

# SECTION 2 CHAPTER 6 OTHER HEALTH CARE SERVICES AND FACILITIES

## 6.0 OTHER HEALTH CARE SERVICES AND FACILITIES

### 6.1 RELATIONSHIP TO CERTIFICATE OF NEED

Connecticut General Statutes Section 19a-638(a)(1) specifies a Certificate of Need is required for the establishment of a long term acute care facility. Facilities seeking authorization to establish a new long term care facility are required to demonstrate that they meet clear public need as well as other criteria set forth in Connecticut General Statutes Section 19a-639. With respect to nursing homes, a Certificate of Need is required from the Department of Social Services.

### 6.2 LONG TERM AND REHABILITATIVE CARE SERVICES

Long term and rehabilitative care includes a wide range of services and programs provided to individuals over an extended period of time. These services and programs are designed to meet medical, personal, and social needs in a variety of settings or locations to enable individuals to live as independently as possible. The phrase “long term care” refers to care and services over an extended period of time in settings such as: institutional; managed residential; other sites within the community; or in the home. The need for these services might be due to a terminal condition, disability, chronic illness, injury or infirmity of old age.<sup>81</sup>

The need for long term and rehabilitative care services may last for a few weeks or months to years, depending on the underlying reason or reasons for needing care. The need for temporary long term and rehabilitative care for weeks or months may be necessary for: rehabilitation from a hospital stay; recovery from illness; recovery from injury; recovery from surgery; or a terminal medical condition. The need for ongoing long term and rehabilitative care for months or years may be necessary for: chronic medical or psychiatric conditions; chronic severe pain; permanent disabilities; dementia; ongoing need for help with activities of daily living; or need for supervision.<sup>82</sup>

#### 6.2.1 FUTURE GROWTH OF THE OLDER POPULATION

The American population, age 65 and older, will continue to grow significantly in the future, especially between now and 2030 as the “baby boom” generation reaches age 65. This population has increased from 35 million in 2000 to 40 million in 2010 (a 14.3% increase) and is projected to increase to 55 million in 2020 (a 37.5% increase for that decade). By 2030, there will be about 72.1 million older Americans, almost twice their number in 2008. People 65+ represented 12.9% of the population in 2009, but are expected to account for 19.3% of the population by 2030. The 85+ population has increased from 5.6 million in 2009 to 5.8 million in 2010 and is projected to increase to 6.6 million in 2020 (a 13.8% increase) for that decade.<sup>83</sup>

#### 6.2.2 SKILLED CARE AND CUSTODIAL CARE

Skilled care and custodial care are terms used by the medical community, health insurance plans, Medicare, Medicaid and the Veterans Administration to differentiate care provided by medical specialists from care provided by aides, volunteers, family or friends. The use of these terms and their application is important in determining whether insurance will pay for services. Generally, skilled services are paid for by a health care plan, whereas custodial services, not in conjunction with skilled care, are not covered. However, custodial services are almost always a part of a skilled service plan of care and as such they are covered.<sup>84</sup>

#### 6.2.3 MEDICAL REHABILITATIVE CARE

The primary aim of medical rehabilitation is to restore an individual’s ability to accomplish activities of daily living and

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<sup>81</sup>State of Connecticut, Aging and Disability Resource Centers, Long Term Services and Supports (2012). *What are long-term services and supports?* Retrieved from <http://www.ct.gov/longtermcare>.

<sup>82</sup>Day, T. (2012). Guide to Long Term Care Planning: About Long Term Care. *National Care Planning Council*. Retrieved from [http://www.longtermcarelink.net/eldercare/long\\_term\\_care.htm](http://www.longtermcarelink.net/eldercare/long_term_care.htm).

<sup>83</sup>United States Department of Health and Human Services, Administration on Aging. *A Profile of Older Americans: 2010*. Retrieved from [http://aoa.gov/AoARoot/Aging\\_Statistics/Profile/2010/4.aspx](http://aoa.gov/AoARoot/Aging_Statistics/Profile/2010/4.aspx)

<sup>84</sup>Day.

live as independently as possible. Rehabilitation reduces the limitations that an individual may experience with certain activities. Kinds of rehabilitation programs are: acute rehabilitation; subacute rehabilitation; day rehabilitation; home care; outpatient rehabilitation; and nursing home rehabilitation. A patient may need and receive care in more than one rehabilitative setting, depending on medical condition and rehabilitation needs. One program may serve as a “bridge” to another.<sup>85</sup>

**Acute rehabilitation** programs provide both medical care and a full range of rehabilitation services. These services include physical therapy (PT), occupational therapy (OT), rehabilitation nursing, speech language/pathology services (S/LPS), vocational rehabilitation (VR), therapeutic recreation (TR) and other services. An acute interdisciplinary rehabilitation program is designed to meet each patient’s needs. Doctors are in direct contact with the patient (usually daily, but no less than three times a week) to monitor medical condition and progress. The patient also receives 24-hour nursing care. Acute rehabilitation program is appropriate for individuals with complex medical needs. Such programs can be found in free-standing rehabilitation hospitals and in acute care hospitals with dedicated specialized rehabilitation units.<sup>86</sup>

**Subacute rehabilitation** programs often provide therapy needed before or after a person completes acute rehabilitation but before they go home. A fairly wide range of rehabilitation services, including PT, OT, S/LPS, and TR, is provided. Subacute rehabilitation is less intensive and generally lasts longer than acute rehabilitation. A subacute rehabilitation program includes 24-hour nursing care, and a treatment plan supervised by a rehabilitation doctor. The rehabilitation doctor also provides additional health care, as needed. A patient will see the rehabilitation doctor less often than would occur in an acute rehabilitation program however. Subacute rehabilitation is best for a patient having a high level of disability, who does not require the amount or intensity of therapy given in an acute rehabilitation program. Subacute rehabilitation also requires that the patient be in stable medical condition but needs continued medical care to avoid possible complications. Subacute rehabilitation is offered in many different settings, including: free-standing, subacute rehabilitation facilities; general, acute care hospitals; skilled nursing units that are a part of general, acute care hospitals; and skilled nursing units located in nursing homes.<sup>87</sup>

**Day rehabilitation**, or day treatment, programs are similar to subacute rehabilitation programs except that patients do not stay overnight in a hospital. These programs offer many rehabilitation services supervised by rehabilitation doctors. Nursing care and general medical care are also offered as needed. If the patient is medically stable and doesn’t need intensive nursing care or constant monitoring by a doctor, a day rehabilitation program is appropriate care for the patient. Day rehabilitation programs can be independent free-standing programs or part of rehabilitation hospitals.<sup>88</sup>

**Outpatient rehabilitation** is provided to patients who can travel from home to a treatment facility. It can include a full range of therapy services that make up a coordinated program of care, or only one or two services (such as physical or occupational therapy). Additional nursing care is not provided. Outpatient rehabilitation therapy services are often given to continue treatment after more intensive acute or subacute rehabilitation. Outpatient rehabilitation therapy services are provided in doctors’ offices, hospital-based outpatient units, hospital-owned outpatient centers, and free-standing centers that are not a part of hospitals.<sup>89</sup>

**Home health care** services allow individuals to receive rehabilitation treatment and nursing care at home. Services and care are provided as often as prescribed and once insurance allows. Typically a home health rehabilitation patient receives 1 to 2 hours of therapy per day, 1 to 3 days per week.<sup>90</sup>

**Nursing homes** must offer rehabilitation services, either directly or by contract. The kinds of rehabilitation services offered and the intensity of the rehabilitation treatment may vary from one nursing home to another. Treatment ranges from a single rehabilitation therapy service, such as physical therapy, to a coordinated program of care that includes several different services.<sup>91</sup>

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<sup>85</sup>National Rehabilitation Hospital Research Division and the Health & Disability Research Institute at Boston University, [Guidebook] (n.d.) (n.p.), *Choosing a High Quality Medical Rehabilitation Program: An NRH Field Guide for People with Disabilities*, 17-21.

<sup>86</sup>NRH Field Guide.

<sup>87</sup>NRH Field Guide.

<sup>88</sup>NRH Field Guide.

<sup>89</sup>NRH Field Guide.

<sup>90</sup>NRH Field Guide.

<sup>91</sup>NRH Field Guide.

### 6.2.4 LONG TERM ACUTE CARE

Long term acute care (LTAC) hospitals provide extended medical and rehabilitative care to individuals with clinically complex problems that need hospital-level care for extended periods. In 1983 the United States Congress created LTAC hospitals to facilitate prompt discharge of medically complex patients from acute hospitalizations in an effort to decrease Medicare spending. LTAC hospitals serve in the continuum of care for patients who require longer than usual acute care hospital stays, on average twenty-five (25) days or more.<sup>92</sup>

LTAC hospitals are generally for patients who can be treated, recover, and when well enough return home or move to the next level of their recovery. Alternatives to these hospitals include acute hospital step-down units for the most severely ill patients and skilled nursing facilities or inpatient rehabilitation facilities for the less severely ill.<sup>93</sup>

LTAC hospitals are certified by Medicare as “long term care hospitals” and are licensed by the State of Connecticut as chronic disease hospitals. According to the Centers for Medicare and Medicaid Services, as of March 2011, there are 438 LTAC hospitals across the country. Three free-standing facilities in Connecticut provide LTAC hospital services: Gaylord Hospital in Wallingford, the Hospital for Special Care in New Britain and the Connecticut Department of Veterans Affairs’ Sgt. John L. Levitow Veterans Health Center in Rocky Hill. Additionally, the Hospital for Special Care operates a Hartford LTAC satellite on the Saint Francis Hospital and Medical Center North Campus (or Mount Sinai Campus). Three other licensed chronic disease hospitals in Connecticut operate without the Medicare certification. They are: Hebrew Home and Hospital in West Hartford, Masonicare Health Center in Wallingford, and Mount Sinai Rehabilitation Hospital in Hartford.

Public Act 12-118 imposed a moratorium, from June 15, 2012 through June 30, 2017, on adding LTAC hospital beds to certain licensed chronic disease hospitals. The act prohibits the Department of Public Health’s, Office of Health Care Access from accepting or approving any CON requests during the moratorium that would add new LTAC hospital beds to the system.

LTAC hospitals provide intensive, specialized interdisciplinary care to medically complex patients who require more recovery time than is typically provided in a short-term acute care hospital and more services than a skilled nursing facility may be equipped to provide. These patients typically suffer from multiple concurrent illnesses, including pulmonary disease, cardiac disease, respiratory failure, complicated wound care, neuromuscular disease, gastrointestinal diseases, post-operative complications and end stage renal disease.<sup>94</sup>

LTAC hospitals provide a wide variety of interdisciplinary patient care services, including daily physician visits, nursing, respiratory therapy, physical and occupational therapy, speech-language pathology services, nutritional therapy, case management and social services, laboratory, radiology and pharmacy services, telemetry, dialysis, pain management, family interventions and end-of-life care. They may also provide cancer care, care for psychological disorders or care for Alzheimer’s disease. Depending on the individual hospital, many offer a full complement of clinics, laboratory and pharmacy services, scanning and imaging, and other outpatient services.<sup>95</sup>

### 6.2.5 NURSING HOME CARE

Nursing homes or convalescent facilities are places of residence for people who require constant nursing care and have significant deficiencies with activities of daily living. Residents include the elderly and younger adults with physical or mental disabilities that keep them from living independently. Residents may also receive physical, occupational, or other rehabilitative therapies following an accident or illness.

Nursing homes are certified by Medicare as either skilled nursing facilities (SNFs) or nursing facilities (NFs). The corresponding nursing facility licensure categories utilized by the Connecticut Department of Public Health are chronic and convalescent nursing homes (CCNH) for facilities providing skilled and rehabilitative care and rest homes with

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<sup>92</sup>Acute Long Term Hospital Association. *Why we are unique. What are LTAC Hospitals?*

Retrieved from <http://www.altha.org/why-we-are-unique/what-are-ltac-hospitals.html>

<sup>93</sup>Fiore, K. (2010, June 9). Long Term Acute Care Facilities Grow in Number. University of Pennsylvania, *Medpage Today*.

<sup>94</sup>Greis, J. (2008, November 16). General Questions and Answers. *GreisGuide to LTACs*. Retrieved from <http://greisguide.com/faq>

<sup>95</sup>Greis.

nursing supervision (RHNS) for facilities providing custodial care. Connecticut nursing homes can elect to be licensed in one or both of these categories. Some facilities provide sub-acute care, which is medically more sophisticated than traditional nursing home care. These facilities can usually provide this care at a lower cost than hospitals.<sup>96</sup> CMS does not recognize sub-acute care as being different from SNF care.

As of June 2012, there were 234 licensed nursing home facilities in Connecticut with a total of 27,976 licensed beds. Nursing home information by facility type and bed number from the DPH Licensure Database is presented in the Table 6.2.

**Table 6.2: Connecticut Nursing Homes by Facility Type and Bed Count**

Facility Description:	Facility Number	CCNH Beds	RHNS Beds	Bed Count
Free-standing CCNH	217	26,106	-	26,106
Free-standing RHNS	2	-	163	163
Combined CCNH / RHNS	15	1,446	261	1,707
<b>Total Facility / Bed Count</b>	<b>234</b>	<b>27,552</b>	<b>424</b>	<b>27,976</b>

Source: DPH Licensure Database

Nursing homes act as a cost-effective way to enable patients with injuries, acute illnesses or postoperative care needs to recover in an environment outside a hospital. Nursing homes also serve in caring for residents who have chronic illnesses and long term care needs. Some people never return home and live their final days in the nursing home; federal and State regulations recognize the nursing home as “home” for such residents. The nursing home is equipped to handle medical problems, disability and in some cases behavior problems that cannot be handled safely or effectively in the community. Because there are now so many other options for care prior to a nursing home, the trend is that residents on average are much sicker and older than in the past, at the time of nursing home admission.<sup>97</sup>

Connecticut nursing homes provide a wide variety of patient care services. The following is a program/services listing as contained in the latest version of the Nursing Home Facilities Databook for 2011-2012: adult day care;<sup>98</sup> respite care; I.V. therapy; outpatient therapy; rehabilitation therapy; hospice services; wound management; respiratory therapy; short-term rehabilitation; Alzheimer care; dementia care; pain management; cardiac, orthopedic and stroke; pulmonary rehabilitation and vascular management; pastoral care; peritoneal dialysis or continuous ambulatory peritoneal dialysis (CAPD); traumatic brain injury (TBI); HIV/AIDS; and recreation.<sup>99</sup>

### 6.2.5.1 Chronic and Convalescent Nursing Home

The Connecticut Public Health Code defines a chronic and convalescent nursing home as a long term institution having facilities and all necessary personnel to provide skilled nursing care, under medical supervision and direction, to carry out simple, non-surgical treatment and dietary procedures for chronic disease or convalescent stages of acute diseases or injury. CCNHs are designed for individuals who need continuous skilled nursing services and/or 24-hour nursing supervision. These individuals have been diagnosed with uncontrolled, unstable and/or chronic conditions. Individuals may also have chronic conditions that require substantial assistance based on activities of daily living or cognitive status deficits, inadequate informal support, or insufficient financial resources to pay for home and community-based services. Residents typically need ongoing nursing care, but do not require hospitalization.<sup>100</sup>

### 6.2.5.2 Rest Home with Nursing Supervision

The Connecticut Public Health Code defines a rest home with nursing supervision as an institution having facilities and all necessary personnel to provide, in addition to personal care required in a residential care home, nursing supervision

<sup>96</sup>Connecticut Department of Social Services, Aging Services Division. *Housing Options Available in Connecticut for Seniors*.

Retrieved from <http://www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313066>

<sup>97</sup>Connecticut Care Planning Council. Connecticut Nursing Homes-About Nursing Homes. Retrieved from <http://careconnecticut.org>.

<sup>98</sup>Few Connecticut nursing homes provide this service. If a nursing home provides adult day care it is a separate service regulated by the Department of Social Services and provided via contract.

<sup>99</sup>Nursing Home Facilities Licensed by the State of Connecticut, 2011-2012.

<sup>100</sup>Connecticut Department of Social Services, Aging Services Division.

under medical direction twenty-four hours per day. RHNSs are for individuals with chronic conditions who are unable to live independently but do not need constant skilled care. These individuals typically have controlled and/or stable chronic conditions that require minimal skilled-nursing services, nursing supervision or assistance with personal care on a daily basis. Residents are normally not confined to a bed and usually have a greater degree of mobility than those individuals who reside in chronic and convalescent nursing homes. Nursing supervision under medical direction is provided twenty-four hours a day. A full range of medical, social, recreational and support services are provided.<sup>101</sup>

A Kaiser 2009 nursing home study produced the following comparative results between the Connecticut nursing home experience and that of the rest of the country.<sup>102</sup>

**Table 6.3: Excerpts from Kaiser Nursing Home Facts Comparing Connecticut vs. the United States, 2009**

Description	Connecticut	U.S.
Number of Nursing Home Facilities	241	15,658
Ownership Composition		
For Profit	78%	67%
Non-Profit	20%	26%
Government	1%	6%
Number of Nursing Home Beds	28,955	1,663,959
Number of Nursing Home Residents	26,139	1,393,127
Overall Occupancy Rate	90.3%	83.7%
Payer Mix		
Medicaid	68%	64%
Medicare	15%	14%
Private/Other	18%	22%

Source: Kaiser Family Foundation, State Health Facts

### 6.2.5.3 Trends in Connecticut's Nursing Home Facility and Bed Supply

In 1991, State government attempted to reduce the number of residents in Connecticut's nursing facilities by placing a moratorium on the establishment of additional nursing home beds. From 1995 to 2012, the total number of licensed beds decreased from 32,054 to 27,976, a 12.7% reduction. The development of alternative programs and services that have enabled older and disabled individuals to either remain in their residences or delayed placement in a nursing home has stabilized the state's nursing home bed supply, especially in the light of the state's aging population. The mix of CCNH and RHNS beds changed substantially. In 1991, RHNS beds accounted for 21% of total licensed beds, compared to 1.5% in 2012.<sup>103</sup> The State intends to continue efforts to "rebalance" the long term care system so as to provide more home- and community-based services and fewer nursing home beds. Recently enacted legislation, signed by the Governor on June 15, 2012, under Public Act 12-118 extended from June 30, 2012 until June 30, 2016, the Department of Social Services' moratorium on CONs for new nursing home beds. The law exempts certain nursing home beds from the moratorium, including those beds used by AIDS or traumatic brain injury patients, and beds associated with a continuing care facility.

### 6.2.6 RESIDENTIAL CARE HOME

Residential care homes (homes for the aged, rest homes or personal care homes) in Connecticut are licensed by the Department of Public Health. Residential care home occupants may have some health, social and/or personal care needs, but do not require the extensive medical care. No nursing services are provided by a residential care home. Most residents require some assistance with activities of daily living, supervision of medications and/or protective oversight. Although residents possess some degree of independence, they are not able to live on their own.<sup>104</sup>

The Connecticut Public Health Code defines a residential care home as an institution having facilities and all necessary personnel to furnish food, shelter and laundry for persons unrelated to the proprietor and in addition, providing services

<sup>101</sup>Connecticut Department of Social Services, Aging Services Division.

<sup>102</sup>Kaiser Family Foundation, State Health Facts. Connecticut – Certified Nursing Facility Data. (2009).

Retrieved from <http://www.statehealthfacts.org>

<sup>103</sup>Connecticut Department of Public Health. (1999). *Looking Toward 2000: An Assessment of Health Status and Health Services*.

Retrieved from [http://www.ct.gov/dph/lib/dph/state\\_health\\_planning/dphplans/looking\\_toward\\_2000\\_fullplan.pdf](http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/looking_toward_2000_fullplan.pdf)

<sup>104</sup>Connecticut Department of Social Services, Aging Services Division.

of a personal nature, which do not require the training or skills of a licensed nurse. Some homes employ a licensed nurse on staff. Staff members can supervise medications that residents self-administer and if trained and certified, may administer oral, topical and inhalant medications to residents. They may also help residents schedule their medical appointments. As of June 2012, there were 100 licensed residential care homes in Connecticut providing a total of 2,735 beds.

### 6.2.7 HOSPICE INPATIENT CARE

Hospice care focuses on the palliation of terminally ill patients' symptoms. Hospice patients are generally medically certified to have less than 6 months to live. The associated symptoms can be physical, emotional, spiritual or social. More than 90% of the hospice services provided in the U.S. is provided in home. However, when home care is not an option, hospice inpatient care is available at a free-standing inpatient hospice facility, a general hospital or skilled nursing facility.<sup>105</sup>

As of July 31, 2012, the Connecticut Public Health Code defines hospice care as being provided by one of three entities: a "short-term hospital"; a "special hospice"; or a "hospice inpatient facility" each having facilities, medical staff and necessary personnel to provide medical, palliative, psychological, spiritual, and supportive care and treatment for the terminally ill and their families including outpatient care and services, home based care and services and bereavement services. Hospice care may also be provided by a licensed home health care agency that complies with additional provisions.

Generally, treatment is not diagnostic or curative, although the patient may choose some treatment options intended to prolong life, such as CPR. Most hospice services are covered by Medicare or other providers, and many hospices can provide access to charitable resources for patients lacking such coverage. Connecticut was one of the last states to include a hospice benefit in its Medicaid State Plan. Hospice care allows for compassion and dignity in the process of dying. The objectives of hospice care are the following: manage the patient's pain and symptoms; assist the patient with the emotional and psychosocial and spiritual aspects of dying; provide needed medications, medical supplies, and equipment; coach the family on how to care for the patient; deliver special services like speech language/pathology services and physical therapy when needed; make short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time; and provide bereavement care and counseling to surviving family and friends.<sup>106</sup>

Although most hospice patients are in treatment for less than 30 days, care may extend beyond 6 months. Medical and social services are provided to patients and their families by an interdisciplinary team of professional providers and volunteers; family caregivers; the patient's personal physician; hospice physician (or medical director); nurses; pharmacists, dietitians; social workers; clergy or other counselors; speech language/pathology, physical, and occupational therapists; health aides; complementary therapists; trained volunteers; and consultants.<sup>107</sup>

In 2008, hospice treatment was utilized by 10,591 people in the Connecticut. They were treated within the 31 Medicare-certified hospice programs in the state, generating 505,731 hospice days with an average length of stay per patient of 48 days.<sup>108</sup>

Currently, there are two inpatient hospice facilities in Connecticut, licensed as "hospital facilities" by the Connecticut Department of Public Health. The Connecticut Hospice, a 52-bed facility in Branford, provides inpatient hospice care for adults and children. VITAS Healthcare Corporation Atlantic Inpatient Unit operates a 12-bed adult hospice unit within Saint Mary's Hospital in Waterbury. As of July 31, 2012, a new category of licensure, "hospice inpatient facility" was enacted by the Connecticut General Assembly. These facilities are planned to be smaller in size (i.e. in the 10 to 16 beds range) and provide for a more home-like environment.

### 6.2.8 ASSISTED LIVING SERVICE AGENCIES

Assisted living "managed residential communities" is defined by the Connecticut Public Health Code as a combination of housing, supportive services and personalized assistance designed to respond to the individual needs of the resident. Licensed Assisted Living Service Agencies (ALSAs) provide health care management and monitoring, nursing services

<sup>105</sup>Hospice Association of America. (2010). *All About Hospice: A Consumer Guide*.

<sup>106</sup>Connecticut Care Planning Council. *About Hospice Care*. Retrieved from <http://careconnecticut.org>

<sup>107</sup>Connecticut Care Planning Council.

<sup>108</sup>Hospice Association of America. (2010, November). *Hospice Facts and Statistics: Number of Medicare-certified Hospices by State, 2008*. Retrieved from <http://www.nahc.org/haa/consumerinfo.html>

and medication supervision to their assisted living residents. They also provide assistance with activities of daily living such as bathing, dressing and eating. Assisted living residences may be part of a retirement community, nursing home, senior housing complex, or may be a stand-alone entity. They serve in the continuum of care for residents who require a level of service that exists between the type of care offered by home care services and nursing home facilities. Nursing and personal care services for residents of assisted living communities are licensed by DPH. There are 82 licensed assisted living service agencies in Connecticut.<sup>109</sup>

### 6.2.9 CONTINUING CARE RETIREMENT COMMUNITY

Continuing-care retirement communities (CCRCs or life-care communities) through contractual agreements, provide senior residents living accommodations and a wide variety of services such as long term health and nursing services. Various levels of care, such as independent living, assistance with daily activities and nursing home care are usually provided. Residents may move from one level of care to another as their needs change. There are 18 continuing care retirement communities in Connecticut. CCRCs are not licensed in Connecticut, but they must adhere to certain statutory requirements (17b-520 through 17b-535, inclusive, of the Connecticut General Statutes, Management of Continuing Care Facilities). Various components of their health care packages such as assisted living services and skilled nursing services are, however, licensed by the State.<sup>110</sup>

### 6.2.10 CONGREGATE LIVING

Congregate housing offers semi-independent living in a residential environment with some support services. Connecticut has 24 State-funded elderly congregate housing facilities for low- and moderate-income, frail seniors age 62 and older. Congregate communities are not licensed and do not provide rehabilitation or nursing services, nor do they dispense or monitor the self-administration of medications. Home health care agencies may provide services to these residents as they would in any “home” setting.<sup>111</sup>

### 6.2.11 ADULT DAY CARE

Connecticut’s adult day centers are community-based, nonresidential facilities for frail seniors and disabled adults who cannot be home alone. These services, which help these individuals remain independent in their own homes as long as possible include supervision, social and recreational activities, therapeutic activities, medical and personal care, nursing services, meals, and respite. The adult day care centers are one way for elderly or disabled people to avoid or delay entering a long term care facility and this provides relief for family caregivers.<sup>112</sup>

Adult day centers are not licensed, but they must be certified by the Connecticut Association of Adult Day Centers (CAADC) to receive State funding. Centers can operate without certification, but they do not receive State funding. Currently, 50 centers are operating, 48 of which are certified. One center in Massachusetts and one in Rhode Island serve Connecticut clients; the Connecticut Department of Social Services certifies centers based on their being licensed by their home states.<sup>113</sup>

Adult day centers generally operate on either “social” or “medical” models. The social model serves people who need supervision and activities to reduce social isolation, but it does not provide extensive personal care and medical monitoring. The medical model provides nursing, personal care, and other medical services. According to CAADC, 41 of the state’s certified centers are medical models and seven are social models.<sup>114</sup>

<sup>109</sup>Connecticut Assisted Living Association. [Guidebook] *Consumer Guide: Questions and Answers about Assisted Living in Connecticut*.

<sup>110</sup>Connecticut Department of Social Services, Aging Services Division.

<sup>111</sup>Connecticut Long Term Care. *Persons with Disabilities – Home and Congregate Living*.

<sup>112</sup>Dube, N. (2009, January 23). Connecticut Office of Legislative Research, OLR Research Report-2009-R-0035. *Connecticut Adult Day Care Centers*. 2. Retrieved from <http://www.cga.ct.gov/2009/rpt/2009-R-0035.htm>

<sup>113</sup>Dube, 1.

<sup>114</sup>Dube, 1.



## 6.2.12 HOME CARE

### 6.2.12.1 Home Health Care Agency and Hospice Care Agency

Home health care agencies are public or private organizations, or a subdivision thereof, engaged in providing professional nursing services and rehabilitative services (i.e. physical therapy, speech language/pathology therapy, occupational therapy or medical social services) that are available 24 hours per day, in the patient's home or a substantially equivalent environment, pursuant to Section 19a-490 of the Connecticut General Statutes. Home health agencies deliver a variety of skilled services. The plan of care usually includes custodial services to help the care-recipient remain in the home.

Home health care agencies provide medical care to help people rehabilitate in their homes from acute medical conditions such as accidents, illnesses or surgery. Services provided include registered nurses, speech language/pathology and physical therapists, social services and aides to help with bathing, dressing and ambulation. Home health agencies also may provide hospice care. Hospice care agencies offer palliative care for people who are not expected to live longer than 6 months.

As of June 2012, there were 105 home health care agencies, 29 of which provide hospice services as hospice care agencies, licensed in Connecticut.



### 6.2.12.2 Homemaker-Home Health Aide Agency

Homemaker-home health aide agencies are public or private organizations, except home health care agencies, which provide in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management.

As of June 2012, there were seven homemaker-home health aide agencies licensed in Connecticut.