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1 STATE OF CONNECTICUT

2 OFFICE OF HEALTH STRATEGY

3

4

5 DOCKET NUMBER 22-32511-CON

6 APPLICATION FOR TERMINATION OF INPATIENT LABOR
AND DELIVERY SERVICES AT VASSAR HEALTH
7 CONNECTICUT, INC. D/B/A SHARON HOSPITAL

8

VIA ZOOM

9

10 Oral Argument on Proposed Final Decision held
via Zoom, on Wednesday, November 8, 2023,
11 beginning at 9:08 a.m.

12

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H e l d B e f o r e:

14

DEIDRE SPELLISCY GIFFORD, MD, MPH,
15 Executive Director, Office of Health Strategy,
Senior Advisor to the Governor for Health and
16 Human Services

17 ANTHONY A. CASAGRANDE, ESQ., OHS General Counsel

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Reporter: Lisa L. Warner, CSR #061

1 **A p p e a r a n c e s:**

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3 **For Applicant, Vassar Health Connecticut,**

4 **Inc. d/b/a Sharon Hospital:**

5 **ROBINSON & COLE**

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9 **BY: THEODORE TUCCI, ESQ.**
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10 **LISA BOYLE, ESQ.**

11 **CONOR DUFFY, ESQ.**

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1 (Commenced at 9:08 a.m.)
2 MS. GIFFORD: This hearing is being
3 convened for the limited purpose of hearing oral
4 argument in Docket Number 22-32511-CON. The
5 Applicant in this matter Vassar Health
6 Connecticut, Inc., doing business as Sharon
7 Hospital, seeks to terminate inpatient labor and
8 delivery services.
9 On August 28, 2023, the hearing officer
10 in this matter issued a proposed final decision
11 denying the application.
12 On October 18, 2023, the Applicant
13 filed a brief in opposition and written exceptions
14 to the proposed final decision after an extension
15 and requested an opportunity to present oral
16 argument.
17 On September 29, 2023, the Office of
18 Health Strategy issued a Notice of Oral Argument
19 for today. This hearing before the Office of
20 Health Strategy is being held on November 8, 2023.
21 My name is Deidre Spelliscy Gifford,
22 and I'm the executive director of the Office of
23 Health Strategy. I will be issuing the final
24 decision in this matter. Also present on behalf
25 of the agency is OHS General Counsel Anthony

1 Casagrande.
2 OHS is holding this public hearing
3 remotely by means of electronic equipment. Any
4 person who participates orally in an electronic
5 meeting shall make a good faith effort to state
6 his or her name and title at the outset of each
7 occasion that such person participates orally
8 during an uninterrupted dialogue or series of
9 questions and answers. We ask that all members of
10 the public mute the device that they are using to
11 access the hearing and silence any additional
12 devices that are around them.
13 This hearing concerns only the
14 Applicant's oral argument regarding its brief and
15 exceptions to the proposed final decision, and it
16 will be conducted under the provisions of Chapter
17 54 of the Connecticut General Statutes.
18 The Certificate of Need process is a
19 regulatory process, and as such the highest level
20 of respect will be accorded to the applicant and
21 our staff. Our priority is the integrity and
22 transparency of this process. Accordingly,
23 decorum must be maintained by all present during
24 these proceedings.
25 This hearing is being transcribed and

1 **recorded, and the video will also be made**
2 **available on the OHS website and its YouTube**
3 **account. All documents related to this hearing**
4 **that have been or will be submitted to the Office**
5 **of Health Strategy are available for review**
6 **through our electronic Certificate of Need Portal**
7 **which is accessible on the OHS CON webpage.**
8 **Although this hearing is open to the**
9 **public, only the applicant and its representatives**
10 **and OHS and its representatives will be allowed to**
11 **make comments. Accordingly, the chat feature of**
12 **the Zoom call has been disabled.**
13 **As this hearing is being held**
14 **virtually, we ask that anyone speaking, to the**
15 **extent possible, enable the use of video cameras**
16 **when speaking during the proceedings. In**
17 **addition, anyone who is not speaking shall mute**
18 **their electronic devices, including telephones,**
19 **televisions and other devices not being used to**
20 **access the hearing.**
21 **Lastly, as Zoom notified you while**
22 **entering this meeting, I wish to point out that by**
23 **appearing on camera in this virtual hearing you**
24 **are consenting to being filmed. If you wish to**
25 **revoke your consent, please do so at this time.**

1 However, please be advised that in such event the
2 hearing will be continued to a later date.
3 We will now proceed. Counsel for the
4 Applicant, could you please identify yourself for
5 the record and any other individuals that will be
6 speaking this morning.
7 MR. TUCCI: Yes. Good morning, Dr.
8 Gifford. This is Ted Tucci from Robinson & Cole.
9 And I'm joined this morning by my partner Lisa
10 Boyle and my partner Conor Duffy. I will be
11 principally speaking this morning. And in
12 addition, we have some slides to assist in our
13 presentation this morning. With your permission,
14 we'd like to be able to bring those up.
15 MS. GIFFORD: Of course. All right.
16 So before we begin, are there any other
17 housekeeping matters or procedural issues that we
18 need to address?
19 MR. CASAGRANDE: Counsel, would you
20 please represent and verify on the record that the
21 slide presentation is solely based upon matters
22 that are within the record of this matter.
23 MR. TUCCI: Yes, Mr. Casagrande. Thank
24 you for reminding us of that. I do so affirm.
25 MR. CASAGRANDE: Thank you.

1 MS. GIFFORD: All right. You can begin
2 whenever you are ready.
3 MR. TUCCI: Thank you. Good morning,
4 Dr. Gifford and members of OHS staff. My name is
5 Ted Tucci. Together with Lisa Boyle and Conor
6 Duffy, we represent Sharon Hospital in CON Docket
7 Number 22-32511, which is pending before you.
8 Because this matter is so vital to
9 Sharon Hospital, we're also joined this morning by
10 a number of members of the hospital senior
11 leadership team, including Dr. John Murphy, the
12 president and CEO of Nuvance Health, and Christina
13 McCulloch, president of Sharon Hospital.
14 We're here today to talk with you about
15 a multitude of reasons why the proposed decision
16 against closure of Sharon Hospital's labor and
17 delivery unit cannot be allowed to stand. In our
18 discussion this morning we'll demonstrate that
19 there's an overwhelming basis to conclude that
20 refusing to close the L&D unit is both wrong on
21 the facts and incorrect on the law. But the
22 proposed decision isn't just technically wrong,
23 it's also a seriously flawed health care policy
24 choice for Connecticut. This decision threatens
25 Sharon Hospital's ability to continue delivering

1 care to Northwestern Connecticut.
2 Our hope is that the evidence that we
3 will present to you today will persuade you that
4 it doesn't make sense to force Sharon Hospital to
5 continue operating an underutilized labor and
6 delivery service that loses millions of dollars
7 annually, especially when there are five other
8 area hospitals that can easily absorb Sharon
9 Hospital's minimal volume. That outcome is a bad
10 one for Connecticut health care consumers. Our
11 goal in administering health care in Connecticut
12 should be to have a health care system that
13 promotes delivery of care where there is no
14 duplication in efficiency and where health care
15 costs are contained.
16 It's not an exaggeration to say that
17 the future of Sharon Hospital hinges on approval
18 of this CON application. Connecticut small
19 hospitals are in crisis. Sharon Hospital has a
20 transformation plan to address that crisis. Our
21 plan is to become a vibrant community health care
22 resource. A critical piece of that plan is
23 recognizing that high cost service lines like
24 labor and delivery can't continue, especially
25 where patients are already choosing hospitals with

1 facilities that Sharon will never be able to
2 match, like hospitals that have NICUs.
3 The proposed decision has four major
4 flaws. First, it both violates and at the same
5 time misapplies CON statutory guidelines.
6 Second, it violates the legal standards
7 required for sound agency decisions.
8 Third, review of the reliable record
9 evidence also only supports one conclusion, and
10 that conclusion is that the CON should be
11 approved.
12 Fourth, when you look at the reasons in
13 the proposed decision for refusing to close the
14 L&D unit, those reasons are arbitrary and
15 unreasonable.
16 Add to that the fact that Sharon
17 Hospital is losing tens of millions of dollars
18 annually, and it's inescapable that the status quo
19 can continue, and that closing the L&D unit is
20 absolutely necessary.
21 Now I'm going to summarize the four
22 serious flaws that we just identified, and then
23 we'll discuss them in detail as we go through our
24 presentation this morning. First, the decision
25 violated and misapplies OHS's CON guidelines. As

1 you know, there are a dozen or so guidelines in
2 the statute, but OHS recognizes that when you boil
3 it all down CON determinations involve three main
4 factors, need, access to quality care and cost
5 effectiveness. When you have a proposed decision
6 like the one here that refuses to apply relevant
7 CON factors or applies them in a way that makes
8 them impossible to satisfy, that is the definition
9 of error.
10 Second, CON decisions have to adhere to
11 minimal legal standards. Of course, OHS has
12 discretion to apply its judgment and its expertise
13 to the CON guidelines, but OHS doesn't have
14 discretion to reach conclusions that aren't backed
15 up by substantial and reliable facts, and OHS
16 doesn't have discretion to make conclusions that
17 defy rational explanation. We'll discuss multiple
18 examples of these legal errors in our presentation
19 this morning.
20 Third, a remarkable thing about the
21 decision is that its findings of fact as a whole,
22 when you look at them, support the conclusion that
23 it makes sense to discontinue the L&D service.
24 This is a service where volume has been flat and
25 declining for years. There's no reasonable hope,

1 based on demographics and projections, that it can
2 ever be turned around. This is a service where
3 people have multiple alternate options nearby.
4 The hearing officer recognized all of those facts
5 but decided it wasn't necessary to discontinue the
6 service.
7 Logically that leaves you to wonder how
8 we could get to that result. And this brings up
9 the fourth category of clear error. When you look
10 critically at the conclusions that were reached,
11 they are clearly erroneous. The proposed decision
12 disregards or tries to explain away unrefuted
13 facts that we presented during the hearing that
14 show staffing struggles, huge deficits and ample
15 capacity at nearby hospitals. We'll start by
16 looking at how the decision violates the first
17 category error that we identified which is at the
18 essence of the CON process, and that's the
19 guidelines that OHS applies.
20 Here's how the refusal to allow the L&D
21 unit closure violated the CON guidelines. The CON
22 Guidebook makes it clear that the goal of CON
23 review is to balance the public's need for access
24 to quality care but also minimize unnecessary
25 duplication of services. And this is what helps

1 to promote cost effectiveness in the delivery of
2 health care in our state. Where there is a
3 chronically low demand hospital service and the
4 same services are reasonably accessible nearby, a
5 duplicative service shouldn't continue because of
6 hypothetical concerns about weather or concerns
7 about emergencies that may never happen or hope
8 that volume might bounce back some day, and that's
9 exactly what happened here. Duplication,
10 efficiency, demand, cost and reasonable access
11 were all ignored in favor of speculation that some
12 unknown number of people theoretically might face
13 challenges traveling to a different hospital.
14 Now let's talk about certain guidelines
15 that were analyzed in the decision and that were
16 misapplied. It goes without saying that
17 evaluating need for L&D services at Sharon
18 Hospital requires OHS to analyze whether
19 termination is in the public interest. You can't
20 determine whether ending labor and delivery
21 services serves public interest if you don't
22 analyze whether there's a continuing need and you
23 don't consider whether closure would substantially
24 affect the population served. Here the proposed
25 decision concluded that neither of those factors

1 mattered, and that's clearly wrong.

2 Everyone would agree that OHS shouldn't

3 interpret CON guidelines standards so as to make

4 it impossible to satisfy them. Here at least two

5 conclusions fall into the literal impossibility

6 category. The first involves Section 14a-639a-6.

7 The second involves Section 19a-639a-11. Sharon

8 Hospital has an underutilized and money losing

9 labor and delivery service. Refusing this CON

10 because it changes the way services are provided

11 or because there would be one less provider is

12 simply wrong. The point of closing the L&D unit

13 is it will be a positive change. It eliminates a

14 service that can't sustain itself. Applying the

15 factors this way, as OHS did, makes it impossible

16 for a hospital to essentially ever close a

17 service.

18 Focusing on the second category of

19 error. We respectfully submit to you that this

20 decision violates the legal standards that OHS

21 follows in deciding contested cases. The law

22 gives OHS discretion to apply its expertise and to

23 make reasonable judgments based on data and

24 information that's presented during the hearing

25 process, but the law doesn't give OHS discretion

1 to make decisions that are arbitrary, that are
2 contradictory or that aren't supported by evidence
3 that is reliable, that is credible and that is
4 relevant. It's not appropriate for OHS to rely on
5 speculation or guesswork in granting or denying a
6 CON, but that is exactly what happened here. The
7 next slide we're going to look at focuses on how
8 this decision depends on and relies on
9 speculation.
10 According to the decision, eliminating
11 birthing services at Sharon Hospital would
12 "negatively affect minority races and ethnicities
13 in the service area at a disproportionately higher
14 rate." Here's the problem. There isn't a shred
15 of reliable record evidence that supports that
16 conclusion. We know this because five other area
17 hospitals will still provide birthing services
18 after the Sharon Hospital unit closes. And again,
19 there isn't a single fact to show that minority
20 patients are less able than anybody else to get to
21 those nearby hospitals.
22 OHS, in considering CON applications,
23 makes determinations about quality, accessibility
24 and cost effectiveness, and of course those
25 decisions have to be support by substantial

1 evidence. We're going to talk about some examples
2 this morning where the proposed decision failed to
3 do just that, failed to rely on or identify
4 substantial evidence.
5 First, there's no rational basis to say
6 that quality in birthing services at five
7 different hospitals in Connecticut or in the
8 adjoining area is worse than Sharon Hospital just
9 because they have fewer stars in a CMS survey.
10 Second, it's pure speculation to say
11 that the same patients who went to Sharon Hospital
12 for maternity services won't be able to travel to
13 other hospitals because they might not have a car.
14 Virtually all patients that come to Sharon
15 Hospital today do so by car. There is no reason
16 to believe that they won't be able to drive to
17 other hospitals.
18 Third, the decision says that closing
19 the L&D unit would not be cost effective because
20 Sharon Hospital has low commercial reimbursement
21 rates. This is a disconnect that speaks for
22 itself. Sharon Hospital's reimbursement rate for
23 L&D services is an apple. What it costs Sharon
24 Hospital to provide that service is an orange.
25 The two are simply not the same thing. This

1 decision concludes that it's cost effective for
2 Sharon Hospital to get paid tens of thousands of
3 dollars less than it actually costs the hospital
4 to provide the service.
5 The next category we'd like to talk
6 about is the review of findings of fact. All of
7 these findings of fact come from the proposed
8 decision, and taken together what they show is
9 that there's no good reason to force Sharon
10 Hospital to continue providing a duplicative
11 service that's characterized by low demand, that
12 causes multi-million-dollar deficits and where
13 there are other hospitals nearby that are readily
14 available to provide the service.
15 Here's what we know about. Here are
16 the facts. Here's what we know about Sharon
17 Hospital's PSA. It's a collection of small towns.
18 These towns are predominantly socially and
19 economically homogenous. The population mix is
20 overwhelmingly white. The average household
21 income exceeds $100,000. 95 percent of the people
22 who live in the service area have insurance. In
23 spite of all those facts, the proposed decision
24 speculates that some portion of the minority
25 population in the PSA will be adversely affected.

1 **The problem is the data showed that the Black**
2 **population in the primary service area is 2.9**
3 **percent, four times less than the national**
4 **average.**
5 **Here's what we also know. Sharon**
6 **Hospital does not have a NICU. And without an**
7 **intensive care unit for newborns, patients in the**
8 **high-risk pregnancy category have already chosen**
9 **to go to other hospitals. Problematically, this**
10 **is the only patient segment in a depressed demand**
11 **area where there actually is an increase in**
12 **demand.**
13 **Historical volume and demand trends are**
14 **basically flat to declining, and it's been that**
15 **way for ten years. Outmigration in the Sharon PSA**
16 **has increased because of the NICU issue that we**
17 **just discussed. Despite all that, the hearing**
18 **officer speculated that demand for birthing**
19 **services might bounce back in the future, but the**
20 **numbers don't lie. And the next slide**
21 **demonstrates this.**
22 **Just how bad is it at Sharon Hospital?**
23 **Here are the facts. If you go to the labor and**
24 **delivery unit on any given day, your chances of**
25 **seeing it completely empty are 50 percent. For**

1 the last three years, Sharon Hospital has paid to
2 fully staff the labor and delivery unit with
3 nurses, OBGYNs and a surgical team at the ready 24
4 hours a day, 7 days a week, 365 days a year, all
5 so that two babies a week on average could be
6 delivered.
7 Because the unit is empty half the
8 time, it makes sense that Sharon Hospital hasn't
9 been able to staff it without incurring
10 extraordinary costs for temporary staff. And
11 despite recruitment efforts, there just isn't
12 enough demand to keep new OBGYNs in the area. And
13 the reason for this really isn't a mystery.
14 Doctors and nurses don't want to work in a service
15 that is empty half the time.
16 The facts are clear that other
17 hospitals are reasonably close and have more than
18 ample capacity to absorb Sharon Hospital's volume.
19 We know this is in dispute -- we know that this
20 fact isn't in dispute because the hearing officer
21 reached the very same conclusion.
22 This next slide shouldn't be a
23 surprise. Multi-million-dollar deficits happen
24 when you have a resource intensive service like
25 labor and delivery that is in low demand. Sharon

1 Hospital spends $5 million a year running the
2 labor and delivery unit and it collects $2 million
3 annually. That just has to stop. Financial
4 feasibility is not in question here. The hearing
5 officer recognized this. You see at the bottom of
6 the slide that eliminating a $3 million annual
7 loss caused by labor and delivery makes financial
8 sense.
9 So all of this begs the question of how
10 the decision could reach conclusions that are the
11 opposite of what the facts show. And the answer
12 is that those conclusions are clearly erroneous
13 and/or arbitrary. And these clearly erroneous
14 conclusions go to the heart of what a CON is all
15 about which we've discussed. CONs should be about
16 need, about assessing quality and access and about
17 balancing cost effectiveness. The next group of
18 slides that we're going to go through which are
19 supported by record cites detail every erroneous
20 conclusion concerning need, access, quality and
21 cost.
22 As we said in the beginning, a full set
23 of these slides will be submitted to you, Dr.
24 Gifford, for your consideration after the
25 presentation, but for this morning we're just

1 going to highlight a few of the examples.
2 So for need it's clear error to find
3 that declining volume and aging demographic for
4 the very population served by the labor and
5 delivery unit doesn't justify terminating that
6 service. And the lack of need can't be explained
7 away by speculating about whether Sharon Hospital
8 did enough marketing or by saying that there
9 should be "a study" to prove what the data already
10 showed. We know from the data that 50 percent of
11 the labor and delivery patients in the service
12 area already go to other hospitals now. That's
13 the reality of today. And the reason is most of
14 those hospitals have NICUs.
15 The practical definition of what
16 arbitrary and capricious means is that when you
17 have a decision that finds facts showing declining
18 volume and underutilization but you conclude that
19 the service has to continue even though you
20 acknowledge lack of need, it's hard to explain how
21 that could be a reasonable decision.
22 And the map tells the story. This
23 shows that most of the Sharon Hospital's existing
24 volume comes from patients that can easily go to
25 closer hospitals.

1 I have to emphasize this point because
2 I think it is a remarkable thing for it to have
3 been said in a proposed decision from OHS. Let me
4 say it as simply as I can. There's just no basis
5 to say that Charlotte Hungerford, Danbury or other
6 area hospitals provide inferior birthing services,
7 and that is exactly what was concluded in the
8 proposed decision. Also, the rural labor and
9 delivery closure theory that was advanced in the
10 proposed decision can only be called a red
11 herring. A decision that relies on maternal
12 health studies involving hospitals that are 125
13 miles away simply doesn't reflect the reality of
14 the situation in Litchfield County.
15 It's also error to point to concerns of
16 possible emergency deliveries at Sharon Hospital
17 if the labor and delivery unit ceases operation.
18 We know this because history and common sense
19 tells us that it's not likely to occur. New
20 Milford Hospital closed its labor and delivery
21 unit ten years ago. In the last ten years since
22 New Milford closed there has never been, not a
23 single time, an emergency birth at New Milford
24 Hospital. And the reason is because OBGYNs work
25 with their patients months in advance to help them

1 **choose a hospital where they will go for delivery.**
2 **OBGYNs will not direct patients to Sharon once the**
3 **L&D service is no longer available.**
4 **We know that access to labor and**
5 **delivery services won't be reduced if the Sharon**
6 **unit closes. And also, there's no reason for**
7 **concern about transportation barriers because most**
8 **people in the area have private transportation and**
9 **are close to other hospitals, as we've already**
10 **shown. And here's further evidence of that. Five**
11 **other hospitals offering labor and delivery are**
12 **within one hour from Sharon. And the hearing**
13 **officer confirmed that those hospitals have ample**
14 **capacity. Again, it's not persuasive to rely on**
15 **studies about health care access that talk about**
16 **what the situation is in rural Wyoming.**
17 **It's also misplaced to deny the CON**
18 **because of speculative weather concerns or**
19 **concerns about lack of transportation. The**
20 **existing situation today is that half the patients**
21 **in Sharon Hospital's PSA already choose to drive**
22 **to other hospitals for L&D services. A large**
23 **percentage of Sharon's historical patient census**
24 **live closer to other hospitals. Despite that, the**
25 **proposed decision speculated that PSA residents,**

1 "often do not have their own vehicle," but the
2 problem is there isn't a single fact in the record
3 to support that claim.
4 And we already know that the total
5 number of maternity beds at these five area
6 hospitals well exceeds their past and even their
7 future projected average daily census, so there's
8 no concern about capacity or availability here.
9 The proposed decision's conclusions
10 concerning impact on minorities I have to say is
11 especially troubling, and that's because these
12 conclusions rest completely on speculation and
13 gross generalizations. For example, there's no
14 data to support speculation that "people of color"
15 in the PSA are more likely to be poor, and there's
16 no data about how many of the 42,000 PSA residents
17 in this rural area don't have cars.
18 The proposed decision goes on to
19 speculate that it might be more costly for
20 Medicaid patients to get to other hospitals
21 because, again, maybe they don't have cars. But
22 we know this is a rural area, and we know that
23 people couldn't function in this area without
24 access to a car. And we also know that most
25 patients who already come to Sharon Hospital do so

1 **by car. People are not arriving at Sharon**
2 **Hospital by taxi now, and there's no facts to**
3 **support a notion that all of a sudden, if the**
4 **labor and delivery service terminates, people will**
5 **suddenly have to hire taxis to go to other**
6 **hospitals.**
7 **Finally, the proposed decision tries to**
8 **minimize the undisputed $3 million annual loss**
9 **caused by operation of the labor and delivery**
10 **unit. The decision says that this $3 million**
11 **annual loss is "negligible." I guess that's true**
12 **when compared to the nearly $24, $25 million**
13 **deficits that the hospital is running. The**
14 **decision says that labor and delivery staffing**
15 **challenges hadn't been so bad that Sharon hospital**
16 **was forced to close the labor and delivery unit.**
17 **What that reasoning amounts to is OHS punishing**
18 **the hospital for Herculean efforts to continue the**
19 **labor and delivery service. What that reasoning**
20 **amounts to is punishing Sharon Hospital for**
21 **following the rules in asking for CON approval to**
22 **terminate the service.**
23 **OHS's own data tells the financial**
24 **story at Sharon Hospital. Sharon Hospital is at**
25 **the very bottom of the operating margin chart.**

1 **Fixing the problem with annual deficits**
2 **approaching $25 million a year simply can't wait**
3 **any longer. Eliminating the financial drain**
4 **caused by the labor and delivery unit is essential**
5 **to securing the hospital's future.**
6 **I'm going to conclude where I started.**
7 **Sharon Hospital is in crisis. The hospital has a**
8 **plan to address that crisis. Transporting Sharon**
9 **Hospital to become a local health care and**
10 **wellness resource with lifesaving emergency**
11 **services and care that keeps people healthy**
12 **benefits everyone. This effort shouldn't be**
13 **thwarted by hypothetical fears.**
14 **We're facing a situation where the**
15 **future of another small hospital in Connecticut is**
16 **in peril. Some people would like Sharon Hospital**
17 **to stay the way it was 50 years ago, but the days**
18 **of small community hospitals being what they once**
19 **were are simply over. We don't live in a Leave it**
20 **to Beaver world. The pace of change in medicine,**
21 **technology and health care delivery doesn't give**
22 **us the luxury of keeping the status quo.**
23 **We know that making a decision to**
24 **discontinue a service is not easy, but the**
25 **question is not whether the decision will be**

1 popular. The question is this: Is closure a
2 health care policy choice that would be better for
3 all in the long run? Here the facts speak for
4 themselves. The right policy choice is to end an
5 underutilized expensive service that is bleeding
6 red ink. The policy choice that best serves
7 patients is to transform Sharon Hospital into a
8 resource that delivers the right care in the right
9 place at the right time.
10 I thank you very much for your
11 attention. I'm happy to address any questions you
12 may have.
13 MS. GIFFORD: Thank you very much,
14 Mr. Tucci. I don't have any questions. Your
15 presentation was very clear. And so I think that
16 if your team is done on your side, that concludes
17 the proceedings for today. So thank you very much
18 for your attendance, both to you and to the team
19 from Sharon Hospital. And we will proceed to
20 issue a final decision in accordance with Chapter
21 54 of the general statutes. Thank you very much.
22 MR. TUCCI: Thank you, Dr. Gifford. We
23 appreciate it.
24 (Whereupon, the above proceedings
25 concluded at 9:40 a.m.)

1 CERTIFICATE FOR REMOTE HEARING

2 STATE OF CONNECTICUT

3

4 I, Lisa L. Warner, L.S.R. 061, a Notary Public duly commissioned and qualified, do hereby certify that on November 8, 2023 at 9:08 a.m., the foregoing remote Oral Argument on Proposed Final Decision for the OFFICE OF HEALTH STRATEGY IN RE: DOCKET NUMBER 22-32511-CON, APPLICATION FOR TERMINATION OF INPATIENT LABOR AND DELIVERY SERVICES AT VASSAR HEALTH CONNECTICUT, INC. D/B/A SHARON HOSPITAL, was reduced to writing under my direction by computer-aided transcription.

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10 I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which these proceedings were taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

11

12

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14 In witness whereof, I have hereunto set my hand this 13th day of November, 2023.

15

16

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18 ---------------------------

19 Lisa L. Warner, CSR 061
Notary Public
My commission expires:
May 31, 2028

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