that staffing was going
18 to be an issue at labor and delivery in Johnson
19 Memorial, and it wasn't simply a matter of
20 throwing more resources at it, and it wasn't
21 simply a matter of more recruiting. The feedback
22 we got from the nurses was that this was not a
23 situation that they were looking forward to or
24 comfortable working in. Because given the size of
25 the staff at Johnson Memorial in terms of labor

1 and delivery, the nurses would have to be doing
2 substantially more work and taking substantially
3 more on call for fewer potential deliveries.
4 We're talking about one delivery, on average, a
5 little over every two days.
6 There was going to be a tremendous
7 amount of downtime when they are at the hospital
8 when they are at labor and delivery when they are
9 waiting for somebody to come in, and they're not
10 treating or working with patients as opposed to,
11 after they did the training program, the
12 opportunities they got at other area hospitals and
13 at Saint Francis Medical Center where there was a
14 much higher utilization rate, their services were
15 in demand, they were working, they had their
16 normal shifts, and they were not going to be
17 forced to do the same amount of on call that they
18 would have to do if they took a job at Johnson
19 Memorial.
20 And I think Ms. Pettorini-D'Amico
21 talked about this. That is one of those quality
22 of life issues that doesn't necessarily come
23 across when you're talking about dollars and
24 cents. Because when the nurses are on call, that
25 means they have to be near the hospital and they

1 have to be ready to respond when they are called
2 to come and deliver services. So they are going
3 to be on call significantly more at Johnson
4 Memorial than they would be at Saint Francis or
5 any other area hospital, and they are going to be
6 utilized much less. It's not a position that's
7 attractive to the people that you need to fill
8 those positions. That was a hill that was going
9 to be too high for Johnson Memorial to climb.
10 Because again, the training program
11 that they did in collaboration with Saint Francis
12 was incredibly successful. All of the nurses that
13 went through that training program got jobs. They
14 were working for Saint Francis Medical Center or
15 they were working for other area medical centers.
16 It was a successful training program.
17 And because of what we're talking about
18 with labor and delivery at Johnson Memorial, we're
19 not talking about taking any jobs out of the
20 marketplace. We're not talking about layoffs.
21 We're not talking about any cost savings. Because
22 all of those people that were recruited to work at
23 Johnson Memorial got and have jobs with Saint
24 Francis Hospital or in the Trinity network.
25 Furthermore, when it appeared and it

1 was clear that labor and delivery services and
2 staffing labor and delivery services were not
3 going to be tenable at Johnson Memorial Hospital,
4 Johnson Memorial, as part of their service to the
5 community and the women, men, children and
6 everyone in that community, started dedicating
7 those resources to pre and postnatal care. Dr.
8 Roose talked at great length about all of the
9 services that were being offered in Enfield and
10 the surrounding communities to support women when
11 they were pregnant, after delivery, and all of
12 those other things. These same nurses that we're
13 talking about, the same staff that we're talking
14 about sitting at Johnson Memorial waiting for
15 somebody to come in and give birth are now fully
16 utilized at these other area service centers
17 treating patients, touching numerous lives every
18 single day, having positive outcomes on mothers
19 and children, both before birth and after birth.
20 And when you want to talk about health
21 equity and you want to talk about access to health
22 care and you want to talk about a positive impact
23 on the system, that is the positive impact that
24 we're talking about here. You could have an
25 employee sitting around waiting for something to

1 happen, or you could have that same employee in a
2 different setting seeing multiple patients all day
3 long in a fully utilized shift and having a
4 positive impact on those women and children in
5 their lives.
6 And Dr. Roose talked about it. When
7 you improve that quality of care, when you improve
8 that accessibility, when you improve that access,
9 you're also talking about improving cost
10 effectiveness and positive outcomes for people in
11 that system. So when you talk about the community
12 and our service area as well, you're talking about
13 a changing community which is experiencing an
14 aging population, fewer births, you have that
15 inverse curve moving away from each other, and yet
16 you have these services that are being offered
17 that touch more lives in that same community.
18 It's more cost effective, it's more accessible,
19 and you're delivering higher quality services.
20 And again, when you talk about our
21 service area, you're talking about changes in the
22 overall access to health care that are reflecting
23 the natural changes in the population in the
24 service area. Patients were already moving away
25 from using Johnson Memorial Hospital to deliver.

1 When you look at the trend over the last ten years
2 prior to COVID, the number of births taking place
3 at Johnson Memorial was decreasing. They were
4 using facilities such as Hartford Hospital or
5 Saint Francis that had more robust programs, that
6 were fully staffed, that had access to specialized
7 services that Johnson Memorial was never going to
8 have. Johnson Memorial was never going to have a
9 neonatal intensive care unit. People that needed
10 those types of services were always going to go to
11 one of these larger hospitals.
12 And people that were talking to their
13 OBGYNs and coming up with birth plans and coming
14 up with an idea about how they were going to deal
15 with this incredibly stressful but miracle that is
16 happening in their lives had a plan, for the most
17 part, that was already in place prior to going
18 into labor to visit one of these other facilities.
19 Now, Johnson Memorial has said even
20 despite having the challenges with which they were
21 dealing with in terms of staffing labor and
22 delivery, they have a trained emergency department
23 on staff and ready to respond should somebody come
24 in in distress and need emergency treatment. They
25 maintain the equipment that Johnson Memorial had

1 for labor and delivery near the ER. And I
2 apologize, I have to say "near the ER" because, as
3 I'm saying this, I don't remember exactly where
4 they are keeping the equipment in the facility,
5 but it was immediately available to the ER doctors
6 should somebody come in and need that type of
7 service. And Johnson Memorial, the nurses and the
8 ER doctors and the medical specialists were
9 trained to provide those types of services.
10 Johnson Memorial had taken efforts to
11 look at the transportation and safety plan so that
12 if patients did show up and they had to be
13 transferred, whether it be to Manchester or
14 Hartford Hospital or Saint Francis Hospital, they
15 had EMS on site, they had registered nurses that
16 were prepared to accompany the people in the
17 ambulance being transferred to these other
18 facilities.
19 This proposal to close labor and
20 delivery at Johnson Memorial is not a proposal to
21 actually diminish the access to health care in the
22 region. It's a proposal to increase access to
23 health care in the region. It's a proposal to
24 appropriately utilize the resources that are
25 available to Johnson Memorial and the people in

1 those service areas in a way that reflects the
2 needs of that service area in a way that reflects
3 the work that those professionals, the nurses and
4 the doctors, in those service areas want to
5 provide in a setting in which they want to provide
6 it.
7 So this is not a one-sided equation
8 where we're talking about taking something away
9 from everybody. We're trying to find a solution
10 and we are trying to move forward with something
11 that reflects what the nurses and the doctors and
12 the people living in the service area want and
13 what Johnson Memorial can safely provide in terms
14 of quality services and where they can provide it.
15 And Dr. Roose has testified that the best services
16 and the best impact touching the most lives and
17 having the most positive outcomes that they
18 possibly can is not to maintain labor and delivery
19 at Johnson Memorial health but to provide these
20 other outpatient and inpatient services to women
21 and children in the service area such as through
22 the Enfield facilities.
23 What we're talking about here is not
24 going to result in any unnecessary or duplication
25 of existing health care services. It's going to

1 be streamlining and more effectively using the
2 health care services that are available in the
3 service area and available to the people in the
4 service area.
5 So in conclusion, we would respectfully
6 submit that the proposal to close labor and
7 delivery at Johnson Memorial be granted because it
8 is a proposal that reflects all of these things
9 and all of what we want our health care system to
10 accomplish. It's going to be effectively
11 utilizing the resources that are available. It's
12 going to be providing more access to health care
13 to more people in the service area in a much more
14 positive and productive manner than keeping labor
15 and delivery open at Johnson Memorial would
16 accomplish. It's not going to negatively impact
17 the financial structure of the health care system
18 overall. It's not going to negatively impact the
19 financial situation of the individuals within the
20 service area who take advantage of these services.
21 It's about quality, accessibility and cost
22 effectiveness, not just in terms of health care
23 but in terms of quality of life. Thank you.
24 HEARING OFFICER NOVI: Thank you very
25 much. I do appreciate your time here today from

1 **both you and your witnesses. And your co-counsel**
2 **coming down from Boston, I really appreciate that.**
3 **I'd like to thank everybody for attending today.**
4 **It is now 3:22 p.m. I will be adjourning this**
5 **hearing. As I said, we will be sending a letter**
6 **with all of the Late-Files, and we will give you**
7 **time to get those in.**
8 **I would like to remind anybody who is**
9 **listening, we will take public comment for seven**
10 **calendar days from today, and that can be**
11 **submitted through email to CONcomment,**
12 **C-O-N-c-o-m-m-e-n-t, at ct.gov. Thank you for**
13 **listening, and we will close this hearing -- I'm**
14 **sorry, the record will remain open, but we will be**
15 **closing this portion of the hearing.**
16 **(Whereupon, the witnesses were excused**
17 **and the hearing adjourned at 3:22 p.m.)**
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1 CERTIFICATE OF HYBRID HEARING
2
3 I hereby certify that the foregoing 130 pages
4 are a complete and accurate computer-aided
5 transcription of my original stenotype notes taken
6 of the hybrid Hearing held before the Connecticut
7 Office of Health Strategy in Re:
8 DOCKET NUMBER: 22-32612-CON, A HEARING REGARDING
9 THE TERMINATION OF INPATIENT LABOR AND DELIVERY
10 SERVICES BY JOHNSON MEMORIAL HOSPITAL, which was
11 held before ALICIA J. NOVI, ESQ., HEARING OFFICER,
12 at the Public Utilities Regulatory Authority, 10
13 Franklin Square, New Britain, Connecticut, and
14 Zoom, on July 12, 2023.
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20
____
21 Lisa L. Warner, CSR 061
Court Reporter
22
23
24
25

1 I N D E X

2

3 *ADMINISTRATIVE NOTICE ITEMS ADOPTED ON PAGE 8

4 WITNESSES: (Sworn on page 12)
ROBERT ROOSE, M.D., M.P.H.
5 (Direct testimony on page 13)

6 SUSAN PETTORINI-D'AMICO, DNP, RN, NEA-BC
(Direct testimony on page 38)
7

EXAMINERS:	PAGE
Ms. McLaughlin	54,59,64
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Mr. Lazarus	62,86,89,93,106
Hearing Officer Novi	56,61,68,80,83,92,104

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12 INFORMATION REQUESTED

REQUEST	PAGE
Provide inpatient obstetric capacity and number of deliveries for most recently completed fiscal year in Trinity Health of New England network	67
What was the labor and delivery staffing like in the past three years, how many physicians, nurses, et cetera, and then what are the staffing numbers like now - Also, what are appropriate staffing levels at JMH for labor and delivery - Also, define FTE	76
Average cost of deliveries per self-pay patient for C-section deliveries and vaginal deliveries, a clarification for '17, '19, '20, '21 and '22	78
Provide the cost for labor and delivery services at hospitals outside of Trinity Health of New England	78

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1 **I n d e x: (Continued)**

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REQUEST	PAGE
Compare the costs for like services at the different facilities	79
While en route to JMH, has EMS diverted any patients to another hospital in the past three to four years	84
Provide any protocols related to OBGYN services that are provided in the ED setting	86
Are there any guidelines at a national level that are utilized and what association for guidance is being used	87
Provide article with 200 number	89
When was nursing training completed	92
What is the annual cost of labor and delivery for Johnson Memorial financially, the last full year of operation	99
Are there professional guidelines that would provide a minimum level of volume for OB	101
Provide an update to the financial attachment, to the most recently completed or year to date, as well as any of the tables that are within the CON application that could be updated	103

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