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1 PETERSHAM TOWN HALL

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3 SPECIAL PERMIT APPLICATION PRESENTATION

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5

6 FEBRUARY 12, 2015

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9 PROJECT: THE RETREAT AT PETERSHAM

10 BEHAVIORAL HEALTH

11 ADDICTION RECOVERY CENTER

12 211 NORTH MAIN STREET

13 PETERSHAM, MASSACHUSETTS

14

15

16 BEFORE:

17

18 MARYANNE REYNOLDS, CHAIR

19 BRIAN MacEWEN

20 DONALD EATON

21

22

23

24 DENISE M. O'LEARY
Registered Professional Reporter

2

1 P R O C E E D I N G S

2 THE CHAIR: I'd like to call the

3 meeting to order. Good evening everyone. This

4 is a meeting of the Petersham Zoning Board of

5 Appeals on February 12, 2015. We're here

6 tonight on the Public Hearing of Heywood

7 Healthcare, Inc. Let's pick it right up with

8 our consultant, Kevin Flynn, who is here this

9 evening. Kevin, I believe you have a report to

10 present?

11 MR. FLYNN: I do. I think some of

12 this we saw from the last meeting of the Board,

13 there was some preliminary work done. I

14 finalized that since then. There are a couple

15 of spare copies here. I think a couple of

16 copies have already been handed out, there are a

17 couple of black and white ones that have been

18 handed out, too. I believe the folks from

19 Heywood have copies.

20 I added some tables since the last

21 meeting. Sometimes it's easier to represent

22 some of the data that way. I put those into the

23 report. I tried to clarify a couple of points

24 since the last time. I think we all want to go

3

1 to the question that's been on everybody's mind

2 and that is, what's the economic impact and

3 what's the impact on services. There is a

4 pullout page in the report.

5 THE CHAIR: Do you have an extra one,

6 mine doesn't have a pullout page.

7 MR. FLYNN: Page 8. Before that is

8 information that Heywood Healthcare provided as

9 part of its application. They indicated that

10 there would be so many positions on various

11 shifts and gave us total numbers. This is at

12 full build-out so three years or so hence. If

13 everything goes according to plan, they are

14 predicting 148 positions.

15 I asked for some information at the

16 last meeting and Rebecca provided that to me,

17 how many of these were new jobs, typical work

18 weeks and those sorts of things. I plugged that

19 into some logarithms that planners and economic

20 analysts use to determine the impact of jobs.

21 New jobs created in an area that people have

22 those jobs are bringing in extra money to bear

23 on the economy and that's good for them and it's

24 good for the local economy. It will also

4

1 generate additional jobs.

2 There are formulas, logarithms, ways

3 to project out what the impact will be depending

4 on the type of job and the number of positions

5 and the wage rates and so on. It's based on

6 numbers that are generated or a statistical

7 analysis was done by two federal agencies, the

8 Bureau of Economic Analysis at the Department of

9 Commerce provides some of the numbers and the

10 Bureau of Labor Statistics of the Department of

11 Labor provides some of the numbers. That's

12 where these multiplier numbers come from.

13 In the chart it's in the seventh

14 column over -- excuse me, the eighth column over

15 and the tenth column over. Right here, a number

16 that's four decimal places. Those are numbers

17 that are calculated for different geographic

18 areas of the United States. Within

19 Massachusetts there are several ranges of them.

20 These are the numbers that are attached to a

21 particular type of position in a particular

22 location and these are updated frequently.

23 It will tell us, for example, the

24 person who is a dietician that the employment

5

1 multiplier for dieticians is point 6045. That
2 means for every dietician that's a new position,
3 the effect of their new hire and the money that
4 they spend in the economy will generate 6/10 of
5 another job somewhere. It doesn't have to be
6 one job, it could be a total of 6/10, it could
7 be multiple jobs.

8 Applying these multipliers to the
9 number of jobs gives us the next column which
10 tells us about the indirect positions. The
11 direct positions are what Heywood is projecting
12 to hire, the indirect positions are what that
13 multiplier effect is going to create somewhere
14 in the economy. Not necessarily just in
15 Petersham, it could be somewhere regionally.
16 You can see a variety of figures here for how
17 many potential jobs are created by the numbers
18 of jobs that Heywood is talking about.

19 There's also a multiplier that's used
20 for wages and how much will be transferred onto
21 those new jobs. That's the next column with the
22 wages multiplier again, the statistical analysis
23 that they do, and they generate these numbers
24 periodically and make them available at a price.

6

1 You apply that to the wages that were generated
2 originally by the jobs that were created and
3 that tells you what the indirect wages will be.
4 You total those up to get what the total job
5 impact is and the total wage impact.

6 That's what you see in the last
7 columns. So many jobs created by Heywood's
8 projections and so many new jobs created by
9 spin-off effects gives us the total number of
10 jobs. So much wages being paid at the rates
11 that Heywood is telling us creates so much
12 indirect wages and it gives us so much total
13 wages overall.

14 When you look at the overall result
15 you can see that the total wages for Heywood's
16 project is somewhere around almost \$6.5 million
17 in wages annually based on those 143 people. 90
18 percent is supposed to be new jobs so there's an
19 adjustment in there. Not all of those will be
20 new. There's about 129 new jobs. Some people
21 will be transferred from other facilities. The
22 increase will be around \$6.5 million in direct
23 new wages, direct new wages. The potential for
24 indirect wages for the spin-off jobs that will

7

1 occur somewhere else in the regional economy is
2 about \$4.5 million. So it's a significant
3 amount of money.

4 It's a surprising amount when you
5 first look at it because we're all sitting
6 around saying, wow, that's a lot of money, but
7 medical positions tend to generate higher wage
8 rates so there's a higher number of spin-off
9 jobs than some other kinds of jobs. If you're
10 hiring people who work at a convenience store,
11 the spin-off rate, the multipliers will be lower
12 on different multipliers. Medical facilities
13 tend to generate high rates of direct wages for
14 their employees and high rates of spin-off wages
15 and high rates of spin-off employment
16 opportunities because of those wages.

17 So based on the information that
18 Heywood had provided, this is the projection as
19 to the potential regional economic impact in
20 wages.

21 If you go to the next page, Page 10,
22 the chart in the middle. There are two parts to
23 the economic impacts of this. One is the
24 long-term ongoing jobs and the multiplier

8

1 effects that that creates, but there's also the
2 economic impact of the construction project
3 itself.

4 In the center of the page there,
5 Table 5 uses those numbers to analyze what the
6 impact would be from the construction project to
7 renovate the building and make it ready. This
8 is at full build-out again. The construction
9 budget is based on numbers that were provided by
10 Heywood. Construction wages are a takeoff from
11 that number. Not everything in a construction
12 budget is wages. There's permitting, design,
13 engineering and then there's labor involved. So
14 there's a multiplier that we can apply to that
15 using typical annual wages in the area. There
16 would be somewhere around the potential for 54
17 construction jobs. Not necessarily full time,
18 but 54 jobs. Construction jobs have time
19 limits, they're not permanent jobs.

20 Applying a wage multiplier to that or
21 an employment multiplier, we find that those
22 will create additional spin-off effects. Those
23 will be short term, those won't be permanent in
24 the economy, so indirect wages. There's a total

1 number there of about \$5.8 million potential
2 economic impact from the construction project in
3 terms of jobs and wages locally. When I say
4 locally, I'm talking regionally not just
5 Petersham.

6 On the last page, I'm going to skip
7 ahead a little bit, I think we talked about some
8 of these things the last time, but I'm trying to
9 highlight the things that everybody is
10 interested in.

11 The last page was the question of the
12 impact. The earlier pages talked about
13 potential impact on local services. One of the
14 questions that we talked about several times and
15 has been in some of the presentation materials
16 is what is the potential impact on municipal
17 services, particularly public safety services,
18 from the addition of an 86-bed or 88-bed
19 facility here in town.

20 What we did, Rebecca did some of this
21 and I did some of this, we both contacted some
22 other facilities that are similar in nature to
23 the proposed facility here and we asked them to
24 look at their call reports for the last year or

1 Actually, very few calls.

2 The outlier there was the Brattleboro
3 Retreat, they had the most calls overall for the
4 time period. We talked about that the last time
5 and there's some discussion in the text as well.
6 Since 2006 the Brattleboro Retreat has more than
7 doubled its size. It's gone from 50 beds to
8 over 120 beds. When you have that kind of
9 growth it doesn't always go smoothly.

10 It has not been smooth for the
11 Brattleboro Retreat. They have had many
12 problems trying to manage that expansion.
13 That's reflected in these numbers as well as in
14 the fact that they've been on probation for a
15 while, they've had a number of consent decrees
16 and a number of internal problems with the
17 regulatory authorities, both State and Federal
18 authorities. It just reflects the fact that
19 they grew very quickly and they weren't prepared
20 for what that was going to require. Even with
21 that said, it's not a hundred calls. They had
22 11 calls for assistance. We know last year when
23 this came up it was a particularly difficult
24 year for them. There were at least three

1 so, calendar year, and tell us how many calls
2 they had and the types of calls. We wanted to
3 know how many times were people calling from the
4 facility for assistance. The chart represents
5 the results of those, of the data that was
6 gathered.

7 What we see on here is that the
8 majority of calls, the vast majority of calls,
9 are related to fire and EMT services. Of those
10 the vast majority, sometimes all of them, are
11 calls for transport. So they're calls to the
12 local ambulance unit for transport to a hospital
13 for some other medical purpose. There are very
14 few to no fire calls otherwise. Usually fire
15 and EMT, a lot of times they're in the same
16 department and that's why they're clustered
17 together.

18 Police calls, again, very little
19 police calls. Occasional police calls are calls
20 for assistance from the hospital, from the
21 facility. Some of these are warrant services or
22 other non emergency calls. They were there to
23 serve a warrant or in one case we had a missing
24 person and a couple of other similar calls.

1 violent incidents on site and they were self
2 inflicted incidents.

3 I have some other statistics here for
4 you that show so many calls per bed because that
5 was a discussion we had. I'm not sure if that's
6 particularly helpful, but it came up so I
7 included that just so people could see what the
8 numbers were.

9 At this point I think I'm going to
10 stop. What we're seeing is a limited impact on
11 police services and fire services. Most of it's
12 on ambulance transport, but that's not something
13 that Petersham provides. That's private. With
14 that I'll just stop.

15 THE CHAIR: I have a couple of
16 questions. In terms of Tables 4 and 5 which
17 were related to employment dollars and
18 construction wages, how would you describe the
19 relationship of those numbers to the impact on
20 the town.

21 MR. FLYNN: Well, the impact here is
22 going to be a regional impact. In terms of
23 medical staff, there may be some people who are
24 new employees who might decide to move into

13

1 town. Petersham has a very small amount of
2 vacant properties. I think the permits in the
3 last few years have averaged one or two a year
4 for new building, new construction. There's a
5 very limited supply of available housing. So
6 even if people were employed and wanted to live
7 here, it would be difficult for them to find
8 someplace. A lot of this is not going to stay
9 locally in the direct wages, the folks who are
10 hired new and move into town.

11 I think the indirect impact, there
12 could be some indirect benefits to local
13 businesses. Heywood has talked about reaching
14 out to local vendors, trying to hire local where
15 they can, but reaching out particularly to local
16 vendors. There's an opportunity there for
17 people, it could be landscaping services,
18 plowing or maintenance work, whatever it is. I
19 think you have your own internal maintenance
20 staff, but some of it gets contracted out. So
21 there's an opportunity there for people. What
22 you see here is what's going to happen
23 regionally. It's not just related to the Town
24 of Petersham.

14

1 THE CHAIR: Okay. To the extent that
2 there is an impact from wages on the town or a
3 city, and I understand that the whole impact
4 wouldn't just be Petersham, but how would you
5 describe what the impact actually is. The
6 availability of jobs draws people to buy homes
7 in the community? I'm just looking for that
8 kind of connection.

9 MR. FLYNN: I think that if there's
10 available housing or new construction it will
11 draw people to buy homes, people who are
12 employed in the facility. Medical people, as a
13 rule, generally live close to their work. They
14 generally participate in the community, they
15 become active in the community. Not always
16 living in the town where their facility is, but
17 even close by. Frequently in the town where the
18 facility is. They make good citizens, they're
19 active in the community, they participate, they
20 take part in public events. Some of those
21 people may, in fact, locate here. I think the
22 problem is that you just don't have enough --
23 there's not an opportunity for people to locate
24 here because there's no place for them to live.

15

1 You have very limited housing here. Where would
2 they live?

3 THE CHAIR: Okay.

4 MR. FLYNN: Now, that may make
5 pressure for some more housing, but I don't
6 think you're going to end up with a hundred new
7 houses or anything like that.

8 THE CHAIR: Okay. Another question I
9 had was about the public safety calls associated
10 with the psychiatric hospitals, that's Table 6.
11 I was recalling your prior presentation where
12 you discussed that every call associated with a
13 particular address doesn't necessarily mean that
14 that is a one to one relationship. So there may
15 have been a call that was recorded as to your
16 address at home, but it had to do with an
17 accident in front of your house and it had
18 nothing to do with you.

19 My question is related, but just a
20 little bit different. Does this data show us
21 whether there were calls to the police or fire
22 department or any public safety officials
23 related to the hospital, but not going to the
24 hospital address. In other words, in the

16

1 neighborhood of the hospital.

2 MR. FLYNN: These are calls from the
3 facility versus at the facility. These are not
4 calls from the neighbor who said he has a
5 barking dog here or something else going on, or
6 whatever. These were calls -- what they were
7 requested to provide us was how many times were
8 you called to go to this facility. That's what
9 my understanding was of what you were looking
10 for.

11 THE CHAIR: Okay. Does it give us a
12 sense of the impact on the community outside of
13 the facility boundaries itself. Do you have any
14 sense of that? If not even from this particular
15 table of information, but just from your
16 conversations with officials in those towns, did
17 you get any sense of --

18 MR. FLYNN: Yeah. Again, other than
19 Brattleboro where I heard differently, I would
20 say that this is a pretty fair representation of
21 the level of calls that you would see at a
22 facility like this. In the community as well,
23 not just the facility. It's a limited amount of
24 impact on services and mainly on emergency

17

19

1 transport services.

2 THE CHAIR: Okay. So I should

3 understand that -- I guess I'm just kind of

4 trying to understand the weight of it because we

5 weren't clear about asking the police

6 department, for example, are you chasing after

7 runaways and somebody a mile down the road is

8 saying there's somebody in my back yard and they

9 don't belong there, can you come and

10 investigate. They go and investigate and they

11 determine that that person was a client of the

12 facility. Is that type of event occurring and

13 if it is occurring is it reflected in the

14 numbers?

15 MR. FLYNN: I think it is. I think

16 it's reflected in the numbers. The request was

17 that we're trying to understand the impact of

18 this facility on local public safety services,

19 police, fire, rescue. Can you look at your

20 records and identify how many times you had to

21 respond to an incident that was caused by the

22 fact of that facility being there, something

23 that was going on there. Then they went through

24 their records and came back and said, "This is

1 no.

2 THE CHAIR: Thanks. Any other

3 questions?

4 MR. EATON: No.

5 THE CHAIR: Paul.

6 MR. YOUD: Paul Youd, 16 Hardwick

7 Road. Just to follow-up with that, Maryanne. I

8 imagine that it would be Heywood's policy that

9 if somebody was missing at the facility they

10 would notify the local police.

11 MR. GRIMMER: Correct.

12 MR. FLICK: I would also add that

13 those issues are reflected because if you look

14 at Westwood Lodge, the only calls they had there

15 were for missing persons.

16 DR. BIALECKI: They were all found on

17 site.

18 MR. FLICK: Right.

19 DR. BIALECKI: But it is their

20 standard practice that the moment a staff

21 notifies administration that someone is missing

22 it automatically goes to the police.

23 THE CHAIR: Yes, we talked about that

24 at the prior meeting.

18

20

1 what we've seen. We do get calls, but they're

2 this type of call. Other than that we

3 essentially get no calls."

4 A couple of them were very positive

5 about the facilities without my prompting. In

6 the course of conversation and discussions I

7 said, "This is what we're looking at, impacts on

8 the community, impacts on the neighborhood,

9 impacts on the property values." They would

10 volunteer that they made very good neighbors.

11 Again, Brattleboro is the exception. They made

12 very good neighbors, they took very good care of

13 their property, they had no problems with them,

14 that they were good people and good citizens in

15 the community. That's without my even putting

16 that out there.

17 You know, sometimes when you do a

18 survey you say, Are they good citizens? I've

19 already prompted you with the answer. So when

20 we do surveys you don't say, Are they good

21 citizens. How would you characterize them?

22 What's it like having them there? People were

23 volunteering the answers. We weren't saying,

24 Are they good citizens or bad citizens, yes or

1 MR. YOUD: That doesn't mean that the

2 police have to go out and look. You're doing

3 that to notify the community of that. You

4 wouldn't be asking the Petersham Police then to

5 go out and look for that person.

6 DR. BIALECKI: Right.

7 MR. FLICK: That person would be

8 looked for on site by clinical staff, support

9 staff and security. If that person was not

10 found on site, the police would absolutely be

11 alerted.

12 MR. YOUD: Right, but not to scour

13 the neighborhood.

14 MR. FLICK: No.

15 THE CHAIR: Any other questions?

16 Okay.

17 MR. MacEWEN: Actually, the medical

18 transport issue being the higher number of calls

19 generated by the inquiry here, can you just

20 refresh my memory on how all that is going to be

21 handled by Heywood within the facility.

22 MR. FLICK: Private contracts.

23 Heywood has contracts with ambulance providers

24 to do transports to tertiary care centers like

21

1 UMass. It's all done through those private
 2 contracts.
 3 MR. MacEWEN: Kevin, in your review
 4 of this, these calls for medical transport, they
 5 were providing medical transport or -- I guess I
 6 don't quite understand the situation.
 7 MR. FLYNN: These are instances where
 8 they were requesting medical transport of the
 9 community services.
 10 MR. MacEWEN: Okay.
 11 MR. FLYNN: But in this case you
 12 don't provide that. It's basically a non issue,
 13 but it was a question that people were curious
 14 about so we solicited the information while we
 15 were getting other information as well. It was
 16 interesting in the end because it showed us that
 17 that's the nature of the calls.
 18 MR. MacEWEN: Most of them are going
 19 to be that.
 20 MR. FLYNN: Right, but that's done
 21 privately.
 22 MR. GRIMMER: Mike Grimmer from
 23 Heywood Healthcare. Just to clarify, if we were
 24 located in Athol, the Athol Fire Department has

22

1 their own transport. If we were in Orange, the
 2 Orange Fire Department has their own ambulance
 3 service. If you're in that area code there is
 4 a -- that's actually a revenue generator for the
 5 town. We have an agreement with the ambulance
 6 services in the town so if that patient comes
 7 from that town we try to make sure they get the
 8 business because it generates revenue for the
 9 town. If the patient is from Athol, we'll
 10 typically call the Athol Fire Department for
 11 them to come and do the transport. Other than
 12 that we have either Woods Ambulance or MedStar
 13 ambulance, two private companies.
 14 MR. MacEWEN: Right, I'm seeing that
 15 here.
 16 MR. FLICK: It's also statutory. Is
 17 the Police Chief here? Does Petersham have a
 18 service zone plan?
 19 POLICE CHIEF COOLEY: We have Athol
 20 Fire. It's up to them. If they can't provide
 21 the service they have to call another ambulance
 22 for us.
 23 THE CHAIR: I'm sorry. For the
 24 benefit of the record, Chief, can you identify

23

1 yourself?
 2 POLICE CHIEF COOLEY: Dana Cooley,
 3 146 South Street.
 4 THE CHAIR: Thank you.
 5 MR. FLICK: Under Mass. General Laws
 6 Chapter 111-C which governs what's called the
 7 service zone, when a service zone plan is in
 8 place and if there is a medical emergency and a
 9 private ambulance service is called, if that
 10 private ambulance service is not the primary
 11 service zone provider for EMS, they're required
 12 by law to transfer the call to the 911 system.
 13 Heywood would become part of that service zone
 14 plan because all medical facilities have to be
 15 part of that service zone plan and it would
 16 allow Heywood then to have contracts with
 17 private transportation for its patients.
 18 They're to be tied into that service zone plan
 19 and 911 process. That's statutory, you can't
 20 get away from that when it's in the service zone
 21 plan. There's other regulatory authorities at
 22 play.
 23 THE CHAIR: Ross.
 24 MR. FRANCE: Ross France, 190

24

1 Hardwick Road. When it comes to ambulance
 2 calls, I'd like to know what the applicant's
 3 expectations are of the town today, the fire
 4 department or the police department's role when
 5 an ambulance is called to a destination. Is it
 6 the expectation of the applicant that we
 7 discriminate and not send the fire and police
 8 with an ambulance call?
 9 MR. FLICK: That would actually be
 10 governed by your service zone plan. If your
 11 service zone plan dictates that police and fire
 12 are called on a 911 emergency medical call then
 13 they have to go under 111-C. Again, that's
 14 something that's not within the applicant's
 15 control.
 16 MR. FRANCE: So if we're under that
 17 plan then there would be an impact on the town.
 18 MR. FLICK: Possibly. If there was
 19 to be an amendment to that plan to alter that it
 20 would have to go up through the State regulatory
 21 authorities for approval. So we start with
 22 Central Mass EMS and then up to the EPA for
 23 final approval. Again, it's only if it's a 911
 24 call.

25

1 MR. FRANCE: Okay.

2 MR. FLICK: If the medical

3 professionals at Heywood at that facility

4 determined that we need to transport this

5 patient for more acute medical care like they do

6 everyday at Heywood Hospital, that is not a 911

7 call. That is a private medical transport call.

8 A 911 call would be if we had an employee fall

9 down the stairs and they're unconscious at the

10 bottom of the stairwell, that's a 911 call.

11 It's different when it's 911 versus a medically

12 determined transport.

13 MR. FRANCE: So I would ask our

14 consultant whether there's any differentiation

15 between the calls that are logged, are these 911

16 calls?

17 MR. FLYNN: These are medical

18 transport calls, routine medical transport

19 calls.

20 MR. FRANCE: So they're not 911?

21 MR. FLYNN: No.

22 MR. FRANCE: Thank you.

23 THE CHAIR: Ross, let me ask you

24 this. Can you explain what the Town's current

26

1 policy is? You seem to have an understanding

2 that when there's a 911 call that we assign a

3 police officer, too.

4 POLICE CHIEF COOLEY: Dana Cooley,

5 146 South Street. Yes, if there's a 911 call

6 and the ambulance is going, our automatic

7 response is that we go. We go to all ambulance

8 calls because they're usually so far out and we

9 can be there quicker than the ambulance. We can

10 provide first responder service to that resident

11 or facility, wherever we go, until the ambulance

12 gets there and takes over the extended care.

13 THE CHAIR: By we, do you mean the

14 police department, the fire department?

15 POLICE CHIEF COOLEY: We both go.

16 Usually the police go out first and then the

17 fire right behind us.

18 THE CHAIR: So both.

19 POLICE CHIEF COOLEY: Right.

20 Sometimes you might only get one officer. If

21 you get something like a cardiac arrest,

22 something serious, you want personnel going out

23 there. Unfortunately, if you call the fire

24 department you're going to get everybody because

27

1 it's one telephone for everybody. You could get

2 anywhere from one to 15 fire fighters.

3 THE CHAIR: Thank you. Paul.

4 MR. YOUD: Paul Youd, 16 Hardwick

5 Road. Just to follow-up on that. I don't know

6 whether it's the -- does Heywood know, from

7 their mental health unit in Gardner right now,

8 approximately how many 911 calls are made during

9 the year?

10 DR. BIALECKI: There were two calls

11 for assistance, but they weren't 911 calls.

12 MR. YOUD: So there weren't any.

13 There were zero 911 calls.

14 DR. BIALECKI: Right.

15 MR. YOUD: So the two for assistance

16 at that unit, was that for transport or what was

17 that?

18 DR. BIALECKI: No, those were a

19 specific request for police assistance with

20 clients who were barely assaulted. That's my

21 best description of the characterization of

22 that. Those were both day shifts. Those are

23 the ones that Win had referred to previously.

24 THE CHAIR: Mark.

28

1 MR. BISHOP: Mark Bishop, 20 south

2 Main Street. Just a couple of quick questions.

3 I don't have the tables in front of me, but how

4 many jobs do you understand are being created at

5 this facility?

6 MR. FLYNN: Heywood has said about

7 143 jobs, which about 90 percent are new jobs.

8 MR. BISHOP: And there are 88 beds?

9 MR. FLYNN: 86.

10 MR. BISHOP: Okay. So somewhere

11 around order of 1.7 employees per patient. How

12 many millions of dollars was that going to

13 create?

14 MR. FLYNN: About \$6.4, about \$6.5

15 million net payroll.

16 MR. BISHOP: What is the total number

17 of million dollars for the spin-off jobs coming

18 from that?

19 MR. FLYNN: About \$4.6 million.

20 MR. BISHOP: Do you think one of

21 those would be a police officer, an extra one

22 for the community.

23 MR. FLYNN: That's up to the

24 community to decide.

1 THE CHAIR: The table itself doesn't
 2 refer to any police officers. Okay. Let me ask
 3 you another question, I did have one more on the
 4 property value section of the report. We
 5 earlier received from the applicant an
 6 Exhibit 14 which had to do with real estate
 7 valuations. It had to do with a study that was
 8 done in the City of Philadelphia several decades
 9 ago. In your report you mentioned that there
 10 are studies on property values. I was wondering
 11 about -- but we don't have the citations to
 12 those.

13 MR. FLYNN: I can give you a list.
 14 There are literally dozens of studies.

15 THE CHAIR: Could you just give us a
 16 couple as to what you think are the most
 17 representative of the conclusion that you draw
 18 in the report.

19 MR. FLYNN: Sure. I don't have that
 20 information with me tonight, but I can add that.
 21 I can't site a study this evening, but I can
 22 tell you that there are dozens of studies about
 23 the impact of treatment facilities and other
 24 similar kinds of projects. The result is pretty

1 much the same across the board, that the studies
 2 show that it doesn't affect values up or down,
 3 it doesn't cause properties to stay on the
 4 market longer because they're nearby than if
 5 they would if they were further away. You don't
 6 see a difference across towns. The property
 7 next to the facility doesn't sell as quickly as
 8 the property farther away. All the things that
 9 we think might possibly happen have been tested
 10 and they don't come out that way.

11 Interestingly, when I mentioned
 12 earlier about officials volunteering things, I
 13 talked to assessors and they volunteered very
 14 enthusiastically before I could even finish a
 15 question. People are concerned that there might
 16 be an impact on their property. No impact, it
 17 had no impact at all. Everybody always thinks
 18 that's going to happen. No, it doesn't make a
 19 difference. They cut me off before I could even
 20 finish the question because they knew where I
 21 was going. It didn't happen once, it happened
 22 several times.

23 The folks who evaluate property for
 24 us, municipal employees who are setting the tax,

1 calculating it, are telling us that there's no
 2 impact on property values from having the
 3 facility there. What makes a difference is
 4 whether or not the person takes good care of
 5 their property. It doesn't matter whether it's
 6 a hospital, a treatment center, a gas station or
 7 a convenient store, it only matters how well
 8 people manage their property. Again, a couple
 9 of them commented that hospital facilities and
 10 treatment facilities generally take very good
 11 care of their property.

12 THE COURT: So when the study shows
 13 that there's no impact, that's no impact in a
 14 positive or negative way.

15 MR. FLYNN: Right. It really makes
 16 no difference.

17 THE CHAIR: Okay. Thank you. Any
 18 other questions. Paul.

19 MR. YOUD: Paul Youd. Just for a
 20 point of clarification. In Kevin's report when
 21 he was talking about the licensing he said that
 22 Heywood was also seeking a Class 7 license and
 23 they subsequently withdrew that.

24 MR. FLYNN: That was in an earlier

1 slide presentation. That is not a license that
 2 this facility will be seeking.

3 THE CHAIR: That's Page 4 of the
 4 report.

5 MR. FLYNN: Right.

6 THE CHAIR: Wait a minute, Page 4
 7 lists the type of licenses. I don't know that
 8 that necessarily says those are the ones that
 9 the applicant said they were going to apply for.

10 MR. FLYNN: No, that's just a listing
 11 of licenses.

12 THE CHAIR: Right.

13 MR. FLICK: There was at one point
 14 that that license was a possibility, but that
 15 license will not be part of the application
 16 process.

17 THE CHAIR: It's actually Page 5, the
 18 third paragraph. It says, "Heywood will offer
 19 both inpatient, outpatient and residential
 20 treatment..." and it continues. Its listing
 21 Class 7. We should cross that out, right?

22 MR. FLICK: It will be reflected in
 23 the record that the applicant has stated that it
 24 will not be seeking a Class 7 license.

1 THE CHAIR: Thank you, Paul, for
 2 picking that up. Eagle eye.
 3 Kevin has another meeting tonight so
 4 I wanted to call him first and let him go.
 5 Thank you, Kevin, for coming in.
 6 MR. FLYNN: Thank you. Will you want
 7 me to attend your next meeting if there is a
 8 next meeting?
 9 THE CHAIR: I guess that's a little
 10 hard to say at this stage. Possibly is the best
 11 I can do at the moment.
 12 MR. FLYNN: Okay, just let me know.
 13 THE CHAIR: I will definitely let you
 14 know. You're willing to come?
 15 MR. FLYNN: One more time.
 16 THE CHAIR: Okay, good to know.
 17 Thank you.
 18 MR. FLYNN: Thank you.
 19 THE CHAIR: I'd like to move the
 20 report we've just been discussing, the final
 21 report, into the record as Hearing Exhibit 26,
 22 unless there's any objection. Hearing no
 23 objection, it will be Number 26.
 24 (Document Marked.)

1 statements heading into what we hope will be the
 2 decision phase after tonight. We can save that
 3 till the end if you want to ask some other
 4 questions. That's perfectly fine.
 5 THE CHAIR: Okay. One question I had
 6 was about medical marijuana. Do you anticipate
 7 the use of medical marijuana at this site?
 8 DR. BIALECKI: No, we do not.
 9 THE CHAIR: Why wouldn't you?
 10 DR. BIALECKI: Because it's not part
 11 of our treatment options available currently.
 12 We don't know what that's going to look like
 13 when it is finally regulated and available. We
 14 have no idea at this point. So right now at
 15 this moment in time, no.
 16 THE CHAIR: I guess the current
 17 status of that is that it's approved. There was
 18 some level of referendum by citizens on an
 19 initiative petition that was voted on and
 20 approved, but there's regulations to implement
 21 and those regulations are in some form, but
 22 apparently they are not yet in a final form; is
 23 that correct?
 24 DR. BIALECKI: Right. DPH has not

1 THE CHAIR: The Board received a
 2 written comment today from a resident of town,
 3 Ellen Anderson of 20 Dana Road. The Board
 4 members have received copies. I gave a copy to
 5 the applicant. Basically, it's a letter that is
 6 expressing -- I would say it fairly
 7 characterizes her opposition to the project for
 8 the reasons stated in the letter. It's too long
 9 for me to read here, but it's available for
 10 anybody to read it. I'd like to move that in as
 11 Hearing Exhibit 27, unless there's any objection
 12 to that.
 13 MR. FLICK: Other than some
 14 objections to the facts stated in the letter
 15 itself, no objections to it.
 16 THE CHAIR: So noted.
 17 (Document Marked.)
 18 THE CHAIR: I have some extra copies
 19 of the letter here if anybody wants one.
 20 John, I had a couple of questions. I
 21 don't know if you had anything else you wanted
 22 to present?
 23 MR. FLICK: We just have a very brief
 24 presentation, it's more of just a summary and

1 completed their work and the regulations about
 2 how that is going to come to market and what the
 3 final specifications are for distribution by way
 4 of physician.
 5 THE CHAIR: Is medical marijuana a
 6 substance that is used to help the type of
 7 clientele that you would be servicing?
 8 DR. BIALECKI: Not currently. It's
 9 extremely contraindicated for substance abuse
 10 treatment, as would several other prescription
 11 drug treatments. For the chronically mentally
 12 ill, or mental illness as a whole, it's not
 13 generally one of the recommended best practices
 14 for treatment. There are, I understand, some
 15 kinds of other long-term illnesses that would
 16 not be patients at our site in Petersham that
 17 that treatment might help, glaucoma, cancer
 18 patients, chronic pain management. The patient
 19 population that we perceive having at this
 20 facility will not be well served by that
 21 treatment.
 22 THE CHAIR: Another question I had is
 23 relative to who is in charge of the facility
 24 when it's up and running at full capacity. Not

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1 a specific individual, but what is the position
 2 that a person would hold that would be in charge
 3 there.
 4 DR. BIALECKI: Right now there is a
 5 plan to hire a medical director who would
 6 oversee that facility from a clinical standpoint
 7 overall. Right now the plan is for myself to be
 8 the administrator who would probably be on site.
 9 THE CHAIR: Would the medical
 10 director be on site?
 11 DR. BIALECKI: Yes.
 12 THE CHAIR: And the administrator
 13 would be on site.
 14 DR. BIALECKI: Yes.
 15 THE CHAIR: In the report that we
 16 just received from Kevin, your employment
 17 numbers, that's Table 4, where are those
 18 positions captured?
 19 DR. BIALECKI: My position is not
 20 included in there. The e-mail that I sent with
 21 those figures that I submitted to Kevin also
 22 included the piece at the bottom which included
 23 the psychiatry and the medical staff who are not
 24 necessarily employees of only that site, but

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1 those figures were on there. They are not in
 2 his chart. They would be in addition to that.
 3 THE CHAIR: So the medical director
 4 and the administrator will be on site, but they
 5 are not reflected in Table 4?
 6 DR. BIALECKI: Right.
 7 THE CHAIR: Are they on site for the
 8 balance if their regular workday or are they
 9 like on site occasionally as they tour other
 10 sites?
 11 DR. BIALECKI: That would be their
 12 primary work site.
 13 THE CHAIR: How come they were not
 14 provided to Kevin for this.
 15 DR. BIALECKI: Because those kinds of
 16 positions are charged off across the whole
 17 healthcare system. They are not charged to the
 18 individual facility. Right now I'm cited at
 19 Athol, but my salary is actually charged to
 20 administration which actually sits in Gardner.
 21 Michael's salary works the same way. That's the
 22 only reason they weren't included in that table.
 23 MR. FLICK: I guess another way to
 24 put it is, at least from an accounting

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1 standpoint, these are employment positions that
 2 would be specifically on the books for this
 3 facility versus on the books for an
 4 administrative position that arches over the
 5 whole system. Heywood Healthcare is a system
 6 that consists of Heywood Hospital and Athol
 7 Hospital and the Petersham Quabbin Retreat would
 8 be part of the system. So you have
 9 administrative which is an umbrella over the
 10 system that's chargeable to the system itself
 11 and then you have positions that are chargeable
 12 to that specific facility.
 13 THE CHAIR: Off the top of my head
 14 I'm not remembering what the slide was or what
 15 the exhibit was relative to traffic counts.
 16 When you provided the traffic counts, did you
 17 provide traffic counts relative to --
 18 DR. BIALECKI: We did include
 19 administration.
 20 THE CHAIR: You did include
 21 administration. So you concluded that --
 22 DR. BIALECKI: I think the number for
 23 the traffic count total was 165 as opposed to
 24 the 133.

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1 THE CHAIR: That would explain what
 2 the difference would be as you were just
 3 describing about the accounting and where the
 4 job is relative to the accounting?
 5 DR. BIALECKI: Correct.
 6 THE CHAIR: Would the facility have a
 7 telephone, like a coin or a card telephone?
 8 DR. BIALECKI: I don't know if those
 9 exist at this point in time.
 10 MR. GRIMMER: We don't have one in
 11 Athol, we don't have one in Heywood.
 12 MR. FLICK: I don't even know if you
 13 can get those through the phone company.
 14 MR. GRIMMER: They're not putting
 15 them out any more.
 16 DR. BIALECKI: We have the ability to
 17 provide patient access to telephones, but not a
 18 public pay phone, I guess.
 19 THE CHAIR: Okay. Can you explain
 20 the difference for me. Like what do you have to
 21 provide patients with access to a telephone.
 22 It's not a public telephone so it's not for
 23 visitors or others.
 24 DR. BIALECKI: Currently on site at

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1 Athol and Heywood there are phones in all of the
2 offices, there are phones in the lobbies so that
3 if someone needed to call for a ride back from
4 an appointment they have access to a phone
5 there, a local phone call. The patients in a
6 unit may or may not have access to a telephone,
7 depending on what their individual needs are and
8 what their restrictions and limitations are. A
9 locked inpatient unit probably would not include
10 telephones in each room, but there would be the
11 ability for a weekly phone call to their family
12 in a supervised setting with their case manager
13 or therapist.

14 THE CHAIR: Any other questions?
15 Okay. Any other questions from anyone? Okay.
16 Why don't you make your presentation.

17 MR. FLICK: Before I get into that,
18 do you want any response from the applicant to
19 the letter that was submitted, Exhibit 27.

20 MR. MacEWEN: I'd like to hear what
21 you have to say.

22 MR. FLICK: Okay. A couple of
23 comments on this. I'll try to go down and
24 categorize it. In Paragraph 2 where the

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1 individual comments about, "In my experience,
2 hospital-like institutions are generally located
3 in an institutional setting with supportive
4 services such as 1) public water 2) public sewer
5 3) public transportation 4) shops, restaurants
6 and such amenities." In the next paragraph down
7 it states that these do not exist here.

8 One, those types of urban amenities
9 are not necessary. There is no public
10 transportation that's necessary. We have
11 transportation through a public transportation
12 provider, but for all intents and purposes we
13 can call it private transportation dedicated to
14 this site. That's already in the works.

15 The water, the septic, the site has
16 been determined to be adequate and those designs
17 and those plans are being worked out with D.E.P.
18 So those really are non issues.

19 I want to correct some factual
20 statements in here. It says, "The Heywood
21 Hospital has chosen this site primarily because
22 they have been offered \$1 million to do so."
23 That is not true. This site was chosen prior to
24 that appropriation being made. This site was

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1 deemed to be an appropriate site regardless of
2 that \$1 million being put in the state budget.
3 That \$1 million is a help, but it is not going
4 to necessarily mean if that money gets cut from
5 the budget, which it just might, we're still
6 here. We're still moving forward. It's not
7 dependent on the \$1 million.

8 As far as the public support and
9 public dollars in comparison to the state
10 hospitals that have been shut down over the
11 years, this is not a state-run facility. This
12 is not like the Worcester Recovery Center. This
13 is a privately operated, privately funded
14 through insurance dollars facility that will not
15 be subject to the whims of the state budgetary
16 process. There may be grants applied for in the
17 future that will be state grants, absolutely,
18 but the funding is not dependent, the operation
19 is not going to be dependent on the state budget
20 and the comings and goings of political dollars.

21 There's a lot of misunderstanding
22 within this letter. Recognizing the concerns,
23 but it is a misunderstanding.

24 As far as any future issues that may

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1 come within the world of healthcare, behavioral
2 health will always be there. It always has been
3 there. What we are reaping right now is the
4 benefit of a failed system that the state tried
5 to operate decades ago. Now we're sitting here
6 reaping the benefits of it with a lot of people
7 who have nowhere to go. I've seen it very
8 recently where people are left in limbo. They
9 literally have no place to go and who are in
10 dire need of treatment. The state is basically
11 throwing up their hands saying it's not our
12 problem.

13 This facility is not going to be a
14 fly by night. It's not going to be here today
15 and gone 10 years, 20 years, 30 years from now.
16 Our hope is that this is going to be a long term
17 institution that will benefit people who are
18 really in need of help.

19 Yes, things may change. It would be
20 wonderful to have a day and age where opiate
21 recovery is no longer necessary, but behavioral
22 health will still be there. There will still be
23 people who need behavioral health. The fear and
24 the concern that one day this will be an empty

1 institution that will just be sitting there
 2 rotting, I don't necessarily see that.
 3 Furthermore, and I actually put this
 4 in the summary slide, Heywood is putting in
 5 close to \$11 million in construction investment
 6 into modernizing this facility and bringing it
 7 up to code both from a structural standpoint and
 8 a technological standpoint. This facility will
 9 be set to serve multiple purposes for many, many
 10 years going forward.

11 Even if they were to decide to sell
 12 it, it's an institution, it would be a facility
 13 that could easily be transformed into something
 14 else because of the work that's going to be
 15 done. I don't see that being an issue because
 16 of the acute need and long-term need for
 17 behavioral health. That's more or less my
 18 response. I don't know if Mike has anything to
 19 add.

20 MR. GRIMMER: Just one comment. The
 21 fact that we're here today is reflective of the
 22 organization's commitment to addressing
 23 community needs. We said this in conversation
 24 the other day, this is not a money making

1 community that needs to be addressed and we're
 2 committed to doing.

3 THE CHAIR: Let me get a point of
 4 clarification. John, you're a member of the
 5 Board of Directors, right, for Heywood?

6 MR. FLICK: Yes.

7 THE CHAIR: So when you're here
 8 speaking, are you speaking in the capacity as a
 9 member of the Board or as counsel?

10 MR. FLICK: I'm speaking as legal
 11 counsel. The Board is well aware of their
 12 votes, there's been approval to allow me to
 13 represent Heywood so we've already addressed all
 14 of that. I'm functioning not as a member of the
 15 Board, but as their legal counsel.

16 THE CHAIR: Okay. In your remarks a
 17 moment ago you mentioned that it's been
 18 determined that the water is adequate, the
 19 D.E.P. --

20 MR. FLICK: Well, it's the DEP that
 21 does --

22 THE CHAIR: Have there been any new
 23 developments since the meeting by the engineers?

24 MR. FLICK: No, because the same

1 proposition. Heywood Healthcare has been
 2 committed to behavioral health for many, many
 3 years. Many other institutions in the state,
 4 most frankly, walked away from it because it was
 5 not a money making institution. Behavioral
 6 health is a need. We are a community healthcare
 7 organization that's committed to addressing that
 8 need. It's not about making phone. It's about
 9 addressing the needs in the community and in the
 10 region. That is what we're doing here.

11 We understand that the political
 12 climate is coming around a little bit to taking
 13 behavioral health needs and to bring it a little
 14 more front and center. Because we remained
 15 committed to that need for the last fifty plus
 16 years, we happen to be in a position to be ahead
 17 of that curve and in a place to take advantage
 18 of whatever resources can help us. This is
 19 about addressing a community need. It's not
 20 about making money. We dropped one of our -- we
 21 call it our traditional care center, our Board
 22 agreed to do that because we need to take those
 23 dollars and put it into behavioral health. It's
 24 a lost leader for us, but it's a need in the

1 issue stands. They won't let us go on and do
 2 more definitive testing until we have site
 3 control. Basically, we need to have ownership.

4 THE CHAIR: Relative to the letter,
 5 Hearing Exhibit 27, one of the suggestions in it
 6 was that if the Board were to grant a special
 7 permit application that it consider basically
 8 like a demolition bond. I know that's something
 9 that we've done where other structures are
 10 involved, like the cell tower that got approved,
 11 there was a bond that would allow for it's
 12 removal in the event it became abandoned. You
 13 may have actually responded to that indirectly
 14 by saying that you don't think it's necessary.
 15 Let me not be left wondering. What do you think
 16 of the idea of a potential condition being a
 17 provision for demolition in the event that that
 18 was abandoned.

19 MR. FLICK: One, a demolition bond,
 20 typically you would put a demolition bond on a
 21 facility that had a specific definitive
 22 lifespan. A solar farm where the lifespan is
 23 typically only 20 to 25 years and that's being
 24 placed on municipal property through a lease

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1 agreement. You would have a de-installation or
2 a bond for demolition to be installed, a
3 decommission of the facility in the event that
4 the property owner didn't do that.

5 I have never heard of a demolition
6 bond on a construction project where you are
7 building -- basically, in this case there's not
8 a building of a facility, there's a
9 rehabilitation of an existing lighted facility
10 that has no defined life limit. It's not like
11 in ten years it's going to use up its purpose or
12 in 15 years it's going to use up its purpose.

13 For a property that may be around for hundreds
14 of years, a demolition performance bond, I don't
15 even know that you can buy one in the market.

16 THE CHAIR: I think where this is
17 coming from is something very specific to
18 Petersham which is the Nichewaugh Inn situation
19 that we have.

20 MR. FLYNN: And every community has
21 them. I can name you tons of those in the City
22 of Gardner that we have. You're never going to
23 get an insurance company or a bonding company to
24 write a bond on something like that. When are

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1 you going to have to demolish it? Whenever it
2 stops being used. When is that gong to happen?
3 We don't know, 100, 200 years from now. You're
4 never going to be able to get a bond on that.
5 Quite frankly, it's an impossibility.

6 THE CHAIR: Okay. Why don't you
7 continue. I do have one more question on
8 another topic which has to do with the pilot.

9 MR. FLICK: Ask away.

10 THE CHAIR: Just the status of the
11 pilot meeting.

12 MR. FLICK: There was a very good
13 meeting on the 5th of February. We have another
14 meeting scheduled for Thursday the 26th. It's
15 our expectation and the discussion at the last
16 meeting was that at that meeting we'll be able
17 to put a final document together for
18 recommendation for the Board of Selectmen
19 meeting which is the following Monday. The
20 recommendation, and one of the Board of
21 Selectmen was there, was that they put a review
22 of the pilot on their agenda for the first
23 meeting in March. We anticipate that those
24 pilots will be done for that meeting.

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1 THE CHAIR: So the Tax Exempt
2 Committee hasn't formed a recommendation yet; is
3 that right?

4 MR. FLICK: The hope is that that
5 recommendation will be done at the next meeting.
6 There are a few terms that we came to some
7 agreement on, some revised language and there
8 are a few other terms that we'll be discussing
9 at the next meeting, but we're very close to
10 having that.

11 THE CHAIR: That would be the
12 February 26th meeting with the Tax Exempt
13 Committee for it deliberating and making its
14 recommendation to the Board of Selectmen and any
15 decision of the Board of Selectmen would then
16 take up the matter at a meeting in March, it's
17 first meeting?

18 MR. FLICK: The first meeting in
19 March.

20 MR. NILSON: Weather permitting.

21 THE CHAIR: And who made that comment
22 for the record? That's Roy Nilson. Okay.

23 MR. FLICK: Just very briefly. As a
24 recap, Heywood Healthcare, through its affiliate

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1 Heywood Realty Corporation, is under contract to
2 acquire a large 21-acre parcel of land known as
3 the Sisters of the Assumption property.

4 We are going to reestablish the
5 property as an 86-bed behavioral health and
6 addiction recovery center to provide mental
7 health diagnosis and treatment on an inpatient,
8 partial inpatient and outpatient basis.

9 The primary use is as a sanitorium or
10 hospital. The secondary use, offices of a
11 doctor. Multiple uses under Section 5.C of the
12 Zoning Board of Appeals or the Zoning Bylaws of
13 the Town of Petersham.

14 Whether or not the Dover amendment
15 limitations apply to this, it's our position
16 that they do. Rehabilitation surely falls under
17 the meaning of education. As an educational
18 facility the facility will prepare its residents
19 to live by themselves outside the institutional
20 setting. The facility's residents will receive
21 instruction in the activities of daily living.
22 They will develop an understanding of how to
23 cope with everyday problems and to maintain
24 oneself in society.

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1 88 percent of this facility will be
2 dedicated to rehabilitating persons with
3 behavioral disorders. The dominant purpose of
4 the Quabbin retreat can reasonably be described
5 as educationally significant.

1 for discussion, seek to close the hearing
2 process and move into the decision phase.

6 Therefore, it is our position under
7 the Dover amendment the Town's regulatory
8 authority under the zoning bylaws is to
9 institute reasonable regulations concerning the
10 bulk and height of structures, which there will
11 be no change to any of that. Determining yard
12 sizes, lot area, setbacks, open space, parking
13 and building coverage requirements.

3 THE CHAIR: Do you have a copy of
4 that?

14 What are the benefits to the
15 Community of the facility? It will meet a
16 significant need for behavioral health and
17 addiction recovery in the North Worcester County
18 and North Quabbin areas.

5 MR. FLICK: Yes. One other piece
6 that I would also offer is that if the Board
7 were to vote to approve a special permit subject
8 to any special conditions, that in the
9 discussion of those special conditions that
10 Heywood be invited to participate in the
11 discussion of those special conditions,
12 particularly because this is a very heavily
13 regulated entity.

19 The presence of a long-standing, well
20 respected institution as a source of employment
21 and healthcare in the Town of Petersham.

14 To the extent that any proposed
15 special conditions would conflict with any of
16 the other regulatory authorities that Heywood
17 has to report to, it would be much easier to
18 deal with those issues in a dialog setting as
19 opposed to passing a special permit, putting
20 those conditions on and then forcing us to have
21 to appeal to the court system in order to
22 facilitate discussions.

22 More than \$6 million in annual
23 employment investment once the facility is 100
24 percent operational.

23 I've had that happen too many times
24 on the municipal side when I get a call from an

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1 Approximately \$11 million in
2 construction investment. Renovation of ageing,
3 blighted facility to modern construction and
4 technical standards. The installation of a fire
5 suppression system in the building which
6 currently contain none. Modernized electrical
7 and plumbing systems within the building.

1 applicant saying your Zoning Board of Appeals
2 just put a whole bunch of conditions that
3 conflict with our regulatory authorities. Now
4 we have to appeal to the Board. Can we discuss
5 a settlement. It's oftentimes more fruitful for
6 both the municipality and for the applicant to
7 discuss those special conditions and come to
8 terms on special conditions that work for the
9 benefit of both the town and the applicant.

8 Other community investment will be
9 through education, local programing and health
10 services, basically through community investment
11 dollars that Heywood is required to spend on an
12 annual basis. Increased foot traffic and use of
13 local businesses including The Petersham Country
14 Store and local inns.

10 With that said, we would respectfully
11 request that if there were discussions on
12 special conditions that we would be invited to
13 those discussions, to participate in those
14 discussions as the Zoning Board saw fit and move
15 forward.

15 Other community impact. As we heard
16 tonight there will be little or no impact on
17 public safety. There will be no use of other
18 municipal services such as DPW, water, sewer,
19 schools, etc. The negative impacts are
20 negligible versus the positive impacts which are
21 significant.

16 THE CHAIR: Procedurally, how would
17 you see that happening?

22 With that we end our presentation and
23 respectfully request that the Zoning Board of
24 Appeals, unless there are any substantive issues

18 MR. FLICK: Once you move out of the
19 public hearing phase and into the decision
20 phase, it's still done in open meeting. The
21 Board, when it's in open meeting outside of the
22 public hearing phase, the Board can invite the
23 applicant to present or to discuss. As long as
24 it's done in open meeting there's no issue. It

1 wouldn't be behind the scenes, e-mailing back
2 and forth. It would be done in open meeting.

3 THE CHAIR: Okay, so during the
4 deliberation.

5 MR. FLICK: Correct.

6 THE CHAIR: I'd like to move this
7 presentation into the record as hearing
8 Exhibit 28, unless there's any objection.
9 Okay.

10 (Document Marked.)

11 THE CHAIR: I had a question on one
12 of the pages. The page where it talks about
13 benefits to the community. It's the second to
14 the last bullet, "Other community investment
15 through education, local programming, provision
16 of health services, etc." Could you clarify
17 what you mean by that.

18 MR. FLICK: Heywood Hospital, Athol
19 Hospital, they're required to use what are
20 called community investment dollars back into
21 the community. Heywood right now has programs
22 with Gardner Public Schools, Athol Public
23 Schools, all through the community investment
24 dollars. These are monies that Heywood owns

1 that we're required to spend back into the
2 community. Because we would have the facility
3 here in Petersham that would necessarily put
4 Petersham within that target of investment
5 dollars to be spent. As well as being a
6 facility in this town for people who lived here
7 and who needed those services, that facility is
8 here. That's why we say the provision of health
9 services is local.

10 DR. BIALECKI: Rebecca Bialecki from
11 Heywood. We've also had conversations with the
12 Chief of Police about going into the schools and
13 doing some parent education and some prevention
14 work in partnership with the police department
15 as well.

16 THE CHAIR: Prevention work?

17 DR. BIALECKI: With young people and
18 their parents.

19 THE CHAIR: Prevention of?

20 DR. BIALECKI: Substance abuse.

21 THE CHAIR: Chief, I see you nodding
22 your head.

23 POLICE CHIEF COOLEY: Yes, we have
24 had conversations.

1 MR. GRIMMER: Mike Grimmer, Heywood
2 Hospital. Again, getting back, we identify
3 needs in the community. As a Community
4 Healthcare partner we will help communities
5 address those needs whether it be obesity,
6 diabetes, cardiac issues. We have food programs
7 for children, we have activities that we sponsor
8 for children in schools, so we have behavioral
9 programs. With our needs in the community
10 related to health we become a partner in health.

11 THE CHAIR: Relative to the need
12 within the Town of Petersham as opposed to the
13 larger region, in the earlier presentation there
14 were no Petersham numbers showing a need. I
15 think there was some suggestion that that's
16 because Petersham was too small. I think
17 Wendell was listed among that group and Wendell
18 is just as small if not even smaller.

19 DR. BIALECKI: It depends on the
20 number of patients who have been identified for
21 treatment. The Department of Public Health
22 counts all the admissions to treatment centers
23 for substance abuse, for example, or for mental
24 health separately. If the number in Petersham

1 was one they wouldn't tell you it was one
2 because that would be in itself self
3 identifying. If a town the size of Wendell had
4 three or four it would be a little tougher to
5 figure out from that town's population who those
6 might be.

7 THE CHAIR: On the same page relative
8 to the information that's come into the Board
9 through the exhibits or through the testimony,
10 on the second bullet you say, "The presence of a
11 long-standing, well respected institution as a
12 source of employment and healthcare in the Town
13 of Petersham." What would you say is the
14 evidence that we have that the applicant is a
15 long-standing, well-respected institution?

16 MR. FLICK: Well --

17 THE CHAIR: And please don't take
18 offense at that. Consider it from the point of
19 view of when the Board writes its opinion it
20 cites to the evidence that it has before it and
21 not our personal opinion. If you just think
22 it's generally known, that's fine if that's your
23 answer.

24 I know that between the last meeting

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1 and this meeting I asked you to bring in
 2 evidence that Heywood Healthcare is in good
 3 standing on all of its licenses relative to the
 4 type of treatment. You opted not to do that.
 5 We heard from Kevin that management is a
 6 critical issue in terms of how well these things
 7 actually operate in a town. I think it's a fair
 8 question. Obviously you feel quite confident
 9 and I'm glad that you feel quite confident.
 10 It's also consistent with things that I've heard
 11 outside of the meeting that you're very well
 12 respected. I just feel that it's a fair
 13 question for me to ask at this point since we do
 14 know that quality of the management seems to be
 15 a key indicator of how these types of facilities
 16 impact towns.

17 DR. BIALECKI: In three meetings
 18 prior to this, the presentation that I did that
 19 was specific to the treatment methodology that
 20 was going to be used, there was an entire slide
 21 dedicated to the State's recognition of Heywood
 22 Hospital's behavioral health treatment that they
 23 do currently, a long history of successes, of
 24 very low recidivism rates, of State recognition

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1 in being recognized as a center of excellence.
 2 There was a whole page full of those documented
 3 places where Heywood has been recognized by
 4 State regulatory agencies as being well
 5 qualified and of good quality in managing that
 6 kind of work.

7 THE CHAIR: Just refresh my memory.

8 DR. BIALECKI: That was the one in
 9 the December meeting, the earlier December
 10 meeting.

11 MR. FLICK: The first December
 12 meeting.

13 THE CHAIR: Power point of the
 14 December meeting.

15 DR. BIALECKI: Yes.

16 MR. FLICK: I would also add to that.
 17 Heywood Hospital as the central institution has
 18 been in existence for over a hundred years,
 19 1906. It has seen a significant amount of
 20 growth and development, recently putting on a
 21 very sizable emergency room as well as two new
 22 wards just completed. The construction of a
 23 brand new cardiac and vascular center within
 24 Heywood Hospital itself is building a gym

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1 facility for its employees in the hospital.
 2 There are plans in the works for Athol Hospital
 3 right now for a new ER, new professional office
 4 building, new oncology suite.

5 This is a well-respected,
 6 well-managed institution that financially, as a
 7 community hospital in a country right now where
 8 community hospitals are falling by the wayside
 9 because under federal regulations it's harder
 10 and harder for them to exist financially,
 11 Heywood Hospital has demonstrated a resilience
 12 to that, a significance amount of resilience,
 13 and is financially in a very good position
 14 compared to other community hospitals across the
 15 country. It has been an innovator in managing
 16 its contracts and managing other aspects of the
 17 healthcare in partnership with other
 18 institutions. It is quickly becoming seen as a
 19 leader in the community hospital environment,
 20 especially within New England.

21 I don't think that's really anything
 22 that we really have to provide. You can go on
 23 line and look at the Joint Commission data. We
 24 invite you to look at the Heywood Healthcare

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1 website, Heywood Hospital and Athol Hospital,
 2 look at the information that is there.

3 I think the facts -- I'll provide
 4 this as well for your consideration, the fact
 5 that Heywood has put so much effort into
 6 community education in the Town of Petersham on
 7 this project apart from just the ZBA process,
 8 the Town Meetings that it has held, the people
 9 that it has reached out to in the community to
 10 talk to them, to share with them, to educate
 11 them on what it is that Heywood is looking to do
 12 demonstrates clearly their commitment to the
 13 community as well as the ability to reach out
 14 and to care about who they are and wanting to be
 15 a good neighbor. I think a lot of that speaks
 16 for itself. Also, we are local. There is that
 17 aspect of general knowledge, that it is a
 18 quality institution.

19 MR. GRIMMER: Speaking just a little
 20 more quantitatively, in a parallel track we
 21 became partnered with Athol a little over two
 22 years ago now. The two years prior to us
 23 partnering with them they lost over \$7.5
 24 million. In our first eight months of

1 partnership we turned their organization around
2 and made it profitable. Not by a lot, but it
3 was profitable. Last year again we had a very
4 good year. We have a track record of coming in
5 and doing the right things.

1 THE CHAIR: Thank you. I want to
2 just note that the exhibit that Rebecca
3 mentioned was Exhibit 21, I have it marked as
4 21. I was going through -- well, when we get
5 all the transcripts we'll take another look at
6 all the numbers and make sure we have them all.
7 I'm not quite sure what Exhibit 22 was, but we
8 can figure that out. If anybody knows off hand?
9 Exhibit 23 was Kevin's preliminary report. Not
10 to worry. I know there was one night I came
11 without my folder and my numbers and we may have
12 picked up on the wrong number. That's one great
13 thing about the transcript.

6 As a community hospital in Athol,
7 these programs that we're talking about where
8 the hospital was a bit of a drain on the
9 community, they were always asking the community
10 to support the hospital to keep it open. We've
11 turned that around and we're providing
12 behavioral health and nutrition and diabetes
13 education to the schools. Now we are becoming
14 what we should be, what a community hospital
15 should be, a resource for the community instead
16 of being a drain on the community. We expect
17 very similar things here in Petersham.

14 Okay. I have no further questions at
15 this time. Brian or Don, do you have any
16 question?

18 Just to note, we met with Roy. Roy,
19 you can correct me on this or not. The Tax
20 Exempt Committee, we met with them last week.
21 Based on our willingness to work with the Town
22 on the pilot program, Roy and the other folks on
23 the Tax Exempt Committee are now using us as an
24 example to say, Okay other non profits in the

17 MR. EATON: No.
18 MR. MacEWEN: No.
19 THE CHAIR: Okay. Does anybody here
20 have any further questions? Paul.
21 MR. YOUD: Paul Youd, 16 Hardwick
22 Road. On the presentation that John just did,
23 has Heywood considered the builder amendment
24 applicable to their operational facility in

1 Town of Petersham, I think it's time that you
2 guys came to the table as well. I'm not sure
3 that would be happening if Heywood had not said,
4 Listen, we think a pilot is a good idea for the
5 Town as a non-profit and being a good community
6 member. Roy, you can comment on that if you
7 want, right or wrong.

1 Gardner?

8 MR. NILSON: Roy Nilson, Chairman of
9 the Tax Exempt Committee. Your statement is
10 essentially correct, except that we anticipate
11 waiting until we've actually got a pilot in
12 hand.

2 MR. FLICK: Well, that facility
3 pre-dates Dover and zoning so it would be
4 grandfathered in. There's no special permit in
5 place. It's actually zoned as a permitted use
6 as a hospital. As a hospital where the primary
7 purpose is medical provision, surgeries, it's a
8 different facility.

13 MR. GRIMMER: We look forward to
14 putting it in your hands.

9 MR. YOUD: You have mental health and
10 substance abuse.

15 MR. NILSON: Before we use you as an
16 example to others in the community who might
17 contribute.

11 MR. FLICK: Mental health is what
12 percentage of the beds?

18 MR. GRIMMER: Just one example of
19 being a going neighbor.

13 MR. GRIMMER: It's about 15 percent.

20 MR. NILSON: Understood. We clearly,
21 as a community, agree with Heywood's
22 representation that they have behaved as a good
23 citizen throughout this entire process. We
24 expect that they will continue to do that.

14 MR. FLICK: About 15 percent of the
15 beds. So that's not a primary use. Here 88
16 percent of the beds is recovery which has been
17 determined by the courts to be an educational
18 use. So it's a flipped model.

19 MR. YOUD: So you don't consider
20 Dover.

21 MR. FLICK: No. If Heywood were
22 looking to site this type of facility in the
23 City of Gardner, then the determination -- well,
24 even as a City Solicitor for the City of Gardner

1 I would say, yes, it falls into Dover. In fact,
2 we have had similar recovery centers on a
3 smaller scale which have recently gone into the
4 City and there have been no argument covers on
5 Dover. South Middlesex Opportunity Council, for
6 example, where they put in an alcohol
7 rehabilitation center is covered by Dover. We
8 had no say. None. If it was an apples to
9 apples facility, yes, absolutely it was covered
10 by Dover.

11 THE CHAIR: Any questions, any
12 comments? Okay. Before Kevin left he mentioned
13 that he could supplement the information he gave
14 us with some studies. I'm not inclined to
15 necessarily feel that they are necessary. Let
16 me open it to you.

17 MR. FLICK: I would feel that they
18 are not necessary. When I did the research
19 there were a lot of studies out there. They all
20 come back with the same conclusion. The reason
21 we presented the Philadelphia study is because
22 it had the most analysis. Really, there was not
23 a whole lot available through the Internet
24 without spending oodles of money to get to some

1 us. We have had a lot of meetings. Rebecca is
2 holding up her hands indicating 10, somebody
3 else told us it was 11. We're definitely in
4 double digits. Do I have a motion?

5 MR. MacEWEN: I make a motion to
6 close the public hearing.

7 MR. EATON: Second.

8 THE CHAIR: All in favor?

9 MR. MacEWEN: Aye.

10 MR. EATON: Aye.

11 THE CHAIR: Aye. So now we will move
12 into the deliberation phase. We're not going to
13 be deliberating tonight.

14 MR. EATON: I have a procedural
15 question. Can we vote and then do conditions or
16 does that come after deliberations?

17 THE CHAIR: Do you want to make a
18 motion? I mean, you're free to make a motion.

19 MR. EATON: No, I'm asking how it
20 works.

21 THE CHAIR: Okay. It would be that
22 we would set another open meeting for purposes
23 of deliberating at which point the three of us
24 would be talking over the pros and cons. When

1 of the more sophisticated databases like
2 LexisNexis, etc. They all come out saying the
3 same thing. These facilities on property values
4 are neutral. I don't think you're going to get
5 any value out of waiting on any further studies
6 on the impact on real estate.

7 THE CHAIR: Okay. Does the Board
8 want to close? As the applicant you're asking
9 us to close the record now?

10 MR. FLICK: We have nothing
11 substantive to submit.

12 THE CHAIR: Obviously that means
13 you're not asking us to keep it open so we can
14 hear the pilot or whatever happens with that,
15 correct?

16 MR. FLICK: Correct.

17 THE CHAIR: Does the Board want to
18 keep it open? I really think the only kind of
19 thing might be is after tonight if you started
20 looking at the materials, if you had further
21 questions and wanted to follow-up on anything,
22 that may be a reason to keep it open.
23 Basically, the applicant is saying they want us
24 to make a decision based on what they have given

1 we reach the point where we feel like we've
2 exhausted the benefit of the discussion somebody
3 would make a motion and we would see if the
4 motion is seconded and then take a vote.

5 MR. EATON: Personally, I have no
6 problem with Heywood interacting with the
7 conditions. It makes sense.

8 THE CHAIR: Okay.

9 MR. EATON: If they're against
10 regulations we need to know that. It would
11 probably streamline the process.

12 THE CHAIR: I imagine, John, that you
13 plan on attending the deliberations?

14 MR. FLICK: Yes.

15 THE CHAIR: So they're going to
16 attend. If during the deliberations we'd like
17 to invite them to comment and discuss conditions
18 with us they'll be there to do that. Brian is
19 nodding his head.

20 MR. MacEWEN: I'm in favor of that.

21 THE CHAIR: I think it's a good idea
22 and Brian thinks it's a great idea so we'll plan
23 on that. Okay. We need to do some other
24 business. We need to set the next date when

1 we'll meet. That basically concludes the
 2 Heywood matter for tonight other than setting
 3 the next meeting which we might as well do while
 4 we're all here so we'll all know it.
 5 We have an FY 2014 annual report that
 6 the Town has asked us to submit. I submitted a
 7 draft to you. Did you get a chance to read it?
 8 MR. EATON: Yes.
 9 MR. MacEWEN: No.
 10 THE CHAIR: You didn't?
 11 MR. MacEWEN: Do you want to take
 12 care of this or do you want to take care of
 13 setting up a time?
 14 MR. EATON: We can set the time.
 15 THE CHAIR: We'll set the time, yeah.
 16 We need to do this as part of our meeting.
 17 MR. MacEWEN: We can close the
 18 meeting and they can be on their way.
 19 THE CHAIR: Sure.
 20 MR. MacEWEN: My question is do we
 21 want to get the applicant's input relative to
 22 the availability. It sounds like everything is
 23 going to come together within the next couple of
 24 weeks relative to the pilot agreement. Are we

1 There's a different between making a decision
 2 and issuing a decision.
 3 MR. FLICK: Correct.
 4 THE CHAIR: You're saying 90 days to
 5 issue a decision. We should meet. Let's see,
 6 our regular meeting is the third Tuesday of the
 7 month.
 8 MR. MacEWEN: The 19th. It sounds
 9 like the first week in March is what they're
 10 kind of shooting for, the March 3rd Select Board
 11 meeting maybe. I think that's what you
 12 mentioned.
 13 MR. FLICK: Is that Monday night?
 14 MR. MacEWEN: March 2nd is Monday
 15 night. We can either go to the second week in
 16 March sooner rather than later. That would
 17 probably be beneficial for everyone involved.
 18 Just in case the decision process drags out.
 19 THE CHAIR: Do you want to say March
 20 10th?
 21 MR. MacEWEN: Do you want to get back
 22 on a Tuesday schedule. March 10th, Tuesday.
 23 See if everybody is available
 24 THE CHAIR: Yes.

1 at odds if we wait until that's -- it sounds
 2 like that's going to be nailed down or have some
 3 real definitive answer from the Select Board.
 4 MR. FLICK: I don't see that it would
 5 be prejudicial if you wanted to hold the meeting
 6 after.
 7 MR. MacEWEN: After that first Select
 8 Board meeting?
 9 MR. FLICK: Correct. The Select
 10 Board may want to ask questions. The Select
 11 Board has final say. They could even come back
 12 and say we want to see this term changed or that
 13 term changed. That's their prerogative as the
 14 Executive Branch of the Town. Hopefully, a
 15 recommended final document will be presented to
 16 the Board of Selectmen. If you want to schedule
 17 that after that meeting it would be appropriate.
 18 MR. MacEWEN: Okay.
 19 MR. FLICK: You have 90 days from
 20 today.
 21 THE CHAIR: 90 days from today to do
 22 what?
 23 MR. FLICK: To issue a decision.
 24 THE CHAIR: Issue a decision.

1 MR. FLICK: I don't see that as a
 2 problem.
 3 THE CHAIR: Actually, when will we
 4 get the transcripts?
 5 MR. FLICK: I'll put those in the
 6 mail to you, the hard copies. The electronic
 7 I'll do tomorrow. Typically I get them in a
 8 week.
 9 THE COURT REPORTER: Two weeks for
 10 this.
 11 THE CHAIR: Okay, two weeks. Why
 12 don't we make it our regular -- Oh, that's
 13 St. Patrick's Day in March. When will we have
 14 the transcript from tonight?
 15 MR. FLICK: The hard copies I'll have
 16 two weeks from tomorrow, that's the 26th. If I
 17 get them electronically before that I can have
 18 those to you very quickly.
 19 THE CHAIR: So we would have two
 20 weekends to look at them. I think that's enough
 21 time.
 22 MR. MacEWEN: That's reasonable.
 23 These transcripts will be pretty light.
 24 THE CHAIR: Okay. So the 10th at

1 7:30. Are you going to be bringing a
 2 transcriptionist for that or not?
 3 MR. FLICK: I think at that point
 4 it's up to the applicant whether they want a
 5 transcriptionist here. It's really not a
 6 submission of evidence.
 7 THE CHAIR: Right. Do you think
 8 you're going to want one.
 9 MR. FLICK: I don't think so, but
 10 I'll discuss it with them.
 11 THE CHAIR: Because we might want to
 12 meet across the way. Do you people think we
 13 should meet here again? I mean, do people plan
 14 on coming? We'll plan on doing it here rather
 15 than across the way. Okay, we'll plan on doing
 16 it here. Do I have a motion for setting the
 17 next meeting? We're not adjourning because we
 18 have a little business to do.
 19 MR. EATON: I propose that our next
 20 meeting be March 10th at 7:30.
 21 MR. MacEWEN: Second.
 22 THE CHAIR: All in favor?
 23 MR. MacEWEN: Aye.
 24 MR. EATON: Aye.

1 CERTIFICATION
 2
 3
 4
 5 I, DENISE O'LEARY, hereby certify the
 6 foregoing to be a true and complete transcript
 7 of the oral evidence presented at the subject
 8 hearing.
 9
 10
 11
 12
 13 _____
 14 REGISTERED PROFESSIONAL REPORTER
 15
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 20 DOES NOT APPLY TO ANY REPRODUCTION OF THE SAME
 21 IN ANY RESPECT UNLESS UNDER THE DIRECT CONTROL
 22 AND/OR SUPERVISION OF THE CERTIFYING REPORTER.
 23
 24

1 THE CHAIR: Aye. Great. Thanks
 2 everyone for coming tonight.
 3 (Whereupon the public hearing then
 4 ended.)
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