

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH STRATEGY

NEWPORT ACADEMY
ESTABLISHMENT OF TWO HEALTH CARE FACILITIES
(MENTAL HEALTH RESIDENTIAL LIVING CENTERS)
IN FAIRFIELD, CONNECTICUT

DOCKET NO. 19-32305-CON

MARCH 4, 2020

1:00 P.M.

FAIRFIELD UNIVERSITY
200 BARLOW ROAD
FAIRFIELD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

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1 . . . Verbatim proceedings of a hearing
2 before the State of Connecticut, Department of Public
3 Health, Office of Health Strategy, in the matter of
4 Newport Academy, Establishment of Two Health Care
5 Facilities (Mental Health Residential Living Centers) in
6 Fairfield, Connecticut, held at Fairfield University, 200
7 Barlow Road, Fairfield, Connecticut, on March 4, 2020 at
8 1:03 p.m. . . .

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11

12

13 afternoon, everyone. We're going to go ahead and get
14 started.

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1 Statutes.

2 My name is Micheala Mitchell. I have been
3 designated by Victoria Veltri, who is the Executive
4 Director of the Office of Health Strategy, to preside
5 over today's hearing.

6 To my left and your right is Brian Carney,
7 and to my right, and maybe most of your lefts, is Jessica
8 Rival, and they are the staff from the Office, who are
9 going to assist me today. The hearing is being recorded
10 by Post Reporting Services.

11 At all times during the hearing today,
12 references to the Health Systems Planning Unit is going
13 to be referred to as HSP.

14 If the Applicant, witnesses and members of
15 the public use acronyms, we just kindly ask that you
16 define the acronym first. I will also direct anyone, who
17 forgets to do so.

22 The Applicant, Newport Academy, has been
23 designated as a party in this proceeding.

24 At this time, I'm going to ask Mr. Carney

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1 to read into the record those documents already appearing
2 in HSP's Table of Record in this case. All documents
3 have been identified for referencing purposes.

4 MR. BRIAN CARNEY: Okay. At this time,
5 I'd like to enter into the record Exhibits A through Y.
6 A couple of additions, which will be Exhibit AA, motion
7 for reconsideration and articulation, and Exhibit BB, the
8 ruling on the motion for reconsideration and
9 articulation.

10 HEARING OFFICER MITCHELL: I'm going to go
11 to the Applicant's counsel and just ask that you identify
12 yourself and, also, indicate whether or not you have any
13 objection to the inclusion of the exhibits into the
14 record.

15 MS. KIM RINEHART: Good morning, Hearing
16 Officer Mitchell, and thank you, also, to Ms. Rival and
17 Mr. Carney.

18 My name is Kim Rinehart from the law firm
19 of Wiggin & Dana, and I'm here today representing the
20 Applicant, Newport Academy. We have no objection to
21 those exhibits going into the record.

22 My only question was that there was an
23 objection to the motion for reconsideration, which was
24 not listed, and, so, I just wanted to raise that.

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1 HEARING OFFICER MITCHELL: I'm going to
2 note that, and we will update the Table of Record. I
3 believe that there may be some additional late files that
4 we may ask for, so we'll make sure that everything is up-
5 to-date once the Table of Record has been finalized, so
6 duly noted.

7 MS. RINEHART: Thank you very much.

8 HEARING OFFICER MITCHELL: You're welcome.
9 Anything additional?

10 MS. RINEHART: Hearing Officer, there was
11 a motion that we had filed, asking for just some
12 instruction and guidance, in terms of the scope of the
13 hearing today, and we'd ask, obviously in your
14 discretion, whether you'd like to give some guidance on
15 those parameters.

16 HEARING OFFICER MITCHELL: So I will.

17 I'll just go forward and give a few more instructions,
18 and then I will rule on the motion for the setting of
19 parameters for the hearing.

20 MS. RINEHART: Thank you.

21 HEARING OFFICER MITCHELL: You're welcome.
22 So for the hearing today, the Applicant is going to
23 present a 15-minute overview of the proposed project by
24 way of Direct testimony.

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1 HSP is then going to have the opportunity
2 to question the Applicant. Following those questions, we
3 are going to hear comments from the public.

4 Each person, who wishes to speak, should
5 have written their name on the sign-up sheet that I
6 believe is outside of the room. If you haven't signed
7 up, just make sure that you sign up.

8 We're going to call legislators and
9 municipal officials first, and then proceed to call
10 members of the public from the sign-up sheets in the
11 order in which they signed up.

12 I understand from reviewing the
13 application and correspondence in the record that there
14 is a disagreement between some residents of the town and
15 the town Zoning Board about whether or not this proposal
16 is appropriate for the neighborhood, and I just want to
17 make clear that the Office of Health Strategy does not
18 have jurisdiction to consider any zoning issues, so,
19 accordingly, this is not the appropriate venue to raise
20 those issues.

21 All testimony and comments should be
22 limited to the guidelines that are set forth in Section
23 19a-639a of the General Statutes, and you'll find those
24 guidelines on the back of the agenda that Ms. Greer

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1 should have provided everyone with today. If you veer
2 outside of those guidelines, I'll guide you back into the
3 appropriate area.

4 With regard to the ruling on the motion,
5 I'm going to make the ruling verbally. So looks like, on
6 February 25th of 2020, the Applicant submitted a motion
7 to OHS to establish parameters for the hearing, and my
8 ruling is as follows.

9 The Applicants request that the Hearing
10 Officer make an opening statement at the public hearing,
11 explaining the importance of a respectful process,
12 reiterating the purpose of the hearing and, also, the
13 statutory criteria upon which the CON decision must be
14 made as granted.

15 As stated just a few moments ago, this
16 hearing is not about zoning. It's not about the
17 proximity of the locations contained in the proposal to
18 others in the community, and if OHS would try to weigh
19 that, it would be inappropriate for us to do so.

20 This is not the venue to argue about the
21 proposal's affect on traffic, crime, the residential
22 nature of the location. It is not.

23 This hearing is about the guidelines that
24 are set forth in 19a-639a, and they are as follows. We

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1 consider whether the proposed project is consistent with
2 any applicable policies and standards adopted in
3 regulations by the Office of Health Strategy.

4 We consider the relationship of the
5 proposed project to the Statewide Health Care Facilities
6 and Services Plan.

7 We also consider whether there is clear
8 public need for the health care facility or services
9 proposed by the Applicant.

10 We consider whether the Applicant has
11 satisfactorily demonstrated how the proposal will impact
12 the financial strength of the health care system in the
13 state or that the proposal is financially-feasible.

14 We look at whether the Applicant has
15 satisfactorily demonstrated how the proposal will improve
16 quality, accessibility and cost effectiveness of health
17 care delivery in the region, including, but not limited
18 to, the provision of or any change in the access to
19 services for Medicaid recipients and indigent persons.

20 We look at the Applicant's past and
21 proposed provision of health care services to relevant
22 patient populations and payer mix, including, but not
23 limited to, again, access to services by Medicaid
24 recipients and indigent persons.

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1 We look at whether the Applicant has
2 satisfactorily identified the population to be served by
3 the proposed project and satisfactorily demonstrated that
4 the identified population has a need for the proposed
5 services.

6 We look at the utilization of existing
7 health care facilities and health care services in the
8 service area of the Applicant.

9 We look at whether the Applicant has
10 satisfactorily demonstrated that the proposed project
11 shall not result in an unnecessary duplication of
12 existing or approved health care services or facilities.

13 We analyze whether an Applicant, who has
14 failed to provide or reduce access to services by
15 Medicaid recipients or indigent persons, has demonstrated
16 good cause for doing so, which shall not be demonstrated
17 solely on the basis of differences in reimbursement rates
18 between Medicaid and other health care payers.

19 We look at whether the Applicant has
20 satisfactorily demonstrated that the proposal will not
21 negatively impact the diversity of health care providers
22 and patient choice in a geographic region, and whether
23 the Applicant has satisfactorily demonstrated that any
24 consolidation resulting from the proposal will not

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1 adversely affect health care costs or accessibility to
2 health care.

3 Those are our factors.

4 Just one last thing on the first request
5 that was made by the Applicants, and that is to reiterate
6 that this is a regulatory proceeding.

7 My job as the presiding Officer is to
8 manage these proceedings and to make sure that the record
9 is complete.

10 Everyone, who wishes to speak, will have
11 an opportunity to do so. We want to hear from you.
12 However, I expect that everyone, who is in the room, will
13 be respectful of one another during these proceedings.

14 Only one person speaks at a time. There
15 will be no yelling, no calling out, no speaking out of
16 turn. Anyone, who engages in improper conduct designed
17 to interrupt the proceedings or who is speaking out of
18 order during the proceedings, will be directed to leave.

19 The Applicant's second request is denied,
20 in part. I have no issue with persons, who are providing
21 public comment, having a supportive person to be with
22 them while they make their comments.

23 However, because I expect that everyone is
24 going to adhere to my directions regarding the

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1 appropriate conduct for these proceedings with regard to
2 giving their public comments, I'm going to go in the
3 order in which people have signed in, rather than have
4 the Applicant's guests speak first.

5 At this time, I'm going to have the
6 Applicant's witnesses raise their hand, so that they can
7 be sworn in, and I will ask the hearing reporter to do
8 the swearing in.

9 (Whereupon, the parties were duly sworn
10 in.)

11 HEARING OFFICER MITCHELL: At this time,
12 the Applicant may proceed with its testimony.

13 MS. RINEHART: Thank you. Our application
14 will be presented by Joseph Procopio, the CEO of Newport
15 Academy, Carter Barnhardt, the Chief Experience Officer
16 of Newport, and Dr. Michel Mennesson, a long-time
17 provider with Newport Academy. Joe, please go ahead.

18 MR. JOSEPH PROCOPIO: Thank you. Good
19 afternoon, and thank you, Hearing Officer Mitchell, for
20 providing us an opportunity to discuss our program to
21 provide residential mental health services to young
22 adults ages 18 to 26 here in the Town of Fairfield.

23 My name is Joe Procopio. I am the Chief
24 Executive Officer for Newport Academy, and I ask that my

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1 pre-filed testimony be adopted.

7 Our mission was launched in Southern
8 California in a single-family residence early in 2009,
9 and something remarkable happened at that singular house.
10 Young people came to treatment and they got healthy.

11 Since that time, Newport has grown to over
12 20 programs, including a residential program for
13 adolescents and young adults ages 14 to 20 in Bethlehem,
14 Connecticut, and an outpatient program in Darien. We are
15 nationally recognized for high quality, effective life-
16 changing care.

17 Today, we stand before you with a simple
18 request. Allow a decade-old experienced high-quality
19 provider to expand access for care to young adults with
20 primary mental health diagnosis by opening our program
21 here in Fairfield.

22 The need for these services are profound.
23 According to SAMHSA, 8.2 percent of young adults in
24 Connecticut have reported seriously considering suicide

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1 in the last 12 months. As a parent, that should be
2 shocking to most and frightening. 6.2 percent have a
3 serious mental illness.

13 On the topic of quality, Newport Academy
14 is a result-driven organization, so much so we have that
15 terminology built right into our mission statement.

16 All of our programs are certified by the
17 Joint Commission, widely known as the Gold Seal in health
18 care. For calendar years 2017 and 2018, we engaged
19 Vanderbilt University to review our outcomes data, which
20 we collected using well-accepted tools, PHQ-9, the GAD-7
21 and the WHO-5, which are a depression scale, an anxiety
22 scale and overall wellness, and, as will be discussed
23 further by Dr. Mennesson, this study showed significant
24 improvement in all measures.

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1 Also, on quality here in Bethlehem, 76
2 percent of the clients, who came to us for care last
3 year, were referred by professional reference.

17 And, finally, as a statement of quality,
18 there's a reason, we went to bed last night, there were
19 147 individuals on a Newport Academy wait list. Here in
20 Connecticut, that list had 65 as of last evening.

21 On the topic of access and who will pay
22 for our service and will we adversely affect other
23 providers in the area, it is clear that we have generated
24 enough interest in Newport, as defined by our utilization

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1 of our current capacity and by our wait list, that we
2 don't need to pull clients from other providers.

3 Last year in Bethlehem, we admitted 55
4 clients between the ages of 18 and 20, and we also had
5 300 clients hit our wait list in that same age cohort,
6 who eventually fell off the wait list, because of lack of
7 access to care.

8 Unlike how our opposers frame us, we are
9 an insurance-based health care provider. Ninety-seven
10 percent of our revenues in 2019 came from third party
11 payers.

12 Average out-of-pocket costs for families
13 in 2019 was \$3,200, and for our families, who can't
14 afford their portion of the subscriber responsibilities,
15 we offer financial hardship relief. Only 1.5 percent of
16 all of our admissions in Bethlehem were cash pay clients.

17 In my experience, this commitment to
18 working with insurance companies is crucial in providing
19 access to care.

20 Additionally, in 2019, Newport provided
21 over \$3 million in uncompensated care, 1.1 million here
22 in the State of Connecticut. Notably, this does not
23 include the hardship waivers that I previously mentioned.

24 Finally, to further relieve the fiscal

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1 burden of families, who cannot afford to pay, Newport has
2 committed a \$100,000 scholarship fund annually for the
3 purpose of the proposed programs to support local
4 clients, who cannot access care otherwise.

5 In conclusion, we are excited about the
6 opportunity to provide much needed care, high quality
7 mental health services to young adults here in this
8 community and the surrounding communities.

9 I'll allow the rest of my time to Dr.
10 Mennesson, who is the interim Medical Director for
11 Newport's Fairfield project.

12 DR. MICHEL MENNESSON: Good afternoon. My
13 name is Michel Mennesson, and I'm a psychiatrist at
14 Newport Academy Bethlehem program and the interim Medical
15 Director for the proposed youth adult program in
16 Fairfield. As I discussed -- I adopt my pre-filed
17 testimony.

18 As I discuss in my pre-filed testimony,
19 there's a need, a specific need for services for this
20 young population, young adult.

21 The emerging adulthood delay in
22 development is increasingly recognized, as it can
23 incapacitate young adults for years; dropped out of
24 college, not working, dependent financially to their

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1 parents, not emotionally responsible, or not active in
2 society.

3 The challenges and concern of young adults
4 are sufficiently different that they are best served with
5 programs that focus on their specific challenges, as they
6 are no longer adolescent, not yet adults.

7 While young adults need treatment, they do
8 not access readily outpatient treatment, IOP or PHP, due
9 to their patterns of poor functioning, lack of
10 responsibility or denial, along with depression and
11 anxiety.

12 They refuse to attend, and, because they
13 are legally adults, parents cannot make them go. As a
14 result, they can be stagnant for years.

15 It can be difficult for parents to get
16 withdrawn young adults to say yes to treatment every day,
17 as it is required for PHP and IOP program, rendering
18 outpatient treatment ineffective.

19 With residential services, parents can
20 capitalize on moments of acceptance and clarity, in which
21 a young adult agrees to treatment.

22 As long as a program has availability, the
23 parents and these young adults only need one yes. Once
24 in treatment, support from staff and peers helps reduce

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1 the risk of the resident leaving the program and dropping
2 out of treatment.

3 Additionally, residential treatment allows
4 for more intensive engagement. We provide at least four
5 hours of clinical program daily, using evidence-based
6 intervention, addressing their mental health needs. We
7 also provide training in much-needed life skills.

8 The significant support from staff
9 prevents residents from retreating to their preferred
10 maladaptive coping strategies.

11 They also have the opportunity to develop
12 supportive relationships with peers and a sense of
13 community that these often isolated young adults
14 desperately need.

15 Furthermore, family members are integrally
16 involved in treatment, which helps address painful
17 enabling behaviors and conflictive relationships.

18 Through this intensive residential
19 experience, failure to launch is transforming to a
20 successful launch into adulthood, where these young
21 adults can move to college, live independently in their
22 own apartments, working and not returning to mom and dad.

23 To monitor quality and effectiveness of
24 this treatment, Newport Academy measured its outcome

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1 measures and commissioned a third party physician to
2 analyze the data.

3 We provided the entire study to you as
4 Appendix D to our responses to the first set of
5 completeness questions.

6 The statistician found that the results
7 were highly statistically significant, as well as showing
8 a high degree of clinical improvement.

9 Generally, an improvement of 10 percent or
10 more is considered clinically significant. Newport
11 Academy's outcome showed 45 percent improvement in
12 resident well-being, 47 percent decrease in anxiety index
13 and 53 percent decrease in depression index in practice.

14 This translates into residents feeling
15 better, less anxious, less depressed, and with a sense of
16 well-being noticeable by residents and family. They
17 become ready to move into adulthood.

18 A Connecticut young adult population will
19 be well-served by a residential treatment program
20 specifically designed for the age group that brings that
21 kind of improvement, as documented by validated measures.

22 MS. CARTER BARNHARDT: Good afternoon. My
23 name is Carter Barnhardt, and I'm the Chief Experience
24 Officer at Newport Academy. I adopt my pre-filed

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1 testimony.

2 Thank you for allowing me the opportunity
3 to speak today. I'm extremely passionate about the needs
4 for young adult services, specifically for individuals
5 struggling with primary mental health diagnoses and
6 needing to utilize insurance.

7 I've worked for Newport Academy for the
8 last eight years, and I've served in a variety of roles.
9 Among other things, I developed the Discharge Planning
10 Department and the Alumni Program at Newport Academy.

11 I have also been integrally involved in
12 developing a referral program. As a result, I've
13 personally visited over 300 other programs across the
14 country.

15 We routinely refer to these other programs
16 when an individual does not meet Newport's clinical
17 criteria, it's outside of the age range we serve, or when
18 we have a lengthy wait list.

19 As a result of my experiences, I'm acutely
20 aware of the struggles that young people face in finding
21 treatment.

22 Just last Friday, I received a call from a
23 23-year-old girl, who grew up in Fairfield County and
24 lost her mom when she was 16 years old. A few months

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1 ago, she found out that her dad is terminally ill and is
2 also in debt.

3 As a teenager, she struggled with
4 depression after the loss of her mom, and finding out
5 about her dad's illness, she told me that she just feels
6 totally hopeless. She can't get out of bed, has lost her
7 job, and feels lost. She reached out to me for support
8 and asked for a solution.

9 She sent me her insurance card and
10 explained that she cannot pay out of pocket for a
11 residential stay and would like to stay on the east
12 coast, in case something happened quickly with her dad.

13 I called every program I know.
14 Turnbridge, Mountainside and Rushford all require a
15 primary substance use disorder diagnosis, and she has not
16 touched drugs or alcohol in months.

17 She did not qualify for Silver Hill's
18 inpatient, as she was not acutely suicidal, and their
19 residential program is \$46,000 with her insurance
20 coverage, and no additional scholarshiping is available.

21 Angelus House with a scholarship would
22 still be about \$390 per day, and, finally, I called
23 Institute of Living. They explained that she was not
24 acute enough for their three to seven-day inpatient

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1 program. Desperate, I asked if they had any other
2 suggestions. The woman said I wish I did.

3 This is a huge reoccurring issue in the
4 State of Connecticut. If clients have money, we send
5 them to Florida or California. Otherwise, we have no
6 options for primary mental health residential treatment.

7 Ultimately, I was unable to find a single
8 program on the east coast that would treat her trauma,
9 anxiety and depression and accept her insurance.

10 She is now paralyzed with fear, trying to
11 decide if she should fly to California to the one program
12 that takes her insurance and delivers evidence-based care
13 or not.

14 If she were 20 years old, Newport Academy
15 in Bethlehem would be able to work with her and accept
16 her insurance. Unfortunately, she is outside of our age
17 range for that program, and she is not alone.

18 Every week, I personally receive many
19 calls similar to this one. Newport Academy as a company
20 receives even more. We have a dedicated referral
21 relations specialist, whose whole job is finding
22 appropriate placement for people, who are not able to be
23 served by Newport's existing programs.

24 Our goal is for every person that calls

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1 Newport to find an appropriate treatment option, and we
2 aim to provide three referrals to any person that calls.

3 On average, we provide recommendations to
4 about 85 people a week. As a result, I'm highly
5 knowledgeable about the options for treatment and,
6 specifically, about the lack of adequate options for
7 young adults requiring residential treatment.

8 It is my hope that OHS will approve
9 Newport's application to open the two homes in Fairfield,
10 so that we can help address at least a small part of this
11 need.

12 I would also like to take a moment to
13 highlight two other aspects of Newport's programming that
14 I believe are very unique; our focus on discharge
15 planning and family involvement.

16 We believe that, for long-term success,
17 individuals must have tailored treatment plans after they
18 leave Newport Academy's residential program, and they
19 must have family support. Family involvement is integral
20 to our programming.

21 In addition, we begin discharge planning
22 from the beginning of treatment, and every Newport client
23 leaves with a thorough after care plan.

24 We also contact individuals and their

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1 families weekly after discharge for the first month to
2 offer support, then monthly for at least a year, often
3 longer.

4 We also have a parent and alumni app,
5 which allows our community to support one another in
6 their recovery, and many alumni attend our events for
7 years after they leave our program. In fact, this past
8 year, we had over 300 alumni and their families attend
9 our event.

10 As you have seen from the letters from
11 alumni and their families I submitted with my pre-filed
12 testimony and as you will hear from the alumni and
13 families, who courageously want to share their stories
14 here with you today, the need is crushing. These
15 testimonials also demonstrate the high quality services
16 Newport Academy provides.

17 I am hopeful that Newport Academy's
18 application is approved, so that we can continue to be a
19 part of the solution for the young adults struggling with
20 mental health conditions.

21 I am happy to answer any questions. Thank
22 you.

23 MS. RINEHART: Thank you.

24 HEARING OFFICER MITCHELL: Nothing

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1 further?

2 MS. RINEHART: Nothing further.

3 HEARING OFFICER MITCHELL: Okay. I'm
4 going to go out of order a little bit. Are there any
5 elected officials? I think we have a list for the
6 elected officials that are here that wanted to speak.7 I know I saw Senator Hwang. I don't know
8 if he's still here. Senator Hwang, did you want to come
9 and give your public comment?

10 Is Representative Devlin here?

11 (APPLAUSE)

12 FIRST SELECTWOMAN BRENDA KUPCHICK: Good
13 afternoon. My name is Brenda Kupchick. I am the First
14 Selectwoman of the Town of Fairfield.15 I submitted a letter from myself and,
16 also, the Board of Selectmen to you a couple of weeks
17 ago.18 I looked at the criteria that you
19 established for testimony today, and I'm going to try to
20 fit into that criteria the best I can.21 I'd like to just give you a little
22 history. As a State Representative before I took this
23 office for nine years, I was probably one of the biggest
24 leaders on mental health services and expanding access to

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1 mental health in the state legislature. I take that
2 issue very seriously.

3 I met with the CEO of Newport Academy, and
4 I think that their services are important and valuable
5 and needed.

6 I offered the CEO the opportunity to work
7 with us at the Town of Fairfield to locate space in our
8 town in a commercial zone, because I view this medical
9 facility, while very important, as being a medical
10 facility, a business, and I don't believe businesses
11 should be operating in residential areas in our town,
12 like any other business.

13 I am willing to work, as the leader of the
14 Town of Fairfield, to assist Newport Academy in finding a
15 location in a commercial zone to provide services that I
16 believe are desperately needed for our state for people
17 with addiction and with mental health, but I don't
18 believe it is appropriate in a residential neighborhood,
19 and I'm here to speak about that.

20 So that is all I wanted to say, that I am
21 willing to work diligently with Newport. We do have a
22 lot of locations that are prime opportunities for this
23 facility, because I have had many family members myself,
24 who have suffered from drug addiction, and the treatment

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1 that they received was about what was happening inside
2 the facility, not where it was located.

3 It was the staff, it was the services, it
4 was the treatment that helped them, not where it was
5 located, so I still have that invitation open, and I hope
6 that you will take me up on it. Thank you for the time.

7 (APPLAUSE)

8 HEARING OFFICER MITCHELL: So let me just
9 -- let me just make a brief statement about the content
10 of the statements that are going to be presented to us
11 through public comment.

12 I do understand that there is an ongoing
13 issue of whether or not this proposal is appropriate in a
14 residential area. That is not something that we can
15 decide. I didn't want to interrupt you at all, because I
16 want to give you deference, because of your position.

17 I respect your position, but OHS has no
18 authority to make decisions about where this Applicant
19 can put their program.

20 We have authority to decide the criteria,
21 based upon the criteria that I read to everyone that's
22 here just a few moments ago, and we're bound by that.

23 So I'm just going to ask, if there's
24 anything that you're going to say that is regarding the

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1 appropriateness of this proposal in this specific area
2 that relates to zoning, that you hold it. Don't say it.

3 MS. LAURA DEVLIN: So your rules do make
4 this a little bit of a challenge. I'm Laura Devlin,
5 State Representative for the 134th District, which
6 includes parts of the community of both Fairfield and
7 Trumbull.

8 Because I think we can all agree the issue
9 of mental illness, the issue of drug addiction is vast,
10 it is widespread, it has been growing, it is serious, and
11 probably I would guess every single one of you and
12 everybody in this room, if they haven't dealt with those
13 issues personally, directly, has a friend or family
14 member who has, so I don't think there's any question
15 related to that.

16 You do make it a bit challenging with the
17 rules to be able to comment further, because -- and I do
18 believe that Newport Academy has a positive reputation.

19 I don't think it's unique that other
20 facilities that are private pay at \$1,000-plus a day,
21 near \$100,000 for a round of treatment that already
22 exists within our state, also include family involvement,
23 also include planning for discharge when that patient
24 comes in.

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10 There's been a lot of talk about NIMBY
11 issues and all of that. There is no desire to want to
12 limit opportunities for people in protected classes to
13 live and exist in our communities. I want to make that
14 perfectly clear, but there absolutely is opposition to
15 corporations trying to exploit group home protections.

16 (APPLAUSE)

17 MS. DEVLIN: So I will turn it over to
18 Senator Hwang.

19 MR. TONY HWANG: First, thank the Office
20 of Health Strategy. I'm going to acronym you as OHS as
21 we begin this conversation, and I do understand the
22 purview and the cognizance that you have in this hearing.

23 It is unfortunate that we have gotten to
24 this point and the frustration that you will sense. And

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1 I appreciate the emotions that you're feeling and the
2 asking of the participants in the audience to respect the
3 process, but we've gotten to this point, because of
4 concerns on how the process has been undertaken, so
5 indulge me, if I may, if you may, and let me share with
6 you.

7 I'm State Senator Tony Hwang. I represent
8 the 28th District in the Connecticut General Assembly,
9 which encompasses Fairfield, Southport, Westport, Weston,
10 Easton, Newtown and Sandy Hook.

11 I'm also the ranking minority leader in
12 the Housing Committee, which recently held a public
13 hearing regarding and considering the definition of group
14 homes under Section 8-3e, and it was important to review
15 that process, which articulated the state law exempting
16 group homes in a protected population --

17 MS. RINEHART: I'm just going to make an
18 objection on the record.

19 MR. HWANG: -- so my testimony will focus
20 on the statutory process.

21 HEARING OFFICER MITCHELL: I'm going to
22 note the objection. I'll still let him make his point.

23 MR. HWANG: Thank you.

24 HEARING OFFICER MITCHELL: But I'm just

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1 going to ask, if there's any distinction about whether or
2 not a group home belongs in a residential area, this is
3 not the appropriate venue for that, and I don't want
4 people to follow you and believe that that is the case
5 and then start going down that road.

6 I have to be able to control this hearing.
7 I have to be able to make sure that we have all the
8 information that is pertinent to the criteria in the
9 record, and, when I'm not able to do that, it makes our
10 job very difficult, and our job is very distinct from
11 what the Zoning Board does. We are not the Zoning Board.

12 MR. HWANG: Ma'am, I fully appreciate
13 that, and I fully appreciate the concern, and I
14 appreciate the latitude, but it is important, because
15 what came out of the statutory hearing was an insightful
16 conversation in regards to 8-3e.

17 And the reason I offer that is the basic
18 premise of why I am objecting to this application,
19 because this application, from its onset, was made under
20 the premise of the protection afforded under 8-3e.

21 You can refer back to your notes, and I
22 would encourage your body to take that examination to
23 understand that the premise of this entire application up
24 to this point has been based on a premise of protection

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1 in its application under 8-3e, and I will be happy to
2 share with this Committee or this hearing body testimony
3 and feedback that was part of the legislative process
4 that truly articulated, in almost a unified voice,
5 whether you supported it or you were opposed to the
6 statute, the definition of group homes precludes Newport
7 Academy's application.

8 So if you're basing it on this --

9 HEARING OFFICER MITCHELL: We are not.

10 MR. HWANG: Then it's unfortunate, but
11 allow me, and I appreciate the latitude. If you are
12 basing a foundation of this application on a false
13 premise --

14 HEARING OFFICER MITCHELL: We are not.

15 MR. HWANG: But I would offer and like to
16 enter into the record that it is, that if you were to
17 look at the process and look at the definition in which
18 these initial applications were made, they were made
19 under the premise of 8-3e. If that is incorrect --

20 HEARING OFFICER MITCHELL: Senator Hwang,
21 you're not listening to me when I talk about the
22 criteria, and I don't mean to be disrespectful to you,
23 but, in order to keep this process focused on what we
24 have jurisdiction to look at, I'm going to ask you if you

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1 can focus on our statutory criteria. That would be
2 helpful.

3 MR. HWANG: Ms. Mitchell, if I may, I will
4 share with you a premise of an application, based on a
5 false premise, has no foundation at all.

6 (APPLAUSE)

7 MR. HWANG: And it is important that the
8 initial application was based on a false premise and
9 based on a statutory exclusion of Newport Academy.

10 Now for me and I would propose the
11 solution moving forward, because, make no mistake about
12 it, there are people that I know, there are people that
13 we all know that struggle from the challenges and the
14 emotions of substance abuse and mental health supportive
15 services. There is no denying that.

16 The articulation by Newport Academy was
17 quite telling, quite emotionally pulling. Nevertheless,
18 there is not a problem with me or with any other people
19 in addressing the critical need. There's no doubt of it,
20 but what I have a struggle with this is, and I'll repeat
21 again, the foundation of this original application does
22 not apply under 8-3e.

23 And when you are on a base of a false
24 premise, everything you do after that is tainted by that

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1 inaccuracy. I am challenged to think that you will not,
2 under an open process and a, I hope, a proceeding to
3 evaluate this, the foundation in which you're going to
4 make your decision on and which you tell me you're bound
5 by, if it is based on a false premise, the entire process
6 is flawed.

7 (APPLAUSE)

8 MR. HWANG: So are you going to tell me
9 that if you found that out to be a complete mislead or a
10 misunderstanding, that you're going to approve something,
11 because everything else, based on a, quote,
12 "misrepresentation or non-applicability" is going to be
13 okay?

14 I think, from your legal background or
15 whatever your background is in evaluating that, you
16 cannot ignore the fact that the foundation of this
17 premise, where we are right now, was based upon a false
18 premise.

19 In my testimony, you will see the timeline
20 to that process. You will look at the application
21 process. You know, as I review this process, I look at
22 the initial application in which there were multiple
23 names being used, and, as I looked at the application on
24 its original approval by the Town body, it was

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1 represented as a group home.

2 I have the Chairman of the Housing
3 Committee, I have participants in a public testimony,
4 bound by statute in evaluating 8-3e, that uniformly said
5 Newport Academy, however important their mission is,
6 however important the need is, does not qualify under 8-
7 3e. They support the services.

8 So my solution to this, ma'am, and to your
9 body is I support their access to services, I support
10 their efforts to come to Fairfield and to provide
11 critical services to our community and throughout the
12 country. I simply ask them to begin the process under
13 the proper context and make the application to our town
14 and to any other town.

15 HEARING OFFICER MITCHELL: We don't have
16 jurisdiction over where they can make their application
17 to the town. You're asking the wrong people to help you
18 with that.

19 MR. HWANG: But you raise a very
20 interesting point. The approval process that led to here
21 --

22 HEARING OFFICER MITCHELL: Is for a
23 Certificate of Need, not for to decide where to go.

24 MR. HWANG: Madam, Madam, I think you will

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1 see my presentation in my testimony.

2 MS. RINEHART: I'm going to object at this
3 point.

4 HEARING OFFICER MITCHELL: We have to move
5 on.

6 (Public disruption)

7 MR. HWANG: I think it's a frustration
8 point, if I may.

9 HEARING OFFICER MITCHELL: I'm going to
10 give you a few more minutes, and then we're going to take
11 a break, and then I'm going to come back, and we will
12 talk about it again, but I can't have people yelling out.

13 This is not how this is going to proceed.
14 This is not a zoning hearing, it's not, and you're making
15 it something that it's not.

16 MR. HWANG: Well I would ask that the body
17 evaluate the testimony written, and I will repeat again,
18 you know, as you have charged under OHS, that grounds for
19 denial of said licensure included if the resident
20 furnishes or make any false or misleading statement to
21 the Department of Health, in order to obtain --

22 HEARING OFFICER MITCHELL: We are not the
23 Department of Health. We're not the Department of
24 Health.

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1 MR. HWANG: So what you're saying, also,
2 again, is, if there was a false statement made to the
3 Department of Health and it was brought up in this
4 meeting --

5 HEARING OFFICER MITCHELL: You would need
6 to go to the Department of Health. We can only look at
7 what is before us. We are not the Department of Health.
8 I cannot make a determination on the part of the
9 Department of Health.

10 MR. HWANG: Well allow me to be on the
11 record to say that, if the foundation of this
12 application, of which you're only considering, is based
13 on a house of cards and lack the foundation, as provided
14 under statutory requirements, that there are grounds for
15 people to pursue alternative action to ensure that this
16 process is proper and that it is correct.

17 All I'm asking for is that people follow
18 the law and respect the process of the application.

19 HEARING OFFICER MITCHELL: We will ensure
20 it.

21 MR. HWANG: And this is not just for
22 Fairfield.

23 HEARING OFFICER MITCHELL: Right.

24 MR. HWANG: It is for the entire State of

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1 Connecticut, and it is an important separation. Let us
2 make no mistake about this premise. I think everyone
3 standing up here and the people out in the audience
4 support that there is a critical need to provide for
5 loved ones and individuals impacted by addiction and
6 mental health services.

7 There is no doubt, but what I am deeply
8 troubled and deeply disappointed is the fact that we have
9 gotten here to this meeting with many a voice, with one
10 hand tied behind their back, in not being able to have
11 the due process afforded to them. It's disappointing.
12 It's frustrating.

13 HEARING OFFICER MITCHELL: Is this not due
14 process? Is this hearing not due process?

15 MR. HWANG: Ma'am, you have just hamstrung
16 the entire proceeding --

17 HEARING OFFICER MITCHELL: I have not.

18 MR. HWANG: -- with regulations. We may
19 agree to disagree, but the guidelines that you offered
20 is, and I appreciate the latitude that you've given me,
21 but, nevertheless, I provided written testimony, and I
22 hope it's a basis for us to continue further
23 conversations.

24 HEARING OFFICER MITCHELL: Thank you.

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1 MR. HWANG: Thank you.

2 (APPLAUSE)

3 HEARING OFFICER MITCHELL: I'm going to
4 make another comment before we take a break. I want the
5 people in this room to know that the Office of Health
6 Strategy does not not empathize with you regarding
7 whatever you may feel about zoning.8 We do not have jurisdiction over zoning
9 matters. We do not. This is not the proper venue for
10 that. I'm sorry. I have to control this hearing. I
11 have to.12 We're going to take a 10-minute break.
13 We're going to come back, and then OHS is going to ask
14 some questions.

15 (Off the record)

16 HEARING OFFICER MITCHELL: We're going to
17 go back on the record. So we're back on the record, and
18 I just wanted to talk a little bit about the Office of
19 Health Strategy and what we look at when we look at an
20 application, because what I did earlier was I read the
21 criteria that's in the statute, and it's quite wordy, so
22 I just want to make sure that I try to bring it into
23 focus, in terms of what we do have jurisdiction over,
24 and, when I say jurisdiction, I mean power to make a

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1 decision.

2 So we have power to make a decision over
3 whether or not this Applicant establishes need for the
4 program, whether or not it's cost effective, whether or
5 not it's a quality program, and whether or not they can
6 demonstrate that they will provide access to all people
7 of Connecticut, including those who are indigent or those
8 who receive Medicaid. That's our criteria that we look
9 at.

10 And now I'm going to just turn it over to
11 my colleague, Jessica Rival. She's going to ask our
12 questions of the Applicant, then we'll go back to public
13 comment.

14 MS. RINEHART: Hearing Officer Mitchell,
15 may I briefly address the prior comment before we go to
16 questions?

17 HEARING OFFICER MITCHELL: Which one?

18 MS. RINEHART: The comment made by Senator
19 Hwang.

20 HEARING OFFICER MITCHELL: I'm going to
21 ask that you do so briefly.

22 MS. RINEHART: Very briefly. We just want
23 to set the record straight that there was absolutely no
24 misrepresentation made by Newport Academy in connection

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1 with our application, and, indeed, the reference to 8-3 -

2 -

3 (Public disruption)

4 HEARING OFFICER MITCHELL: Let me just say
5 that, in order for us to proceed with the hearing, that
6 everyone needs to make sure that they exhibit proper
7 decorum.

8 Doing that doesn't facilitate the hearing.

9 It doesn't help in the decision, so I just ask that
10 everybody is respectful, even if you disagree with what's
11 being said. You're going to have the opportunity to
12 talk. I'm going to give it to you. I want to listen to
13 what you have to say. Thank you.

14 MS. RINEHART: So I just wanted to make
15 very clear that there was absolutely no
16 misrepresentations made in the applications, and, in
17 fact, this reference to 8-3, there is no reference to
18 that in the application, whatsoever, so I wanted to
19 correct any confusion with that on the record.

20 It is not relevant, as the Hearing Officer
21 has already noted, but we wanted to be very clear in that
22 regard, and I would also request that the Hearing Officer
23 issue an order that there be no clapping, cheering,
24 booing, or other things, because the hearing is already

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1 in a very emotional place.

2 HEARING OFFICER MITCHELL: So I do note
3 your concern, counsel. I do also note that there are a
4 lot of people in here that are emotionally vested in the
5 outcome of this decision, so I don't mind if people clap.

6 I just don't want you to disrupt the
7 hearing. It's okay if you clap, it's okay if you cheer,
8 but coughing while someone is speaking, yelling out,
9 those are things that are disruptive to the orderly, you
10 know, flow of the proceedings, and I have to control
11 that. Is that understood, everybody? I heard a couple
12 of yeses. Thank you. Thank you.

13 All right, so, we'll move on. Thank you,
14 counselor. We're going to -- I'm going to turn it over
15 to my colleague, Jessica Rival, who is going to ask our
16 questions.

17 MS. JESSICA RIVAL: Good afternoon. On
18 page 61 of the pre-filed testimony that was submitted by
19 Ms. Barnhardt, you discuss managing the wait lists for
20 patients needing services.

21 Could you please speak to these wait
22 lists, specifically, the approximate number of patients
23 that are currently wait listed and the number of wait
24 listed potential clients that could be appropriate for

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1 the proposed program in Fairfield?

2 MS. BARNHARDT: I think you shared the
3 exact numbers, as of this morning, so do you mind if I
4 have Mr. Procopio answer, in terms of numbers?

5 MS. RIVAL: Sure.

6 MR. PROCOPIO: So, as of this morning, as
7 of last night, we had 147 clients on our wait list
8 nationally, and 65 of those clients were waiting for a
9 bed here in Connecticut.

10 MS. RIVAL: Okay and how many of those do
11 you feel would be appropriate for the proposed program?

12 MR. PROCOPIO: For the proposed program,
13 there's minimally a handful of those clients that would
14 be available to access care here in Fairfield.

15 MS. RIVAL: Okay.

16 MR. PROCOPIO: We had 11 specific clients,
17 who were from Connecticut, on our wait list as of today.

18 MS. RIVAL: And for each fiscal year that
19 Newport Academy in Bethlehem has been open, what
20 percentage of those patients have been Connecticut
21 residents?

22 MR. PROCOPIO: It's approximately 20
23 percent.

24 MS. RIVAL: Twenty percent?

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1 MR. PROCOPIO: And we think, by providing
2 greater access, more capacity here, we'll be able to
3 accept more Connecticut residents to our program.

4 MS. RIVAL: Great. Thank you. Could you
5 describe how your proposal would help improve the
6 continuum of care for behavioral health services in the
7 area, including how clients would be referred into the
8 program, the program, itself, and post-discharge care?

9 MS. BARNHARDT: Yeah, so, as Mr. Procopio
10 had noted, the majority of our referrals do come from
11 professional referral sources. I think he said 76
12 percent of our referrals come from professional
13 reference.

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1 ourselves fitting in.

2 Discharge planning is something that we
3 think about from the very beginning of treatment. How
4 are we going to support the client afterwards? What's
5 the home environment going to look like? Will they stay
6 locally? What does that exactly look like? And we
7 really try to make that plan as thorough as possible.
8 Does that answer your question?

9 MS. RIVAL: Yes. Thank you.

10 MR. CARNEY: Can I just follow-up? What
11 percentage of patients, who complete your program, are
12 referred for post-discharge care, like on an outpatient
13 basis?

14 MS. BARNHARDT: At one of our programs or
15 just in general, an intensive outpatient or a partial
16 hospitalization?

17 MR. CARNEY: In general.

18 MS. BARNHARDT: Most of our clients are
19 recommended to transition to a lower level of care once
20 completing residential treatment. That could be an IOP.
21 It also could just be outpatient providers. We do also
22 offer a virtual care program, continuing connections. It
23 depends on what's most appropriate.

24 MR. CARNEY: And you have an outpatient

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1 program already established in is it Darien?

2 MS. BARNHARDT: Yes.

3 MS. RIVAL: Could you identify any
4 agreements that you have with other providers within the
5 state to coordinate step-downs from residential to the
6 next appropriate level of care?

7 MR. PROCOPIO: There are no formal
8 agreements between ourselves and other providers. We do
9 business associate agreements with local hospitals, as we
10 have in the Bethlehem community. We're seeking one with
11 Norwalk in reference to this particular program.

12 In terms of referring professionals, it is
13 really the majority of clients who come to us, you know,
14 through the professional network, go back to the same
15 referent when they are discharged from care.

16 And just to follow-up on one of the
17 comments that Carter made, all of our clients leave with
18 a discharge plan, a step down to a lower level of care.

19 Typically, from a residential setting, no
20 one goes directly unsupported back to home without a plan
21 of treatment. That continues while they're at home.

22 MS. RIVAL: Can you identify the
23 components in a discharge plan?

24 MS. BARNHARDT: Yes. So we do something

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1 called attachment-based family therapy while our clients
2 are with us in treatment, so we're looking at the family
3 relationship. We do a family session at the end that's
4 really spelling out what after care is going to look
5 like, so will there be weekly family dinners, things like
6 that, social activities?

7 What's the client passionate about? We
8 really want to make sure that the kids and young adults
9 that come to our program are getting reconnected to their
10 passion, so tapping into their creative outlets, tapping
11 into what they're passionate about, different activities,
12 and then, also, putting in that therapeutic component, as
13 well, so that could be an IOP, PHP, outpatient, really
14 looking at all the different needs that a client has, as
15 well as educational needs.

16 MS. RIVAL: Could either of you provide an
17 estimate percentage of each of the primary diagnoses to
18 be treated at the proposed locations in Fairfield?

19 MR. PROCOPIO: That may be difficult to
20 predict, but, if we look at our history, this past year
21 69 percent of the clients, who were admitted to a Newport
22 program, had major depressive disorder, was the primary
23 diagnosis.

24 Second on our list was anxiety disorder,

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1 which I believe was nine percent.

2 MS. RIVAL: And are there other
3 residential programs within the service area that provide
4 similar treatment to young adults?

5 MS. BARNHARDT: There's programs that
6 provide primary substance use disorder treatment, so
7 Mountainside is a great example, good program here in
8 Connecticut that provides primary substance use disorder
9 treatment, and then Silver Hill Hospital provides
10 inpatient care. They do also have a residential program.
11 The residential does not, however, work with insurance.

12 MR. PROCOPIO: And Center for Discovery
13 does eating disorders, specifically, here in Fairfield.

14 MS. BARNHARDT: Turnbridge also is an
15 example of a program locally that provides. They have a
16 residential component, where they take the clients to an
17 IOP, but you have to have a primary substance use
18 disorder diagnosis.

19 MR. CARNEY: And none of those other
20 programs are treating the same age population that you're
21 proposing in this matter?

22 MS. BARNHARDT: Turnbridge's program is
23 young adult, however, they go down to age 16.

24 MR. CARNEY: Okay.

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1 MS. BARNHARDT: But, again, it's primary
2 substance use disorder, and it's not a licensed
3 residential treatment center.

4 MS. RIVAL: Could you tell me what the
5 average daily cost of treatment for a client in the
6 program would be?

7 MR. PROCOPIO: Our average cost nationally
8 for services at the residential level of care run about
9 \$800.

10 MS. RIVAL: Per day?

11 MR. PROCOPIO: Per day. Per day, yeah.
12 Per patient day. Some, obviously, are more expensive,
13 depending on the geographic setting. Others are a little
14 bit less.

15 MR. CARNEY: So how would that compare
16 here in Connecticut? What do you estimate the cost to
17 be? The same? Higher or lower?

18 MR. PROCOPIO: I would estimate that it
19 would be very similar.

20 MR. CARNEY: Could you provide us any
21 further evidence to support your assertion about average
22 cost of your service? That's part of our criteria, is to
23 evaluate the cost of care.

24 MR. PROCOPIO: Sure.

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1 MR. CARNEY: It's highly important to our
2 Executive Director.

3 MR. PROCOPIO: Certainly. I mean we can
4 provide -- I guess, when you asked the question about
5 cost of care, I'm assuming you were asking the cost that
6 we incur or the cost for a client?

7 MR. CARNEY: Cost for the patient, for the
8 client.

12 MR. CARNEY: Okay. Okay, so, for the
13 patient, 1,100. Your cost, 800. Is that what you're
14 saying, basically, generally speaking?

15 MR. PROCOPIO: Yeah, so, again, I will say
16 the cost is typically reimbursed by insurance companies,
17 97 percent of the cases this past year.

18 MR. CARNEY: Thank you.

19 MS. RIVAL: On page 104 of the pre-filed
20 responses to the public hearing issues, it states that
21 Newport Academy is ineligible for both DMHAS grants and
22 Medicaid participation. Will Newport Academy continue to
23 actively reach out to both DSS and DMHAS to explore
24 Medicaid eligibility and potential DMHAS funding in the

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1 future?

2 MR. PROCOPIO: Yes.

3 MS. RIVAL: And could you talk to us a
4 little bit about single case agreements and how those
5 work?

6 MR. PROCOPIO: Sure. So, in many cases,
7 we have relationships with third party payers, Anthem
8 Blue Cross here in Connecticut, for instance, Aetna,
9 Optimum, and, because of those relationships, we, through
10 the utilization review process and the admission process,
11 contact the payer, and we sign single case agreements,
12 which basically allow the subscriber almost the same
13 benefit as being in in-network payment, in terms of co-
14 pays and deductibles.

15 And, so, we establish those on a patient-
16 by-patient basis with the payers, and, here in
17 Connecticut, that represented 44 percent of our business
18 last year.

19 MS. RIVAL: And will Newport Academy be
20 willing to enter into single case agreements with DSS or
21 DMHAS in the event of a client referral?

22 MR. PROCOPIO: Yes. We have in the past,
23 in our history.

24 MS. RIVAL: Okay. Given the stated

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1 scholarship level of \$100,000 annually, how many patients
2 would that treat in a given year?

3 MR. PROCOPIO: It's dependent on length of
4 stay, but it will be two to three clients per year.
5 Again, though, I would reference you back to, you know,
6 Newport has I think been a good community partner, in
7 that we've provided significant free care, and this would
8 be in addition to that free care.

9 Here in Connecticut last year, it was
10 about a million dollars.

11 MS. RIVAL: Would you be willing to
12 consider offering additional scholarship dollars to help
13 serve clients without adequate means to afford the
14 services?

15 MR. PROCOPIO: I'd welcome that
16 discussion.

17 MS. RIVAL: And have you ever considered
18 establishing a priority bed for Medicaid recipients or
19 indigent clients?

20 MR. PROCOPIO: We have not.

21 MS. RIVAL: Is that something that Newport
22 Academy would ever consider?

23 MR. PROCOPIO: Again, we'll welcome that
24 discussion for sure.

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1 MS. RIVAL: Page 106 of the pre-filed
2 response to public hearing issues states that Newport
3 Academy continues to work to become an in-network
4 provider with commercial payers in Connecticut.

5 Aside from single case agreements, have
6 any agreements been formalized to become an in-network
7 provider with any of the major insurers in Connecticut?

8 MR. PROCOPIO: We have a multi-plan
9 agreement, which covers Connecticut, and we have a first
10 choice agreement that also gives coverage to Connecticut,
11 although, again, to be fully transparent, most of those
12 patients are in the northwest part of the country. It's
13 a national agreement that we have in place.

14 We strategically have come to the
15 conclusion that we want to be in-network. We've been
16 working diligently over the past two years to gain more
17 in-network agreements, and we have some on the west
18 coast, you know, in some of our other programs.

19 We've also employed a Chief Payer Officer
20 with whom her sole responsibility is to gain in-network
21 agreements on our behalf.

22 We've had long conversations with many
23 payers here on the east coast. We just haven't gotten to
24 a place that we've been able to get a signature on the

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1 bottom line yet. I do suspect we will be successful
2 before the end of the year.

3 HEARING OFFICER MITCHELL: Can you tell me
4 if you're able to -- why is it taking so long to come to
5 an agreement with these payers?

6 MR. PROCOPIO: You know, it's, as any
7 business arrangement, it's a give and take with the other
8 side, and, you know, again, as someone who has worked in
9 health care for 30-some-odd years, it does take months
10 literally to get an agreement in place with a third party
11 payer.

12 Now a lot of that is situated around
13 pricing, and a lot of that is situated around if you have
14 a vehicle in place already to give access, like a single
15 case agreement. There isn't always the initiative to get
16 an in-network agreement in place.

17 MR. CARNEY: Just for curiosity, how long
18 does it take to complete one of the single payer
19 agreements?

20 MR. PROCOPIO: They are happening
21 literally in a matter of hours now. Again, those
22 relationships with Optimum, Aetna, you know, our folks in
23 our admissions call center know who to speak with, and we
24 are typically able to get those in a matter of hours.

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1 HEARING OFFICER MITCHELL: I have to ask
2 this question.

3 MR. PROCOPIO: I hope I have an answer.

4 HEARING OFFICER MITCHELL: Are the single
5 case payer agreements more lucrative than becoming an in-
6 network provider?

7 MR. PROCOPIO: Today, they are slightly
8 more. Again, they are slightly more profitable than our
9 in-network agreements, but it's not substantially
10 different.

11 HEARING OFFICER MITCHELL: Can you give me
12 an idea what you mean by substantially?

13 MR. PROCOPIO: Ten percent.

14 MS. RIVAL: Page 106 notes that 97 percent
15 of the reimbursement received by Newport Academy was from
16 commercial payers. What percentage of the reimbursement
17 from commercial payers represents in-network agreements?

18 MR. PROCOPIO: Twenty-four percent.

19 MS. RIVAL: Thank you.

20 HEARING OFFICER MITCHELL: I have a
21 question for the doctor. Is it Dr. --

22 DR. MENNESSON: Mennesson.

23 HEARING OFFICER MITCHELL: Mennesson. Got
24 it. Dr. Mennesson, you were talking about it only takes

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1 one yes to have a patient enter treatment with Newport
2 Academy. How do you reduce the risk of them dropping
3 out? Can you talk about the mechanism for that?

4 DR. MENNESSON: Sure.

5 HEARING OFFICER MITCHELL: How that works?

6 DR. MENNESSON: Sure. It's really a
7 relational model. We believe strongly that people, who
8 are feeling connected to the staff they work with and
9 with the other peers that are in the program, have more
10 chance of remaining in treatment.

11 They see themselves as identical, similar,
12 having commonality with them, and that has reduced
13 drastically any tendency to want to go away. They
14 belong. They have a sense of belonging.

15 Remember, a lot of them are isolated in
16 their room. They don't go much. Some of them, many of
17 them are depressed, isolating, not leaving their room.
18 They are now beginning to belong to a place, and they
19 don't have to do that choice every single day.

20 Even if they don't feel like getting up
21 that morning, the staff is there present to them, and
22 they help them engage in treatment. It's been very, very
23 -- yeah, it's been very helpful to do it that way.

24 HEARING OFFICER MITCHELL: How often, if

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1 any, do your patients or clients, I want to make sure I'm
2 saying it correctly, how often do they drop out or leave?

3 DR. MENNESSON: So it tends to be usually
4 around critical events; a phone call that doesn't go the
5 way they may have wished, a rupture in an outside
6 relationship, then they all of the sudden say, you know,
7 I want to leave, and then usually, with people talking
8 and reasoning them, they just settle down and come back
9 and stay in treatment, so it's managing the struggles of
10 daily life, and most of them try to rely on avoidance, so
11 working with the engagement and the sense of connection
12 they settle down.

13 HEARING OFFICER MITCHELL: How often do
14 people leave?

15 MR. PROCOPIO: I may be able to answer
16 that. So, here in Connecticut, our treatment completion
17 rate is greater than 80 percent, so the inverse of that,
18 obviously, are someone who leaves treatment prematurely,
19 and that's a combination of those who we feel can't
20 comply with the program and, also, parents or individuals
21 who self-select leave, or those who need a higher level
22 of care.

23 And I apologize. I don't have the
24 statistics for each one of those discharges available.

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1 HEARING OFFICER MITCHELL: I have another
2 question, and it's regarding financial hardship relief.
3 You said that, in terms of financial hardship relief, you
4 have spent 1.1 million in Connecticut. Did I get that
5 right?

6 MR. PROCOPIO: No, that's not correct.

7 HEARING OFFICER MITCHELL: Okay.

8 MR. PROCOPIO: We did provide \$1.1 million
9 of free care, uncompensated care, and that would be a
10 combination of scholarships and/or keeping someone in
11 treatment after their insurance ceases to pay for
12 insurance.

13 The financial hardship, so if a family has
14 a, you know, a large co-pay that they cannot afford, we
15 have a process, where they can fill out an application.

16 We look at the cost of care versus their
17 adjusted gross income, we look at their total income as a
18 comparison to the poverty level, and then we make a
19 judgment, as to whether or not we can forego their co-
20 pays or deductibles, and that is not included in the \$1.1
21 million.

22 MR. CARNEY: Is the 1.1 million for
23 Connecticut only?

24 MR. PROCOPIO: Yes, that's correct.

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1 That's a combination of Bethlehem and Darien.

2 HEARING OFFICER MITCHELL: I want to ask a
3 couple of questions about continuum of care, after care,
4 and I heard that there are calls that happen weekly, then
5 monthly. What's discussed during those calls, and, if
6 there is an issue that's raised, how is that issue then
7 resolved?

8 MS. BARNHARDT: So it depends on where
9 that client is in their transition, right? So we do have
10 parent alumni coordinators, as well as alumni
11 coordinators, so those are individuals that reach out to
12 alumni and reach out to parents.

13 If there's any sort of an issue that
14 arises on that phone call, they will reach out. We
15 generally have consents for the local provider that
16 they're seeing. We'll reach out to the local provider,
17 collaborate with that local provider to help make sure
18 that the client is safe.

19 HEARING OFFICER MITCHELL: And one thing I
20 heard during the public comment is that the discharge
21 process would be to discharge a patient like a hospital
22 would. Can you speak to that?

23 MS. BARNHARDT: Yeah, so, I don't really
24 know what it means to discharge a patient like a hospital

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1 would, but I think our process is pretty different, just
2 that clients are with us for a longer length of stay, so
3 we're really able to address all the different emotional
4 issues that's going on with the client; the behavioral
5 issues, the educational issues.

6 My understanding of hospital discharge
7 planning is just that it refers you to a program, maybe
8 gives the name of two programs that you could go to next,
9 but doesn't actually do that family work, the family
10 contracting, the family agreement, as to what's going to
11 happen next.

12 It doesn't always look at the educational
13 needs. We're really thorough about what that client is
14 going to be returning to and what exactly that looks like
15 and working with the family and establishing plans.

16 HEARING OFFICER MITCHELL: And then one
17 other question about the cost of care. So, in the
18 application, it looks like there was going to be \$100,000
19 in kind of, and I'm not saying it the way that you put it
20 in the application, but kind of like a grant that would
21 be given year-over-year that would carry over to the next
22 year to help people, who may be unable to afford for
23 care.

24 In one of the questions, we asked is how

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1 many patients or clients that would cover in any given
2 year, so the answer was two to three, and I'm just
3 wondering if you can expand upon that and break that
4 down, given the average cost of care is \$1,100 per day.

5 How does that, you know, in terms of the
6 length of stay, how does that kind of pan out?

7 MR. PROCOPIO: Again, we intend that to be
8 at our cost, our cost, so we would actually apply that
9 against our, you know, potential \$800 a day in cost for
10 services, and, so, we would provide services.

11 Our average length of stay is typically --

12 HEARING OFFICER MITCHELL: Hold on one
13 moment. Thanks. Okay. Go ahead.

14 MR. PROCOPIO: All right, so, let me try
15 again. So our intentions with that \$100,000 are to
16 provide access to indigent clients. We would apply it
17 against our cost, not our typical reimbursement, and over
18 an average length of stay of 45 days, and that's where I
19 came up with the estimate of, you know, two to three
20 clients per year.

21 HEARING OFFICER MITCHELL: So that was at
22 the \$800 rate that you were talking about?

23 MR. PROCOPIO: And, again, we don't know.
24 I mean we've created a budget. We don't know

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1 intentionally today what all of our costs will be, but
2 that's just an estimate, based on our history in other
3 markets.

4 MR. CARNEY: And your average length of
5 stay for the program is 60 days?

6 MR. PROCOPIO: That would be our hope.
7 I mean that's what we calculated, was I think in the mid
8 fifties, actually, in the application that we submitted.
9 Our average length of stay nationally it varies. In
10 Connecticut last month it was 50 days for our Bethlehem
11 campus.

12 HEARING OFFICER MITCHELL: All right, so,
13 OHS has concluded with its questions. We are going to
14 take another 10-minute break, then we're going to come
15 back for public comment. Thanks. We're off the record.

16 (Off the record)

17 HEARING OFFICER MITCHELL: Public comment.
18 I just want to mention that each person that wishes to
19 speak should have written their name on the sign-up sheet
20 with Leslie Greer, who is standing over to my right and
21 most of your left.

22 We're going to be calling people in the
23 order in which they signed up to speak, and we're going
24 to give you three minutes each to make your comments.

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1 I just want to reiterate that what we do
2 have the power to consider is whether or not there's a
3 need for this service, whether or not it's cost
4 effective, whether or not it's a quality program, and
5 whether or not it creates access to all Connecticut
6 residents to those services.

7 I know that some of you want to talk about
8 zoning. I know that this is really dear to your heart.
9 I know that some of you live in the area. I do empathize
10 with you. I empathize with everyone, who has an opinion.

11 I can't show any preference to either
12 side, but I want to reiterate that we really don't have
13 the jurisdiction or the power to make a decision about
14 zoning issues and whether or not this group home that
15 many are referring to it as whether or not it's
16 appropriate for it to be where it is. We can only
17 consider need, quality, access and cost.

18 I'm going to go ahead and turn it over to
19 Ms. Greer. She's going to call up the first five
20 commenters.

21 (Whereupon, public comment was given.)

22 HEARING OFFICER MITCHELL: All right, so,
23 we have a few additional questions for the Applicant.
24 We're just going to convene for about 10 minutes to get

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1 those questions together, and then we'll come back on the
2 record, so it will be 5:12 when we come back.

3 MS. RINEHART: May we ask for 15 minutes?

4 HEARING OFFICER MITCHELL: Yeah, I have no
5 problem with that. So we'll come back at 5:17.

6 (Off the record)

7 HEARING OFFICER MITCHELL: Back on the
8 record. All right. Based on the public comment that I
9 heard, I just have a couple of follow-up questions, and
10 then I will let you give closing remarks, and we may have
11 a late file or two.

12 The first question that I have, based upon
13 what I heard from the public, are questions surrounding
14 the amount of the scholarship that you plan to give to
15 people, who are unable to afford services for whatever
16 reason, and then, also, an assertion that you don't want
17 to serve Medicaid. Can you talk about those two things?
18 Can you respond to those two issues?

19 MR. PROCOPIO: Sure. First, I mean,
20 service of Medicaid would require a change in policy by
21 DSS and/or DMHAS, in terms of how they reimburse for-
22 profit entities that provide the same level of care that
23 Newport is intending to do.

24 HEARING OFFICER MITCHELL: When you say

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1 change in policy, what do you mean by that?

2 MR. PROCOPIO: So we've contacted DSS, and
3 we asked whether or not there is reimbursement available
4 for our level of care and were told that that is not
5 available to us at this time, and our understanding of
6 DMHAS is that they will do grant funding for not-for-
7 profits.

8 We have, in the past, as I mentioned
9 earlier, worked with DCF to do single case agreements,
10 again, and there have been few, but we've done some with
11 them.

12 HEARING OFFICER MITCHELL: And I think we
13 asked this before, but is it possible that you could also
14 do that with people, who are covered under Medicaid?

15 MR. PROCOPIO: Sure. Absolutely.

16 HEARING OFFICER MITCHELL: Are you willing
17 to do that?

18 MR. PROCOPIO: Yes.

19 HEARING OFFICER MITCHELL: And then what
20 about the amount of the scholarship? I don't want to
21 mischaracterize what I heard, but somebody, and this is
22 not my statement, but someone said that it basically was
23 a token, but can you respond to that, please?

24 MR. PROCOPIO: Sure. I think, for all the

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1 folks, who took the deep dive into our application, you
2 can see our operating margins, based on our budget, are
3 fairly narrow, and, so, we dedicated a piece of that
4 margin back to the community, and we would do that in
5 addition to the free care that we traditionally give at
6 all of our Newport campuses, whether they be scholarships
7 and/or extending stays, when insurance runs out.

8 (Public disruption)

9 HEARING OFFICER MITCHELL: Everyone should
10 be quiet in the audience. Thanks.

11 MR. PROCOPIO: We also have hardship
12 waivers, so, when a family can't afford their co-pay or
13 deductible, there's a process where they can appeal
14 financial relief for those co-pays and deductibles.

15 There's been a lot of conversation about
16 affordability of our program, and I think I said in my
17 opening remarks our average out-of-pocket for a family in
18 2019 was \$3,200.

19 HEARING OFFICER MITCHELL: Do you have any
20 proof of that?

21 MR. PROCOPIO: Sure. I mean what type of
22 proof would you like? Again, I could provide you with
23 the spreadsheet that I got from my finance office. Would
24 that suffice?

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1 HEARING OFFICER MITCHELL: What's on the
2 spreadsheet?

3 MR. PROCOPIO: It just basically shows I
4 asked the question of our revenue team what is the
5 average out-of-pocket our clients have paid in the past
6 year?

7 HEARING OFFICER MITCHELL: Can you give it
8 to me for the past three years?

15 HEARING OFFICER MITCHELL: I don't know.
16 Let me just ask a -- let me think about that.

17 MR. PROCOPIO: Okay.

18 HEARING OFFICER MITCHELL: Let me just ask
19 another follow-up question. That amount that you're
20 talking about, the \$3,200, that is for which programs?

21 MR. PROCOPIO: That is for across the
22 country. Across the country, all of our programs.

23 HEARING OFFICER MITCHELL: So I heard
24 someone talk about being -- someone purchasing their own

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1 insurance, that they were, you know, buying it directly,
2 and they would have the inability to pay.

3 In a situation like that, where someone is
4 having problems meeting, you know, the premiums and would
5 probably not be able to pay a deductible, how do you work
6 with them?

7 MR. PROCOPIO: So, again, I'll lean back
8 to our financial hardship policy. So our admissions
9 office would work with that individual family, and we
10 would have them fill out that hardship policy and see
11 where it landed, in terms of financial relief.

12 We look at 300 times the poverty level,
13 and we look at I think it's eight, it's eight percent,
14 8.1, 8.2 percent of adjusted gross income, and then we
15 also take a look at whether or not there's an immediate
16 crisis in the family.

17 HEARING OFFICER MITCHELL: Do you ever
18 turn people away, who would otherwise meet the criteria
19 for admission, because they can't pay?

20 MR. PROCOPIO: We have turned away -- I
21 can tell you that nine percent of our inquiries were
22 excluded from treatment, because of financial
23 limitations. 9.5 last year.

24 HEARING OFFICER MITCHELL: And then what

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1 happens when they're turned away?

2 MR. PROCOPIO: Carter's team jumps into
3 play and helps find an adequate resource for them.

4 HEARING OFFICER MITCHELL: There was also
5 an assertion that you're targeting affluent populations
6 and that you're not interested in assisting kids who are
7 involved in the juvenile justice system, maybe kids who
8 are involved with child welfare. Can you speak to that?

9 MR. PROCOPIO: Sure. I mean we've done
10 single case agreements with other states that include
11 those types of individuals. We are not targeting the
12 affluent.

13 I think I, again, earlier in my testimony,
14 we treated only seven clients in the Bethlehem campus,
15 who are pure cash pay, and that's of 473 admissions last
16 year, and I think across all of Newport there were a
17 total of 15 clients that were pure cash pay, and we've
18 done 1,524 admissions last year.

19 HEARING OFFICER MITCHELL: You addressed
20 this a little bit in your application, but can you talk
21 about why you're not seeking licensure from the
22 Department of Public Health to serve or provide services
23 to people specifically with substance use disorders?

24 MR. PROCOPIO: Sure. We have that

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1 capability at our Bethlehem campus today. You know,
2 again, nationally, I apologize, I don't have it
3 specifically for Connecticut, but about six percent of
4 our clients, who come to us for care, are primary
5 substance use clients. Another 21 percent are secondary
6 co-occurring substance use disorders.

7 We have that capability in our Bethlehem
8 campus. We decided that we were specifically going to
9 focus on mental health diagnosis here in Fairfield, but
10 that doesn't eliminate someone, who has a co-occurring
11 condition for substance use.

12 HEARING OFFICER MITCHELL: Is it your
13 opinion that you can serve them as well without the DPH
14 licensure?

15 MR. PROCOPIO: I think we can, yes.

16 HEARING OFFICER MITCHELL: On what basis?

17 MR. PROCOPIO: Based on our experience.

18 As I think I mentioned earlier, 69 percent of the folks,
19 who come to us for care, are a primary diagnosis of major
20 depressive disorder. Nine percent of them are anxiety
21 disorders.

22 HEARING OFFICER MITCHELL: Have you had
23 discussions with DPH Facilities Licensing &
24 Investigations Unit to determine whether or not that's

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1 the case?

2 MR. PROCOPIO: We have not, no.

3 HEARING OFFICER MITCHELL: There were
4 questions, as well, about regulatory oversight. You
5 talked about the Bethlehem location being subject to
6 oversight by the Department of Children and Families.

7 Are there any other agencies that would be
8 providing oversight of the programs, both of them?

9 MR. PROCOPIO: Sure. So DPH, the
10 Department of Public Health, also will be licensing this
11 individual facility, and we will obviously seek Joint
12 Commission accreditation, as well.

13 In addition to those outside regulatory
14 bodies that license us and supervise the care that we
15 deliver routinely on an annual basis, sometimes every six
16 months, we also have internally significant assets
17 dedicated to compliance.

18 We have a compliance office that looks at
19 how we are living up to our standards that we set in our
20 own policies and procedures.

21 We have our Chief Clinical Officer works
22 under the model of fidelity to the model. We ensure that
23 the treatment program is being delivered as it's
24 designed. She looks at all of our programs on a

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1 quarterly basis, and, again, if there's any opportunities
2 for improvement, we act on those.

3 We have Carter, who is sitting to my left,
4 as our Chief Experience Officer, and her job is to ensure
5 that the client experience and the family experience
6 meets the expectations that we set for ourselves, so we
7 have a robust internal process, and then, of course,
8 we're regulated by all the licensing bodies, and, on top
9 of that, we have Joint Commission oversight, as well.

10 HEARING OFFICER MITCHELL: Someone also
11 pointed out that your use of the wait list at the
12 Bethlehem location was irrelevant, because of the fact
13 that the age difference between that program and the
14 proposed program is different. The age range, not the
15 age difference.

16 The age range is different, and then, in
17 addition, they pointed out that a lot of them aren't
18 Connecticut residents, so I'm talking kind of about two
19 things when it comes to how you're going to fill the
20 proposed program and kind of meet the requirement that
21 you're serving Connecticut residents. If you could
22 address that?

23 MR. PROCOPIO: Sure. So, first, on the
24 wait list, the wait list someone described that, if we

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1 initially put in 20, 17 to 20, it has literally ballooned
2 in the back half of last year and continues to rise.

3 The highest our wait list has ever been is
4 150, and that literally was about two or three days ago,
5 and, again, that's company wide.

6 Our wait list in Connecticut for our
7 Bethlehem campus was 65 last night, and there were 11
8 clients on that or potential clients on that wait list
9 from the state of Connecticut.

10 Access is really an interesting topic, in
11 terms of who we provide access to, so, typically, when a
12 young person goes on our wait list, it's just systematic.

13 The next person moves up. We contact the
14 family. We have a bed, you know, here in Connecticut.
15 We have a bed in California. We have a bed in Washington
16 State.

17 This is what we think your insurance, you
18 know, your co-pays and deductibles will be, based on
19 where you choose to go, and you can accept that bed or
20 not, and, so, we don't discriminate, based on where
21 someone comes from, in terms of providing access to
22 treatment.

23 I was having a conversation with a
24 neighbor, and she said, well, can't you just give

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1 Connecticut folks priority access to treatment, and I
2 think that's a little bit of a slippery slope, in that,
3 you know, if you have a kid, who is from, you know, 26
4 miles away in New York and he's sitting on the wait list
5 for two weeks and he has suicidal ideations and you want
6 to bump him with somebody who is new, because they're
7 from Connecticut, that's a really difficult clinical
8 decision for us to make.

9 If everything were equal, we would provide
10 access to Connecticut folks first, but we have to take
11 into consideration the acuity of the folks, who are
12 coming to treatment for us, and how long they've been
13 sitting on a wait list waiting for a bed.

14 HEARING OFFICER MITCHELL: So the next
15 thing I want to talk about is need, so people have been
16 raising issues surrounding need.

17 They say that there are already other
18 places in Connecticut that can serve this population.
19 Can you talk about why you feel like the proposed program
20 is needed in Connecticut?

21 MS. BARNHARDT: So, as I spoke about this
22 morning, really what we get a ton of calls for are local
23 Connecticut families that are looking for primary mental
24 health services.

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1 In order to qualify for the treatment
2 centers that do exist currently in the state, either you
3 have to have a primary eating disorder diagnosis, a
4 primary substance use disorder diagnosis, which many of
5 our patients, even if they're smoking weed, they may not
6 meet criteria for an SUD diagnosis, have true levels of
7 dependence, or it has to be someone whose -- the primary
8 mental health facilities all require out-of-pocket
9 payments, so there's no availability right now within the
10 state.

11 Even Institute of Living, one of the
12 biggest programs here in Connecticut, said that this is a
13 problem that they're facing every single day, is that
14 they cannot find residential treatment centers that are
15 able to treat clients from Connecticut using their
16 insurance that have a primary mental health diagnosis.

17 HEARING OFFICER MITCHELL: And then I
18 think --

19 MS. BARNHARDT: And I can go through all
20 the -- I have all the programs here in Connecticut. I'm
21 happy to go through all of them and kind of highlight
22 which one does which, if you would like, if that would be
23 helpful.

24 HEARING OFFICER MITCHELL: Can we talk

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1 about the ones in your service area?

2 MS. BARNHARDT: Yeah. Yes.

3 HEARING OFFICER MITCHELL: Then I would.

4 MS. BARNHARDT: So like Silver Hill
5 Hospital?

6 HEARING OFFICER MITCHELL: Yes.

7 MS. BARNHARDT: Okay, so, Silver Hill
8 Hospital has an inpatient program. It's a three to
9 seven-day program. They're actually one of our largest
10 referral sources in our Bethlehem campus, because they
11 often treat clients for three to seven days, and then are
12 in need of a step-down program to a residential treatment
13 center.

14 The only programs that they offer are all
15 out-of-pocket for an average of about \$50,000. With
16 insurance benefits, it goes down to about \$47,000 per
17 month for the residential.

18 They are a non-profit, but, in order to
19 qualify for a scholarship in their program, you have to
20 be in their program, and then you can maybe get a
21 scholarship for another week or two once you're there, so
22 we get a lot of referrals from Silver Hill for
23 residential treatment, because we're able to work with
24 those clients and with their insurance.

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1 Rushford, Rushford requires a primary
2 substance use disorder diagnosis. Mountainside we work
3 with well. We love Mountainside. They also require a
4 primary substance use diagnosis. And many of the clients
5 that we treat that are ages 18 to 20 just don't meet
6 criteria for that SUD diagnosis.

Turnbridge is another one that's come up a couple of times today, so Turnbridge also requires a primary SUD diagnosis. They only provide IOP level of care.

14 They do have a transitional living
15 facility, so you're able to live there, but the
16 transitional living facility is an out-of-pocket cost to
17 families, typically around \$10,000 per month, and that's
18 a 12-month program, so around \$100,000 to \$120,000.

19 HEARING OFFICER MITCHELL: Okay, so, just
20 a couple more questions.

21 MS. BARNHARDT: Oh, sorry. Angelus House.
22 Angelus House is another big one, another great program.
23 They're a non-profit. They're part of Wellspring. They
24 treat primary mental health clients, however, they do not

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1 accept insurance, so it's \$390. Eli's House, \$390 per
2 day.

3 There's Eli's House, which is a part of
4 IOL, and you have to get a referral from the State, from
5 the Department of Mental, I believe. DCF into DMHAS into
6 Eli's House.

7 HEARING OFFICER MITCHELL: So just a
8 couple of questions on the quality, and, so, I heard a
9 comment about one of the pieces of -- one of the studies
10 that you provided us that basically says that six to 12
11 months is the, I guess, the best amount of time I want to
12 say.

13 I might be mischaracterizing it, but six
14 to 12 months is kind of the necessary amount of time for
15 someone to receive benefit from a residential facility.

16 Did you hear that comment?

17 MS. BARNHARDT: I heard the comment, but I
18 thought they said it was up to six to 12 months. I'm not
19 sure which article it points to.

20 HEARING OFFICER MITCHELL: Maybe you can -
21 - I was going to say, Doctor, maybe you can kind of
22 respond to the number of days that your organization
23 recommends and how that works, in terms of -- or how that
24 falls in with this study that was provided in the

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1 application.

2 DR. MENNESSON: Sure. I don't have it in
3 front of my eyes, but I'm pretty sure it's a study that
4 at least is 15 years old, or something like that.

5 HEARING OFFICER MITCHELL: Okay.

6 DR. MENNESSON: Where, at that time, all
7 treatment were much longer, and they trend as being both
8 from inpatient to residential to shortening the length of
9 stay driven by the pressure put by insurance to have the
10 treatment done faster and faster, so there's this tension
11 where, clinically, you know, it would be clear that some
12 -- there will be some benefit to continuing to treat
13 residents in all programs around the country, not just in
14 Newport, but there is not a commitment from a society to
15 provide that kind of work and that kind of coverage.

16 Now, so, the moral shifted from doing work
17 from six to 12 months in a residential. A lot of it is
18 engaging the person into treatment within this 45 to 60
19 days engaging them in treatment, so imagine you have
20 someone, who doesn't want treatment, doesn't think
21 there's anything wrong with them, and, within 45 to 60
22 days, can you get them motivated to really take on the
23 work of doing the, you know, taking care of themselves,
24 definitely.

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11 So by trying to do a fair amount of work
12 upfront, the hope is that the improvement will continue
13 over the months when they are in the less restrictive
14 environment.

15 MS. BARNHARDT: As a program, we do
16 believe in a continuum of care for all of our clients.
17 For local Fairfield County clients, we do have a PHP and
18 IOP for young adults in Darien.

19 We do believe that a continuum of care is
20 very important. We try to have that for all of our
21 clients, regardless of where they're discharging to,
22 setting up after care resources, a thorough after care
23 plan that includes clinical, as well as educational,
24 emotional needs and fun activities to keep them

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1 motivated.

2 HEARING OFFICER MITCHELL: Okay and can
3 you also talk about your quality initiatives? Can you
4 talk about some of the assertions that you haven't met
5 the threshold to establish that your program is a quality
6 program, that the information that was provided was self-
7 serving?

8 MR. PROCOPIO: It's a little bit difficult
9 to respond to. I mean the quality of the information is
10 from our clients, themselves, and, so, those three
11 outcome studies that we've done that measure depression,
12 anxiety and wellness are by self-report, and that's how
13 they're intended to be, by self-report.

14 I'm not a statistician that can debate.
15 You know, we had Vanderbilt University look at that
16 study, and the opposers had someone from Columbia. I
17 guess we can get their resumes together and figure out
18 which of the two are smarter, but what I do know with
19 absolute certainty is that the number of clients, who
20 completed the outcome study, over 700 of them, measured
21 significant wellness.

22 And, so, if we can impact the quality of
23 700 young people over the course of two years, I think
24 that that's pretty impressive from my perspective.

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1 So, in addition to measuring quality with
2 the customers, themselves, we measure quality with our
3 reference, we asked them for feedback about their
4 clients' treatment stay, and the majority of our business
5 comes from professional reference in the community.

6 We measure family surveys. We do client
7 satisfaction surveys to measure quality. We look at, you
8 know, we have key performance indicators, where we look
9 at, you know, the number of incidents that may occur on a
10 particular location.

11 We use our national database to determine
12 how to make those -- our facilities safer and to improve
13 care. We look at discharge rates, in terms of how many
14 of our clients successfully complete treatment, so
15 there's a whole myriad of statistical indicators that we
16 follow with the purpose of, you know, again, finding
17 opportunities to do better and improve care.

18 And, so, we study quality very seriously,
19 and then, overarching all of it, we got the State DPH,
20 DCF, and we've got Joint Commission, and they all look
21 at, you know, quality factors and determine whether or
22 not we're a viable program, and, today, all of our
23 licenses across the country are in good standing.

24 we're fully certified at all of our

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1 programs by the Joint Commission, so I think we have a
2 lot on the quality side that I would hope that OHS would
3 appreciate.

4 DR. MENNESSON: There was a question about
5 why we use self-report. Self-reports is different than
6 just asking a person how they're doing, because it's not
7 always standardized.

8 In a self-report, there are very standard
9 questions that have been tested, over 1,000 answers, and
10 we have -- we note by that that person reporting
11 that improvement is somewhat significantly better or not,
12 so it's a way of standardizing the subjective impression
13 of the person, so that person ultimately saying I'm less
14 depressed, I'm less anxious, and I'm feeling better.
15 That's what self-report does.

16 Now you could argue that maybe it should
17 be done by an outsider, but then you will have the
18 argument that the outsider has advised full, good
19 outcome, and, ultimately, it's somewhat better to rely on
20 that person's subjective experience, who say I'm feeling
21 less depressed.

22 HEARING OFFICER MITCHELL: Okay.

23 DR. MENNESSON: Those PHQ-9 and GAD-7 and
24 all that are very well standardized around the world. I

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1 would say it's very well-established as measures of
2 anxiety and depression.

3 MS. BARNHARDT: Joe touched on, too, the
4 client survey, in terms of the client experience and the
5 family experience, so we survey our clients throughout
6 the treatment experience, so when they first get there,
7 during the middle of their stay, I think it's at day 21
8 of day 45, and then at day of discharge.

9 HEARING OFFICER MITCHELL: And these are
10 all standardized?

11 MS. BARNHARDT: Yeah.

12 HEARING OFFICER MITCHELL: Okay.

13 MS. BARNHARDT: Yeah, and we're tracking
14 client satisfaction and family satisfaction and are able
15 to make really immediate changes if we need to. Luckily,
16 we normally score pretty high. Our kids complain about
17 no sugar, but, other than that --

18 HEARING OFFICER MITCHELL: All right. We
19 do not have any additional questions, but I'm going to
20 actually turn it over to counsel for the Applicants, in
21 case there's anything that she wants to add to the
22 record, or any closing remarks that she wants to make.

23 MS. RINEHART: Thank you very much. We
24 really appreciate the opportunity to have a chance to

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1 speak to you today about this important program.

2 I think we've heard a lot of comments that
3 were raised on speculation, but those people, who have
4 had a direct experience with this program, have come in
5 here to tell you the amazing life-changing impact that
6 this had.

7 The data on need is overwhelming, and the
8 HUD report indicated that the need is even more severe
9 among patients who have commercial insurance than it is
10 in many cases among those who are on Medicaid for DMHAS,
11 because there are special programs for them, whereas many
12 programs, as we've heard, do not take any commercial
13 insurance, so there is a huge need for people with
14 insurance, and this program is very unique in the way
15 that it works with insurance.

16 So we do believe that the need is
17 overwhelming. The quality data is overwhelming. There
18 has been no contrary evidence.

19 There is just an overwhelming and crushing
20 need for this type of service that's transformative to
21 the lives of those that it touches, and we really
22 appreciate the opportunity to present the program and
23 hope that you will grant the CON application.

24 HEARING OFFICER MITCHELL: Thanks. I just

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1 have possibly two late files for you. I just want ask,
2 when you guys keep track of your wait list, do you track
3 age, gender, those types of things?

4 MR. PROCOPIO: Yeah. Yes, we do. We do
5 both.

6 HEARING OFFICER MITCHELL: So for your
7 current wait list, you said, I believe, there are 65?

8 MR. PROCOPIO: Yes. For Bethlehem today?

9 HEARING OFFICER MITCHELL: Yeah.

10 MR. PROCOPIO: Yeah.

11 HEARING OFFICER MITCHELL: So can you
12 provide us with information regarding the gender, town of
13 residence and age for that wait list?

14 MR. PROCOPIO: Yes, we can.

15 HEARING OFFICER MITCHELL: All right and
16 then, additionally, we're looking for some evidence over
17 the last three years of the average out-of-pocket cost.

18 MR. PROCOPIO: Okay.

19 HEARING OFFICER MITCHELL: I know that you
20 raised some issues with regard to competitive
information. Let me ask counsel. Do you have any
22 concerns about that? Is there any way that you think
23 that you can get us that information without --

24 MS. RINEHART: I think we need to see what

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1 data exists and what form it's in, and we can certainly
2 do something like an affidavit from the CFO, confirming
3 the average out-of-pocket cost.

4 HEARING OFFICER MITCHELL: All right. I
5 really want to see how that is derived. I don't want to
6 put you at risk for any type of confidential, private,
7 competitive information, but this is something that we're
8 interested in, because this has been raised multiple
9 times throughout the hearing, and it's a huge issue that
10 I know that I have to be able to justify to the Executive
11 Director if she's going to sign a decision related to
12 that, so I will leave the record open for seven days, so
13 that you can provide information, both on the wait list
14 and then, also, on the out-of-pocket cost, so we're
15 looking for a three-year trend.

16 Any questions that you have about that?

17 MS. RINEHART: No. I guess just one
18 question, in terms of the wait list.

19 HEARING OFFICER MITCHELL: Yes.

20 MS. RINEHART: One thing that is helpful
21 to understand is that, if these programs were allowed to
22 open, because, currently, there is a small overlap in the
23 age groups served, it's not just the wait list that
24 matters. It would allow rebalancing of the ages served,

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1 so, potentially, folks that are currently in the program,
2 not on a wait list, would be able to move, you know what
3 I mean?

4 HEARING OFFICER MITCHELL: Forward to the
5 new program, if it was open?

6 MS. RINEHART: You have more focus on the
7 14 to 18 year olds in Darien, taking some of the 18 to 20
8 year olds that may not be on a wait list, but may be
9 currently served out of that population and moving them
10 over.

11 I'm not saying, obviously, current people
12 would be moved, but, in the future, it would allow them
13 to focus more and to serve more of the folks that are on
14 the wait list in both age groups.

15 MS. BARNHARDT: I also think it's
16 important to note that the clients that we're serving
17 right now professionals in the community know us as
18 treating clients up to age 20.

19 HEARING OFFICER MITCHELL: Right.

20 MS. BARNHARDT: So they're not sending us
21 clients that are 21 to 26 years old. We would have more
22 people.

23 HEARING OFFICER MITCHELL: I think we're
24 interested in a couple of things, so one of the things is

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1 how many of the people on the wait list are actually from
2 Connecticut, because that was raised, so we're looking at
3 that, and then, you know, while we're talking about it,
4 I'm kind of backtracking, I know that we were talking
5 about late files, but this is one thing that I think I
6 forgot when I was asking questions, so I just want to
7 make sure that I ask you this.

8 So it was brought up that a lot of your
9 advertisement, you know, kind of would appeal to people,
10 who are out of state, and, so, is there anything that you
11 can say about that, because the overarching concern is
12 that your program might be tailored, according to some
13 people's opinions, to people, who are not in Connecticut,
14 so, you know, I think that this is something that we want
15 to make sure that we cover.

16 MR. PROCOPIO: Sure. So, on that same
17 website where that information was derived, in that back
18 of that, you'll see a map that shows where all of our
19 clients came from. It's like a map of the United States,
20 and you'll see there's a significant density around our
21 facilities.

22 Typically, the majority of our clients
23 come from a three-hour radius of where we are.

24 MS. BARNHARDT: We do make parents, also -

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1 - parent participation is mandatory in treatment, so, if
2 they're closer, they're able to participate in a more
3 meaningful way.

4 HEARING OFFICER MITCHELL: Okay. All
5 right. I don't have any additional questions. Anything
6 additional from the Applicant?

7 MR. PROCOPIO: I just would like to make
8 one comment to our families, and I know most of them have
9 left who came, just the, again, and I think others have
10 said this and not to sound redundant, but the courage
11 that they showed to come and talk about their personal
12 experience and share what little part Newport had in
13 their treatment, because, really, the young people are
14 doing all the work.

15 We get them started on the right path, but
16 those young people, who came in and spoke about their
17 treatment experience with us and how it has helped them
18 in their life, I just wanted to thank them for standing
19 up in a really difficult circumstance and talking about
20 the care they received.

21 MS. RINEHART: Thank you very much.

22 HEARING OFFICER MITCHELL: Thank you. So
23 the hearing is now adjourned. We're going to keep the
24 record open for seven calendar days, that would be March

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1 11, for the production of late files. Thanks, everybody.

2 (Whereupon, the hearing adjourned at 5:51

3 p.m.)

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CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify and attest that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinto set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness, whereof I have hereunto set my hand and do so attest to the above, this 10th day of March, 2020.



Paul Landman
President