

**STATE OF CONNECTICUT  
OFFICE OF HEALTH STRATEGY**

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IN RE: TERMINATION OF INPATIENT ) DOCKET NO. 20-32394-CON  
OBSTETRICS SERVICES AT WINDHAM )  
HOSPITAL )  
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 ) NOVEMBER 2, 2021  
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**PREFILED TESTIMONY OF ADAM BORGIDA, M.D., CHIEF,  
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY AND  
DIRECTOR OF WOMEN’S HEALTH SERVICES, HARTFORD HOSPITAL**

Good morning, Attorney Yandow and members of the Office of Health Strategy (“OHS”) staff. My name is Dr. Adam Borgida and I am the Chief of the Department of Obstetrics and Gynecology (“OBGYN”) and Director of Women’s Health Services at Hartford Hospital. Hartford Hospital is the flagship hospital of Hartford HealthCare Corporation (“HHC”), an integrated healthcare delivery system that counts among its acute care general hospitals Windham Hospital (“Windham” or the “Hospital”), located in Windham in the Northeast corner of Connecticut. Thank you for this opportunity to testify in support of the CON Application for closure of Windham’s obstetric (“OB”) service. In my capacity as the OBGYN department head of HHC’s largest obstetric program, I was consulted and participated in the decision to close Windham’s OB services. It was a difficult decision driven by quality and patient safety concerns arising from steadily declining births at Windham.

My testimony today will focus on what drove the decision to terminate OB services at Windham. As you heard from my colleague, Dr. Kalla, volume was declining precipitously and the Hospital was finding it nearly impossible to put together the physician, nursing, and ancillary clinical staff coverage required to operate a safe labor and delivery service. I will discuss our decision to engage a third-party expert, Dr. Sindhu Srinivas, to review the Windham OB program and make recommendations about whether it should be closed and how any closure should be carried out. Dr. Srinivas presented literature in her report to Windham about the correlation between low-volume obstetric services and increased birth complications and morbidity – a reality of which all physicians in our profession are aware. That research supported the closure of Windham OB in 2017 and, along with updated research, continues to support the decision in 2021.

I will also speak about the considerable efforts made by Windham to keep OB services open, even after Dr. Srinivas recommended that the unit be closed, and those factors that eventually required the Hospital to make the difficult decision to suspend OB services pending OHS approval to close them permanently. I will testify today about how Windham went about suspending its OB program, consistent with Dr. Srinivas' recommendations and with input from professionals such as myself. A system has been put into place that ensures proper triage and transport of women from the Windham prenatal program to Backus Hospital or another hospital of their choosing for delivery of their babies. As you heard from Dr. Kalla, we work with women and their families from the early days of their pregnancies to ensure a seamless transition to the hospitals where they will deliver. Area hospitals such as Backus boast high-volume programs that can better handle birth complications, which occur even in low-risk pregnancies, as well as neonatal providers to care for children who need these specialized services. These

hospitals are located within a reasonable travel distance and have ample capacity to absorb the small numbers of women who were giving birth at Windham in recent years. Importantly, this has been done without incident for 16 months since the Windham OB program was suspended in June of 2020. And it continues to be done without increased cost to patients, their families, or the Medicaid program, which covers most of the births arising out of care at the Windham Women's Health Clinic.

Based on the foregoing, I respectfully request that OHS approve Windham's CON Application to terminate its obstetric service. Patients have been receiving, and will continue to receive, high-quality prenatal and postnatal care at Windham and will be transitioned seamlessly to the hospitals of their choice for safe delivery of their babies.

### ***Professional Background***

As previously mentioned, I currently serve as the Chief of the Department of Obstetrics and Gynecology and Director of Women's Health Services at Hartford Hospital. Hartford Hospital is HHC's flagship hospital and boasts one of the busiest obstetric services in the State of Connecticut, birthing approximately 3,500 babies per year. In my role as Chief of the Department of Obstetrics and Gynecology and Director of Women's Health Services, I am responsible for ensuring the health and safety of the women delivering babies and the babies they deliver. I am also responsible for oversight of the safe operation and continual development of appropriate and necessary health services for women in our community.

I am fellowship-trained in maternal-fetal medicine and board-certified by the American Board of Obstetrics and Gynecology, Division of Maternal Fetal Medicine. Maternal-fetal medicine physicians follow women whose pregnancies are deemed high-risk due to conditions

that either preceded or develop during pregnancy. I currently practice maternal fetal medicine at Hartford Healthcare.

In addition, I am board certified by the American Board of Obstetrics and Gynecology and am a Fellow of the American College of Obstetricians and Gynecologists (“ACOG”). I am also a Professor of Obstetrics and Gynecology at the University of Connecticut School of Medicine. A copy of my Curriculum Vitae is attached as Exhibit A.

On a personal level, I was born at Manchester Memorial Hospital and attended the University of Connecticut. As a second year OBGYN resident, I rotated through Windham Hospital, so I have long been familiar with the obstetrics program. Having lived in Connecticut my entire life and practiced here for my entire career, I am acutely aware of the challenges that small hospitals face in maintaining maternity volume and quality.

***Decision to Terminate Windham Obstetric Service: 2017 Expert Review, Report, and Recommendations***

A significant and steady decline in births at Windham, coupled with increasing difficulty maintaining adequate clinical staff for the OB service, led the Hospital to begin exploring the possibility of closing the unit. Births had declined precipitously from 384 births in 2011 to just 99 births in 2019, a 75% decrease in volume. To provide optimal obstetric care for women, hospitals need to have the volume and resources to support a team-based approach to care, continual quality improvement and implementation of best practices, and to allow staff to maintain their skills and build competencies. At approximately two (2) births per week, Windham did not have the volume to support the above-described approach to providing high-quality obstetric care. Although Windham sent high-risk patients to Backus and Hartford Hospital for their deliveries, the staff at Windham was not getting sufficient experience to

maintain the skill sets and competencies required to handle unexpected emergencies for low-risk patients that presented for delivery. Complications occur in 5-10% of low-risk deliveries. This posed a very real threat to patient safety.

As OB volume at Windham declined over the years, so did the unit staff. Dr. Kalla has discussed in detail how these staffing challenges arose and why, despite its best efforts over more than five years, Windham was unable to adequately staff a safe obstetrics service. Windham was able to maintain a small, competent, dedicated obstetrics team, but the overall staffing plan for the unit was fragile at best. The small number of clinical staff working on the OB unit left the Hospital vulnerable from a staffing and resources perspective for many years.

In 2017, recognizing the challenges that the OB service presented, Windham engaged Dr. Sindhu Srinivas, a practicing obstetrician, MFM specialist, and Director of Obstetrical Services at the Hospital of the University of Pennsylvania, to conduct a review of the Hospital's labor and delivery services. The report prepared by Dr. Srinivas, which recommended closure of the Windham OB unit, is attached as Exhibit B (the "Srinivas Report"). Therein, Dr. Srinivas made certain key findings and cited peer-reviewed studies in support of her conclusions about patient safety and the need to close the service. First, Dr. Srinivas noted clear dedication on the part of Windham Hospital to the community it serves. But she also noted a clear concern from OB staff regarding the ability to maintain processes of care, structural and facility needs, and staff skills with declining birth volume.

Dr. Srinivas cited the Council on Patient Safety in Women's Health Care domains for the improvement of safety in women's healthcare through multidisciplinary collaboration that drives culture change including readiness, recognition and prevention, response, reporting

system/learning. She concluded that it is “difficult for hospitals with low and declining volume to continue to support all of these domains, thereby making them vulnerable to safety issues.” She went on to say that with low volume, “the ability to keep staff and resources available to respond in a timely fashion becomes more difficult thus leading to a higher chance of suboptimal outcomes for patients.” See Exhibit B.

The Srinivas Report included a discussion of several studies that examined unit and provider delivery volume and the frequency of obstetrics complications. A study by Kyser et al. concluded that **hospitals in the lowest decile for delivery volume (1-99 deliveries annually), like Windham, have the highest rate of a composite morbidity** (including hemorrhage, severe perineal lacerations, operative complications, infection, thrombotic complications) and mortality.<sup>1</sup> Another study by Kozhimannil et al. found that **postpartum hemorrhage was higher in rural and non-teaching hospitals with the lowest delivery volume.**<sup>2</sup> Rural birth hospitals with less than 200 deliveries showed an 80% higher odds of postpartum hemorrhage and strategic, systematic and proactive planning was required to prevent potential harm. Another study demonstrated **lower maternal mortality when peripartum hysterectomies were performed at higher volume centers.**<sup>3</sup> A study by Janakiraman et al. found a consistent relationship between provider volume and risk-adjusted odds of complications.<sup>4</sup> **Providers in**

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<sup>1</sup> Kyser KL, et al., The association between hospital obstetrical volume and maternal postpartum complications. American Journal of Obstetrics and Gynecology 2012; 207:42 e1-17

<sup>2</sup> Kozhimannil KB, et al. Association Between Hospital Birth Volume and Maternal Morbidity among Low-Risk Pregnancies in Rural, Urban, and Teaching Hospitals in the United States. American Journal of Perinatology 2016; 33:590-9.

<sup>3</sup> Wright JD, et al. Regionalization of care for obstetric hemorrhage and its effect on maternal mortality. Obstetrics and Gynecology 2010; 115:1194-200.

<sup>4</sup> Janakiramam V., et al., Hospital volume, provider volume, and complications after childbirth in U.S. hospitals. Obstet Gynecol. 2011 Sep;118(3):521-527. doi: 10.1097/AOG.0b013e31822a65e4. PMID: 21826039.

**the lowest volume quartile had higher rates of each type of complication, and 50% higher risk-adjusted odds of complications overall than providers in the highest-volume quartile.**

After completing her review of the Windham OB service, Dr. Srinivas and her colleagues published a study showing that **patients with high-risk medical and surgical conditions had decreasing adverse maternal outcomes as total obstetric delivery volume increased.**<sup>5</sup> There were increased odds of adverse maternal outcomes in centers with high volume of high-risk patients. **Total obstetric volume and the number of high-risk patients had a significant combined effect on maternal risk.**

Dr. Srinivas recognized Windham's efforts to risk stratify pregnant women with the goal of referral of high-risk patients to more appropriate delivery settings. However, this approach does not account for the need for all delivery units, including those that do fewer births and handle primarily low-risk patients, to be ready and trained with staff and equipment to take care of women who have unexpected emergencies. Recruiting and retaining staff and maintaining these skills and competencies is extremely difficult in low-volume obstetric units. When the Srinivas Report was published in June of 2017, the doctor remarked that due to the small number of trained staff, any additional changes or leaves would make the OB unit vulnerable from a staffing perspective. This was before the various changes in physician coverage and nurse staffing that led to the decision to suspend the Windham OB service in June of 2020. *See Exhibit B.*

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<sup>5</sup> Bozzuto L, et al. Effects of Delivery Volume and High-Risk Condition volume on Maternal Morbidity Among High-Risk Obstetric Patients. *Obstetrics and Gynecology* 2019, vol. 133, 2, 261-268

The Srinivas Report cites trends for low-volume OB units, most notably, the fact that 14% of hospitals with less than 100 birth in 2008 reported discontinuing OB services within two years. Note that 7.9% of all US hospital reported less than 100 births per year. *See Exhibit B.*

Dr. Srinivas ultimately recommended that the Windham OB unit be closed due to a decline in delivery volume making it increasingly difficult to have facilities and personnel ready for unpredictable obstetric emergencies and catastrophic events, calling into question the safety of the unit. She concluded that the presence of higher volume hospitals within a reasonable distance created the ability to have a sustainable and safe transition for women then delivering at Windham. Her recommendations for closure included:

- Holding a town hall meeting with the community to ensure appropriate messaging on Windham's continued commitment to the community.
- Publicizing the continued ability to receive prenatal care at Windham.
- Creating seamless communication mechanisms between Windham Hospital prenatal care centers and future delivery centers to ensure high-quality care for women receiving their prenatal care at Windham.
- 24-7 available emergency transportation services as women may continue to present to Windham after the closure has occurred.
- Planned transportation services to assist women in their travel to delivering hospitals.

*See Exhibit B.*

## *Efforts to Keep the Windham Obstetric Service Open & Decision to Suspend Services*

Notwithstanding Dr. Srinivas' recommendation that the OB unit be closed, Windham worked tirelessly for another three years to piece together an obstetrics program due to our desire to maintain these services for women in the community. Dr. Kalla has described for you in detail the issues around physician coverage for deliveries, including anesthesia and neonatal coverage, as well as nurse staffing. We have heard from members of the community that different strategies should have been employed. We can assure both the community and OHS that Windham did absolutely everything in its power to keep the OB unit open. Some of the strategies that were suggested by others not involved in this process were simply not feasible. Several examples are noted below:

- Both OHS and members of the community have asked why HHC, as a large health system, cannot redeploy resources to fill gaps in clinical coverage such as those being experienced in the Windham OB unit. This is simply not how it works. Obstetricians affiliated with HHC are in private practice and are not employed by the system. They maintain admitting privileges at HHC hospitals to deliver babies but work out of their own private practices. HHC is not at will to direct the deployment of these obstetricians throughout its system. Furthermore, it is not feasible, practically, financially or from a standard of care perspective, for private obstetricians to leave their practices and the patients they care for to provide coverage at a hospital outside of their community.
- A member of the local healthcare provider community suggested in correspondence to OHS that Windham could have obtained coverage for the OB unit from UCONN's Family Practice Residency Program or from Day Kimball Hospital. The UCONN proposal is problematic on several levels. First, residents require in-hospital attending

physician presence and therefore securing residents to provide coverage for the obstetric unit without the ability to recruit attending physicians is not a viable option. Second, ACOG Guidelines for perinatal care establish 30 minutes as the time within which you should be able to staff an emergency c-section. The Hospital has adopted the ACOG Guideline requiring that on-call providers live within 30-minutes' drive time of Windham. UCONN is located 45 minutes from Windham. I know from my experience with UCONN residents that they would not meet the travel distance requirements and their work hour restrictions would make covering Windham impossible. Regarding Day Kimball, historically, the private practice covering that hospital covers a different service area and does not have sufficient resources to provide ongoing, consistent coverage at Windham. In fact, these physicians occasionally reach out to other area programs looking to address their own coverage issues at Day Kimball.

- Locum tenens coverage was also not feasible. Locums, by definition, are a short-term solution to fill a temporary gap in coverage. Locums are not a good long-term solution because this type of staffing does not provide good continuity of care or a consistent team of providers. This leads to inconsistent and sometimes confusing care for patients. Particularly at a small institution like Windham that has limits to many of the support services that obstetricians are accustomed to, it is even less safe to have a changing roster of providers.

Despite its best efforts, Windham had to make the difficult to decision to suspend the OB service in June of 2020 and seek CON approval to close it permanently. The decision to terminate was made in a thoughtful and deliberate manner, balancing the desire to serve the Windham community with the imperative to keep mothers and babies safe.

Ultimately, a committee of professionals convened by HHC East Region leadership to evaluate the OB service and make recommendations regarding its continued operation determined that it was not possible to provide OB services at Windham in a safe and consistent matter for the following reasons:

- Physician staffing was critically low with no ability to cover PTO, causing periodic interruptions in service. The loss of a physician for call coverage resulted in five (5) OBs covering both Backus and Windham Hospitals.
- RN staffing was critically low, despite efforts to recruit additional staff. Resignations and retirements of nursing staff resulted in ten (10) open shifts per week.
- With two (2) births per week on average, and extended periods of time between births on occasion, clinical staff did not have the opportunity to exercise their competencies with sufficient frequency to maintain and ensure a safe and effective program.

In suspending the OB unit and planning for permanent closure, we followed all of Dr. Srinivas' recommendations, including those around communication with the community and patients, creating a seamless transition with delivering hospitals, having 24-7 emergency transportation available, and having a planned transportation service to assist women in traveling to their delivery hospitals. We also consulted with facility licensure staff at the Department of Public Health before implementing our planned suspension of services. To the best of our knowledge, this is how other community hospitals that were forced to close their services in advance of CON approval handled patient transitions (e.g., Milford Hospital). We are here today to answer any questions that OHS has about why the unit needs to close and how we have

implemented a safe and seamless process for the women who obtain their prenatal care at Windham to deliver at other hospitals.

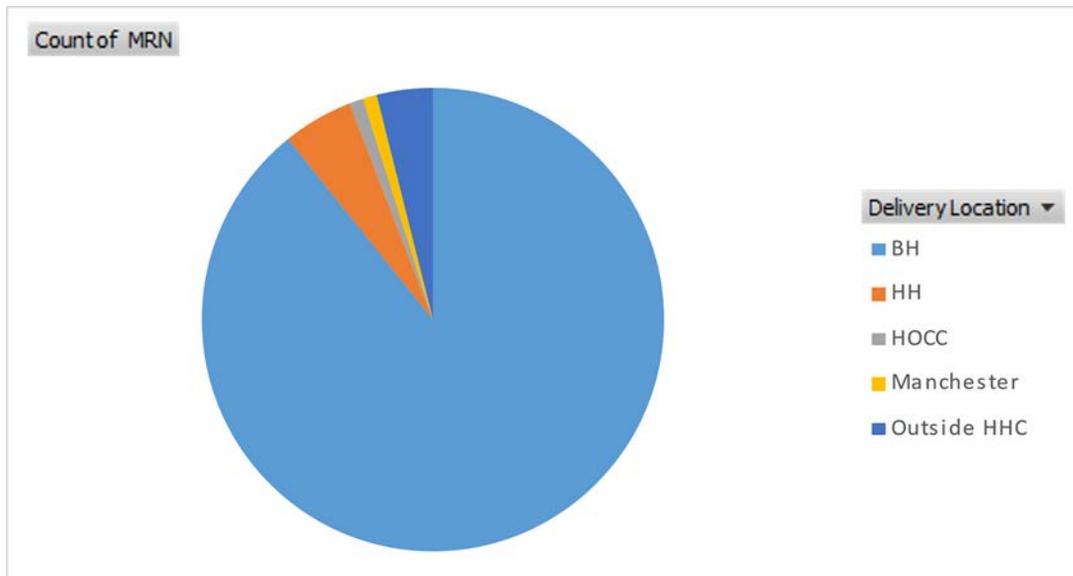
***Manner of Closure and its Impact on Quality, Access, and Cost-effectiveness of Services***

Finally, I would like to touch upon the positive impact that the suspension of OB services at Windham, and the redirection of pregnant women from our prenatal clinic to hospitals with higher-volume programs like Backus for their deliveries, will have on mothers and babies.

The most-recent Community Health Needs Assessment conducted for the Hospital in 2018 indicates that Windham has a significantly higher than average rate of respiratory disease, diabetes, and depression, all of which are underlying chronic health conditions associated with high-risk pregnancies. In addition, there is expected to be an increase in the Hispanic and black population in the service area. Studies have shown that black women have a higher risk of complications from obstetrical hemorrhage and both black and Hispanic women are at higher risk for hypertension disorders in pregnancy. Serious complications from these conditions can lead to poorer outcomes in low-volume obstetric units. Now with all patients of the Windham Women's Health Clinic ("WWHC") being directed to higher-volume hospitals for their deliveries, deliveries will be safer. There will be less risk of complication for women and their children, and the obstetrics staff will be better equipped to handle any complications that do arise.

Based upon our early experience, most women who receive prenatal care at the WWHC are giving birth at Backus Hospital in Norwich. From July of 2020 when OB services were suspended through September 9, 2021, one hundred two (102) women from the WWHC have

delivered their babies. Of the one hundred two (102) deliveries, ninety-one (91) women delivered their babies at Backus.<sup>6</sup>



Each of these babies was delivered safely and without incident. Backus has the capacity to absorb the 100 or less deliveries that were happening at Windham each year. This is based upon a five-year average of births at Backus, as well as a letter from letter from Backus indicating that it has the capacity and capability to safely provide labor and delivery services for any patient choosing to transition their care from Windham.

In addition, in my experience the travel distance between Windham and Backus Hospitals is not an unreasonable distance for women to travel to deliver their babies, even factoring in the lack of highway access in the area. The trip is less than 20 miles and approximately 25 minutes driving distance.<sup>7</sup> If a woman is transported by ambulance with lights and sirens, the travel time

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<sup>6</sup> Of the remaining eleven (11) births, five (5) were at Hartford Hospital, one (1) was at the Hospital of Central Connecticut, one (1) was at Manchester Memorial Hospital, and four (4) were at other hospitals outside of the HHC system.

<sup>7</sup> As noted by Dr. Kalla in his testimony, from FY 2017 through FYTD May 2020 46.7% of women from the Windham primary service area were already choosing to travel to Manchester (approximately 30 minutes/19 miles)

would likely be only 10 to 15 minutes. Women routinely travel these distances and farther to deliver at hospitals across our state. As previously mentioned, ACOG Guidelines allow obstetricians to travel up to 30 minutes to begin an emergency c-section. Windham OB is offering a robust, free transportation program that allows women to be transported (by ambulance if needed) to Backus or the hospital of their choosing. An ambulance is available on-site at Windham Hospital during the hours of 11 p.m. through 9 a.m. in the event a laboring patient presents at the Emergency Department. During the hours of 9 a.m. through 11 p.m., ambulances are available via dispatch and can be at the Hospital in 10 to 15 minutes for transport. If an ambulance is needed sooner, the Willimantic Fire Department can respond within 5 minutes.

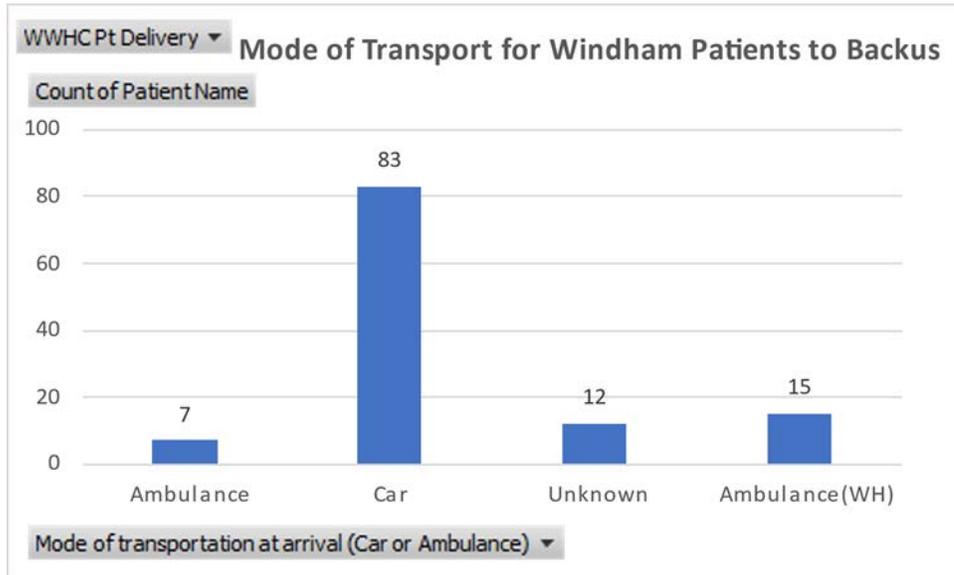
For reference, OHS's predecessor agency the Office of Health Care Access approved the termination of obstetric programs at both New Milford and Milford Hospital. Women from New Milford now travel 30 minutes to Danbury Hospital to deliver their babies, or farther if they opt for a different hospital for delivery. For the former Milford Hospital (now the Milford Campus of Bridgeport Hospital) patients, they are either traveling to Yale New Haven Hospital (15 minutes without traffic) or the Bridgeport Campus of Bridgeport Hospital (15 minutes without traffic) for their deliveries.

Since the Windham OB program was suspended, one hundred seventeen (117) pregnant women from the WWHC have been transported to Backus Hospital for emergency care and/or delivery of their babies. Of the 117 women, a total of twenty-two (22) women were transported to Backus by ambulance for their deliveries, with fifteen (15) of those transports originating from

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to deliver their babies. An additional 12% were giving birth at Hartford Hospital (approximately 45 minutes/28 miles).

the Windham Hospital Emergency Department and seven (7) from the patient’s home via a 911 dispatch. Eighty-three (83) women provided their own transportation to Backus Hospital and did not require transportation assistance. Zero (0) women have been transported by Life Star.



You will hear during the public comment portion of this hearing that women are being transported by Life Star and that they are giving birth in the helicopter or in an ambulance on the way to the airport; this is simply not true. **All women receiving prenatal care at the Windham Women’s Health Clinic have delivered their babies at their destination hospitals and without incident. None of the babies were born in a helicopter or an ambulance or in a car enroute to the hospital.**<sup>8</sup> You will also hear stories about babies being delivered in the Windham Emergency Department by untrained nurses and women being forced to have caesarian sections. None of this is true. Since July of 2020, not a single woman who received prenatal care at the WWHC has delivered her baby in the Windham ED. The Hospital does have

<sup>8</sup> As noted by Dr. Kalla in his testimony, a woman from Willimantic who was a patient of the Hartford Hospital prenatal service delivered her baby in an ambulance on the way to Backus. The baby came just 15 minutes after EMS providers left her home, which means had the ambulance gone to Windham the baby would have been born in the ED at best even if the Windham OB service was active.

the capacity to deliver a baby in an emergency, but as the last 15 months prove, it is a rare occurrence. And contrary to misinformation being spread in the public forums about the capabilities of the Windham ED to deliver babies, woman can safely deliver their babies in the ED vaginally.

In addition, between July of 2020 and September 9, 2021, the Windham ED triaged nine (9) pregnant women in need of emergency care or in labor who were not patients of the WWHC. These women were either patients of Mansfield OB or OB GYN Services or had received no prenatal care. Seven (7) of these women were safely transferred to Backus for delivery or they were evaluated and discharged home. One (1) woman, an unregistered patient who arrived at Windham with fetal parts presenting, had her baby safely delivered in the ED and was then transferred to Backus for placenta delivery and follow-up care. The infant received follow-up care at UCONN, as would have been the case if the delivery had taken place in the Windham OB unit. Another was a patient was a Mansfield OBGYN who arrived at the Windham ED with crowning. Her baby was safely delivered in the ED. She was then transferred to Backus for placenta delivery and follow-up care.

Finally, although the decision to terminate OB services at Windham was based on patient safety considerations, it is worth noting that this closure will not result in increased costs for pregnant women. A vast majority (82%) of the women delivering at Windham were Medicaid patients. Medicaid reimburses Connecticut hospitals on behalf of patients the same base rate for deliveries, with some adjustments dependent on the wage index and other factors. Including the adjustments, both Backus Hospital and Windham Hospital receive the same payment for obstetric patients, **with no out-of-pocket costs for the patient.** **In addition, transportation for**

**women to Backus or the hospital of their choosing, whether by ambulance or other means, is free of charge to the patient.<sup>9</sup>**

*Conclusion*

Thank you again for this opportunity to speak in support of our CON Application for permission to close the Windham OB service. Windham OB was, and would have continued to be, an extremely fragile service that was unable to consistently staff the unit and deliver babies with enough regularity to maintain skills and competencies. Closure of this service, and the redirection of women to higher volume hospitals such as Backus for their deliveries, is in the interest of patient safety and will lead to the best possible outcomes for the women of Windham and their babies. For these reasons, I respectfully request that you approve our CON request.

I am available to answer any questions that you have.

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<sup>9</sup> As noted by Dr. Kalla in his testimony, here was a single instance where a patient was inadvertently charged for an ambulance ride by the EMS provider. The situation was remedied, and the full cost was covered by Windham.

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